

# Tobacco Health Systems Change

## Starter Toolkit for Clinics



## Overview

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The Tobacco Health Systems Change Starter Toolkit for Clinics provides key resources and practical tools to help clinics and health systems improve how they address tobacco use.

There is a wealth of tobacco health systems change resources out there - but which are most useful? What type of information will help create the case for change? What are some concrete examples? This toolkit compiles select resources and tools that have been tried and tested in the field.

Health systems are unique, and not all resources found here will suit every organization. Where possible, multiple examples are provided with this reality in mind. Further adopt or adapt to find what works for your system.

Many of these resources have been used by our network of champions advancing tobacco as a priority across their health system. Many of them have been used in the field by the Institute for Clinical Systems Improvement (ICSI) as they conduct practice coaching and quality improvement support.

### About the Tobacco Health Systems Change Initiative

The Tobacco Health Systems Change (THSC) initiative has been developed by the Institute for Clinical Systems Improvement, in partnership with its funder, ClearWay Minnesota<sup>SM</sup>. The purpose of the initiative is to:

- **Build capacity among health care provider organizations** to systematically address patients' tobacco use.
- **Disseminate systems change strategies, tools, and resources** to the broader health care community.
- **Build partnerships and develop strategies** to sustain systems change efforts.

More information, resources and case studies can be found on [ClearWay Minnesota<sup>SM</sup> website](#).

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## MAKE THE CASE FOR CHANGE | Tobacco As A Priority

Why should your health system reinvigorate its efforts to more effectively address tobacco? Most importantly, quitting tobacco improves health and can positively impact patients' well-being. In addition, addressing tobacco can have a tangible impact on improving clinical quality outcomes and supporting your organization's population health improvement goals. Resources in this section will help you make the case for change with leadership and clinician audiences.

**It's critical to discover and understand the "why" for your organization – what are the specific ways your organization and patients will benefit from advancing tobacco health systems change work?**

### Some questions to ask:

- What percentage of our patient population uses tobacco? How does this compare to the rest of the state?
- What populations do we serve who are disproportionately affected by tobacco use? Addressing tobacco use is a key way to improve health disparities.
- How does patient tobacco use currently affect our quality measures (such as our optimal diabetes or vascular measures)?

**DON'T MISS IT:** On the following pages you'll find:

- **Return on Investment for Tobacco Cessation**  
(ClearWay Minnesota)
- **Quality Measures and Tobacco**  
(American Lung Association)

In addition, here's a link to [How to Make the Case for Tobacco Cessation](#) by the American Lung Association.

**Key Articles:**

- [Updated Priorities Among Effective Clinical Preventive Services](#). Maciosek MV, LaFrance AB, Dehmer SP, McGree DA, Flottemesch TJ, Xu Z, Solberg LI. Ann Fam Med January/February 2017 15:14-22; doi:10.1370/afm.2017
- [Health Benefits and Cost-Effectiveness of Brief Clinician Tobacco Counseling for Youth and Adults](#). Maciosek MV, LaFrance AB, Dehmer SP, McGree DA, Xu Z, Flottemesch TJ, Solberg LI. Ann Fam Med January/February 2017 15:37-47; doi:10.1370/afm.2022
- [Prevention Priorities: Guidance for Value-Driven Health Improvement](#). Isham G, Sanchez E, Jones WA, Teutsch S, Woolf S, Haddix A. Ann Fam Med January/February 2017 15:6-8; doi:10.1370/afm.2023

## **SUPPORTING THE WORK | Advancing Change**

You've made the case for change. Now, how can you help your organization move forward? This section contains quality improvement and project management tips and tools to help support your tobacco health systems change activities. Also included are some specific examples used in tobacco health system change work (shared with permission).

Here are some key steps in guiding your systems change efforts:

### **1. Develop a team and create engagement at all levels**

- Do you have leadership support? How can you engage them?
- Who else might be champions - or allies - for this work? A clinic champion will be essential. Example champions include a physician, nurse, care coordinator, social worker, clinic manager, etc.
- Who do you need to include on the team? Clinical, technical, quality improvement, information technology staff, other? When you discover you are missing a department/role, invite them.
- Having protected meeting time for the team is critical. Set regular meeting times to discuss, review, plan, and do the work.
- This team should be agile and flexible, continually asking themselves if their tests of change are things they should adopt, adapt or abandon - what makes sense for the organization, department, etc.
- Are there existing meetings / teams throughout the health system where you can influence change?

### **2. Understand the current practice for addressing tobacco**

This will help the team more clearly identify your goals and capacity for system change.

- What problem are you specifically trying to solve? What is your focus?
- What current workflows and protocols exist for addressing tobacco use?
- What is actually happening in practice? (Consider interviewing staff, walking through the process alongside a few patients, doing a process map with people who do the work). Seek to understand why things are happening the way they are.
- What gaps do you have between your desired state and current state? For instance, are you asking the question effectively? Once asked, how is tobacco being addressed with the patient? For example; Are providers advising the patient to quit? What resources or information are being provided to the patient? Is the patient being referred to internal or external resources to support their quitting efforts? Are prescribers up to date on cessation medications?

### **3. Identify small tests of change**

Once you have assessed current practices - often very different from what's on paper - it's time to brainstorm possible solutions with the team.

- What are the key gaps you discovered in your current process?

- What are the solutions to close those gaps?
- Where do you want to start? Define specific, small tests of change to learn their potential. If something doesn't work, that's ok! You've learned. Try something else.

#### 4. Implement change

Once your team has identified a change that will be adopted on a larger scale, determine what tools and processes are available to ensure your success. Example tools and resources include:

- Quality improvement and/or project management support and tools
- Clinical practice guidelines
- Electronic Health Record (EHR), reportable fields, flowsheets, smart phrases, etc.
- Internal training and education resources

#### 5. Measure the impact

How will you know if the changes made are working? Ongoing monitoring and attention is required to ensure system changes are implemented and maintained and can help you identify what should be adopted, adapted or abandoned.

- What will you monitor; what data will you collect to know if you are making an impact?
- What will you communicate about the initiative with staff? How will you communicate it? (e.g., overall goal, what actions you are taking, how will it impact their work)
- How will you gain feedback from staff and patients on the process?
- How will you share data and feedback with staff? In what format and how often? (e.g., email, daily huddles, face-to-face meetings, newsletter).

#### 6. Sustain the change

- Educate (train and re-train) staff on new protocols and practices
- Training and communicating is an ongoing process. What can your organization do to systematize the changes? Provide training and self-learning materials, such as short videos? Tools in the electronic health record (e.g. flowsheets, order-sets, alerts, etc.)?
- Turnover is a concern in all organizations. What is your check and balance process to ensure that all staff are aware and educated? How will you address this?

**DON'T MISS IT:** On the following pages you'll find:

- [Basic project management and QI tools](#)
- [Key questions to guide your EHR planning](#)

Sample Workflows

- [Essentia Health workflow - CTTS visit](#)
- [Essentia Health workflow - Provision of Resources](#)
- [Hennepin County Medical Center – Tobacco Cessation Workflow](#)
- [Tri-County Health Care Nicotine Dependence workflow](#)

**Key Articles – Additional Resources for Measuring Impact:**

[The effect of systematic clinical interventions with cigarette smokers on quit status and the rates of smoking-related primary care office visits.](#) Land, T. G., Rigotti, N. A., Levy, D. E., Schilling, T., Warner, D., & Li, W. *PLoS One*, 7(7), (2012) e41649. doi:10.1371/journal.pone.0041649

[Effect of systems change and use of electronic health records on quit rates among tobacco users in a public hospital system.](#) Moody-Thomas, S., Nasuti, L., Yi, Y., Celestin, M. D., Horswell, R., & Land, T. G. *Am J Public Health*, 105 Suppl 2, e1-7. (2015) doi:10.2105/AJPH.2014.302274

**Key Resources:**

[The Million Hearts Initiative](#) of the U.S. Department of Health and Human Services has tobacco cessation protocols and templates.

QAPI tools, general tools for quality assurance and process improvement shared by The Centers for Medicare & Medicaid Services, are found [here](#).



## CLINICAL PRACTICE GUIDELINES AND TOOLS

This section contains links to clinical and implementation guidelines to support both health systems changes for tobacco use as well as providing evidence-based tobacco cessation treatment to patients.

### Clinical Practice Guidelines:

- [Clinical Practice Guideline - Quick Reference Guide for Clinicians](#) (Public Health Service, summary by Agency for Healthcare Research and Quality)
- [Tobacco as Part of Healthy Lifestyles Guideline](#) (ICSI)
- [2015 USPSTF updated recommendations on Tobacco Cessation Treatment Factsheet](#) (American Lung Association)

### Tools For Talking With Patients

Most health systems do ask patients about their tobacco use. But is it effective? And is the patient connected to cessation resources? While tobacco cessation interventions have not been a focus of the Tobacco Health Systems Change initiative, following are multiple resources that participants in the initiative either developed and/or have adopted.

**DON'T MISS IT:** On the following pages you'll find:

Scripting tips, including:

- [How to Ask the Question Without Lighting a Fire](#) (THSC partners)
- [The Brief Tobacco Intervention 2 A's & R and 5A's Pocket Card](#) (Department of Health and Human Services, Centers for Disease Control, American Cancer Institute, American Medical Association)

Patient education materials, including:

- [Benefits of Quitting Card](#) (Essentia Health)

## Select Cessation Treatment Information and Resources

### Key Article:

- [Combined pharmacotherapy and behavioral interventions for smoking cessation](#)  
Stead LF, Koilpillai P, Fanshawe TR, Lancaster T. Cochrane Database Systematic Review. 2016 Mar 24;3:CD008286. doi: 10.1002/14651858.CD008286.pub3.

### Key Resource:

- From Mayo Clinic a [summary](#) of tobacco dependence treatment medications

**QUITPLAN® Services:** QUITPLAN Services are free and available to all Minnesotans. Services include text messaging support, a two-week nicotine replacement therapy (NRT) starter kit, an email program and a guide to quitting tobacco use. Everyone who lives in Minnesota has access to free phone coaching to quit tobacco, either through their health plan, employer or through QUITPLAN Services. Special programs are available for: Pregnant women, [American Indian commercial tobacco users](#) and individuals living with mental illness and/or substance use disorders. Providers and patients can learn more about QUITPLAN Services at [www.quitplan.com](http://www.quitplan.com) or by calling 888-354-PLAN (7526). For services in Spanish, call 855-DEJELO-YA (335-3569). For phone coaching in a language other than Spanish, call 888-354-PLAN (7526) and ask for an interpreter.

**Minnesota Quitline Network:** (formerly the Call it Quits Referral Program): Health care providers can further assist patients in quitting tobacco by registering to become a member of the Minnesota Quitline Network. Providers fax a standard referral form to one number for any patient interested in quitting, regardless of the patient's insurance. The appropriate health plan Quitline makes the first call to the tobacco user. All Minnesota residents - whether covered by a health plan or not - have access to free support to quit. The Minnesota Quitline Network is a collaboration of Minnesota's major health plans and ClearWay Minnesota and is administered by the Minnesota Department of Health. For more information on the Minnesota Quitline Network and to register your clinic, visit their [website](#).

**Tips from Former Smokers:** In 2012, the Centers for Disease Control and Prevention (CDC) launched the first-ever paid national tobacco education campaign—*Tips From Former Smokers® (Tips®)*. This [website](#) provides both patient and provider resources.

**Smokefree.gov:** A [website](#) created by the National Cancer Institute with many different tools and resources – online resources, several text messaging programs for different populations, and smartphone apps.

More information, resources and case studies can be found on [ClearWay Minnesota<sup>SM</sup> website](#).

# Return on Investment for Tobacco Cessation

*Costs to Minnesota's economy from smoking are estimated in excess of \$7 billion each year.*

Tobacco use is the **single most preventable cause of death and disease** in the U.S., causing 6,300 deaths each year in Minnesota.<sup>1</sup> Smoking affects nearly every system in the body, causes serious health problems and increases medical costs. Roughly 10 percent of smokers live with a smoking-related illness.<sup>2</sup>

**Tobacco use has substantial direct and indirect costs** for the state and the public, health care providers, employers, insurers, and individuals. Smokers have estimated health care costs that average 34 percent higher than nonsmokers.<sup>3</sup> Spending on health care due to a smoking-related illness is estimated to cost Minnesota \$3.19 billion each year.<sup>1</sup> In addition, each year smoking costs Minnesota \$4.3 billion in lost productivity.<sup>1</sup> In total, costs to Minnesota's economy from smoking are estimated in excess of \$7 billion each year.<sup>1</sup>

*Health care spending due to smoking-related illness is estimated to cost Minnesota \$3.19 billion each year.*

*Each year smoking costs Minnesota \$4.3 billion in lost productivity.*

**Tobacco dependence treatment is one of the most cost-effective preventive services**, providing substantial return on investment in the short and long term.<sup>4</sup> Investments in smoking cessation lead to improved health outcomes, resulting in lower health care costs and more affordable health insurance premiums.<sup>3</sup> Tobacco cessation treatment will become increasingly important as providers, employers, insurers and the state look to improve the public's health and reduce the total cost of health care. The following brief highlights current evidence quantifying the return on investment and cost-effectiveness of tobacco cessation treatment and its implications for Minnesota.

## ***ROI for Providers, Health Systems and Clinics***

**Routinely helping patients quit smoking is a core responsibility of health care delivery systems.** An estimated 70 percent of the 40 million adult smokers in the U.S. see a health care provider each year, representing over 28 million opportunities for brief intervention and treatment. Data show that advice from health care providers increases the use of evidence-based cessation treatments and improves outcomes.<sup>5,6</sup>

**Tobacco use screening and brief intervention is one of the three most cost-effective clinical preventive services.**<sup>7,8</sup> The U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence – 2008 Update* demonstrated that effective treatments for tobacco users exist, are cost-effective and should become part of standard health care.<sup>4</sup> The cost per quit of smoking cessation interventions ranges from a few hundred to a few thousand dollars.<sup>4</sup> Tobacco screening is estimated to result in lifetime savings of \$9,800 per person.<sup>9</sup>

**Quitting smoking can lower total health care costs within two years.** Research shows that cessation treatment in the outpatient setting lowers health care costs within 18 months of quitting.<sup>10</sup> Within three years, a former smoker's health care costs will be at least 10 percent less than if they continued smoking.<sup>3</sup> Addressing smoking cessation in primary care can reduce health care costs within a relatively brief period of time.<sup>10</sup>

**Research shows that people are much more likely to successfully quit tobacco use if they receive help.**<sup>4</sup> Among current smokers who made quit attempts in the past 12 months, over half (56.6 percent) made multiple attempts to quit. Data show that advice from health care providers increases the use of evidence-based cessation treatments and improves outcomes.<sup>5</sup>

**The majority of Minnesota smokers want to quit.** According to the 2014 Minnesota Adult Tobacco Survey (MATS), more than half (53.4 percent) of current adult smokers made a quit attempt in the past year.<sup>11</sup>

## ROI for Insurers and Employers

**Smoking cessation programs cost little compared to other commonly covered services.** A comprehensive cessation benefit (all counseling, all medications) typically costs less than \$0.50 per member per month<sup>12</sup> and the cost per quit for smoking cessation interventions ranges from only a few hundred to a few thousand dollars.<sup>4</sup> In contrast, the average initial cost for treating a single case of lung cancer is approximately \$40,000.<sup>13</sup> For most smoking cessation treatments, the benefits of providing such treatments greatly outweigh the cost of providing them.<sup>14</sup>

**Investments in smoking cessation save health plans and employers money in the short and long term.** Research has demonstrated a positive return on investment for employers beginning in the first year that the investment in cessation services was made and continuing over the five-year period of the study.<sup>3</sup> Other studies have shown that each employee or dependent who quits smoking reduces annual medical and life insurance costs by at least \$210 almost immediately.<sup>12</sup>

**Cessation program expenditures can be fully offset in three years.** Over a three-year period, expenditures for smoking cessation programs in the range of \$144 to \$804 per smoker can be fully offset by health care cost savings.<sup>3</sup> Greater savings will likely occur within special populations, such as pregnant women (\$3 in health care costs for every \$1 invested in smoking cessation treatment for pregnant women<sup>15</sup>) and persons with cardiac conditions (\$47 during the first year and about \$853 over the following seven years<sup>16</sup>).

**Smoking cessation increases productivity.** The American Productivity Audit, a national survey of over 29,000 workers, found that tobacco use was a leading cause of worker lost production time—greater than alcohol abuse or family emergencies. Quitting smoking improves a worker's productivity.<sup>17</sup> It is estimated that employees who smoke will cost self-insured employers an additional \$5,816 annually, on average, including absenteeism, smoking breaks, healthcare costs and other benefits.<sup>18</sup>

## ROI for the State

**Medicaid enrollees smoke at approximately twice the rate of the general population.**<sup>19</sup> Smoking-related diseases accounted for approximately 15 percent of annual Medicaid spending during 2006–2010, amounting to more than \$39 billion per year.<sup>20</sup> In Minnesota, over \$563 million of smoking-related health care costs are covered by Medicaid.<sup>21</sup> For every dollar Minnesota spends on counseling and nicotine replacement therapy, \$1.29 is saved.<sup>14</sup>

**Including comprehensive tobacco cessation services in Medicaid insurance coverage can result in substantial savings for Medicaid programs.** Every dollar invested in the Massachusetts Medicaid Tobacco Cessation Program led to an average savings of \$3.12 in cardiovascular-related hospitalization expenditures. These savings were realized within one year of the benefits being used.<sup>22</sup> Strategies to increase smoking cessation among Medicaid enrollees can reduce smoking-related disease and death among a population disproportionately affected by tobacco use, and can reduce smoking-related health care costs incurred by the state.

**Smoking cessation reduces Medicaid claims.** When Massachusetts implemented and aggressively promoted a smoking cessation benefit with minimal co-payments to all Medicaid enrollees, smoking prevalence among enrollees dropped 26 percent in the first two and a half years.<sup>23</sup> Analysis of Medicaid claims data also found a 46 percent decrease in the likelihood of hospitalization for heart attacks and a 49 percent decrease for other coronary heart disease diagnoses during this same time period.<sup>24</sup>

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Tobacco use is the leading cause of preventable death and disease in the U.S. The most important thing any smoker can do to improve his or her health is to quit smoking completely. More than two out of three smokers want to quit but, only half received advice to quit from a health professional and made a quit attempt. Quality measures, especially when linked to provider payment, can change provider behavior and increase the advice given to patients to quit smoking.

## What are quality measures?

- According to CMS, “quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.”<sup>i</sup>
- Quality measures compare performance among providers, healthcare systems and outcomes to meet goals of effectiveness, safety, efficiency, patient-centeredness, equity and timely care.
- The goal of using health quality measures is to provide consistent, timely and high-quality patient care.

## How do quality measures influence provider behavior?

- Health professionals and health systems are incentivized by reimbursement: *what is measured gets done and what is paid for gets done.*
- Provider payments linked to health quality measures drive provider behavior and influence outcomes. Reimbursement is a huge driver of clinical services and delivery.
- The Affordable Care Act partially shifted provider reimbursement from quantity of care towards quality of care, encouraging payment based on the value of care provided. Value-based care is designed around patients and their health outcomes, basing payment on best practices that improve quality and outcome rather than the number of healthcare services delivered.

## How can health systems use quality measures to incentivize health professionals to address smoking and recommend tobacco cessation treatments to patients?

- Tobacco screening and brief help by a health professional on tobacco cessation during an office visit is effective for smokers who want help to quit.<sup>ii</sup> Smokers consistently cite a doctor’s advice to quit as an important motivator to attempt quitting.<sup>iii</sup>
- Integrating system-level tobacco intervention efforts such as electronic health records (EHR) that prompt questions on tobacco use into healthcare practice can prompt providers to identify smokers and document tobacco use status.
- Quality measures for tobacco cessation encourage providers to help smokers quit and connect patients to cessation resources because outcomes are directly linked to reimbursement.

## Quality Measures and Tobacco Cessation

### Meaningful Use

- “Meaningful Use” is using certified EHRs and exchanging patient clinical data between providers, between providers and insurers and between providers and patients
- The goals of Meaningful Use are to:
  - Improve quality, safety, efficiency and reduce health disparities
  - Engage patients and family
  - Improve care coordination, and population and public health
  - Maintain privacy and security of patient health information<sup>iv</sup>

- CMS awards incentive payments to eligible providers and eligible hospitals that demonstrate Meaningful Use<sup>v</sup>
- Meaningful Use has significant participation among health professionals and hospitals, and provides an economic incentive for these stakeholders to record structured data including tobacco use.

## Medicare Access and CHIP Reauthorization Act (MACRA)<sup>vi</sup>

- The Medicare Access and CHIP Reauthorization Act (MACRA) is a 2015 law that enacted a new payment framework and Quality Payment Program (QPP) focused on quality and value-based care. Medicare payments are adjusted based on the amount of data submitted and how well providers did on certain performance measures.
- Tobacco Use: Screening and Cessation Intervention, National Quality Forum Performance Measure #0028 is one of the QPP performance quality measures and assesses the percentage of adult patients screened for tobacco use and for those identified as a tobacco user, the percentage who received cessation counseling or referred to a more intensive cessation intervention.<sup>vii</sup>

## Tobacco Performance Measure Set

- The Joint Commission developed the Tobacco Performance Measure Set, which are three standardized performance measures addressing tobacco screening and cessation counseling.<sup>viii</sup>
  - Measure 1: Tobacco use screening of patients 18 years and over
  - Measure 2: Tobacco use treatment, including counseling and medication during hospitalization
  - Measure 3: Tobacco use treatment management plan at discharge

CMS began using all three Joint Commission tobacco performance measures as part of its Inpatient Prospective Payment System (IPPS) in 2016-2017. IPPS is a quality reporting mechanism that incentivizes compliance with key performance goals by withholding a portion of federal Medicare reimbursements for states that do not meet those goals.

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<sup>i</sup> [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/qualitymeasures/05\\_ehrincentiveprogramappeals.asp](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/qualitymeasures/05_ehrincentiveprogramappeals.asp)

<sup>ii</sup> [https://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/cessation/quitting/index.htm](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm)

<sup>iii</sup> <http://www.tobaccofreemaine.org/channels/providers/>

<sup>iv</sup> <https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives>

<sup>v</sup> <https://www.healthit.gov/providers-professionals/ehr-incentive-payment-timeline>

<sup>vi</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

<sup>vii</sup> [http://healthmonix.com/mips\\_quality\\_measure/preventive-care-and-screening-tobacco-use-screening-and-cessation-intervention-measure-226/](http://healthmonix.com/mips_quality_measure/preventive-care-and-screening-tobacco-use-screening-and-cessation-intervention-measure-226/)

<sup>viii</sup> [https://www.jointcommission.org/tobacco\\_treatment/](https://www.jointcommission.org/tobacco_treatment/)

## SMART AIMS

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SMART aims help improve achievement and success. A SMART aim clarifies exactly what is expected and the measures used to determine if the aim is achieved and successfully completed.

**A SMART aim is:**

**Specific (and strategic):**

- Defined population
- Outcome metric is clear (not dollars)
- Baseline is measured

Answers the question Who and What?

**Measurable:** The success toward meeting the aim can be measured.

Answers the question—How?

- Statement articulates improvement  
*from numerical baseline to numerical aim*
- Validated measurement system in place
- Measureable verb, usually starts with “Increase” or “Decrease”

**Actionable:** Aims are realistic and can be achieved in a specific amount of time and are reasonable. Empowers team to create change.

**Realistic and Relevant (results oriented):** The aims are aligned with current tasks and projects and focus in one defined area; include the expected result.

- Aligned with strategic aim
- Achievable within deadline
- Consider a stretch aim (70% chance to get there)

**Time framed:** Aims have a clearly defined time-frame including a target or deadline date. Answers the question of when?



## SMART Aim Planning Form

Specific – WHO? WHAT?

Measurement/Assessment – HOW?

Attainable/Achieve – REASONABLE?

Relevant – EXPECTED RESULT?

By

Timed – WHEN?

## Evaluation Measurement Template

**Name of Organization:**

**Name of Clinic:**

**Key Contact:**

**Start Date:**

**End Date:**

**Identified Focus area:**

**SMART AIM(s):**

**Key Players to Involve:(List specific people)**

- QI Committee:
- Clinicians:
- Nursing:
- Health Information Services:
- EHR-Information Systems:
- Clinic staff (front desk, lab, radiology, etc.):
- Other:

**Quality Committee (Interdisciplinary):**

List committee members:

Frequency of meetings:

**Measurement Definition(s):**

**Defining Patient Population:**

(ie: gender, age, diagnosis driven)

**Ways to Identify the Patients:**

- ie:
- IS runs based on age, gender, visit dates
  - IS runs base on diagnosis
  - Current or past schedules: computerized or manual
  - Log books

**Methods of Data Collection:**

- ie:
- Retrospective chart review/EHR
  - Concurrent chart review/EHR
  - Patient survey
  - Visit Planning forms

**Sample Size:**

(Consider: size of the patient population, what resources allow, whether results will be communicated as aggregate across sites, site specific, provider specific)

**Frequency of Data Collection:**

(ie: ongoing, monthly, quarterly)

**Data Collectors:**

(ie: QI staff, patient care staff, other)

**Where will the data be shared or presented? Frequency?**

(Quality oversight committee, implementation team, clinic sites)

**References (Evidenced based practice, guidelines, citations, etc. )**

SMART AIM/GOAL: <i>INSERT SMART AIM/GOAL HERE</i>		<i>(Insert Months of the project in the green boxes below)</i>												Complete? (date)	
Activities	Resource(s)														
Decide on what you want to improve	Internal QI and/or Change Team														
Determine your Readiness to take on the QI Project	Use a general AHRO -SWOT and GAP Analysis tools. Readiness Tools														
Determine Capacity: What will it take to implement the QI Project.	Capacity evaluation: Internal QI and/or Change Team														
Develop SMART aim/goal	1a. SMART aim/goal instructions, 1b.template, 1c. QAPI Goal Setting Worksheet														
Establish Data Measurement metric(s) including what will comprise baseline data (What will be gathered and where does it come from?)	2a. Measurement Plan narrative, 2b.Evaluation Measurement Template														
Develop Project Plan	3a. Project Plan Template														
Develop/establish/Implement Communication Plan (Share findings and results)	4a. Communication Plan Tool, 4b. QAPI Communications Plan Worksheet														
Develop process map for: Workflow Current and Future states (What you are working on or your focus area)	5a. Process Mapping Overview														
Develop data measurement metric(s) & Visual Display of Data (Trend Chart)	6a. Trend Chart Template and Example, see also 2a & 2b above. 6b. Access creating and editing trend charts video: <a href="https://mnsimpracticefacilitation.org">https://mnsimpracticefacilitation.org</a>														
Develop or Plan "Small Tests of Change" document: Organize what you are going to test and establish PDSA.	7a. Small Tests of Change Narrative, 7b. Small Tests of Change Worksheet														
Pilot or Do "Small Tests of Change" to address focus area:	See 7a & 7b. See GAPS from workflow to address steps in the process to be changed. "Do" phase														
Implement Action Plan(s) or Study & Act "Small Tests of Change"	See 7a & 7b. "Study & Act" Phase														
*Additional "Small Tests of Change" ADD Rows as needed	*See above "Small Tests of Change" activities														
Evaluation: Measure results against interventions	See 6a & b and 2a & b. Trend Charts (Visual display of data)														
Sustainability: What will it take to sustain the improvement? (Light Grey shows thinking about sustainability starts at the beginning)	8a. QAPI Sustainability Decision Guide														

## Communication Plan

**Who** should I communicate to?

- Leadership
- Champions
- Team
- Staff

**What** information should I communicate?

- How does that differ for different audiences?
- Consistent messaging to all levels in the organization

**When** should I communicate about this work?

**Where** do I find information to share?

- SMART Aim
- Process Map document
- Trend Chart document
- Evaluation Measurement document
- PDSA document
- Other

**How** do I communicate about the work?

- How frequently should I communicate about the work?

(See page 2)

Key Messages	Who	How	Date Completed
You are participating in a project to:			
Your smart AIM/Goal			
Time frame for project			
Elements of your future state process map			
New tools and processes will be developed to achieve this goal			
You will piloting each of the components of the future state process map			
How long you will be testing/piloting each tool			
Who will be testing/piloting each tool			
What you can expect from those who are asking you to test/pilot each tool			
What is expected of you when you test/pilot each tool			
You will be looking for input on each of the tools and processes			
Who will this project impact?			
Monthly dashboards will be shared			
New strategies will be tested until the results are achieved and sustained			
The goal may change			

**Your Electronic Health Record (EHR) as a tool to support tobacco systems change:  
Going beyond Meaningful Use**

**Considerations of where to focus:**

- Workflows
- Order sets
- Population management (creating Registries)
- Proactive Triggers/flags (identifying patients at the time of visit or between visits who need services)
- Referrals (ensuring something happens and is followed-up on).

**Questions to Ask:**

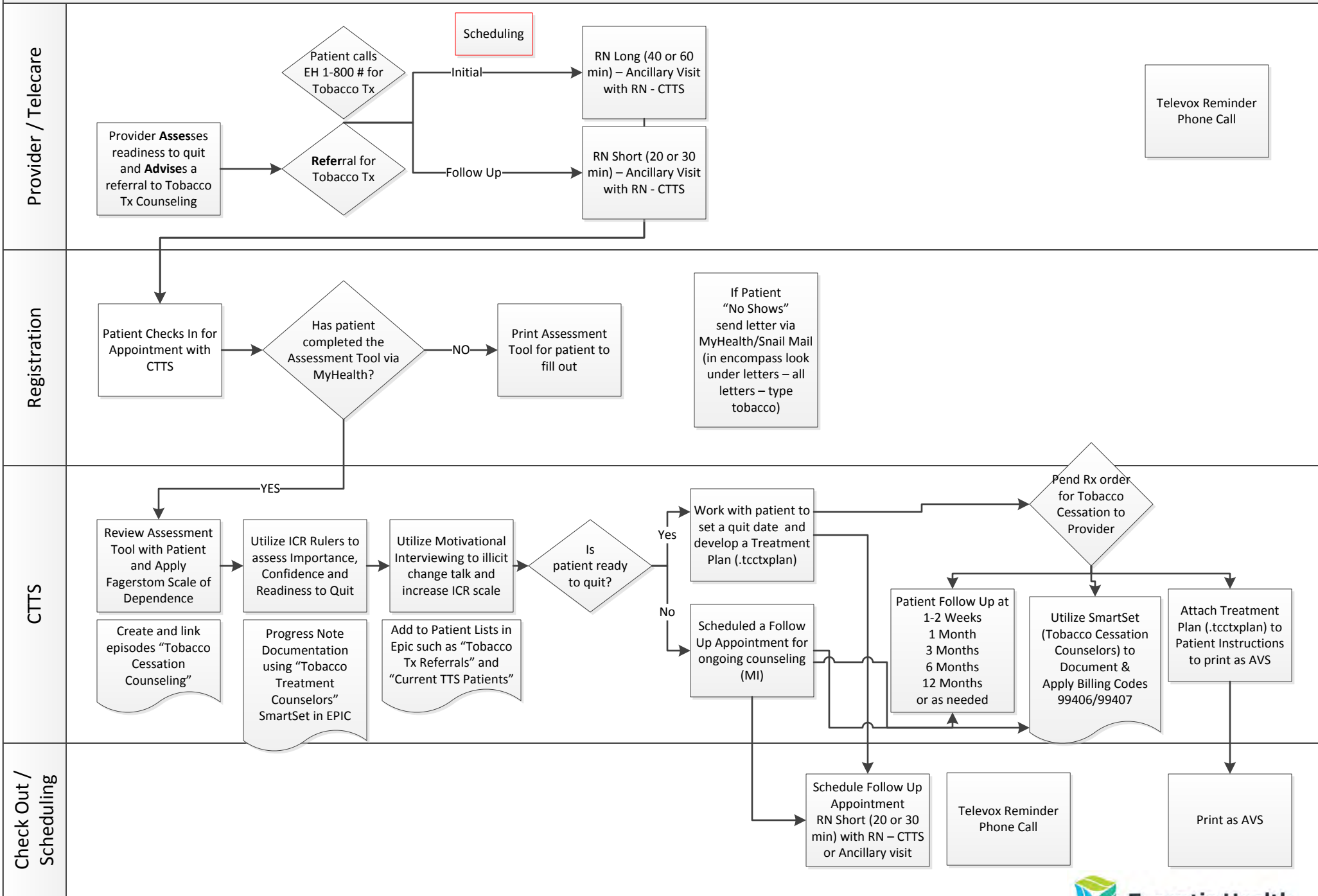
- What are the specific changes you'd like to make in your EHR?
- How do you currently leverage your EHR to ensure consistent care for your tobacco using patients?
- Do you have a way to do the following?
  - Generate a list of tobacco using patients?
  - Quickly and easily see a patients' tobacco status when you pull up their record?
  - Place orders for:
    - Cessation consultation or other resource (Quit line, Health Coach, Care Manager, group class, etc.?)
    - If "yes" can you easily track and see what happened after the referral was placed (Follow-up and follow-through)?
    - Tobacco cessation Medications?
    - Nicotine Replacement Therapy (NRT)?
    - Do you have order sets/panels for cessation work?
- Does the change requested support your current workflow (is this being done on paper or other tool currently) or is this a change to a new (enhanced) workflow?
- Do the changes you are requesting align with your organization's current system for treating patients with chronic conditions (e.g. would your staff proactively work a Registry of tobacco using patients like they would a Registry of diabetic patients)? If "no", why not? Do you have the right staff to support this future state workflow? Would additional training be needed?
- What does your EHR vendor offer in terms of tobacco cessation tools and suggested workflows?
  - Are you fully using those (why/why not)?
- Are you able to make the changes you desire to your EHR internally (on-site staff) or do you need to request the change from a vendor /external source?
- How long does the request to change made process take?
- What is the cost of making this change (both in \$ and resources)?
- Who will be affected by the changes (and have you engaged them)?
- What other workflows will these changes affect (e.g. Pre-Visit Planning(PVP), Referrals, Rooming)?

**Composition of Work Team: Considerations**

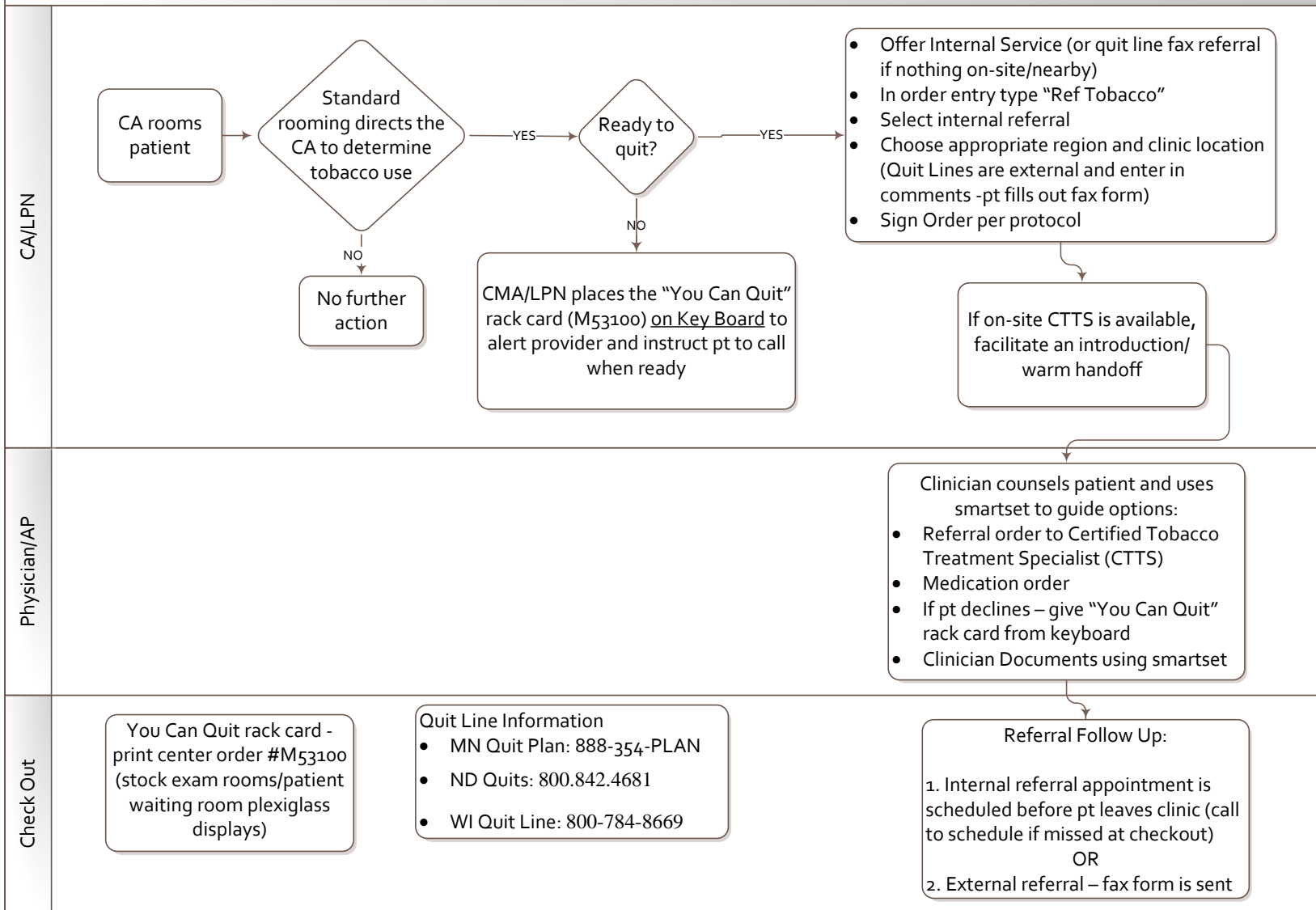
Who needs to be at the table? Who touches the work? Clinical as well as IT technical staff should come together to increase understanding to create what is needed to meet the patient needs.

# Standard Workflow for an Appointment with a Certified Tobacco Treatment Specialist (CTTS) for Tobacco Cessation Counseling

May 16, 2016









# Tobacco Cessation Workflow

**Ask – Advise – Assess – Assist – Arrange**

## Medical Assistant/Rooming Staff Responsibility

During the rooming process, the MA will **ask** and document the patient's tobacco use at each primary care visit.

If patient is a tobacco user

The MA **advises** the patient to quit by letting them know that the most important thing they can do to improve their health is to quit using tobacco.

The MA **assesses** the patient's willingness to quit by asking if they would be interested in speaking to their doctor about resources to help the patient quit today at visit.

No

The MA gives the patient a "tips for quitting" brochure and checks 'Counseling Given' box.

Yes

The MA gives the patient a "tips for quitting" brochure and checks 'Counseling Given' box and informs the patient to take a look at the available resources outlined in the brochure while they wait for the doctor.

## Provider Responsibility

Provider **assists** patient in smoking cessation attempt by making appropriate referrals. In EPIC, the smartset has 5 options for referrals. [Click to open smartset](#)

### Tobacco Cessation Smartset

Primary Care Counseling & Medication Management  
[Click to open med options](#)

Provider prescribe meds and proceeds with plan of care

Call It Quits Phone/Text Counseling  
[Sample form](#)

Provider completes referral form in Communication Management  
*\*Fax referral to: 1-800-483-3114*

Behavioral Health/Psych Consult

Provider orders referral to Psychology (downtown or neighborhood clinic)

HCMC Smoking Cessation Clinic (Wed mornings in P7)

Provider orders referral to smoking cessation clinic

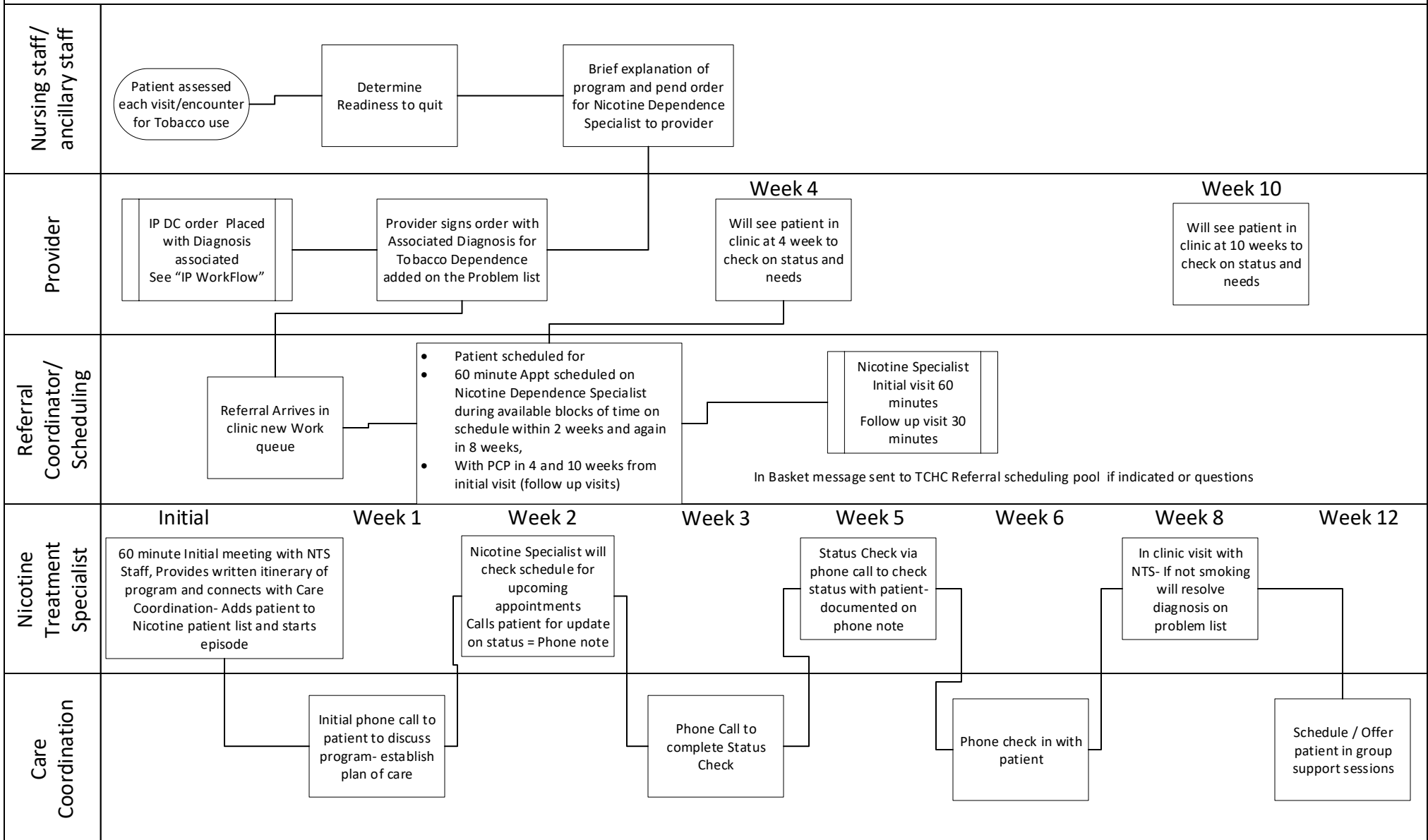
Clinical PharmD Counseling & Medication Management

Provider orders referral to PharmD (downtown or neighborhood clinic)

Provider **arranges** for patient follow up.

# Nicotine Dependence Workflow

## Out-Patient Nicotine dependence process



\* PRN patient contact on weeks 9 and 11- team to decide  
 \*Each visit will be linked to the Episode of care – Shared Services (250012)  
 \* Order and Smart sets available for Documentation and orders

## How to Ask about Smoking Without Lighting a Fire!

The way you engage a patient on the topic of smoking matters. If you've ever gotten a reluctant response or seen a patient disengage before your eyes, you may be looking for a new approach. Using insights from motivational interviewing best practices, the following script is designed to defuse a patient's possible frustration when asked about smoking.

### Assessment question:

- **Common approach (the old conversation):** Do you smoke? Are you exposed to smoke?
- **Optimal question (the new conversation):** Do you use nicotine or are you exposed to nicotine?

*Rationale: Asking about smoking only may elicit an emotional response tied to stigma and shame about smoking. Patients may give a yes or no answer and shut down. Asking about nicotine is important because some people are using e-cigarettes or chewing tobacco only and do not consider it "smoking." The nicotine topic also opens the patient's thinking and curiosity about where you might go about the topic.*

- **If yes, "Tell me more about how you are exposed"**
  - If they are trying to quit (e.g. nicotine gum), encourage them and ask what additional resources they want.
  - If they are not trying to quit, proceed with Engagement Questions (outlined below).

### Engagement Questions (ask in order shown):

1. **"How many times in the last year have you thought about quitting?"**

*Rationale: This question is designed to acknowledge that most people who smoke have occasional desire to quit.*

2. **"What made you think about quitting?"**

*Rationale: This question is designed to engage their intrinsic motivations, a powerful tool in addressing addiction.*

3. **"The quitting feeling comes and goes. I can connect you to some free resources...."**

*Rationale: These are non-judgmental, supportive statements that meet the patient where they are at and test readiness for change.*

Examples of resource referrals:

- **"...including medications that we know increase your odds of success. I'm happy to write the prescription now for Zyban or Varenicline (Chantix) or nicotine replacement therapy (patch, gum, lozenges) so you can have them handy at home for the next time you get the urge."**
- Quit Plan Pamphlet and / or phone number
- Tobacco Treatment Specialist (if applicable)

4. “One other quick thing, do you have kids or grandkids?”
  - If yes, “We have seen a huge rise in kids using e-cigarettes which are dangerous and a gateway to nicotine addiction. Just wanted you to know.”
    - *Rationale: This question and statement are designed to educate people about the pervasively unknown risks of e-cigarettes.*

#### Key points about why motivational interviewing can be more effective than current protocols:

- Motivational Interviewing is a person-centered, guiding method of counseling to elicit and strengthen motivation for change.
- Motivational Interviewing principles include: expressing empathy, avoiding arguing, managing resistance without confrontation, and supporting the individual’s self-efficacy by using counseling techniques such as open-ended questioning, reflective listening, summarizing, affirming and eliciting new thinking.
- Motivational Interviewing has been found to be effective even when delivered in a brief format by non-specialists in a variety of settings.

This script incorporates open-ended questions provided in a non-confrontational way. The approach is designed to elicit and support self-motivation for change while directing patients toward applicable resources.

#### Evidence Citations:

“E-cigarettes are now the most commonly used tobacco product among youth, surpassing conventional cigarettes in 2014. E-cigarette use is strongly associated with the use of other tobacco products among youth and young adults, including combustible tobacco products.”

Source: United States. (2016) E-Cigarette Use Among Youth and Young Adults A Report of the Surgeon General. Executive Summary. [Rockville, Md.]: Dept. of Health and Human Services, U.S. Public Health Service

Here is a nice fact sheet with several references as well:

[https://e-cigarettes.surgeongeneral.gov/documents/2016\\_SGR\\_Fact\\_Sheet\\_508.pdf](https://e-cigarettes.surgeongeneral.gov/documents/2016_SGR_Fact_Sheet_508.pdf)

[https://e-cigarettes.surgeongeneral.gov/documents/SGR\\_ECig\\_ParentTipSheet\\_508.pdf](https://e-cigarettes.surgeongeneral.gov/documents/SGR_ECig_ParentTipSheet_508.pdf)

Lundahl, B., Moleni, T., Burke, B.L., Butters, R., Tollefson, D., Butler, C. and Rollnick, S., 2013. Motivational interviewing in medical care settings: a systematic review and meta-analysis of randomized controlled trials. *Patient education and counseling*, 93(2), pp.157-168.

- MI can successfully be delivered by a range of professionals with a minimum investment of time in medical care settings in a variety of formats and time frames for patients of different ages, genders, and ethnicities. .

Heckman, C.J., Egleston, B.L. and Hofmann, M.T., 2010. Efficacy of motivational interviewing for smoking cessation: a systematic review and meta-analysis. *Tobacco control*, 19(5), pp.410-416.

- Comprehensive review showed MI smoking cessation approaches can be effective

# THE BRIEF TOBACCO INTERVENTION

## The 2As & R

### **A**SK about tobacco use:

*“Do you currently smoke or use other forms of tobacco?”*

### **A**DVISE the patient to quit:

*“Quitting tobacco is one of the best things you can do for your health. I strongly encourage you to quit. Are you interested in quitting?”*

### **R**EFER the patient to resources:

**IF READY TO QUIT:** Provide direct referrals to resources that will assist the patient in quitting. Provide direct referrals. Prescribe medications, if appropriate.

*“This is a resource I recommend. It will provide you with support, help you create a plan to quit, and talk to you about how to overcome urges you might have to smoke after you quit.”*

**IF NOT READY TO QUIT:** Strongly encourage patients to consider quitting by using personalized motivational messages. Let them know you are there to help them when they are ready.

### **Recommended resources include:**

- Free telephone-based state tobacco quitlines:  
**1-800-QUIT-NOW**
- The National Cancer Institute’s website:  
**[www.Smokefree.gov](http://www.Smokefree.gov)**
- The National Cancer Institute’s text-messaging quit smoking program: SmokefreeTXT;  
**Text QUIT to 47848**
- The Department of Health and Human Services website:  
**[BeTobaccoFree.gov](http://BeTobaccoFree.gov)**
- Appropriate community-based or local cessation resources (e.g., classes, support groups)

# THE BRIEF TOBACCO INTERVENTION

## The 5As

### **ASK** about tobacco use:

*“Do you currently smoke or use other forms of tobacco?”*

### **ADVISE** the patient to quit:

*“Quitting tobacco is one of the best things you can do for your health. I strongly encourage you to quit. Are you interested in quitting?”*

### **ASSESS** readiness to quit:

*“Are you interested in quitting tobacco?”*

### **ASSIST** the patient in quitting:

**IF READY TO QUIT:** Provide brief counseling and medication (if appropriate). Refer patients to other support resources that can complement your care (e.g., quitlines, Smokefree.gov, SmokefreeTXT, BeTobaccoFree.gov, group counseling).

For tips on how to offer brief counseling, see:  
[www.ahrq.gov/path/tobacco.htm](http://www.ahrq.gov/path/tobacco.htm).

**IF NOT READY TO QUIT:** Strongly encourage patients to consider quitting by using personalized motivational messages. Let them know you are there to help them when they are ready.

### **ARRANGE** for follow up:

Follow up regularly with patients who are trying to quit.





## When you're ready to quit, *we're here to help*

**Quitting is hard.** It takes time, patience and practice to quit smoking. It may take more than one try to quit for good.

***Don't give up!***

### **We can offer you:**

- Individual counseling with a local Certified Tobacco Treatment Specialist (CTTS)
- Discuss medication options to help you quit
- Personalized quit plan with on-going follow up and support along the way

Schedule an appointment today by calling us toll-free at **844.403.7010**.



**Essentia Health**

Here with you



## Your Body After You Quit

**20 minutes after quitting:** Your blood pressure improves and the temperature of your hands and feet goes back to normal.

**8 hours after quitting:** The carbon monoxide level in your blood drops to normal.

**2 weeks to 3 months after quitting:** Your blood circulation improves and your lung function increases up to 30 percent.

**1 year after quitting:** Your risk for heart disease may be half that of a smoker.

**5 years after quitting:** Your stroke risk can be close to that of a nonsmoker (this can take between 5 and 15 years).

**10 years after quitting:** The risk for cancer of the mouth, throat, esophagus, bladder, kidney, and pancreas goes down.

## How much money will you save?

Based on smoking a pack each day

(average price per pack in MN = \$7.50)

1 Month = **\$225**

1 Year = **\$2,737.50**

5 Years = **\$13,687.50** ←



Learn more today by calling us toll-free  
at **844.403.7010**.



**Essentia Health**

Here with you