

2019

Using Triage Systems to Improve Access to Cessation Services



Introduction

Quitlines offer evidence-based cessation treatment and services for helping tobacco users quit. Each year, state quitlines receive nearly one million calls and provide evidence-based cessation services to approximately 350,000 smokers. Over the past 10 years quitlines have implemented referral programs with health care providers and community-based programs. In recent years, quitlines have begun to develop consumer-oriented triage systems through which they can help quitline callers access cessation services included in their health plan coverage. Triage systems offer a number of advantages over referral programs, including: 1) improving access to intensive cessation services which exist within health plans for callers with health care coverage; 2) establishing the foundation for a statewide cessation system; and 3) creating collaboration and partnerships between cessation service providers within the state. Much of this activity to increase referral systems and implement a consumer-orientated triage system has been made possible by the [Affordable Care Act \(ACA\) requirement](#) that cessation services (an A level preventive service) be provided by health plans.

A growing number of states have successfully partnered with Medicaid and commercial insurers to increase their coverage for comprehensive cessation services; therefore it has become important for state quitlines to develop a capacity for triaging callers who have more intensive cessation services available through Medicaid or commercial insurers to those services. Through triage, quitlines are able to expand services offerings to ensure that anyone that wants to quit gets connected to the service best suited to their needs. Over the past 3 years, capacity for quitlines to triage callers to other tobacco cessation services has grown. Several states have implemented or sought to implement triage protocols to address priority populations, such as the Medicaid recipients.

The North American Quitline Consortium (NAQC) sought to learn more about the types of triage programs that exist, the intended goals of those programs, how the programs operate, program outcomes and any lessons learned. To accomplish this, NAQC established a workgroup comprised of 6 members representing state quitlines, service providers and funders with a range of experience implementing triage programs. The workgroup, which met by telephone between June and September 2019, was charged with sharing their state's experience with triage programs and lessons learned.

This report is designed to outline the key findings of the triage workgroup's discussions and present next steps for NAQC and the quitline community to consider.

Distinguishing Triage versus Referral

Prior to discussing the importance and benefits of triage, it is important to first establish common definitions for, and distinguish between, the terms *triage* and *referral*. NAQC conducted a survey and key informant interviews with quitline service providers and state tobacco control programs with longstanding triage programs to establish a definition for the term "triage". Based on the information and feedback gathered from the survey and interviews, NAQC is defining "**triage**" as *the sorting and allocation of treatment to quitline callers according to a system of priorities designed to maximize and augment the number and types of treatment services provided*. Operationally, this may involve the quitline serving as a hub for connecting (via a warm transfer or provision of resource contact information) quitline callers with either more intensive counseling and medication services available through their health plan/insurer and/or additional cessation resource available in the community. Additionally, based on the quitline communities' long-standing practice of working with health care providers and clinics to establish referral programs NAQC is defining "**referral**" as *the act of a provider sending or directing a caller to the quitline for treatment, resources, materials, or to other resources*. Referrals can be either direct, where a health care provider connects the tobacco user to the quitline via eReferral, fax referral or another method to initiate enrollment in cessation services or indirect where the provider provides information about the quitline for the tobacco user to follow-up. Quitlines may also provide educational activities to support referrals.

Referrals are an integral part of state quitlines and the services they provide. Quitline referral programs build the capacity of state quitlines to share data and reports with other health care and cessation providers, and to increase the awareness of quitline callers about additional cessation services available to them. All state quitlines have a referral program that allows health care providers (and sometimes community service providers) to refer patients (or clients) who use tobacco and are interested in quitting to the state quitline for cessation services. Since 2013, all 53 state quitlines have had the capacity to accept referrals via fax.¹ Over time, as technology has evolved and been adopted, state quitlines have expanded to accept e-mail, online and eReferral.² In addition to accepting referrals, state quitlines also make referrals. In FY2019, 83.3% (n=40) state quitline reported referring quitline callers to other cessation services offered by public or private health plans and 52.1% (n=25) state quitlines reported referring quitline callers to other public and private health services for chronic conditions (e.g., diabetes, hypertension).³ However, there are limitations to referral. Since the referral does not involve connecting a quitline caller to a service or resource, it is the responsibility of the caller to follow-up to access or receive the service recommended.

Benefits of Triage to Quitlines

Triage programs are the next evolution of referral programs and offer several benefits to state quitlines and quitline callers. Triage programs allow states to ensure everyone receives cessation support by connecting quitline callers who have health care coverage for cessation services with those services, and utilizing the state quitline services for callers who are uninsured or underinsured. In addition, triage programs can work in collaboration or in tandem with cost-sharing program efforts states may have or may be exploring. By implementing a triage program, quitlines have been able to:

- *Facilitate and increase access for quitline callers to intensive cessation services which exist within health plans for callers with health care coverage;*
- *Increase quit attempts and utilization of evidence-based cessation services;*
- *Establish a foundation for a statewide cessation system;*
- *Establish collaborations and partnerships between cessation service providers within their state;*
- *Expand service offerings to ensure that anyone who wants to quit gets connected to the service best suited to their needs; and*
- *Increase adoption of measures specific to tobacco cessation and quitlines by providers during future stages of Meaningful Use.*
- *Facilitate access to additional cessation service options for which the tobacco user is eligible. For example, a quitline caller may be eligible for cessation services from a health plan or employer. However, to appropriately and effectively triage, state quitlines must gather and monitor the information needed to determine what cessation programs are available. In addition, decision rules are needed to determine eligibility criteria for each service, and the process for matching or offering the services.*

Types of Triage Models

Through surveys and conversations with service providers and states, NAQC discovered a variety of triage programs. Of the programs that exist, several states have implemented triage programs to address priority populations, such as the Medicaid recipients. Three established triage programs are highlighted below, featuring the varying motivations, processes and potential benefits triage programs can offer.

¹ North American Quitline Consortium. 2018. Results from the 2018 NAQC Annual Survey of Quitlines. M. Rudie, editor. Available at <http://www.naquitline.org/?page=2018Survey>

² North American Quitline Consortium. 2018. Results from the 2018 NAQC Annual Survey of Quitlines. M. Rudie, editor. Available at <http://www.naquitline.org/?page=2018Survey>

³ North American Quitline Consortium. 2018. Results from the 2018 NAQC Annual Survey of Quitlines. M. Rudie, editor. Available at <http://www.naquitline.org/?page=2018Survey>

Triage Model #1: Clearway Minnesota

Established 2001

Objective(s) of Triage Program: Established in 2001 to address a court order that the state quitline not duplicate or supplant services offered by other entities in the state, the objectives of Clearway Minnesota's triage program include:

- *Better coordinate with health plans.*
- *Develop a collaborative process to direct commercial tobacco users to the correct quitline.*

Key Steps in Clearway Minnesota's Triage Process:

- *All callers are offered cessation services via either the quitline/helpline or individual service offerings.*
- *If a caller chooses the helpline (i.e. telephone counseling), the helpline asks if the caller has insurance.*
- *If the caller has insurance, caller is transferred to their health plan's cessation services if the helpline knows the phone number. If the helpline does not know where to transfer the caller, then the caller is directed to call their health plan.*
- *If a caller finds they do not have coverage for telephone counseling or NRT through their health plan, they can call the state quitline back and will be enrolled in helpline services.*
- *Any caller reporting being uninsured will be enrolled in helpline services.*

Benefits Realized:

Through implementing a triage program, Clearway Minnesota has realized the following benefits:

- *All health plans in the state of Minnesota agreed to offer quitline services with no copays – essentially providing free coverage for tobacco cessation services to all Minnesotans.*
- *Established lasting partnerships with all health plans in the state of Minnesota.*

Triage Model #2: New York Smokers Quitline

Established 2009

Reason for implementing a triage program: Established in 2009, the objectives of New York Smokers Quitline's triage program include:

- *Maximize access to tobacco cessation services and programs available to participants have available to them or at least make them aware of their options.*
- *Reserve quitline resources for those without any other access to tobacco cessation services and/or programs.*

Key Steps in New York Smoker Quitline's Triage Process:

The state quitline then triages callers to the caller's health plan's cessation resources. The key steps involved in establishing New York's triage program included:

- *Caller's insurance status and health plan is assessed during intake question.*
- *Caller is provided scripted information based on health plan identified. If caller reports having a health plan with a known cessation program, then caller is provided with plan information. If caller identifies as belonging to a Medicaid MCO, caller is provided with cessation information and encouraged to call and find out what services are available to them.*
- *If insurance status can be verified in real-time then caller is made aware of benefits available. If not, caller is informed of possible tobacco cessation benefits available.*
- *Caller receives coaching and NRT from the quitline.*
- *Health plan program will follow-up coaching sessions & NRT screening for eligible members or eligibility status is checked through an external portal to identify potential additional benefits.*

Benefits Realized:

Through implementing a triage program, New York Smokers Quitline has realized the following benefits:

Triage Model #2: New York Smokers Quitline

Established 2009

- *Increased access to and awareness of cessation services available for callers.*
- *Program cost savings*
- *Meeting funder's objectives for the state quitline.*
- *Meeting broader tobacco control objectives.*

Triage Model #3: Nevada Tobacco Quitline

Established 2016

Objective(s) of Triage Program: Established in 2016, the primary objective of the Nevada Tobacco Quitline's triage program was to offset the cost of triaging Medicaid MCO enrollees who have called the state quitline to the appropriate Medicaid MCO cessation service.

Key Steps in Nevada Tobacco Quitline's Triage Process:

- *Gather Medicaid identification numbers from quitline callers who report being enrolled in Medicaid.*
- *Maintain access to current Medicaid eligibility files to determine which Medicaid MCO to transfer the caller to.*

Benefits Realized:

Through implementing a triage program, Nevada Tobacco Quitline has realized the following benefits:

- *Established relationships with CMS, the state Medicaid agency and Medicaid MCOs in the state.*
- *Created an opportunity to educate state Medicaid and Medicaid MCOs on evidence-based cessation services and explain how the state quitline and their service provider can assist the state Medicaid and Medicaid MCOs in providing evidence-based cessation services to Medicaid enrollees.*
- *Obtain approval from CMS to include Medicaid MCO triage administrative costs in its Federal Financial Participation (FFP) agreement.*

Challenges Implementing Triage Programs

While states that have established programs to triage callers to the quitline have experienced a variety of benefits from doing so, they have also encountered several challenges. Some of the challenges encountered are easily overcome while others may require substantial resources (i.e., funding and/or staff) to overcome.

Common challenges states have encountered establishing triage programs include:

- *Lack of awareness of health plan services.* Members can be very confused about their health plan coverage. Some members are simply not aware of the tobacco cessation treatment services and resources that are offered through their health plan. Even with accurate information available, when a member is pursuing information, sometimes the health plan's representative is not aware of or does not have up to date information on tobacco cessation resources and services to provide the caller. This leads to the quitline doing a lot to educate the health plan on the benefits they offer. Better promotion of the services offered by health plans from the health plan could help mitigate this challenge.
- *Fluctuating eligibility criteria and cessation offerings among health plans.* To appropriately and effectively triage, state quitlines or a third party will need to be responsible for gathering and monitoring the information needed to determine what cessation programs are available. This can be challenging when health plans eligibility criteria and cessation offerings change without notice and those changes do not get communicated to the quitline or even properly promoted to health plan members. This fluctuation can cause confusion and uncertainty among members and potentially serve as a deterrent to getting smokers connected to services and treatment. Additionally, maintaining and sustaining accurate information is time consuming on the part of the quitline.

- *Addressing the needs of callers that do not report insurance status.* Some members may choose not to report their insurance status for fear of being penalized for previously reporting being a non-smoker on their health insurance application. The fear of potential increased costs (premiums) could prevent them from disclosing their insurance status. As such, the caller will identify as uninsured and default to using the quitline's services which negates the potential benefit of triage.
- *Access to health plan member databases is unwieldy.* While self-report is a less than perfect way to collect health insurance information, without access to a health plan's database, it is the only option the quitline currently has to identify the insurance status of callers. Decision rules are needed to determine eligibility criteria for each service, and the process for matching or offering the services. However, gaining access to the data needed to assess eligibility, especially for online enrollees is not often feasible and comes with challenges regarding maintaining the privacy of a callers' information.
- *Tracking whether callers' follow-up to receive services through their health plan.* Triage programs create the potential for service options for the tobacco user and a quitline caller may be eligible for cessation services from multiple sources. Tracking quitline callers to determine whether they actually received services is a great challenge that quitlines are trying to address.

Lessons Learned

By implementing triage programs, state funders of quitlines have learned the following:

- **Establish a dialogue between the state funder and quitline service provider to develop mutual goals and objectives for the triage system.** Simply putting a triage program requirement in a state quitline Request for Proposal is not sufficient to have an effective and efficient triage program.
- **Establish strong partnerships with health plans/Medicaid MCOs.** This will be vital to ensuring continuity of the partnership though staffing changes.
- **Understand how health plans and employer-based programs work prior to engaging.** The state and/or quitline service provider should understand the health plans and employer groups they seek to engage and the services they offer. The quitline staff may also find it helpful to educate themselves on terminology used by health plans (i.e., self-insured vs. commercial vs. self-funded). A glossary of commonly used terms is included in Appendix A of this report.
- **States are not always the catalyst for triage.** Health care plans may have their own reasons for triage and may be the driver for putting a triage program in place.
- **Determine what kind of leverage the quitline brings to the table up front.** Knowing what the quitline offers will help determine the approach used to encourage health care plans to contract with quitline vendors.

Key Considerations for Implementing Triage Programs

Based on the experiences of states that have implemented triage programs, there are several things that states exploring the development of a triage program should take into consideration prior to embarking on the process. First, it is important to define the goal(s) of a triage program. Is it to simply get all tobacco users seeking cessation assistance into a cessation program? Is it to ensure tobacco users contacting quitlines have access to evidence-based cessation services? Is it to reserve state resources for people who do not have access to cessation services? Or all of the above?

Second, for a triage program to be effective, state quitlines must critically consider eligibility requirements for cessation services offered by the state quitline. For example, if a state quitline offers a 5-call counseling program and free nicotine replacement therapy (NRT) available to all callers, then there is no incentive for health plans or employers to engage in a triage program because their members can receive robust cessation services via the state quitline at no cost to the health plan or employer. Whereas, if state quitlines creates eligibility requirements that reserve robust quitline services for those without access to other cessation support (i.e., uninsured) and those who encounter significant barriers to accessing cessation services available (i.e.,

Medicaid enrollees), then state quitlines can work in collaboration with health plans and employers to ensure their members who call the state quitline are either connected with cessation services via triage or are served by the state quitline via a cost sharing program (i.e., the health plan or employer pays the cost for providing cessation services to their member).

Lastly, the information needed to make the case for triage will depend on “who” the audience is for making the case for triage. For example, does the state want to work with all health plans or just Medicaid MCOs? Gathering this information helps to create an understanding of the type of triage program that will work for that state and “who” the key stakeholders are. Once a quitline knows its audience, it will then be able to consider the audience’s level of knowledge about the quitline and the importance of cessation services, as well as the types of state and federal laws that govern the health plans and insurers. This information will be imperative to make the case for triage appealing to the intended audience.

Ultimately the quitline will need to perform an assessment of its needs to determine the type of triage program that will make the most sense for the quitline. This will involve defining the type of triage program that the state is seeking to implement, the program goals and offerings, which partners to engage and the roles and responsibilities of each partner. It is important to note that the outcome of the assessment may lead to the quitline determining that it may be better for the state to continue referring rather than triaging callers.

Next Steps for NAQC

The concept of triage is appealing to state quitlines due to its potential benefits to expand access to cessation services, however implementing a triage program is not an easy task and may not be feasible for all quitlines. The benefits, challenges, key considerations and lessons learned outlined in this report represent input from a small subset of stakeholders within the quitline community. Ultimately the workgroup recommended that more information is needed to obtain a comprehensive understanding of triage in the quitline community. The perspective of additional stakeholders should be gained, such as health plans and Medicaid MCOs. Workgroup members agreed that obtaining the perspective from these entities is an important next step for understanding the potential of triage programs for quitlines. The workgroup also suggested that NAQC:

- *Gather more details on states that have implemented triage to determine if there is a preferred approach or common elements that make implementation of a triage program efficient and effective.*
- *Identify a method for calculating the cost benefit to quitlines for implementing triage programs.*

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For more information about the NAQC's Triage Project, contact naqc@naquitline.org.

APPENDIX A - Glossary of Terms

Affordable Care Act (ACA)

The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or “Obamacare”). The law has 3 primary goals:

- Make affordable health insurance available to more people. The law provides consumers with subsidies (“premium tax credits”) that lower costs for households with incomes between 100% and 400% of the federal poverty level.
- Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.)
- Support innovative medical care delivery methods designed to lower the costs of health care generally.

Cost-Sharing⁴

The option for a health plan or employer to pay the costs (or some portion of the costs) of providing state quitline services to their population of quitline users.

Commercial Insurance

A health insurance plan not administered by the government.

Managed Care Organization (MCO)

An organization that provides for the delivery of health benefits and additional services through contracted arrangements at a set per member per month (capitation) payment for services.

Meaningful Use⁵

The use of certified electronic health record (EHR) technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology connects in a manner that provides for the electronic exchange of health information to improve the quality of care.

Medicaid⁶

A public insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Medicaid is the largest safety net provider in the U.S. serving 65,152,400.⁷ Many states have expanded their Medicaid programs to cover all people below certain income levels.

Private Health Insurance

Health insurance offered by a private entity, such as an employer, insurance company or a licensed broker or agent.

Public Health Insurance⁸

A program run by U.S. federal, state, or local governments in which people have some or all of their healthcare costs paid for by the government. The two main types of public health insurance are Medicare and Medicaid. Medicare is a federal health insurance program for people aged 65 years or older and people with certain

⁴ Lemaire, R. H., Bailey, L., & Leischow, S. J. (2015). Meeting the Tobacco Cessation Coverage Requirement of the Patient Protection and Affordable Care Act: State Smoking Cessation Quitlines and Cost Sharing. *American journal of public health, 105 Suppl 5*(Suppl 5), S699–S705. doi:10.2105/AJPH.2015.302869

⁵ <https://www.cdc.gov/ehrmeaningfuluse/introduction.html>

⁶ Healthcare.gov

⁷ Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey, 2008-2017

⁸ <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/public-health-insurance>

disabilities. Medicaid is a public health insurance program for some individuals and families with a low income or disabilities.

Quitline

A quitline is a tobacco cessation service available through a toll-free telephone number. Quitlines are staffed by counselors trained specifically to help smokers quit. Quitlines deliver information, advice, support, and referrals to tobacco users—regardless of their geographic location, race/ethnicity, or economic status—in all U.S. states.

Referral

The act or process of a provider directing or sending a caller to the quitline for tobacco cessation treatment, services, materials, or to other resources. Referrals can be either direct or indirect. In a direct referral, a health care provider connects the tobacco user to the quitline via eReferral, fax referral or another method to initiate enrollment in cessation services. In an indirect referral, the provider provides information about the quitline for the tobacco user to follow-up.

Third-party Payer

An institution or company that provides reimbursement to health care providers for services rendered to a third party (i.e., the patient).

Transfer

When a quitline caller is connected to a specific person and/or tobacco cessation service or resource. Transfers can be either warm or cold. A warm transfer occurs when information is taken from the caller before the transfer occurs and given to the receiving staff for the conversation. Typically with warm transfers, the transferring staff remains on the line until the caller is directly connected to the service. A cold transfer is where the caller is connected to a service without any introduction or knowing if the call will be accepted.

Triage

The sorting and allocation of treatment to quitline callers according to a system of priorities designed to maximize and augment the number and types of treatment services provided.