NORTH AMERICAN QUITLINE CONSORTIUM

|CASE STUDY|

Establishing Referral Programs Between Quitlines and Community Health Centers

Context

Cigarette smoking disproportionately affects the health of people with low socio-economic status (SES)[1]. In February 2017, a new U.S. Department of Housing and Urban Development (HUD) rule took effect requiring Public Housing Agencies (PHA) administering low-income, conventional public housing to implement a smoke-free policy[2]. The HUD rule prohibits lit tobacco products (cigarettes, cigars, or pipes) in all living units, indoor common areas, administrative offices, and all outdoor areas within 25 feet of housing and administrative office buildings. A key goal of the HUD rule is to improve the health of all PHA residents by reducing exposure to secondhand smoke. In the rule, HUD acknowledges the importance of connecting residents interested in quitting smoking to cessation resources, preferably at no cost, and included quitlines as a free evidence-based cessation resource that PHA residents could access.

Low-SES individuals are more likely to utilize a safety-net provider such as a community health center (CHC)[3], which provides care to some of the most vulnerable members of society, including residents of public housing. Although evidence-based guidelines for delivering smoking cessation treatments (medications and counseling) in primary care settings constitute standard care[4] and increase the likelihood of smoking cessation[5], delivery of these services by healthcare providers remains low[6]. According to the Surgeon General's Report, quitlines are an effective population-based approach to motivate quit attempts and increase smoking cessation[7]. Health systems can use quitlines as an adjunct to clinical care and to provide ongoing follow-up support to patients who are engaged in a quit attempt[8]. Further, referral links between CHCs and state quitlines may facilitate the provision of cessation assistance by offering clinicians a practical method for referring smokers to this effective service[9].

Smoke-Free Public Housing: Helping Smokers Quit

In mid-2018, the North American Quitline Consortium (NAQC), in partnership with the American Cancer Society (ACS) and Smoking Cessation Leadership Center at the University of California San Francisco (SCLC), launched a two-year national project *Smoke-Free Public Housing: Helping Smokers Quit* (SFPH:HSQ). This project was funded by the Robert Wood Johnson Foundation to enhance cessation services for selected HUD housing developments in five selected states: California, Kentucky, Missouri, Pennsylvania, and South Carolina. The goal of the SFPH: HSQ project was to increase the demand for cessation services among PHA residents to reduce tobacco use and improve the overall health, well-being, and equity of PHA communities. To achieve the project's goal, NAQC sought to increase the reach of state quitlines to PHA residents and connect residents to evidence-based, cessation tools and resources to help them quit smoking by: increasing demand for quitline services; increasing cross-sector collaborations between quitlines, PHAs, and community health clinics; and developing resources to help quitlines triage and connect PHA residents with evidence-based cessation services in their community. Five state quitlines participated in this project. The five state quitlines include:

- California Smokers Helpline
- Quit NOW Kentucky
- Missouri Tobacco Quitline
- Pennsylvania Free Quitline
- South Carolina Tobacco Quitline

This case study describes how the five state quitlines participating in the SFPH:HSQ project collaborated with designated CHCs to implement referral

programs to connect PHA residents with evidence-based tobacco cessation resources. It also highlights the importance of referral programs between CHCs and quitlines, describing the process undertaken, successes, and lessons learned. Highlighting elements of success is intended to motivate and inspire other quitlines to collaborate with CHCs to implement similar referral programs in their states.

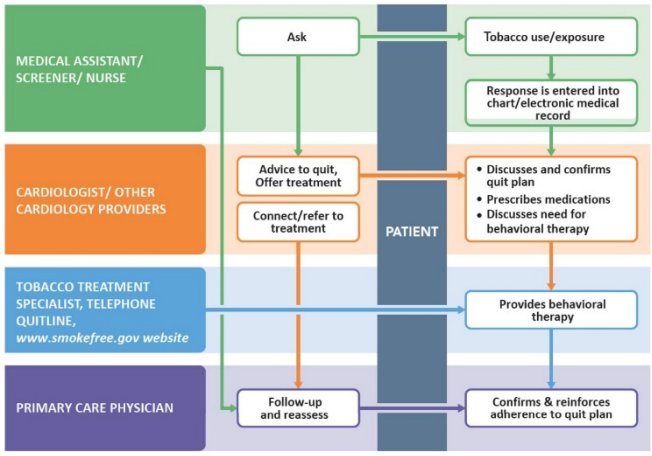
Role of Community Health Centers in Tobacco Cessation

More than 80% of smokers see a physician every year[10], and most smokers want and expect their physicians to talk to them about quitting smoking and are receptive to their physicians' advice[11]. Evidence indicates that provider assistance can more than double the odds that a patient will be successful in quitting[12]. The U.S. Public Health Service (PHS) Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, recommends implementing the 5A's (Ask, Advise, Assess, Assist, and Arrange) to systematically address tobacco use in clinical settings[13,14] as the standard of care. Implementing the 5A's in the clinical setting is associated with greater tobacco cessation efforts among patients compared with no intervention[15].

Many health-care systems, however, have struggled to incorporate tobacco cessation treatment into their clinical encounter and connect tobacco users to evidenced-based cessation resources and services. Even when providers are motivated to screen for tobacco and refer their patient to tobacco cessation treatment, they face challenges in implementing a process to do so. With the average primary care appointment lasting only 15-minutes, providers often struggle to screen for tobacco during an encounter, especially when that patient presents with multiple other chronic conditions. According to the 2020 Surgeon General's Report, only 57% of smokers who had seen a health professional in the past year reported receiving advice to quit[16]. Another study found that patient reports of their physicians providing each of the 5A's typically decreased as the steps progressed, with "Asking" about tobacco use (87.9%) being more prevalent than "Assisting" with a quit attempt (78.2% of those who wanted to quit) and the prevalence of "Assisting" being far more prevalent than "Arranging for follow-up" (17.5% overall)[17].

CHCs are well positioned to identify patients who smoke and to provide them with smoking cessation assistance. While the 5A's method is considered the gold standard for delivering a brief tobacco cessation intervention, studies show that even brief (<3 minutes) advice from a physician during an encounter improves cessation rates and is highly cost-effective[18]. Reorganizing the practice environment and establishing clinic workflows to help clinicians delegate the time-consuming steps of counseling and arranging follow-up may improve rates of treatment delivery and enhance the level of support smokers receive[19]. In 2018, the American College of Cardiology (ACC) published the ACC Expert Consensus Decision Pathway for Tobacco Cessation Treatment report, which provided guidance for addressing cigarette smoking efficiently and effectively during a routine office-based clinical encounter[20]. Figure 1 describes how CHCs might incorporate a discussion about tobacco cessation into their clinic workflow. The workflow begins with a medical assistant/screener asking the patient about tobacco use and secondhand smoke exposure, followed by the provider advising the patient to quit and offering treatment, concluding with a medical assistant or administrative staff or nurse referring the patient to the quitline for additional counseling and support.

Figure 1: ACC Expert Consensus Decision Pathway for Tobacco Cessation Treatment



2018 ACC Expert Consensus Decision Pathway on Tobacco Cessation Treatment. J Am Coll Cardiol 2018; Dec 5

Collaboration Between Community Health Centers and Quitlines

Instituting tobacco cessation interventions in a systematic way significantly increases the likelihood that health care providers will consistently screen patients for tobacco use and intervene with patients who use tobacco to provide or connect them with appropriate treatment[21,22]. State efforts to promote this health systems change involve working with health care delivery systems, such as CHCs, and associated organizations to fully integrate tobacco dependence treatment into the clinical workflow[23]. Once a CHC implements a workflow, such as AAR, to screen for tobacco use and advise users to quit, establishing a referral program with the state quitline can subsequently support the larger delivery system. For example, referral programs between CHCs and quitlines support health systems change by providing a process whereby providers consistently screen for tobacco, advise those that do use tobacco to quit, and–importantly–connects them to evidence-based cessation services to help them quit and stay quit. Establishing these systems has promise to improve health care and reduce health care costs. Currently, there are three available mechanisms that allow providers to securely refer tobacco users from the CHC to the quitline:

- **Fax referral**: seamlessly fax a form containing the tobacco user's information to the quitline.
- **Email/web-based referral:** complete the referral online at the web portal or submit the referral via email to the quitline.
- **Electronic Referral (eReferral):** submit the referral to the quitline via the Electronic Medical Record (EMR).

In fiscal year 2018, U.S. quitlines received a combined total of 211,774 referrals submitted by providers from all referral methods (fax, email/online and eReferral)[24]. The type of referral program varies by quitline, with some having the capability to accept referrals through multiple methods and some only one. As of 2018, 100% of quitlines accepted fax referral, 87% accepted email/online referral, and 46% accepted eReferral[25]. The type of referral offered by each U.S. quitline can be found using NAQC's quitline map at http://map.naquitline.org/.

The referral methods offered by the five quitlines that participated in the SFPH:HSQ project are displayed in the table below.

	Fax referral	Email Online	EReferral (via EHR)
California	✓	✓	✓
Kentucky	✓	✓	✓
Missouri	✓	✓	
Pennsylvania	✓	✓	✓
South Carolina	✓		✓

Project Process and Outcomes

To launch the SFPH: HSQ project, representatives from collaborating PHAs, CHCs and quitlines in each of the five participating states convened at a day-and-a-half meeting in Atlanta, GA in January 2019. Participants got to know each other, set goals and metrics for the SFPH:HSQ project, and determine next steps. Importantly, the meeting provided quitline representatives with the opportunity to become acquainted with their CHC counterparts, determine needs, and develop goals and priority actions to address over the course of the project to develop referral programs. This meeting was the foundation for the relationships between the quitlines and the CHCs and a springboard for the collaborative work accomplished throughout the project.

The kick-off meeting also provided an opportunity for quitline representatives to learn what CHCs knew about the quitline and whether they currently had a tobacco screening and cessation referral process established. A surprise was the lack of awareness among the CHCs of quitlines. It became evident that an immediate first step required educating CHCs on what a quitline is, the services it provides and importantly, that it is an evidence-based free service available to their patients. As such, following the kick-off meeting and return to their states, quitline representatives provided technical assistance (utilizing resources such as quit cards, flyers, and brochures) and presentations to educate providers and staff at the CHCs on the quitline.

The next step was to develop and operationalize a referral program between the quitline and CHC. This

process varied by state due to several factors, mainly the mechanism by which the quitline could receive the referral and the capability of the CHC to send the referral. The type of referral programs established, the process taken to implement the programs, and outcomes achieved in each of the five states are summarized as follows.

California Smoker's Helpline & Curry Senior Center
Referral Type: Web-based
Process ▪ Assessed CHC needs and workflow. ▪ Provided education on the quitline referral options available. ▪ Discussed CHC workflow and referral capabilities. ▪ Helpline and CHC staff determined that web-based referral was the best method to implement initially. ▪ Helpline provided training to CHC staff on how to perform web-based referrals. ▪ Web-based referrals between Helpline and Curry Senior Center were successfully established.
Outcomes Achieved During the project, the Helpline began receiving referrals from Curry Senior Center. The Helpline continues to provide monthly reports on the number of referrals received and referral' disposition (counseling, materials, declined services, etc.). The reports help evaluate referral efforts and determine if additional technical assistance is needed to increase referrals.

Quit NOW Kentucky & Shawnee Christian Healthcare
Referral Type: Web-based
Process ▪ Established CHC needs and current workflow during the kick-off meeting. ▪ Subsequently provided the CHC with education on the quitline and referral options available. ▪ Web-referral elected as the preferred method. (Physicians viewed eReferral as potentially cumbersome to implement since it was not already a part of their daily routine.) ▪ CHC staff developed a referral form as part of the workflow to help facilitate the physician referring the patient to the quitline. ▪ Quitline representatives provided technical assistance to CHC staff on web referrals. ▪ Web referral process established between the quitline and Shawnee Christian Healthcare.
Outcomes Achieved Shawnee Christian Healthcare successfully integrated web referrals to providers' workflow.

Missouri Tobacco Quitline & Affinia Healthcare
Referral Type: Fax/email
Process ▪ Affinia Healthcare already had an established workflow for screening for tobacco use, attributed to Missouri Department of Health's contract with the Primary Care Association (PCA) to engage CHCs. The contract includes specific language that requires CHCs to screen for tobacco dependence and refer to the quitline. ▪ Despite having a workflow in place, Affinia Healthcare's provider engagement in making referrals was low. ▪ The quitline provided technical assistance on what the quitline is and how to perform fax and web-referrals. ▪ Web-referrals were integrated into established provider workflow to increase the number of referrals. Nevertheless, during a project meeting, another CHC presented their workflow and discussed their ability to increase provider engagement utilizing a new workflow, prompting Affinia to reassess and subsequently adjust their processes. ▪ Fax/email referrals were successfully implemented between the quitline and Affinia. ▪ The quitline developed a form to track referrals from Affinia and notify them of referral outcomes.
Outcomes Achieved Since implementation, the number of fax referrals received from Affinia Healthcare by the quitline has increased. Affinia has become a model CHC collaborator with the Missouri Tobacco Quitline, one that they would like to replicate with other CHCs in the state.

PA Free Quitline & Lancaster Health Center
Referral Type: eReferral
Process ▪ Need for CHC to gain an understanding of the quitline, and for the quitline to provide the CHC with materials to share with patients, was determined during the kick-off meeting. ▪ On return from the kick-off meeting, the quitline representative engaged the regional primary contractor for Lancaster Health Center to share materials with the CHC for use with their patients. (Eight regional primary contractors provide tobacco use prevention and cessation activities across Pennsylvania.) ▪ Quitline representatives helped the CHC establish a process to screen patients for tobacco use, including provision of education to staff on the 5A's Model for Treating Tobacco Use and Dependence. ▪ The team then focused on implementing a referral process and the quitline provided the CHC education on available referral methods. ▪ Staff members were particularly interested in implementing eReferral as an effective and efficient way to engage doctors' involvement; however, cost to implement was a concern. ▪ The quitline's program paying the $9,000 installation fee for clinics to implement the standard system of eReferral eliminated the cost barrier. ▪ Lancaster Health Center moved forward to work with the quitline to establish eReferral.
Outcomes Achieved Testing was completed and eReferral was successfully established with Lancaster Health Center. The quitline was also successful in having the quitline phone number include on patient discharge instructions.

South Carolina Tobacco Quitline & Hope Health
Referral Type: Fax
Process: ▪ The CHC's current workflow and needs were established during the kick-off meeting. ▪ Education was provided on the quitline and referral options available. ▪ The initial goal was to establish eReferral from the CHC to the quitline; however, during the project, South Carolina underwent a major transition in its quitline referral program, delaying implementation of eReferral. ▪ In the interim, South Carolina Tobacco Quitline worked with Hope Health to implement fax referral.
Outcomes Achieved Fax referral implemented and eReferral test files are underway with goal of roll out in 2020.

Lessons Learned

The following are valuable lessons learned during the SFPH: HSQ project for consideration by quitlines seeking to establish referral relationships with CHCs in their states. These include levers cited by quitline representatives as contributing to this project's success.

CHC awareness of the quitline and its services. Despite quitlines being established across the U.S. for over 20 years, there is still considerable room to increase CHC awareness of this tobacco cessation service. Through participation in the SFPH: HSQ project, quitlines recognized the need to increase outreach to and education of CHCs and other entities on the services quitlines provide and the resources and tools available.

In-person project launch. The face-to face kick-off meeting for the SFPH: HSQ project provided the foundation for the quitlines' relationship with the CHCs and was a springboard for the collaborative work accomplished throughout the project. Participants agreed that the connections established at the meeting paved the way for follow up work within each state, valuing the opportunity for quitline representatives to meet and work with their CHC counterparts, assess and determine needs, set goals and metrics for the project, and determine next steps.

Conveners to integrate cross-organization and multi-state initiatives. Several conveners supported the quitline-CHC partnership during the SFPH: HSQ project. NAQC staff supported the five state quitlines in their partnerships with the CHCs. Also, the ACS health systems representative for each state provided support to the state teams and was credited with ensuring accountability across stakeholders. The ACS representative followed up with team participants following the project kick-off meeting and frequently was the organization that coordinated and facilitated check-ins and meetings of state team members.

Subject matter experts and technical assistance. The quitlines and CHCs were invited to participate in bi-weekly ECHO (Extension for Community Healthcare Outcomes) sessions by Zoom web conferencing, providing them access to subject matter experts and technical assistance. (ECHO is a collaborative model of medical education and care management that empowers providers to provide better care to more people where they live.) The ECHO sessions were welcomed by participants as a constructive learning opportunity that fostered camaraderie and a sense of support. The ECHO sessions also allowed quitlines to gain greater insight into tobacco cessation challenges from national tobacco cessation experts, obtain technical assistance to address the challenges through review of case studies, and gain a "boots on the ground" perspective of how tobacco use impacts people in real life.

Champions and collaborators for implementing change. The HSQ: SFPH project provided quitlines with willing collaborators who were eager and poised to implement change. Participating quitlines established partnerships with their CHC and PHA counterparts, the ACS Health Systems Managers, and the state's Primary Care Association. To build on success, quitline representatives have sought other opportunities to identify and connect with CHC staff who embody the energy and drive necessary to implement a similar effort, i.e., project champions. Quitline representatives indicate that joining and attending coalition meetings for chronic diseases in

their state to be a helpful tactic to engage CHCs. As well as identifying and engaging CHC staff, these meeting help quitline representatives increase quitline awareness.

Workflow models such as the ACC Expert Consensus Decision Pathway for Tobacco Cessation Treatment. When seeking to establish a new workflow that incorporates tobacco cessation conversations and referrals to quitlines, health systems such as CHCs are encouraged to consider staff other than or in addition to primary care providers to facilitate the referral effectively and efficiently. Other qualified staff in the clinic, such as a medical assistant/screener or nurse, can assess smoking status and make the referral, or set up the referral to be made by the provider.

Quantitative measures of change.

While considerable progress was made in establishing referral programs between the five state quitlines and the CHCs, it is important to note that it required a substantial amount of the project period to plan and implement these programs. Although key outcomes are qualitative, approximately 140 referrals from the CHCs to the state quitlines took place April 1, 2019 to March 31, 2020.

Next Steps for Quitlines and CHCs

While the SFPH: HSQ project ended in March 2020, work will continue through the established relationships and referral programs. All participating quitlines intend to continue the connections they established with the CHCs, with some planning to apply the project learning to expand and engage additional CHCs. Specific next steps to be taken by each of the quitlines are:

The California Smokers Helpline will continue to monitor the number of referrals to the quitline from Curry Senior Center and – depending on funding - hopes to establish a regular schedule of continued check-ins with the CHC team.

Quit NOW Kentucky will continue to participate in workgroups with Shawnee Christian Healthcare. Inspired by the project outcomes, quitline and CHC representatives are also working on grant proposals to obtain funding to continue advancing tobacco cessation efforts established through the project.

Missouri Tobacco Quitline will remain responsive to Affinia Healthcare's requests for quitline resources and tools. Additionally, the quitline is exploring opportunities to share Affinia's success with other CHCs using a peer-to-peer approach, such as through a case study, webinar or formal presentation at a primary care association meeting.

PA Free Quitline will continue its partnership with Lancaster Health Center and is exploring options to replicate the process undertaken and outcomes achieved through the SFPH: HSQ project. One option is to identify and engage CHCs by adding a requirement to the state's regional primary contracts that holds these contractors accountable for engaging a quota of CHCs in their region.

South Carolina Tobacco Quitline will continue collaboration with Hope Health to increase awareness of tobacco cessation resources available to PHA residents and is expanding its referral program to launch before the end of 2020. The expansion will offer multiple methods for provider referrals to the Quitline, with an emphasis on electronic referral technology.

Concluding Thoughts

Establishing referral programs between quitlines and CHCs can increase the number of tobacco users who are connected to evidenced-based cessation services through secure information exchange and coordinated services. This is especially important for CHCs whose patient base includes vulnerable populations that experience a disproportionate burden of tobacco dependence. The HSQ: SFPH project provided the opportunity and support for five quitlines and CHCs to successfully establish referral systems. It is hoped that the lessons learned from their experience can be used to inspire additional quitlines to embark on similar efforts.

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