

University of Minnesota Family Medicine Residency Clinics Strengthen Treatment of Tobacco Dependence

Between October 2010 and June 2012, ClearWay MinnesotaSM provided the University of Minnesota Department of Family Medicine with funding and technical assistance to further integrate best-practice tobacco dependence treatment within four residency clinics.

The University of Minnesota (U of M) team focused their efforts on the Smiley's and Broadway Clinics in Minneapolis and the Bethesda and Phalen Clinics in Saint Paul, Minnesota. All four clinics, which operate under the Department of Family Medicine Clinical Services Unit (CSU) of the University of Minnesota Physicians, serve as training sites for medical residents specializing in family medicine, serve as training sites

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During the 21-month grant period, the U of M systems-change team worked toward implementing standardized tobacco user identification, documentation, brief intervention and referral processes, based on best practices in tobacco cessation across the four clinics.



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Standards Established Across Clinics

New, improved treatment standards

ClearWay Minnesota funding allowed the U of M systems-change team to emphasize the importance of addressing tobacco use in the outpatient clinic setting as a way to reduce the burden of disease and poor health outcomes associated with tobacco use.

The U of M team, consisting of representatives from each clinic, formulated a standard minimum intervention to be implemented in each clinic, based on the *United States Public Health Service Guideline, Treating Tobacco Use and Dependence – 2008 Update*, otherwise known as the “5 A’s” model.

The standard minimal intervention includes screening every patient for tobacco use at every visit, as well as assessing tobacco users’ willingness to quit and providing treatment referrals to those interested in quitting. While these intervention elements are standardized across the clinics, the way in which they are implemented varies from clinic to clinic due to differences in clinic culture and

operations. For example, at one clinic a medical assistant or nurse may provide patients with a referral to internal or external cessation counseling, while at another clinic these referrals are handled by physicians.

Adopting a team approach to intervention

In addition to developing standard work documents, all four clinics take a team approach to implementing the new tobacco-related protocols so the responsibility for treating tobacco use is shared among clinic staff.

For example, before patients see their physician, medical assistants or nurses ask about and document tobacco use

“If you take the point of intervention out of just the doctor visit and broaden it to a team-based approach . . . everyone on the team sees themselves as part of that [patient behavior] change process.”

--Christine Danner, Clinical Psychologist,
Bethesda Clinic champion

status and assess readiness to quit. The results of this assessment are then

shared with the physician. Physicians can then provide brief interventions and/or information about different counseling and medication options. Physicians can write a prescription for medication and/or refer patients for additional counseling (internally or externally). Referrals may also be handled by other team members such as medical assistants or nurses.

Provision of cessation options

Under the new tobacco treatment intervention protocols, tobacco users interested in quitting can opt to receive self-help materials, or be referred to telephone counseling through the Call it Quits Referral Program, which allows providers to refer patients to external tobacco cessation quitline services using a single fax form, regardless of a patient's insurance status.

Additionally, patients at the Bethesda or Broadway Clinics have the option of seeing a pharmacist or clinical psychologist on-site who can provide face-to-face counseling.

Physicians have also been trained to provide brief intervention counseling, discuss cessation medication options

with patients and provide treatment referrals. Clinic staff follow-up with all patients referred to telephone counseling to either congratulate them on their enrollment or to offer to schedule another appointment with their medical provider to review treatment options.

Monitoring implementation and quality of care

The U of M teams worked closely with Quality Improvement (QI) staff to establish discrete data points to monitor tobacco treatment delivery. For example, reports can show how often patients are offered assistance with quitting and the number of patients referred to and enrolled in telephone counseling at each clinic. This information is shared monthly with clinic managers who then post the reports on bulletin boards for all staff to review.

The percentage of smokers and number of telephone counseling referrals are also included in clinical dashboards for asthma, diabetes and cardiovascular patients and discussed at monthly clinical operations meetings.

Keys to System-Change Success

Commitment from key leadership

The U of M team recognized that executive support would be crucial to successfully implementing changes. The team worked diligently to garner support for their tobacco dependence treatment efforts by attending meetings of and having ongoing conversations with key leaders about the importance of treating tobacco dependence, and its impact on chronic disease management and related quality care measures.

As a result of these efforts, the chair of the Family Medicine Department, the CSU Operations Director and the CSU Medical Director became advocates for tobacco-related systems changes. Team members were then able to devote additional time to working on tobacco treatment efforts, including tracking and following up with patients referred to telephone counseling.

Empowered, multi-disciplinary teams

The U of M established a cross-clinic workgroup as well as multi-disciplinary teams within each of the

four clinics to work on tobacco systems-change efforts. The cross-clinic workgroup consisted of physician “champions” from each clinic, a quality improvement/IT liaison and the CSU Medical Director. The multi-disciplinary teams at each clinic typically included the clinic’s physician champion, nurse manager, clinic manager, front desk manager and a medical assistant. These teams met every one to two months during the systems change funding period to maintain momentum and stay on track with systems-change goals.

The multi-disciplinary nature of the team was beneficial to the systems-change project in that it allowed different perspectives to be considered during planning and implementation. Members of the team were also given flexibility to design and pilot processes within their respective clinics. All team members were asked for their feedback in an effort to help streamline processes to each clinic’s particular culture and environment. This feedback and piloting process allowed members of the team to take ownership of the processes and

strengthened belief in the importance of treating tobacco use dependence.

Standard work documents for each clinic were created delineating processes for tobacco dependence screening and referral. While each clinic is expected to ask all clients about tobacco use at every visit, assess client's readiness to quit and provide referrals to cessation counseling, if requested, each clinic is able to implement each of these elements as best suited to their clinic culture. Each step in the process or protocol is tied to a particular job position, not an individual person, which lessens the impact of staff turn-over. The standard work documents are reviewed with all new employees.

Technological challenges did not impede progress

Despite delays in the roll-out of a new electronic medical records system across several clinics, the U of M team was able to develop a solid intervention process using the current system.

Concurrently, the U of M workgroup consulted QI staff to develop a list of changes they intend to have integrated into the new electronic system to help

further streamline tobacco intervention and monitoring efforts.

"Respect the limits of the EMR but don't let the EMR keep you from implementing a process."

--Christine Danner, Clinical Psychologist, Bethesda Clinic champion

Link efforts to other quality improvement initiatives

The U of M recognized that tobacco systems change efforts were only one of many competing quality improvement initiatives within the system.

In order to elevate the importance of these changes, the team linked their work with that of other high priority initiatives within the residency clinics. For example, treatment of tobacco

"Since many of these [quality improvement] projects were related to disease states that are impacted by tobacco use, I think there was synergy around the efforts."

--Dana Brandenburg, Psy.D., L.P., Phalen Clinic champion

dependence is a key factor in the alleviation of several chronic diseases, such as diabetes, asthma and cardiovascular disease. Members of the team reemphasized to physicians, physician residents, staff and administrators how treatment of tobacco use dependence would help them improve on their health care quality measures and ultimately help reduce the burden of tobacco-related illnesses.

Initiative Impact

As a result of the U of M residency clinic's systems change efforts, patients will be more routinely screened for tobacco use and will be more likely to receive assistance quitting tobacco. The more assistance patients receive, the more likely they will attempt to quit or be able to quit successfully. Quitting tobacco use will greatly improve the health of patients while reducing costs associated with treating tobacco-related illnesses.