Texas Tobacco Summit

Best Practices and Cessation Services: Working with FQHCs and Community Clinics

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Delivery of Tobacco Treatment Within Healthcare Systems

• 70% of smokers see primary care provider once per year

• Healthcare systems ideal infrastructure for treatment delivery, yet treatment not well integrated within systems

• Referrals to quitlines in primary care settings low despite well documented efficacy and cost-effectiveness

• Even when referred to quitlines by providers, large majority of smokers fail to follow through

• Crucial trajectory is to formalize partnerships with healthcare systems that include formal referral mechanisms
T2 Translational Research: Partnerships to Enhance Treatment Dissemination

- Developed partnership with Harris Health to systematically connect smokers with treatment delivered via the Texas Quitline

- Harris Health among largest safety net health care systems
  - 90% of patients racial/ethnic minorities
  - > 50% live below poverty line, all uninsured or underinsured
  - 1 million unique patient visits per year

- Parallel project with Kelsey-Seybold Clinic (KSC)
  - KSC patients primarily employed, insured, and of higher SES

- Partnerships directly respond to calls to improve dissemination of evidence-based tobacco treatments through developing partnerships with health care providers

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Study Designs

- Parallel pair-matched, two-treatment-arm group-randomized trials
- Conducted in 10 Harris Health community health centers (18 months) and 10 KSC family practice clinics (9 months)
- Clinics randomized to “Ask Advise Connect (AAC)” or “Ask Advise Refer (AAR)” dissemination approach
Procedures

- EHR used to record smoking status and willingness of smokers to be connected *(AAC)* or referred *(AAR)* to Quitline
- LVNs trained to assess smoking status and advise smokers to quit at every visit when vital signs collected
  - **AAC clinics**: LVNs connected patients directly with Quitline through automated link in EHR
    - EHR link sent smokers’ names and phone numbers to MD Anderson; MD Anderson sent information to the Quitline within 24 hours
    - Quitline called patients within 48 hours; 5 call attempts made
  - **AAR clinics**: LVNs referred patients to Quitline by providing referral card and encouraging patients to call
- Treatment enrollment tracked and recorded by Quitline staff
  - Weekly status reports sent to MD Anderson (enrolled, declined, needs call back, unreachable)
Outcome Measures

RE-AIM conceptual framework used to evaluate reach, efficacy, and impact of AAC and AAR

Reach = \( \frac{\text{number of identified smokers that talked with Quitline}}{\text{total number of identified smokers}} \)

Efficacy = \( \frac{\text{number of identified smokers that enrolled in treatment}}{\text{number of identified smokers that talked with Quitline}} \)

Impact = Reach x Efficacy
Hypothesis 1: AAC will have greater reach than AAR because a much larger proportion of participants in AAC will talk with Quitline

Hypothesis 2: Efficacy of AAR will exceed that of AAC because smokers who follow up with referrals on their own will be more motivated to enroll in cessation treatment

Hypothesis 3: Impact of AAC will exceed that of AAR because of its much broader reach
KSC Study Flow

**Smoking status assessment:**
- 42,277 assessments
- 32,701 assessments represented unique patients

**11.2% smoking prevalence**

**Current smoker?**
- **Yes**
  - 3,663 unique patients
  - AAC Clinics
    - 2,052 unique patients
    - 567 accepted Quitline connection
      - 567 / 2,052 = 27.6%
    - 1485 declined Quitline connection
      - 1,485 / 2,052 = 72.4%
    - 233 talked with Quitline
      - 233 / 567 = 41.1%
    - 160 enrolled in treatment
      - 160 / 233 = 68.7%
  - AAR Clinics
    - 1,611 unique patients
    - 564 accepted Quitline referral card
      - 564 / 1,611 = 35.0%
    - 564 / 1,611 = 35.0%
    - 9 talked with Quitline
      - 9 / 564 = 1.6%
    - 9 enrolled in treatment
      - 9 / 9 = 100%
- **No**
  - 29,038 unique patients
  - 1,485 declined Quitline connection
    - 1,485 / 2,052 = 72.4%
  - 334 unreachable
    - 334 / 567 = 58.9%
  - 73 declined treatment
    - 73 / 233 = 31.3%
  - 555 did not talk with Quitline
    - 555 / 564 = 98.4%
  - 555 / 564 = 98.4%
  - 0 declined treatment
    - 0 / 9 = 0%
KSC Results

AAC associated with 13-fold increase in smoking cessation treatment enrollment compared to AAR

Harris Health System Study Flow

Smoking status assessment:
- 113,200 assessments
- 112,112 assessments represented unique patients

16.0% smoking prevalence

Current smoker?

Yes
17,959 unique patients

AAC Clinics
7,237 unique patients

2,941 accepted Quitline connection
2,941 / 7,237 = 40.6%

1,707 talked with Quitline
1,707 / 2,941 = 58.0%

1,060 enrolled in treatment
1,060 / 1,707 = 62.1%

AAR Clinics
10,722 unique patients

3,698 accepted Quitline referral card
3,698 / 10,722 = 34.5%

53 enrolled in treatment
53 / 56 = 94.6%

No
94,153 unique patients

4,296 declined Quitline connection
4,296 / 7,237 = 59.4%

1,234 unreachable
1,234 / 2,941 = 42.0%

56 talked with Quitline
56 / 3,698 = 1.5%

3,642 did not talk with Quitline
3,642 / 3,698 = 98.5%

7,024 declined Quitline referral card
7,024 / 10,722 = 65.5%

3 declined treatment
3 / 56 = 5.4%
AAC associated with a nearly 30-fold increase in smoking cessation treatment enrollment compared to AAR

CPRIT- and DSRIP-funded Studies

Use of an Automated EMR System to Link Underserved Smokers with Cessation Treatment
- Recently completed CPRIT grant to implement AAC at Good Neighbor Healthcare Center (GNHC)

Implementation of an Automated EMR System to Connect Smokers in a Safety Net Healthcare System with Treatment
- Ongoing CPRIT grant to implement AAC in Harris Health
- Collecting biochemically verified 6-month smoking abstinence rates
  - 7-day point prevalence (ITT) = (320/1,750) = 18%
  - 7-day point prevalence (completers only) = 320/1018 = 31%

Replicating AAC
- Ongoing project supported by CMS Medicaid 1115 Waiver (DSRIP)
- Implementing AAC in 3 FQHC systems comprising 8 clinics
- Collecting biochemically verified 6-month cessation outcome data
Summary

• AAC (vs. AAR) resulted in 13- to 30-fold increase in cessation treatment enrollment

• Among highest rates of treatment enrollment reported

• Effect size larger in safety net healthcare system

• Preliminary 6-month, biochemically confirmed abstinence rates between 18% (intent to treat) and 31% (completers only)

• Tremendous potential to increase tobacco treatment delivery

• Healthcare reform ensures systems-level programs like AAC could be integrate and sustained within systems
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