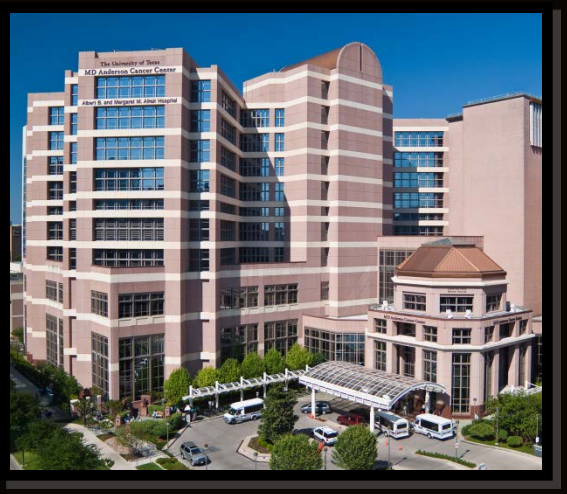

Texas Tobacco Summit

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

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THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

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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Funding provided by the CDC (R18DP001570; PI: JI Vidrine) and MD Anderson Cancer Center

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 = $\frac{\textit{number of identified smokers that talked with Quitline}}{\textit{total number of identified smokers}}$

Efficacy = $\frac{\textit{number of identified smokers that enrolled in treatment}}{\textit{number of identified smokers that talked with Quitline}}$

Impact = *Reach x Efficacy*

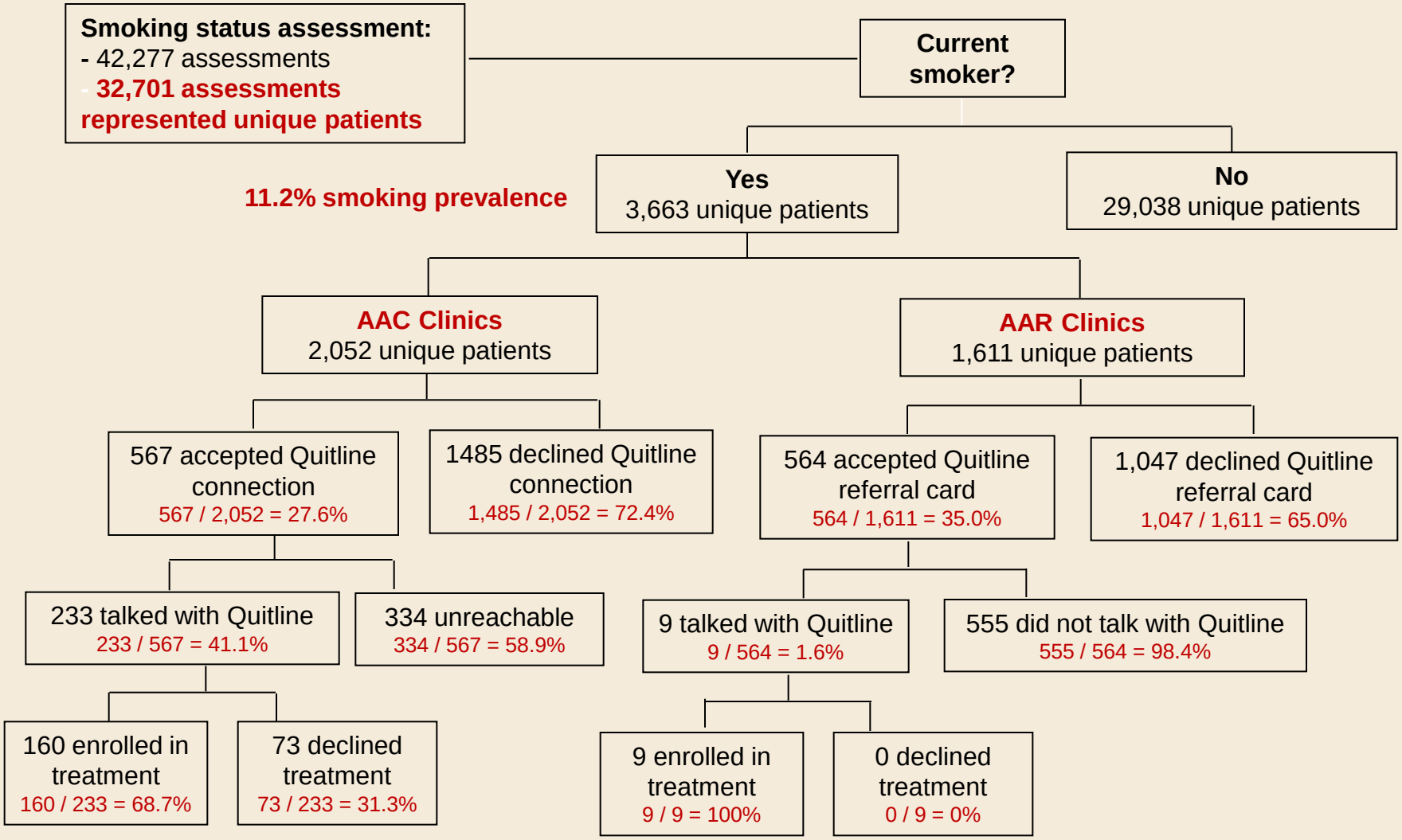
Hypotheses

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

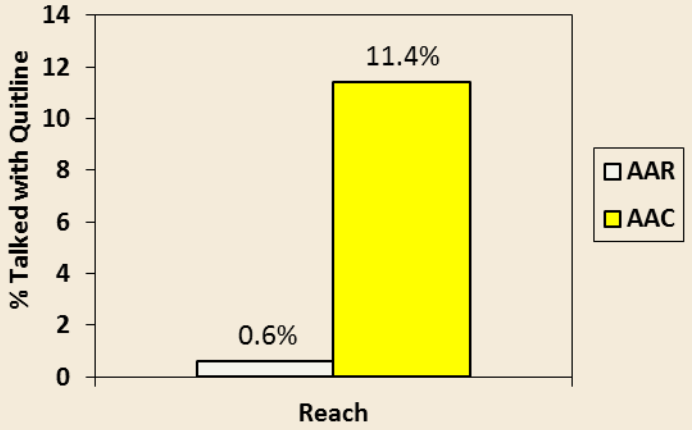
Hypothesis 2: Efficacy of AAR will exceed that of AAC because smokers who follow up with referrals on their own will be more motivated to enroll in cessation treatment

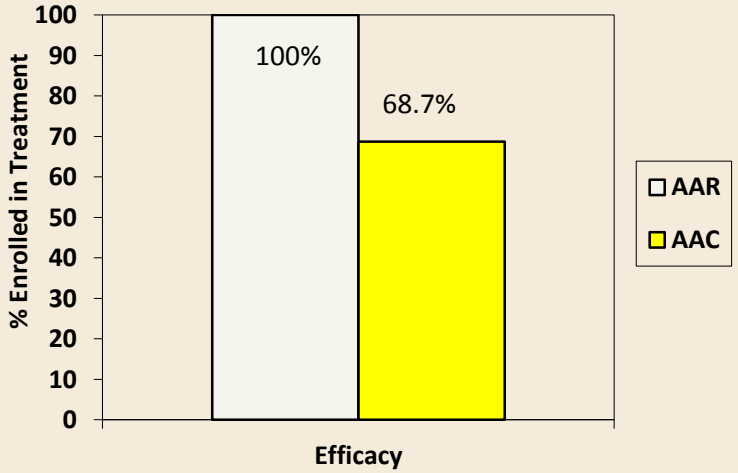
Hypothesis 3: Impact of AAC will exceed that of AAR because of its much broader reach

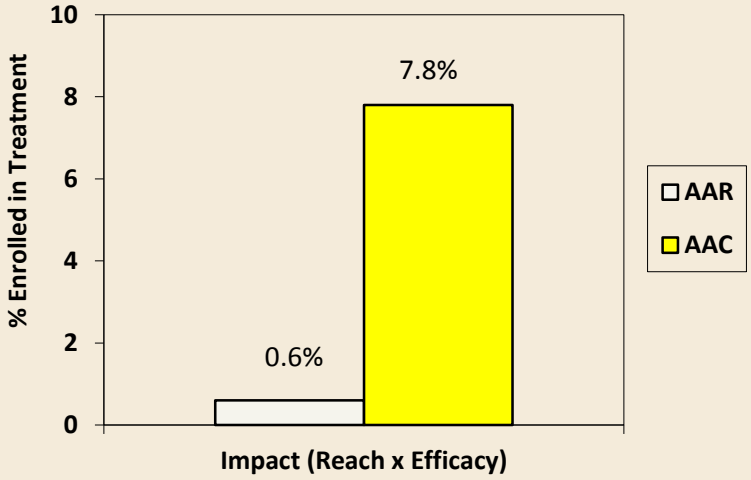
KSC Study Flow



KSC Results



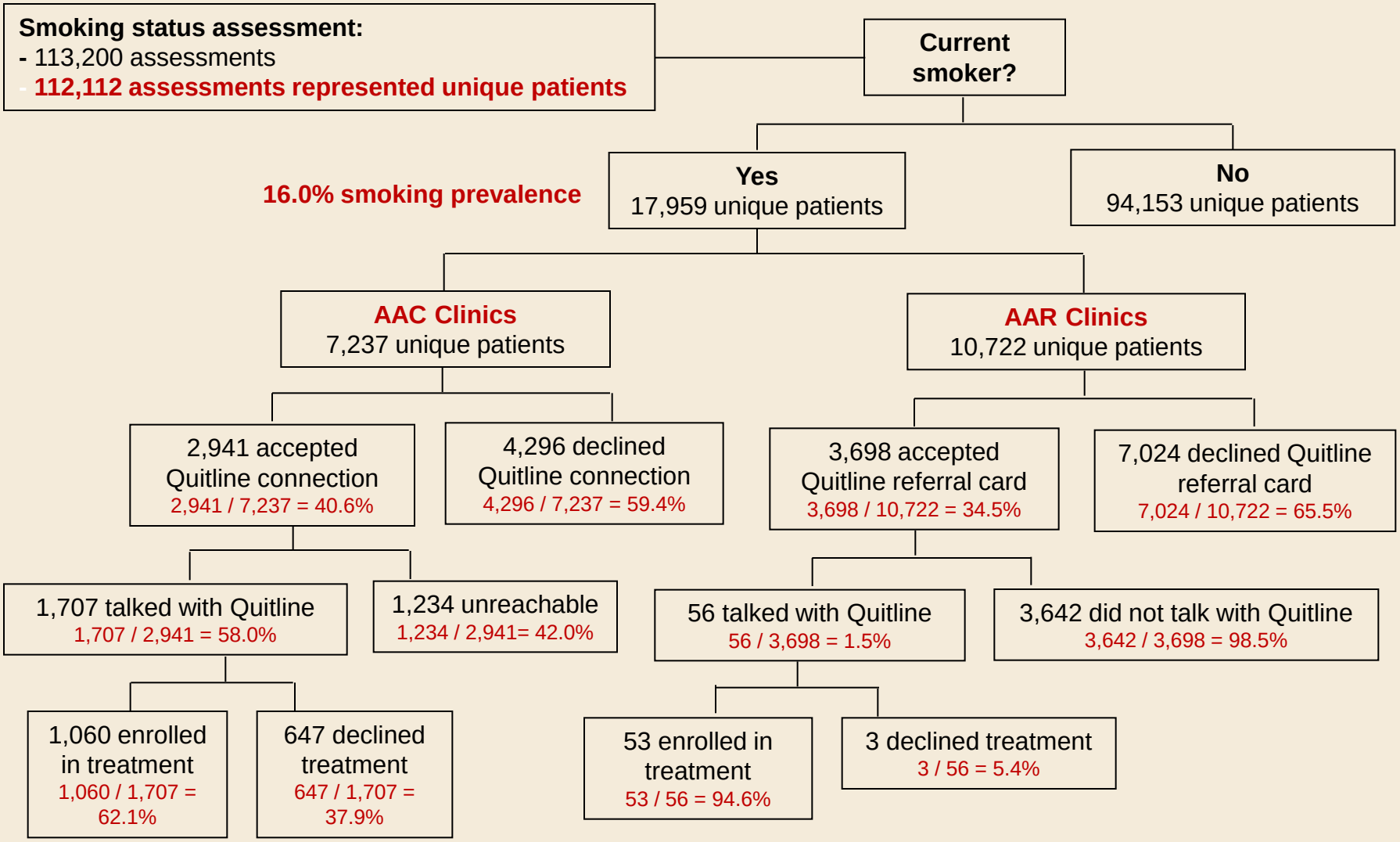




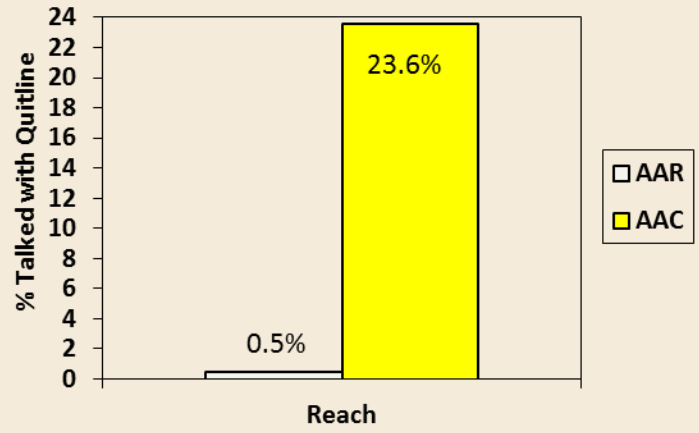
AAC associated with 13-fold increase in smoking cessation treatment enrollment compared to AAR

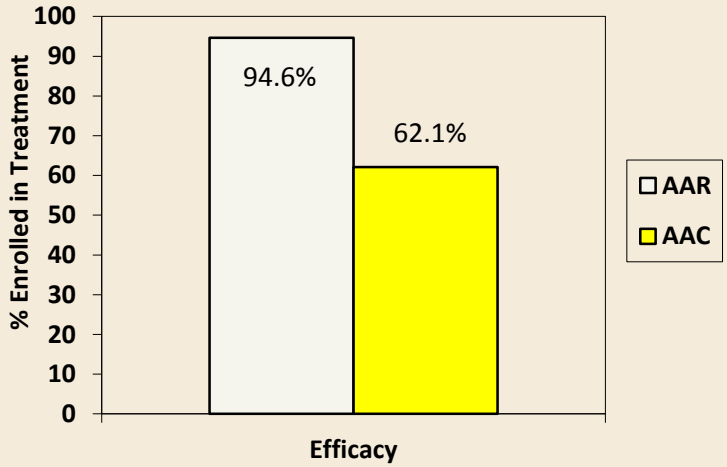
Vidrine JI, Shete S, Cao Y, Greisinger A, Harmonson P, Sharp B, Miles L, Zbikowski SM, Wetter DW. Ask Advise Connect: A New Approach to Smoking Treatment Delivery in Healthcare Settings. JAMA Intern Med 173(6):458-464, 3/25/2013.

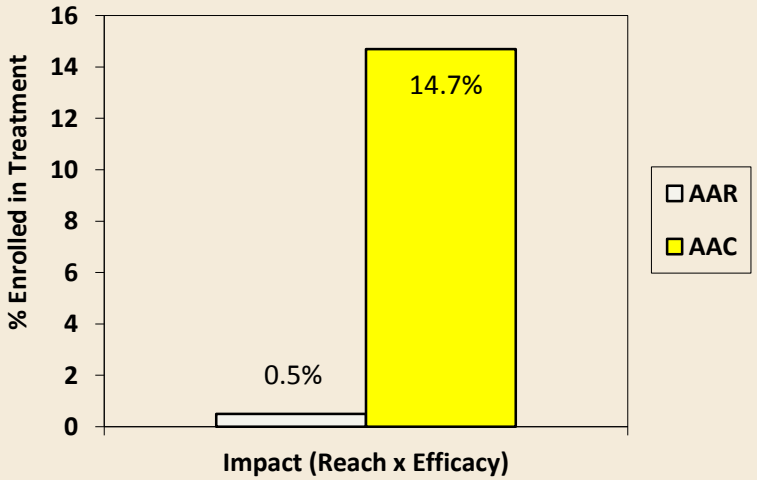
Harris Health System Study Flow



Harris Health Results







AAC associated with a nearly 30-fold increase in smoking cessation treatment enrollment compared to AAR

Vidrine JI, Shete S, Li Y, Cao Y, Alford MH, Galindo-Talton M, Rabius V, Sharp B, Harmonson P, Zbikowski SM, Miles L, Wetter DW. The ask-advise-connect approach for smokers in a safety net healthcare system: a group-randomized trial. Am J Prev Med 45(6):737-741, 12/2013.

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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