

Toward A Tobacco-Free MaineHealth System

Health Status Improvement Project

Action Plan

MaineHealth

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MaineHealth is in the business of providing healthcare. Our vision is to “Make our communities the healthiest in America.” As the state’s largest healthcare delivery system and a trusted source of high quality health services, we have a special commitment to set an example for our patients, clinicians, and employees as well as the communities we serve.

ACTION PLAN PROPOSAL

Introduction

In March 2000, MaineHealth announced that tobacco would be the focus of its second system-wide health status improvement initiative. Tobacco is the leading preventable cause of death and disability in the United States and in Maine. While national smoking rates have leveled off in the last decade, rates in Maine have increased in certain populations. Tobacco addiction rates in Maine have been consistently among the highest in the nation, causing devastating health and economic consequences.

So, why is MaineHealth taking tobacco on now, amidst the flurry of tobacco activity in the state? Actually, MaineHealth is taking on this initiative in part *because* of the state-level activity. The proposed budget for this project is very small. The tobacco settlement funds will provide MaineHealth with an opportunity to coordinate with state programs to ensure a consistent message. Furthermore, MaineHealth intends to pursue state tobacco settlement funds in its efforts to provide treatment to people with tobacco dependency. The availability of these funds means that the healthcare system will have the ability to reach people within the system and it will be able to spread its expertise into communities throughout the state of Maine.

MaineHealth charged a Tobacco Workgroup, with representatives from Member and Affiliate organizations, to lead this effort for the ten-county health system. The goal of the initiative is to become “as tobacco-free as possible” by 2002. That means reducing the disease, disability, and death associated with the use of tobacco products and secondhand smoke among our patients and their families, employees and related populations by: 1) preventing initiation of tobacco use; 2) promoting cessation of tobacco use; 3) reducing exposure to secondhand smoke; and 4) changing organizational norms and environments that support tobacco use.

The Workgroup reviewed the current scientific literature, best practice models, treatment modalities, state and national policies, and more. They discussed their organizations’ experiences in handling tobacco addiction and the chronic diseases it causes. This paper describes the Workgroup’s recommendations for confronting this tenacious problem.

According to the Centers for Disease Control (CDC), the goal of tobacco-use prevention programs is to reduce tobacco use related disease, disability, and death by:

- Preventing initiation of tobacco use among young people;
- Supporting all tobacco users in their efforts to quit;
- Eliminating the public's exposure to secondhand smoke and;
- Identifying and eliminating disparities related to tobacco use and its effects among different population groups.

The project has a two-year time horizon in which the group will develop, implement, and/or facilitate strategies to meet these objectives:

AWARENESS

1) Raise awareness of critical stakeholders¹ regarding tobacco use prevalence, associated costs, benefits of treatment and cessation, treatment efficacy, local resources, and institutional policies through a system-wide educational campaign.

A. First, target intra-organizational decision-makers (Boards of Trustees, administrators), employees, physicians and other healthcare professionals.

B. Second, begin to raise awareness outward, to the people in the communities we serve.

Although public awareness has grown over the past few years, statistics show that tobacco use prevalence in certain Maine populations is rising. For example, data from MaineHealth's first major health status initiative, **Ah! Asthma Health for Children**, revealed that more than 60% of enrolled children are exposed to over 4 hours of secondhand smoke every day. Smoking is the leading cause of preventable death in the state, claiming more lives than alcohol, drug use, car accidents, homicides, suicides, fires and AIDS combined. Approximately 21% of all deaths in Maine are attributed to tobacco use, claiming the lives of 2,300 Mainers each year. Healthcare and lost productivity due to smoking related ailments cost the State of Maine more than \$1.5 billion annually. These costs are borne not only by taxpayers (through the Medicaid program) but by employers and ultimately, by employees through higher health insurance premiums.

The organizations that make up the MaineHealth family of caregivers have a commitment to support those individuals who are dependent on a drug as addictive as heroin. Whether this support comes through policies, treatment, or otherwise, it is imperative for those individuals to know that we care and we are here to help make our communities the healthiest in America.

A system-wide educational campaign, marketed internally, would promote prevention and smoking cessation and would provide consistent messages that are reinforced in

¹ Critical stakeholders include Boards of Trustees, employees, patients, clinicians, and administrators.

multiple settings (hospital, outpatient facility, home health, etc). Increasing awareness among clinicians and administrators about treatment efficacy, benefits, and local resources increases the number of people who will quit using tobacco. Additionally, educating employees and their families, clinicians, patients, visitors and Boards of Trustees about tobacco dependence, could improve the chances of implementing policy changes (public and institutional).

TREATMENT

2) Implement and evaluate a tobacco use prevention and dependency treatments that are available and accessible to patients, employees/dependents and promote their widespread use.

Studies have shown that most smokers want to quit but have a difficult time battling the powerful addiction of nicotine. According to the CDC, a comprehensive tobacco-use prevention program should make cessation products and services more readily available and more affordable to smokers.

Research demonstrates that programs that combine behavioral counseling with nicotine replacement therapies have the highest rate of success. Over the next two years, the Tobacco Workgroup will work to improve and increase the accessibility of state-of-the-art treatment to patients, employees, and their dependents. A major strategy for reaching this goal is to ensure systematic screening for tobacco use across populations such as inpatients, children and parents, and pregnant women. In addition, healthcare providers will be encouraged to systematically refer all inpatients identified as smokers into cessation programs. Quality objectives will be set for referrals and cessation/abstinence after six months, similar to mammography and vaccinations. These quality indicators, combined with other data (e.g. assessment of community reach), will be the basis for program evaluation. Since the individuals that make up the MaineHealth system number in the tens of thousands, including patients, employees, affiliated clinicians and others, the Work Group will also assess how its efforts filter to the community, especially in areas where MaineHealth member and affiliated organizations are major employers.

TRAINING

3) Train physicians and other healthcare professionals throughout the system on using the Clinical Practice Guideline “Treating Tobacco Use and Dependence” (published by the U.S. Department of Health and Human Services) as the standard reference tool to provide effective tobacco dependence treatments.

Health professionals are typically not well trained to routinely identify and effectively treat tobacco dependence. Training providers to be integrally involved is essential to the success of this initiative. The Workgroup will use what is considered the “gold standard” of tobacco cessation: clinical guidelines from the USDHHS, Agency for Healthcare Quality and Research. The guidelines contain evidence-based strategies and recommendations designed to assist clinicians, smoking cessation specialists, and

healthcare administrators/insurers/purchasers in identifying tobacco users and supporting and delivering effective tobacco treatment interventions:

Ask: Systematically identify all tobacco users at every office visit.

Advise: Strongly urge all tobacco users to quit.

Assess: Learn whether participants in cessation programs are motivated to quit.

Assist: Effectively counsel and provide tobacco treatments.

Arrange: Schedule a follow-up contact.

POLICY

4) Implement institutional policies and support public policies that contribute to tobacco use, initiation, prevention, and treatment.

In order to be successful at helping people quit and stay quit, barriers to tobacco cessation must be eliminated or diminished. For example, when providers are trained to routinely identify and treat tobacco dependence, barriers to patient behavior change are reduced. When health systems increase the resources available to help smokers quit, such as behavioral counseling and drug therapies, other barriers are reduced.

The Agency for Healthcare Research and Quality (AHRQ) recommends coverage by health plans for cessation treatments. Studies have shown that significantly more smokers utilize counseling and nicotine patches, and subsequently quit, if their benefits allow full access to those resources. One strategy for the Work Group is to develop and implement a tobacco treatment benefit for employees of the MaineHealth system that maximizes utilization and outcomes.

In addition to treatment benefits, the health system can develop an infrastructure that is supportive to the quitting process. An example is a “tobacco-free institution” policy. The Tobacco Work Group will assess current tobacco policies in member and affiliate organizations. Our goal is to develop policies that are supportive to individual needs and that engage individuals, no matter where they are in the quitting process, while meeting community, system, and state standards.

Public policy also has the ability to support health systems and thus affect quitting outcomes. The Work Group will be asked to identify and achieve local and state public policies that contribute to decreased tobacco prevalence.

Outcomes and Evaluation

Measuring the effectiveness of the Tobacco Free Program is a high priority for the health system and its organizations. Data from a variety of sources will be analyzed and outcomes will be evaluated. Recognizing the two-year time horizon, the workgroup will identify short and “long”-term outcomes for each objective, and will develop indicators for each strategy, which are attainable within the time perimeters. Examples of outcome measures include the number of healthcare professionals trained to provide tobacco dependence treatment; number of educational presentations to stakeholders; number or percent of quit attempts made subsequent to program implementation; number of adopted policies that contribute to tobacco use, initiation, prevention, and treatment.

Overall Strategy

- Workgroup identified (by MaineHealth Management Team)
- Workgroup agrees on objectives, identifies strategies, indicators, outcome measures for *system-level* initiative and framework for members and affiliates
- Collects relevant benchmarking data
- Local groups begin work
- Tobacco Workgroup implements system-level strategies and monitors outcomes
- Local groups implement local strategies and monitor outcomes
- Outreach to other organizations with similar missions
- Secures additional resources needed for implementation and evaluation of system and local strategies.
- Reports to:
 1. Health Status Initiative Advisory Council
 2. MaineHealth Management Team
 3. MaineHealth Board of Trustees(On or about September 30, 2002)

Technical assistance and coordination will be provided by MaineHealth staff, including Deborah Deatrick, MPH, Director of Health Improvement and Education and Robert McArtor, MD, MPH, Chief Medical Officer, and Julie Knight, MS, Program Development/Policy Analyst.

The Tobacco Workgroup will oversee the program until its conclusion. They will provide guidance and direction to the program and develop a network of “champions” at their respective institutions to ensure that the work is carried out. Progress reports will be issued quarterly to the MaineHealth Health Status Improvement Advisory Committee, the Management Team and other interested parties. A final report will be prepared and presented to the MaineHealth Board of Trustees after the completion of the project, anticipated to be September 30, 2002.

Timeline

- Months 1-2** Action Plans for the system are finalized.
Priorities within each objective are identified, detailed strategies are developed.
Organizations develop individualized plans.
Data collection: Awareness survey, national, state, and MaineHealth smoking data.
Awareness campaign *design* begins.
- Month 3** Quality objectives for referral to and cessation/abstinence are set.
Data collection: baseline tobacco screening, baseline systematic referrals of inpatients, provider behavior assessed.
Benefit design is analyzed; recommendations are made.
- Month 4** Awareness campaign begins.
Begin distribution/education of practice guidelines.
Provider training begins and is ongoing.
Policy strategy developed.
- Months 5-12** Implementation of programs (e.g. training, treatment, awareness campaign, policy) ongoing; process evaluations continue.
- Months 13-15** Program evaluation.
Presentation of the one-year report to the MaineHealth Board of Trustees and other stakeholders.
- Months 15-24** Program models expanded to increase program reach (e.g. outpatient population)
Awareness campaign continues.
Provider training and education continues.
Policy initiative implementation begins.
- Months 22-24** Program evaluation completed.
Preparation of final report and presentation to MaineHealth Board of Trustees and other stakeholders.

Budget

The total budget for the project is estimated at \$52,500 and includes personnel, supplies, consulting, printing, and production costs and travel. Additional funds will be sought for specific projects, such as enhancing or expanding tobacco treatment programs.

Appendix I

Tobacco Workgroup Members

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