AAFP Tobacco and Nicotine Prevention and Control Chapter/Family Medicine Residency Program Mini Grants

Final Report

2016-2017

Each question in this Final Report should be answered thoroughly and completely.

Describe your project. Please answer the following questions.

1. **Why did you choose this project? In other words, how was it relevant to your chapter/residency?**
   NJAFP and DAFP had just started a large quality improvement education project aimed at the ABCS of treating T2DM – A1c, blood pressure, cholesterol and smoking. Tobacco cessation is a critical need for any patient with T2DM who smokes. While most primary care practices report high percentages of patients counseled for tobacco cessation, the quality of that counseling and the documentation of the cessation plan varies. This project was the perfect complement to the ABCS of Diabetes project.

2. **What did you do and how did you accomplish it?**
   We supplemented our curriculum with additional tobacco cessation education and added a partnership with the local American Lung Association to provide additional resources. We reinforced that learning with data collection on cessation-related practice changes and tobacco counseling data from the practice EHRs.

3. **What were your goals and to what extent did you achieve them?**
   As stated in our application, we aimed to (1) train practices to use a brief, evidence-based intervention (AAR) and (2) help link practices with cessation services, such as the Quitline. The availability of a Philadelphia-based cessation speaker meant we extended our goals to include (3) change provider attitudes toward patients with tobacco addiction.

   We provided this training at the first learning session for practices participating in the ABCS project, which spans New Jersey and Delaware. It was held Feb. 10 in Philadelphia. You can view the AAR and tobacco cessation sessions at http://njafp.org/content/abcs-diabetes.

   Our intervention training was specific to Ask, Advise, Refer and presented by a trainer from the American Lung Association. 95% of attendees said they intended to implement a new strategy in their practice based on that training. Only 2 people answered that they wouldn't make changes, and 1 of those attendees already uses AAR.

   Referring to the Quitline is a featured intervention in the Lung Association's AAR training so it is among the strategies practices aim to implement. The trainer presented on many cessation options, and there was robust conversation about how practices can access those resources, both online and in their communities. Participants were surprised at how many options there are and how many local services are available.

   While quantitative data on the tobacco addiction session was lost to a non-functioning ARS, pulmonologist Frank Leone's presentation was among the day's most popular. He's very animated and actively engages attendees, asking lots of questions. He challenges healthcare providers' perceptions about smokers, who are often viewed as lacking the will power and strength of character to quit. Dr. Leone helps providers to see smoking for what it is – an addiction that shortcuts any desire to quit and a disease that should be treated and managed over the patient's lifetime. One participant said it was worth traveling through Philly morning rush hour traffic just to participate in his presentation.

Bonus: NJAFP also has scheduled a full-day Freedom From Smoking training June 22 at the NJAFP office so that practice staff can be trained to become certified ALA Freedom from Smoking counselors, providing participating practices with practice-based counseling services.

4. **How did you measure your goals?**
   Analysis included onsite evaluation and conversations with participants and an online evaluation post-event. Unfortunately, we had technical difficulties with our ARS and weren't able to capture all responses.

   We're still in the process of collecting tobacco cessation counseling data from participating practices. "If you don't measure it, you didn't do it" is a QI motto, and we expect practices to implement change through documented small tests of change and measure counseling using their EHR.

5. **How did this project benefit your chapter/residency? Please provide examples.**
   We were able to deliver expanded tobacco cessation training and schedule a speaker who otherwise would have been unaffordable for this project. The resulting training and education improved knowledge and set in motion changes to practice that we expect to improve patient outcomes. This project was part of a 12-month initiative and we will continue to monitor outcomes.

   For example, one practice with already high counseling rates (at/near 100%) stated at the learning session that "we can always do better" and designed a PDSA to target patients with T2DM who smoke for referral to diabetic self-management education (DSME). It's an approach no other practice at the learning session took and aims to address both cessation and uncontrolled A1c. We're waiting for these patients' 3- and 6-month appointment reports for final outcomes. The PDSA report will tell us how many patients agreed to the referral, attended the DSME and what their cessation status and A1c levels were post-intervention.

6. **What challenges did you face implementing your project and how did you overcome them?**
   Participation at the Feb. 10 event was impacted by a snow storm. Smaller than expected participation at the event set us back in data collection and implementation of PDSAs. Key sessions were taped and archived online - http://njafp.org/content/abcs-diabetes - and a "catch-up" plan developed. Data, though off to a late start, is being submitted and NJAFP staff are following up with practices to verify data reports.

7. **Explain how you have or plan to disseminate the findings of your project with others.**
   This project is part of a larger T2DM project, the results of which NJAFP hopes to publish. Meanwhile, PDSA reports from the Feb. 10 event are due May 26 and will be presented to the entire group of participating practices at learning session 2, scheduled for June 1. Results will be summarized and reported to the NJAFP and DAFP membership.

Describe how other chapters/residencies could learn from your project.

8. **Do you think that your project could be easily adapted by other chapters/residency programs? Why or why not?**
   This project can be adapted because local ALA chapters are nationwide. Partnership with ALA opens up opportunities for resources for the chapter – training and speakers – and members – local and online cessation services. This type of education and training can also be blended into existing programs, particularly those targeting chronic disease. Implementing AAR is a great PDSA, even for practices who have never done a PDSA. NJAFP and DAFP hope to provide sample PDSAs to share.

9. **What recommendations would you have for other chapters/residencies who want to replicate your project?**
   - Blend with an existing program. So many practices already have high counseling rates so the topic alone may not have a strong enough draw.
   - Make it super practical. Practices already know they need to help patients quit tobacco. They want to know how to do it – give them tools and sample tests of change.

- Don’t forget the MIPS angle. Tobacco counseling is on the list of MIPS measures. If a practice’s counseling rates need improvement, this program can give them the roadmap to improvement and better payment.
- Partner with your local American Lung Association. There are more cessation resources than we ever expected.
- Address provider attitudes about patients who smoke. That bias is real and a barrier to better outcomes.

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NOTE: AAFP would like to help disseminate your good work by sharing your project with others via the AAFP Mini-grant web page. Please indicate whether you consent to AAFP sharing on its website your project results, poster, final report and contact information. ☒ **Yes** ☐ **No**