A. COVER PAGE

Project Title: Implementation of Enhanced Tobacco Use Measures and Intensive Training in New York

Grant ID*:* 16968713

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ABSTRACT

The focus of this Pfizer Independent Grant for Learning and Change is to develop and implement a new comprehensive measure for tobacco use and cessation attempts within NYS OMH facilities. This is a large system that serves over 23,000 outpatients with serious mental illness (SMI) per year. Improving documentation of tobacco use and cessation attempts through the electronic health record (EHR) is a powerful strategy that increases smoking cessation interventions provided by health care professionals in primary care settings. We will implement a new tobacco use measure in the statewide EHR through a series of training sessions, quality improvement meetings and Learning Collaboratives. A similar approach was used successfully in NYS OMH to implement health screenings for cardio-metabolic disease. Once in place, the measure will be used to evaluate other tobacco interventions and give ongoing feedback to individual clinics and providers. This activity promotes systems change and is synergistic with other planned efforts by NY OMH to provide intensive training for its health care professionals and to develop tobacco free policies for these clinical sites. Implementation of tobacco use and cessation attempts through the electronic health record (EHR) will accomplish many things in the OMH system: it will raise the awareness and importance of addressing tobacco, it will allow for improved ongoing measurement of tobacco use and quit attempts, and it will be an effective longitudinal measure to evaluate the impact of tobacco-related activities on patient outcomes.

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C. MAIN PROPOSAL

Overall Goals and Objectives:
The goal of this project is to reduce tobacco use rates and enhance smoking cessation efforts in outpatients served by the New York State Office of Mental Health (NYS OMH). The goals of this Pfizer Independent Grant for Learning and Change (IGLC) are to improve the competence of healthcare professionals and performance of healthcare systems so that all smokers can be helped to quit. The emphasis is on the special population of smokers with chronic mental illness and the approach addresses systems change.

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TECHNICAL APPROACH

Assessment of Need for the Project

Although public health interventions have resulted in decreased smoking rates in the United States general population over the last fifty years, smokers with mental illness have not benefited as greatly from these efforts. Smoking rates in individuals with a mental illness or substance use disorder are at least double that of the general population (1,2). Some estimates are that two-thirds of current cigarette smokers have a past or present mental health or substance abuse disorder and there is evidence that this group consumes a sizeable portion of the tobacco sold in the United States (3;4). Individuals with mental illness suffer many consequences of tobacco use including 25 years of life expectancy lost, due to excess mortality

from cardiovascular disease (5,6). Despite these statistics, smokers with mental illness have less access to tobacco dependence treatment across the health care spectrum (7;8), and specifically in the behavioral health setting. A newly released SAMHSA report indicates that only one in 4 mental health programs provide tobacco cessation services (9). A review of nine community mental health sites revealed that less than half of the clinicians reported even asking their patients about smoking (10). This is shocking given that screening for tobacco use has been a recommended health care initiative for medical and primary care settings for more than 20 years and further demonstrates the traditional disconnect from physical health care in behavioral health settings.

New York is a recognized leader in Tobacco Control and its Office of Mental Health has been championing efforts at addressing tobacco use in behavioral health populations for several years. In 2010, NY was one of 7 states selected to participate in a Leadership Academy Summit on Tobacco and Behavioral Health based on their readiness to participate in this interdisciplinary partnership (11). The goal of this 2-day Summit, co-sponsored by SAMHSA and the Smoking Cessation Leadership Center, was to develop statewide comprehensive tobacco cessation action plans. Through this initiative NYS OMH began to establish baseline smoking prevalence, set specific measurable targets, develop multiple strategies to achieve those goals, and identify methods to maintain the goals. Measuring baseline values of tobacco consumption in behavioral health populations was identified as a critical first step since it had traditionally not be measured comprehensively and systematically. New York used the 2011 New York State Office of Mental Health's Patient Characteristic Survey to estimate that 30% of patients with serious mental illness were smokers and 50% of patients with mental illness or substance abuse disorders were smokers. The Patient Characteristics Survey is collected from approximately 5000 mental health programs and has a major limitation in that it is collected every 2 years. At the Summit, New York set a target of reducing each group's smoking prevalence by 10% by 2015 yet sadly, despite these initial efforts, smoking rates have remained virtually unchanged and this target will not be met.

At roughly the same time, a different quality improvement measurement for physical health was being implemented within the state operated mental health clinics of NYS OMH. This was in response to research demonstrating increased morbidity and mortality in mental health populations due to high rates of heart disease, diabetes, and cancer. In 2009, NYS OMH implemented regular monitoring of 3 specified health indicators in order to improve rates of screening and intervention. The three indicators are body mass index (BMI), blood pressure, and smoking status (yes/no). These were selected because they are robust measures of health and predictors of risk; are understandable by consumers, families, and clinicians; and can be feasibly obtained at a mental health clinic without reliance on other caregivers or laboratory reports. The Cardiometabolic (CM) measure is collected quarterly in all outpatients treated in NYS OMH facilities.

Implementation of the CM measure throughout a diverse and geographically dispersed state mental health system in 2009-2010 required a concerted effort and included several steps including staff training sessions to ensure accurate collection and data entry of the measures (12). Monthly conference calls were useful in getting feedback from frontline users and regular feedback was given to Clinic Directors. Additional targeted support efforts were given to clinics

with less than 25% completion rates. Finally, Learning Collaboratives were established to promote sharing of strategies for ongoing training and implementation efforts. After one year, CM screening rates went from zero to 50% and continued to increase. Currently over 75% of all patients in the system are screened for CM risk factors with this measure. Co-investigators Miller and Smalling continue to monitor compliance with the CM measure through ongoing dialogue and site visits to state operated facilities.

Although implementation of the CM measure has been successful, tobacco use rates in the NYS OMH consumer population have been stable at about 50% since 2010. Other CM measurements however indicate some improvements through enhanced monitoring. For example, although the overall rate of obesity in the population is approximately 45%, approximately 14% of individuals who were obese at the first measure were not obese at follow up and certain demographic factors including gender and age predicted weight loss (unpublished data).

An additional source of statewide data on smoking and mental illness comes from the telephone survey overseen by the CDC, Behavioral Risk Factor Surveillance System (BRFSS). BRFSS data does not include clinical assessment of mental health problems but rather asks about experiences of stress, depression, or problems with emotions for 12 or more days in the last 30 days. Individuals reporting poor mental health using this measure have not seen a decline in smoking between 2000 and 2009 although rates of smoking did decrease in NY state during the same time period for those not indicating poor mental health (from 21 to 16%; 13). Thus three independent data sources confirm (PCS, current CM measure and BRFSS) stable smoking rates in individuals with mental illness in NY in the last 10 years. This suggests that even in NY State which is a highly ranked state in terms of tobacco control funding and efforts with clean indoor air policies, a high cigarette tax, and a funded program that includes cessation services, is still having difficulty reaching populations with mental illness and more efforts are needed.

The continued high prevalence of smoking among the mentally ill is likely related to several factors. One important factor may be the lack of access to smoking-cessation services in behavioral health settings. Behavioral health professionals have few opportunities for training in tobacco dependence treatment and have been left out of systems change interventions targeting primary care (14,15).The US Clinical Practice Guidelines for the Treatment of Tobacco Dependence are oriented to addressing tobacco in primary care or medical health settings (16).

Community based smoking cessation, which is brief and often localized to primary care practices, is unlikely to meet the needs of smokers with mental illness. There is evidence that those with mental illness experience barriers in accessing health care due to disorganized lifestyles and difficulty communicating needs; this makes it likely that they face similar barriers when trying to access community based tobacco treatments. Mental illness is often associated with heavy smoking, failed quit attempts, and early relapse back to smoking after a quit attempt, factors which warrant a specialized treatment approach (17-19). Paradoxically, although tobacco treatment has traditionally not been offered in behavioral health settings, this sector of health care is well-suited to deliver it. Behavioral health professionals have experience and training in the treatment of other addictions and are skilled in delivering

behavioral therapies. Enhancing system wide approaches for increasing screening and treatment capacity are effective strategies that have been employed in primary care and must now be applied to behavioral health.

Effective strategies to increase provider screening and delivery of cessation interventions in primary and general medical care settings include implementing a tobacco user identification system in every clinic, and providing education, resources and feedback (20). Electronic data capture through EHR or other mechanisms can be powerful tools to facilitate increased cessation interventions (21-23). An EHR-based initiative (Health eQuits) was recently implemented in 19 community (medical) health centers (CHCs) in New York City (NYC) to increase smoking status documentation and cessation interventions. At the end of the initiative, the mean proportion of patients who were documented as smokers in CHCs had increased from 24% to 27%, whereas the mean proportion of documented smokers who received a cessation intervention had increased from 23% to 54% (21, 22). Although this particular project was unique in that it offered financial incentives for increased documentation of services additional aspects to enhance compliance including quarterly clinic reports based on their EHR data. For some sites, provider-level reports also were provided upon request. The Health eQuits program manager called or visited practices quarterly to review reports and answer questions. Additional training and support were offered to all CHCs quarterly. Other EHR studies that did not include financial incentives also found increases in tobacco documentation and treatment (23), although these studies have been limited to primary care settings and none have been done in behavioral health settings.

Project Design and Methods

The focus of the Pfizer Independent Grant for Learning and Change is to develop and implement a new comprehensive measure for tobacco use and cessation attempts within NYS OMH facilities. This is a large system serving over 23,000 outpatients per year who typically have serious mental illness (SMI). The program will be implemented at more than 60 community mental health outpatient clinics operated by 16 adult psychiatric centers statewide.

Successful implementation of the new measure into the EHR will require training to enhance completion by behavioral health professionals. We will develop a 2-hour online training to enhance buy-in and provide instruction about tobacco assessment. The training will include Continuing Education credits for physicians, nurses and other behavioral health professionals. We will also employ additional strategies to maximize the accuracy of reporting by establishing an ongoing dialogue with these providers. This will include web-based training sessions to ensure accurate collection and data entry of the measures, monthly conference calls and the establishment of a Learning Collaborative to discuss sharing of strategies for ongoing implementation efforts. Learning Collaboratives (LCs) have been used in health care and are increasingly used in behavioral health. Fundamental elements include organizations working together using quality improvement methods to close the gap between potential and actual performance, learning from experts as well as one another and using data to track performance; this method is being used successfully in NY State to implement other best practices in behavioral health care (24).

We will provide feedback about progress with implementation to leadership so we can benchmark success and provide targeted support efforts for clinics with less than 50% completion. We will also designate a local "champion" from the clinical team at each clinical site to lead the effort because this was associated with improved tobacco documentation and practice change in a recent EHR study (21).

The new, expanded tobacco measure will collect information on any tobacco use, including emerging tobacco products like electronic cigarettes. It will also collect information about amounts used, quitting behavior, and use of tobacco treatments. Improved surveillance through documentation is an effective quality improvement practice that has been proven to increase the delivery of smoking cessation interventions in primary care. Newer studies of EHR have shown robust findings on increasing provider cessation activities. Implementing a tobacco-user identification system in every clinic is an important first step in health systems change to facilitate the delivery of tobacco treatment because it encourages clinicians to approach tobacco use as a chronic disease, requiring ongoing care similar to that offered to patients identified with depression or hypertension.

Better tobacco use measures are also essential to planning and monitoring, and can be used to evaluate other efforts to reduce tobacco use in the NYS OMH system. NYS OMH is leading other efforts to address tobacco use in its populations making this documentation effort timely and synergistic. Briefly, these efforts include tobacco-free policy and training health care professionals. State psychiatric hospitals and state operated mental health clinics are going tobacco-free. The timeline for implementation started in July 2014 and will be in place by May 2015. Many facilities have already successfully completed the process although more supports are needed to ensure effective treatment planning for tobacco.

NYS OMH also plans to support intensive training on treating tobacco dependence for mental health professionals employed at state operated facilities in 2015 and 2016 using the specialized training curriculum developed by Rutgers-RWJMS Division of Addiction Psychiatry. A recent evaluation of this training program showed that it was effective in improving tobacco treatment practices, compared to baseline, among psychiatrists and psychiatric nurses (24). The proposed documentation project is synergistic with other efforts to address training and tobacco-free policy and is expected to enhance the impact of the proposed environmental strategy (to develop and implement a new comprehensive measure for tobacco use and cessation attempts). This is ideal since some studies show that the mere adoption of EHRs, without supporting efforts may not be sufficient to increase the frequency and quality of smoking cessation interventions. Aspects of implementation that enhance the impact of EHRs include consideration of clinical workflows and designation of a local champion, incentives, and use of quality improvement approaches. Tobacco cessation interventions are most effective when they are implemented in conjunction with environmental strategies that motivate smokers to quit and support their efforts to do so. By promoting a tobacco-free environment and training behavioral health professionals to intervene, OMH is providing leadership and an environment for success with this tobacco effort.

F. Innovation. This project is innovative in several ways. Tobacco-cessation strategies employing an EHR are proven effective in primary care settings but are untested in behavioral health. This model for implementation of data collection on tobacco use measures in a large, statewide behavioral health system can be replicated in other states and settings. The project also links to and builds upon an effort funded by the state of New York for intensive training, thus maximizing resources. Implementing a comprehensive tobacco use measure in conjunction with other training and policy initiatives can increase the impact of each intervention and provide a source of rich data to evaluate the effectiveness of specific interventions. New York has been a leader in tobacco control, not only in the general population, but in populations with behavioral health conditions. The proposed work extends prior efforts and has a high likelihood of success.

Design of Outcomes Evaluation

The source of data is the NYS OMH electronic health record known as MHARS (Mental Health Automated Record System). It provides on-line, real time access to clinical information, including historical diagnosis, treatment plans, evaluations, and client medications. MHARS also facilitates clinical administrative activities, such as service recording. MHARS has been structured in a dashboard format which allows quick easy access to patient records. MHARS accommodates the continuity of care between OMH facilities using abstracts of assessment data that is shared among the facilities that the client has received services from. There is admission documentation, physical assessment, psychiatric assessment, social assessment documentation, referrals, treatment planning documentation; documentation to record services for billing purposes, and discharge and services follow up documentation all collected within the MHARS electronic medical record. OMH treats the whole individual and MHARS is designed to document this and to act as a tool to feed data to the financial systems.

Currently, Cardiometabolic data is collected quarterly on all patients receiving services in OMH facilities. We will build on the existing CM measure and develop an enhanced tobacco use measure that includes more detailed questions on Tobacco Use and Cessation and then implement its completion in outpatients. The enhanced Tobacco Use Measure will be collected quarterly in combination with the CM measure. We will track the implementation rates of the new Tobacco Use Measure with a goal of 70% completion by the end of Year 2. We will use smoking rates at the beginning of the project to measure progress. Our goal is a reduction in tobacco use rates by at least 2% per year and a 25% increase in cessation behaviors in Year 2 compared to baseline (assessed in Year 1). Measures will be adaptable for other EHRs. Measures, methods of dissemination, and results will be presented in academic papers and at professional meetings.

Detailed Workplan and Deliverables:

Anticipated Project Timeline (4/15/15-4/14/17, 24 months):

The anticipated project timeline is 24 months (See Table 1). The initial two months will be used to finalize the exact questions to be incorporated in proposed tobacco measure. Efforts are already underway to identify questions that have been previously vetted and may be already in use in other health systems in New York. In this way this project is expected to be

highly collaborative with other groups and initiatives in New York such as the New York State Office of Alcoholism and Substance Abuse Services and the New York City Bureau of Tobacco Control. Although the project does not include patient identifiers we will obtain an expedited IRB review for the project through Rutgers University. In the initial 6 month period we will also work with the MHARS computer programmers to add the questions to the Cardiometabolic Dashboard in the EMR and troubleshoot the functionality of the new system. We will develop a 2-hour online training to enhance buy-in about the need to screen and identify patients for tobacco use. The training will include also instructions for completion of the new quarterly tobacco measure. Continuing Education credits for physicians, nurses and other behavioral health professionals will be provided at no cost to participants to enhance training completion which will also be archived and available on the NYOMH intranet for later viewing. The program will be implemented at more than 60 community mental health outpatient clinics operated by 16 adult psychiatric centers statewide. We can monitor completion of webinar training via registration to insure completion by key personnel at all participating sites.

Table 1. Project Timeline

Project Month	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	21-22	23-24
Prepare Study IRB	X	X										
Develop tobacco measure for data collection in EHR and work with programmer	X	X	X									
Develop 2 hour web-based CME training for data measure with continuing education credits			X	X								
Implement tobacco measure and web-based training					X	X	X	X	X	X	X	X
Monthly calls with sites to Discuss ongoing implementation issues and establish Learning Collaborative					X	X	X	X	X	X	X	X
Provide feedback reports on initial implementation rates							X	X	X	X	X	X
Analyze data and prepare final results for publication												X

We will also employ additional strategies to maximize compliance with measurements and accuracy of reporting by establishing an ongoing dialogue with these providers. In addition to web based training, we will conduct monthly conference calls and establish a Learning Collaborative with the target group. Learning Collaboratives are an effective strategy to discuss sharing of techniques for and barriers to ongoing implementation efforts and were used previously in the original CM initiative. We will provide feedback about progress with implementation to leadership so we can benchmark success and provide targeted support efforts for clinics with less than 50% completion. We will also designate a local "champion" from the clinical team at each clinical site to lead the effort because this was associated with improved tobacco documentation and practice change in a recent EHR study (21-22).

This measure will become an important benchmark that can be used to evaluate future tobacco control efforts within the NYOMH.

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