

**Developing a Community Based Tobacco  
Cessation Program:  
Lessons Learned from the Primary Care-Public  
Health Learning Community**



**HEALTH CARE HOMES/  
STATE INNOVATION MODEL  
WEBINAR**

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# Presenters



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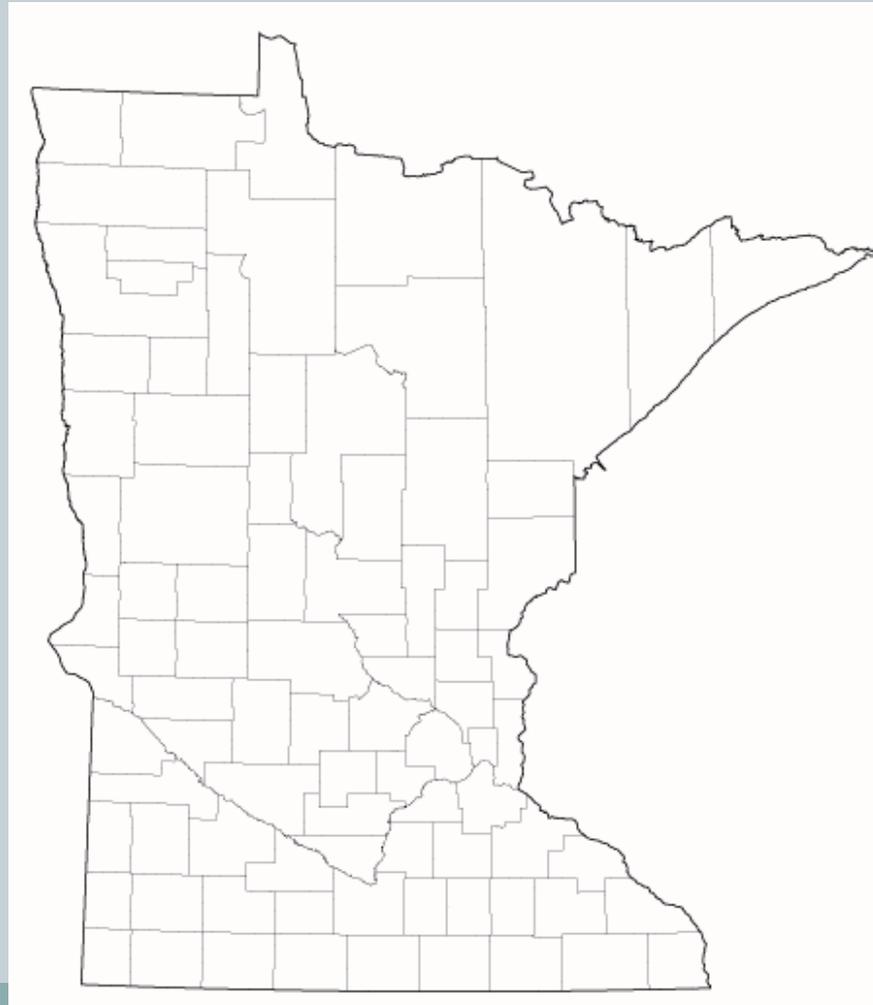


# Objectives



- **Understand the benefit of reviewing electronic health record and community data to identify a common community health priority and at-risk population.**
- **Learn how staff and resources were shared across public health and healthcare system.**
- **Learn new methods to conduct tobacco cessation outreach and increase community awareness of tobacco use.**

# Question 1. Where is Todd County?



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# Background on CCH-LP & Todd County HHS



- Previous work focused on community based projects
- Engaged since 2013 in Community Health Needs Assessment and regional survey process
- Leadership engaged in Research to Action's Primary Care and Public Health collaboration research study
- Long Prairie Wellness Network had built social capital and community engagement

# Staffing- Team Interaction



- **Initial staffing for the Learning Community included staff from CCH, CCH-LP, BLEND- CCH Foundation and Todd Cty HHS**
- **Added additional staff from CCH-LP as tobacco was identified as the main focus**

# Data Findings



- **Initial review of EMR data provided by CentraCare included analysis of risk factors and chronic conditions**
  - Reviewed by age, gender, race/ethnicity, zip code, insurance, and worksites
- **Data was useful for other areas of improvement**
  - Identifying no-shows
  - Hospital and ED visits
  - Co-occurring conditions

# EHR – CCH Population & Chronic Conditions

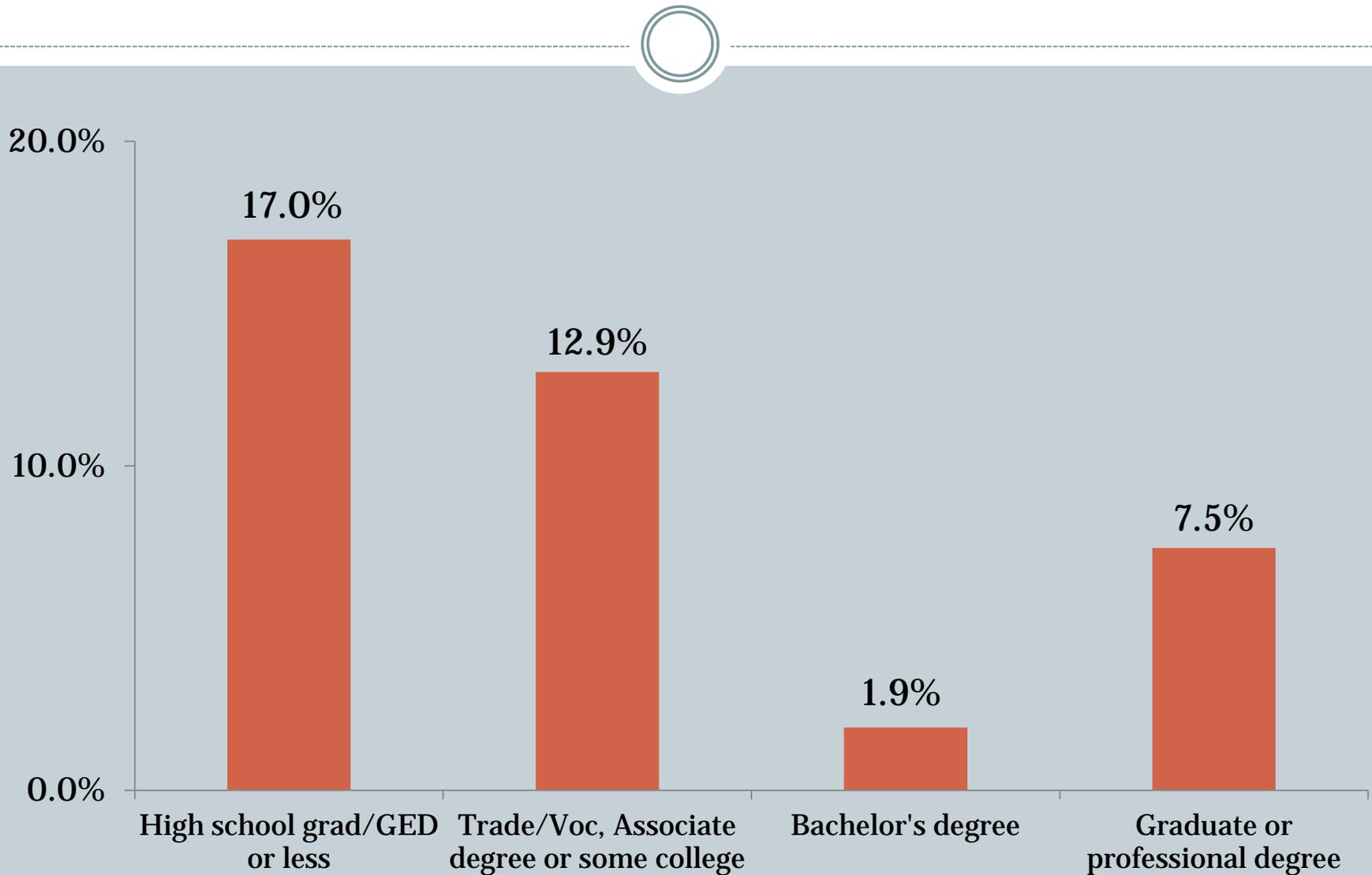
<u>Population 18-64 years old CCH Populations</u>	<u>% Dx w/Depress.</u>	<u>% Tobacco Users</u>	<u>% Dx Hyperten.</u>	<u>% Pre- Diabetic</u>	<u>% Dx w/Diabetes</u>
CCH LP&EV Total	10.4%	29.8%	12.5%	3.5%	8.4%
CCH LP&EV Hispanic	5.2%	11.0%	5.2%	3.4%	5.2%
CCH LP&EV Female	14.7%	24.6%	9.7%	3.5%	6.9%
CCH LP&EV Male	5.8%	35.5%	15.6%	3.5%	9.9%
All CCH	10.4%	22.7%	12.8%	6.7%	6.8%

# EHR – PMAP Clients

<u>CentraCare LP &amp; EV Clinic Population (ages 18-64)</u>	<u>%Tobacco Users</u>	<u>%Depressed</u>	<u>%Overwt &amp; Obese</u>	<u>Ave # ED Visits</u>	<u>Ave # Hosp Visits</u>
<b>Total LP-EV Population</b>	30.1%	10.9%	67.4%	0.48	0.76
<b>All PMAP Tobacco Users</b>	100.0%	23.4%	71.5%	1.19	1.49
<b>PMAP Non-Hispanic Females</b>	42.1%	22.4%	70.2%	0.98	1.46
<b>PMAP Non-Hispanic Males</b>	45.9%	10.8%	74.8%	0.70	0.94
<b>PMAP Hispanic Females*</b>	5.9%	8.8%	79.4%	0.44	2.03
<b>PMAP Hispanic Males*</b>	36.4%	0.0%	72.7%	2.45	2.91

*\*Small sample size*

# Current Todd County adult user of any tobacco, by education status



Source: 2016 Morrison-Todd-Wadena Community Health Survey

**Question 2. What percentage of adults in MN currently use tobacco?**



**A. 10%**

**B. 14%**

**C. 16%**

**D. 18%**

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A. 10%

**B. 14% - 2014 MN Adult Tobacco Survey (MATs)**

C. 16%

D. 18%

# Planning Phase - Project Shifts



- **Realization that HHS & CCH were not integrated at the clinic level**
- **Staff changes**
- **Tobacco data findings**
- **Opportunity with CCH system focus on tobacco cessation**
- **Greater understanding of PMAP barriers**

# Results of Planning Phase



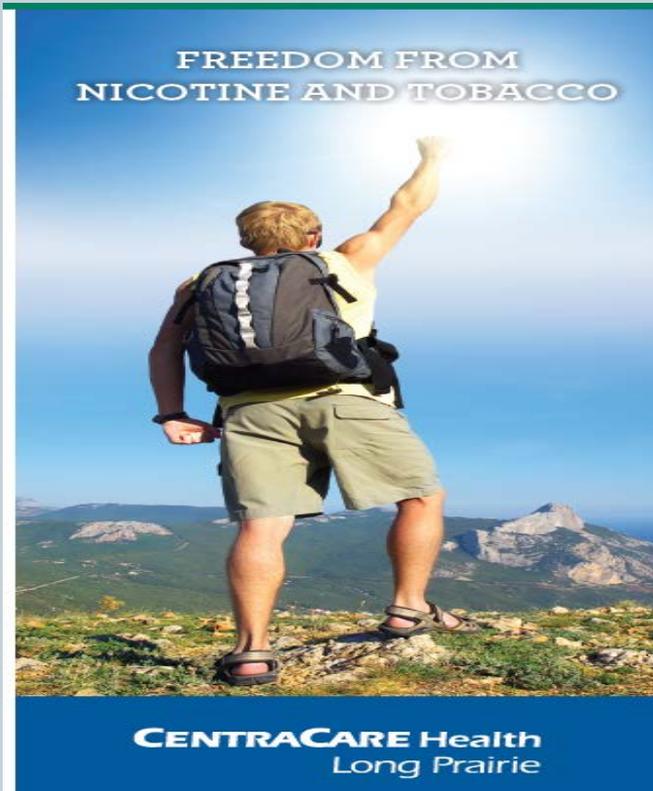
- **Developed logic model to clarify specific activity to focus next 3 months (i.e, referral system)**
- **Identified barriers to developing an integrated referral system (Fishbone diagrams)**
- **Created referral form and staff workflow**
- **PDSA cycles used to test and modify process as needed**
- **Identified data to track and monitor referrals**

# Implementation



- **Developed an integrated tobacco cessation referral process between Todd County HHS and CCH-LP.**
  - First tangible step to better integration of services
- **Identified methods to promote cessation within the community**
  - Creation of promotional materials
  - Outreach to worksites & community based organizations
- **Identified data points and methods to track data long term.**

# CCH Tobacco Treatment Program



- CCH commitment to staffing Tobacco Treatment Specialists
- Direct referrals to the program
- Promoting with worksites and community based organizations to reach low income population

## Question 3. Tobacco Treatment Specialists are trained to...



- A.** Understand the science behind tobacco addiction, nicotine withdrawal symptoms, and effective treatments for tobacco use
- B.** Provide clear and accurate information about the causes and consequences of tobacco use
- C.** Develop individualized treatment plans using comprehensive, evidence-based assessments and treatment strategies.
- D.** All of the above

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# Data Tracking



- **Continue to monitor internal and external referrals**
- **Will track cessation success through 6 week quit rates**
- **Developed a tobacco registry**
  - Breakdown by PCP, insurance, age, race, COO, Zip
- **Developed a report for pediatric tobacco exposure**
  - Identifies all children who reported exposure on their last well child visit

# Lessons Learned- CCH



- CCH- Long Prairie was not fully aware of the intake process and specific workflows at HHS, as well as general application workflows.
- Was helpful to appreciate that past partnerships with HHS were more at the administrative level versus at the front line staff level.
- Has been invigorating to let the data drive the project focus! Eye-opening Data!!!
- Both teams very passionate about the topic and for future partnerships to address at the Policy/System/Environment level.
- Multi-discipline team has been very helpful to appreciate all

# Lessons Learned- Todd County HHS



- **CCH-LP was not aware of many HHS programs or services**
- **EHR data supported anecdotal data, valuable source of information**
- **Needed involvement from all levels at CCH to better identify community health issues and solutions**
- **Addressing health equity long term will be needed to address public health concerns**

# Ongoing Collaboration & Relationship Building



- **Identified PMAP population as a priority population for continued collaboration**
- **Referral system will provide initial steps towards better coordinated care**
- **Commitment to increase staff awareness of clinic services and county programs/services**

# Ongoing Issues & Concerns



- **South Country Health Alliance will be a needed partner to improve the overall health of the PMAP population**
- **Will need to identify barriers to reduce no-show appointments**

# Advice for Other Agencies



- **Be open to the data findings**
- **Ability to change directions and focus is needed- grantors need to be flexible**
- **Look for opportunities/synergy within the agencies**

# Questions?



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