## SPECIAL ARTICLE

# Building and Scaling-up California Quits: Supporting Health Systems Change for Tobacco Treatment

Angela A. Kaslow, MPH,[1] Patrick S. Romano, MD,[1,2] Eleanor Schwarz, MD,[1] Ulfat Shaikh, MD,[2] Elisa K. Tong, MD[1]

The California Tobacco Control Program is the longest standing, publicly funded tobacco control program in the U.S. California's adult smoking rate declined from 23.7% (1989) to 11% (2016) but California still has more than 3 million smokers dispersed over 58 counties, requiring a coordinated approach to further tobacco control. Early California Tobacco Control Program success is rooted in public health policy strategies and a statewide media campaign that shifted social norms. In 2009, concepts for a coordinated approach were introduced by the California Tobacco Control Program in the state's first tobacco quit plan. The state quit plan called for public health's tobacco control programs to engage healthcare systems and insurers to work more directly with the California Smoker's Helpline (Helpline). With California's Medicaid (Medi-Cal) program expansion and the implementation of electronic medical record systems, health care plans and providers received additional support for system changes. Simultaneous with these changes, coordinated tobacco control efforts began, including California's Medi-Cal Incentives to Quit Smoking project (2012−2015). In the Medi-Cal Incentives to Quit Smoking project, safety-net providers and Medi-Cal plans were outreached and engaged to promote incentives for Medi-Cal members to utilize Helpline services. In another effort, UC Quits (2013−2015), the five University of California health systems used electronic medical record tools to promote tobacco treatments and electronic referrals to the Helpline. Now, as tobacco prevention is increasingly prioritized for quality improvement, California Tobacco Control Program is funding CA Quits, a statewide tobacco-cessation learning collaborative and technical assistance resource to promote integration of tobacco treatment services and quality improvement activities into safety-net health systems. CA Quits, in coordination with the Helpline, will connect public health departments, Medi-Cal plans, and safety-net providers to accelerate health systems change for tobacco-cessation treatment throughout the state.

## INTRODUCTION

The California Tobacco Control Program (CTCP) is the oldest publicly funded tobacco control program in the U.S. In its three-decade history, the CTCP has achieved remarkable success, most notably reducing the state's adult smoking prevalence by 53% from 23.7% (1989) to 11% (2016).[1] California now has the second lowest smoking prevalence in the nation, higher only than Utah.[2] Much of this success was achieved by employing population-level strategies including restricting and regulating smoking, taxing tobacco products, and a statewide media campaign to change social norms.[2] However, California still has more than 3 million smokers dispersed over 58 counties, requiring a coordinated approach to further tobacco

From the [1]Department of Internal Medicine, University of California, Davis, Sacramento, California; and [2]Department of Pediatrics, University of California, Davis, Sacramento, California
Address correspondence to: Elisa K. Tong, MD, 4150 V Street, Suite 2400, Sacramento CA 95817. E-mail: ektong@ucdavis.edu.

control. The CTCP has recognized the need to broaden strategies for reaching smokers.[3] California's smokers are disproportionately low-income, facing multiple health disparities and barriers to accessing health care. Reaching this population requires innovative strategies. Thus, in May 2009, CTCP hosted its first summit focusing on a new strategy for marketing the statewide tobacco quitline, the California Smokers' Helpline (Helpline), and encouraging healthcare providers and other professionals to refer tobacco users to it, called A Tobacco Quit Plan for California.[3] The Helpline, established in 1993 at the University of California (UC), San Diego, has demonstrated that its counseling services double the likelihood of long-term quitting.[4] The 2009 Quit Plan encourages healthcare system change, engaging healthcare providers and other stakeholders including social service organizations and employers, to prioritize tobacco-cessation treatment as one of the most cost-effective prevention strategies available.[5,6] Although the 2009 summit and Quit Plan[3] provided a call to action to pursue new innovations to address smoking in California, the full potential of these ideas would not be realized until the implementation of the Affordable Care Act (ACA) in 2010 and subsequent changes to California tobacco legislation in 2016. Following the 2014 ACA Medicaid expansion, the population covered by California's Medicaid program (Medi-Cal) grew to nearly 14 million people (one in three Californians), approximately 60% of whom are adults.[7] The prevalence of smoking in this population (17.5% in 2016) exceeds that of the general adult population,[8] representing an important opportunity for improving population health through smoking cessation.[9]

This Special Article describes the development of a new CTCP-funded statewide initiative called CA Quits. With origins in the 2009 Quit Plan for California,[3] CA Quits further supports population-based tobacco-cessation treatment and multisector collaborative partnerships between public health departments, Medi-Cal plans, and safety-net providers. These are detailed in the following article sections: California Public Health Partners (public health departments); California Health Plans (Medi-Cal plans); and California Safety-Net Health Care Providers (safety-net providers). National legislation and other statewide initiatives have all facilitated this system redesign (Figure 1). For public health, California's 2016 Proposition 56, which increased the tobacco tax by $2.00 per pack, has allowed CTCP to distribute increased funding for tobacco control to 61 public health departments (58 county and three municipal departments). For Medi-Cal plans, the ACA mandates expansion of tobacco-cessation treatment benefit coverage and stimulates statewide initiatives. For providers, practice changes have included efforts to implement and

report electronic medical record (EMR) meaningful use indicators, including the core measure of documenting tobacco use. Together, this creates a triad of partners for collaborating on population-based tobacco treatment (Figure 2). The purpose of CA Quits is to help integrate evidence-based smoking-cessation interventions into each California safety-net health system. This Special Article describes nearly a decade of steps toward system redesign, including the initial pilot of CA Quits and ongoing preparations for statewide expansion of the project.

## CALIFORNIA PUBLIC HEALTH PARTNERS

### Proposition 56: The Tobacco Tax Increase Initiative

In 2016, California voters passed Proposition 56, which increased the statewide tax on tobacco products by $2.00 per pack, bringing the total tax to $2.87 into alignment with the taxes imposed by most other states.[9] California's Proposition 56 levied taxes on all tobacco products including e-cigarettes.[9] Although California had been at the forefront of taxing tobacco products in 1988 when Proposition 99 was passed (implementing an unprecedented tax increase of $0.25 per pack),[10,11] by 2016, California's tobacco taxes were lower than those of 34 states ($0.87 vs an average of $1.65). A key distinction between Proposition 56 and the two previous California propositions implementing tobacco taxes, Proposition 99 (which supports tobacco control, education, and research) and Proposition 10 (which targets early childhood education), is that Proposition 56 also directs funding to support health care. Approximately $40 million is now allocated to train primary care and emergency physicians, $30 million is directed toward preventing and treating dental disease; most remaining funds (82%) are earmarked for services related to Medi-Cal, and the remaining toward tobacco prevention, research, and education.[12] With the passage of Proposition 56, state tobacco funding is now aligned with the Centers for Disease Control and Prevention's recommendations for "investing in comprehensive tobacco control programs,"[13] and the CTCP is well positioned to support healthcare system redesign initiatives. For example, CTCP provides public health partners that have adopted a cessation objective in their work plans with resources to work with healthcare systems to implement population-based tobacco-cessation programs. This additional support to county public health departments may help them to address smoking among the most vulnerable subpopulation groups, such as the homeless and those with mental illness and substance use disorders.[14,15] In addition, the Helpline, the state's population-based cessation resource, will receive

enhanced funding to increase its efforts with additional staff and outreach. These efforts align with the National Quality Strategy's triple aim, established under the authority of the ACA: Reduce the cost of health care, improve overall quality of care, and improve population health by addressing behavioral, social, and environmental determinants.

## CALIFORNIA HEALTH PLANS

### Medi-Cal Incentives to Quit Smoking project

California's Medi-Cal Incentives to Quit Smoking (MIQS) project (2011−2015), funded through the Centers for Medicare & Medicaid Services (CMS) Innovation Center, was a flagship project for the California Department of Health Care Services (DHCS) Strategy for Quality Improvement in Health Care.[16] As described elsewhere in this supplement, the MIQS project offered modest financial and cessation-related medication incentives to encourage Medi-Cal members who smoke to seek cessation services with the Helpline. The MIQS project emphasized healthcare provider and plan outreach, rather than traditional media, to promote and reinforce messages.

### Department of Health Care Services All-Plan Letters

With the growth in Medi-Cal enrollment following the implementation of the ACA, and Medi-Cal's transition away from fee-for-service care, the 28 Medi-Cal managed care plans have assumed a greater role in population health.[17] DHCS now convenes health education staff from each Medi-Cal managed care plan to collaborate on quality improvement[18] as the Health Education and Cultural and Linguistic Workgroup. This builds on earlier quality improvement collaborations.[19]

To guide Medi-Cal managed care plans on best practices and ACA-related requirements, DHCS disseminates All-Plan Letters (APLs), which now includes tobacco cessation. The ACA required that insurance beneficiaries be provided access to all preventive services that receive an A or B recommendation from the U.S. Preventive Services Task Force without cost sharing. The U.S. Preventive Services Task Force has a Grade A recommendation supporting tobacco-cessation services, including individual, group, and telephone counseling and all medications approved by the Food and Drug Administration for tobacco cessation.[20] These tobacco-related provisions have received little publicity but have the potential to contribute greatly to improving health outcomes while reducing healthcare costs.[21] In 2014, DHCS drafted APL14-006 to codify the ACA tobacco recommendations but delayed its release to alleviate concerns

about implementation challenges.[17] In November 2016, DHCS released APL16-014 on "Comprehensive tobacco prevention and cessation services for Medi-Cal beneficiaries." Topics include (1) initial and annual assessment of tobacco use for each adolescent and adult beneficiary; (2) offering individual, group, and telephone counseling for beneficiaries of any age who use tobacco products; (3) coverage of Food and Drug Administration −approved tobacco-cessation medications (for nonpregnant adults of any age); (4) services for pregnant tobacco users; (5) prevention of tobacco use in children and adolescents; (6) provider training; (7) identifying tobacco users by managed care plan providers; and (8) tracking treatment utilization of tobacco users.

This APL further describes how all Medi-Cal members must annually be asked about tobacco use as part of the required Staying Healthy Assessment,[18] although Medi-Cal managed care plans are not yet required to electronically capture, manage, or share their Staying Healthy Assessment data. Currently, Medi-Cal estimates tobacco prevalence and treatment rates from the Consumer Assessment of Healthcare Providers and Systems® survey, but it has sampling limitations.[22] Medi-Cal managed care plans are not yet required to adopt and report tobacco assessment and counseling as a quality metric for Healthcare Effectiveness Data and Information Set® Reports,[22] although this is a goal for the future.

## CALIFORNIA SAFETY-NET HEALTHCARE PROVIDERS

### Public Hospital Redesign and Incentives in Medi-Cal

Tobacco assessment and counseling has become an important quality metric for California safety-net hospital clinics participating in pay for performance programs administered by DHCS. During 2010−2015, California's Bridge to Reform 1115 Waiver program (partially funded by CMS as a waiver under Section 1115 of the Social Security Act) required 17 designated public hospitals (DPHs) to measure an outpatient tobacco assessment and counseling (combined) metric, as defined by the National Quality Forum (#0028).[23] The initial results from assessing this tobacco metric ranged from 1.6% to 97.9% (average 44%), but DPHs varied widely in terms of the methodology used including sample size.[24]

In the 2015−2020 Medi-Cal 2020 1115 Waiver, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program,[25] the outpatient tobacco assessment and counseling metric was incorporated into three required DPH projects (Behavioral Health Integration into Primary Care, Primary Care Redesign, and Specialty Care Redesign) and the elective Million Hearts project.[26]
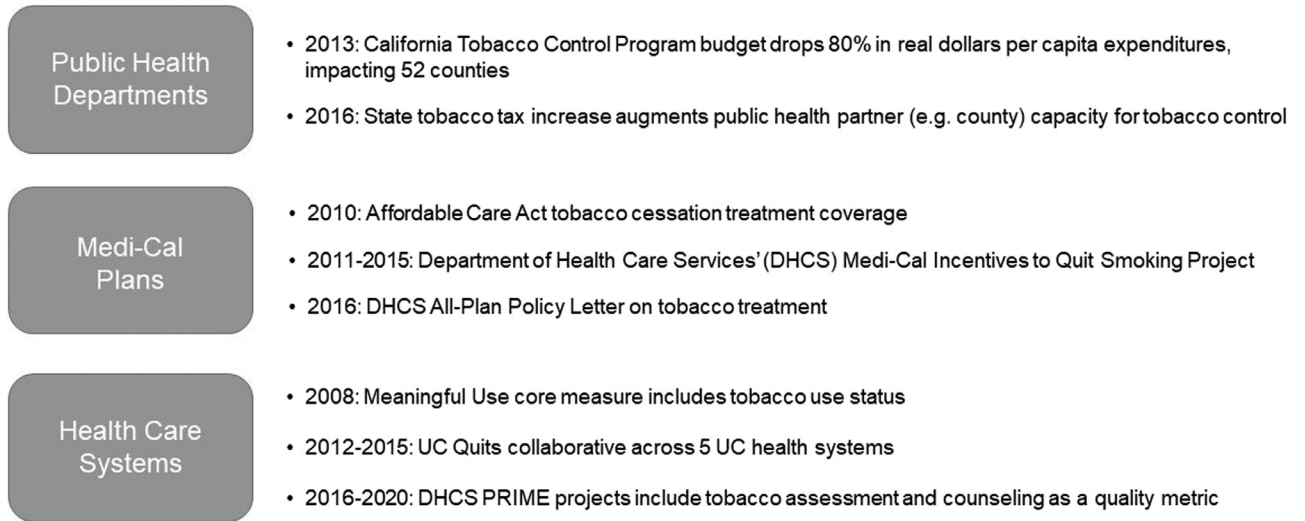
**Figure 1.** Timeline of key highlights for public health departments, Medi-Cal plans, and healthcare systems affecting California tobacco cessation treatment capacity.

UC, University of California; PRIME, Public Hospital Redesign and Incentives in Medi-Cal.

According to DHCS, this waiver "will guide [California] through the next five years as we work to transform and improve the quality of care, access, and efficiency of health care services for over 13 million Medi-Cal members."[27] The goal of PRIME is to improve the way care is delivered through California's safety-net hospital system, maximizing healthcare value and moving toward alternative payment models, such as capitation and other risk-sharing arrangements.[28] The PRIME initiative explicitly includes tobacco quality metrics but has a 5-year window to integrate reforms and identify ways to sustain changes. Participating hospital systems are expected to measure

their quality metrics twice annually in order to receive payments based on their performance.[29]

Besides the 17 DPHs, California's PRIME program includes 37 district/municipal public hospitals (DMPHs).[29] The California Association of Public Hospitals and Health Systems and its 501(c)3 affiliate, the Safety Net Institute, guide the participation of the DPH and their affiliated ambulatory care facilities in PRIME. The DPH comprise 6% of the hospitals in the state, but serve 2.85 million patients annually and provide 34% of all hospital care to the uninsured, 35% of all hospital care to Medi-Cal members, and more than 10.5 million
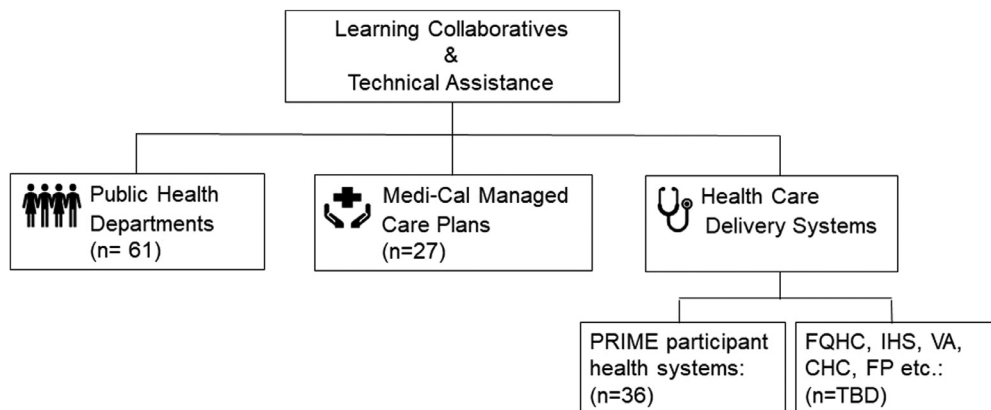


**Figure 2.** CA Quits structure for learning collaboratives and technical assistance for tobacco-cessation treatment with public health departments, Medi-Cal plans and healthcare systems.

PRIME, Public Hospital Redesign and Incentives in Medi-Cal; FQHCs, Federally Qualified Health Centers; IHS, Indian Health Service; VA, Veterans Affairs; CHC, community health centers; FP, family planning clinics; TBD, to be determined.

outpatient visits each year.[24] The DMPHs are smaller hospitals, many of which are located in less-densely populated counties and began participating in PRIME a year after the DPH to provide more opportunity for the DMPH to develop the appropriate infrastructure. The DMPH requirements differ from the more comprehensive DPH requirements in that each DMPH elects various projects and only about half are involved in projects that include the outpatient tobacco quality metric.[27]

## UC Quits

Among the DPHs, the five UC health systems (UC Davis, UC San Francisco [UCSF], UC Los Angeles, UC Irvine, and UC San Diego) had already been collaborating on tobacco-cessation systems change, enabled by the meaningful use requirement that EMRs include documentation of a patient's tobacco status as a core measure.[30] In 2012, UC Davis established the first two-way eReferral to the Helpline with funding from the Centers for Disease Control and Prevention.[31] Specifically, this eReferral system allows clinicians to use the EMR to order a patient referral to the Helpline; after the Helpline attempts to contact the patient, an electronic report is sent to the ordering provider and stored in the patient's medical record. Subsequent EMR modifications have facilitated provider orders for cessation medications and referrals. In 2013, the UC Quits project was established after UC Davis received additional funding from the UC Office of the President's Center for Health Quality and Innovation. The vision of UC Quits is to address tobacco treatment with "every patient, at every encounter," integrate electronically with the Helpline, and support provider training in partnership with the Smoking Cessation Leadership Center at UCSF. UC Quits engaged nursing and physician champions, using a learning collaborative approach, to share EMR modifications and provider workflows across the five UC health systems.[32] Through June 2018, UC providers submitted more than 10,000 eReferrals to the Helpline.

## California Quits: Pilot Year of Learning Collaborative

Building on the UC Quits model, in 2016, the CTCP funded a 1-year pilot for a PRIME DPH tobacco-cessation learning collaborative. (PRIME learning collaboratives are hosted by the Safety Net Institute for DPHs with Harbage Consulting, a private consulting firm that specializes in safety-net programs, for DMPH.) This pilot project's objective was for the 15 DPHs to report having implemented evidence-based tobacco-cessation treatment and routinely promote and refer patients to the California Smoker's Helpline.

Since 2016, the CA Quits pilot project team has focused on building awareness and relationships, assessing technical and technological capabilities and needs, and helping safety-net health systems to understand their tobacco quality metric by examining data for smokers separately from all assessed patients. During this pilot, healthcare providers and quality improvement staff have shown increasing interest in adopting and sharing tools developed as part of the UC Quits program, such as the eReferral to the Helpline, and collaborating with county resources. The Smoking Cessation Leadership Center at UCSF has assisted with developing communication resources for CA Quits with a website (www.caquits.com) and toolkits.

# COLLABORATIVES FOR PUBLIC HEALTH DEPARTMENTS, MEDI-CAL PLANS, AND SAFETY-NET PROVIDERS

## California Quits: Scaling Up Statewide System Redesign

In 2018, CTCP funded a 5-year scale-up of CA Quits, to integrate and institutionalize population-based tobacco-cessation treatment within California's safety-net healthcare systems. The primary objective is to enable a minimum of 30 healthcare systems to screen all adult patients for tobacco use and refer them to evidence-based tobacco-cessation treatment with the Helpline. The second objective is for a minimum of five Medi-Cal plans to participate in a tobacco work group to implement and integrate prevention and cessation programs, including the routine promotion and referral of members identified as smokers to the Helpline. Both objectives will be evaluated by collecting and analyzing specific project metrics for the 61 public health departments, the 28 Medi-Cal managed care plans, and safety-net healthcare delivery systems. The evaluation plan includes analyzing both process and outcome measures, such as organization participation in the learning collaborative activities in addition to trends in assessment, counseling, and referrals.

The CA Quits scale-up will be guided by the Collective Impact theory of change, a framework used to enable multilateral, large-scale social change.[33] The Collective Impact theory posits that structured components are required for multisector collaborative efforts to successfully achieve a singular goal. Collective Impact works on the premise that lasting solutions to large-scale social problems require that many organizations (government agencies, nonprofits, private individuals, and organizations) work together around a clearly defined goal. An example Collective Impact project model is the

Massachusetts Prevention and Wellness Trust Fund, which demonstrated that multisector partnerships could effectively address population health issues, such as smoking, by increasing linkages to community cessation supports.[34] The Collective Impact approach stands in contrast to isolated impact approaches where organizations work individually to solve important problems. Instead, Collective Impact promotes that organizations should form cross-sector coalitions to make meaningful and sustainable progress on shared issues.

Figure 2 shows the expanded structure of the CA Quits project, which will use the learning collaborative approach promoted by CMS for health systems change. The project specifically targets safety-net systems that serve Medi-Cal members, the uninsured, or other high-risk populations, such as the homeless and migrant workers. Other potential systems are not technically labeled "safety net" but serve special populations with elevated smoking rates or tobacco-related risk termed affinity systems. The project will convene four provider system learning collaborative tracks: two from PRIME 1115 Waiver participants (e.g., DPH and DMPH systems) and then two from affinity systems. The affinity systems may include Federally Qualified Health Centers; community health centers; tribally operated ambulatory clinic systems; Veterans Affairs systems; family planning clinics (funded by California's Family Planning Access Care and Planning Treatment program); cancer centers; and migrant clinics.

The project will also convene a Plan and Partner track for collaborating with (1) Medi-Cal and its managed care plans, which may help sustain activities initiated during the MIQS project like direct-to-member mailings; and (2) public health partners, which may include CTCP-funded agencies like county health education departments and new partners, including Maternal, Child, and Adolescent Health programs; and Women, Infant, and Children programs that frequently have contact with the population covered by Medi-Cal. Through CA Quits in coordination with the Helpline (Figure 2), these partners, plans, and providers may more easily collaborate on tobacco-cessation treatment at the local and statewide level.

CA Quits staff will lead monthly meetings on topics, such as understanding tobacco quality metrics, connecting to the Helpline, sharing workflow challenges and solutions, and coordinating with local resources (e.g., public health partners or Medi-Cal plans). UC Davis faculty with expertise in the various domains of tobacco treatment, learning collaboratives, quality measures, state and county health systems, and maternal and child health will provide leadership and guidance for each track. These types of expertise are important given the breadth of the PRIME initiative, size of the Medi-Cal covered population, and types of populations covered.[35] The faculty will also seek to integrate tobacco treatment into healthcare education and training programs, which may be affiliated with safety-net academic programs. The learning collaborative approach will provide opportunities for professional sharing; intersystem mentoring and expert guidance on workflows; connectivity to external services and EMR systems; and institutionalizing protocols, policies, and procedures. The objective of the learning collaborative approach is to exchange ideas and to integrate processes for identifying and referring patients to smoking-cessation support at every encounter throughout California.

The CA Quits concepts are supported by key factors: (1) Medicaid expansion enabled insurance coverage and access to health services for millions of California's low-income populations; (2) California's Medicaid 1115 Waiver institutes safety-net system payment reform and includes tobacco smoking-cessation support as a quality metric in 36 safety-net hospital systems; (3) provisions in the ACA require tobacco-cessation support to pregnant women; and (4) providers have demonstrated effectiveness in supporting tobacco cessation and are well positioned to identify, assess, and refer smokers to resources, such as the California Smokers' Helpline.[4] Although there is opportunity, barriers may also exist for safety-net providers, including tobacco use by provider staff, not providing primary care, lack of tobacco-cessation training, competing priorities, and believing that counseling is not an appropriate service for the practice.[36]

## FUTURE DIRECTIONS

With the launch of the CA Quits expansion, the team will coordinate with the Helpline and new groups with shared interests to work with public health departments, Medi-Cal plans, and safety-net providers. Dedicated provider-specific technical assistance and training teams will focus on behavioral health (with the Smoking Cessation Leadership Center at UCSF funded by CTCP) and dental providers (with UCSF dental faculty funded by the Oral Health Program within the California Department of Public Health). California pharmacists are another key future resource, as under state law they may now furnish the five types of health plan−covered nicotine replacement therapy without a prescription.[31,37] Harnessing these provider-based resources will broaden the project impact to a variety of health professionals who are recognized as first line in dispensing tobacco treatment services.[36]

Finally, the CA Quits project will work with other tobacco research and policy-related initiatives and will explore the potential of health informatics to help create flexibility and sustain growth in implementing cessation supports in various provider settings. The California Tobacco-Related Disease Research Program has a Community Practice-Based Research grant mechanism "to support partnership development. . . and collaborative research. . .[across] health service researchers and health care practitioners to promote sustainable systems change and elucidate factors associated with quality care improvements in tobacco cessation efforts in safety net health systems."[38] One of the initial awards with Los Angeles Department of Health Services has been utilized to support an eConsult web-based system to implement a two-way electronic referral mechanism between providers and the Helpline; more than 600 eConsults have been placed in over a year.[38] As Tobacco-Related Disease Research Program funds additional research to address emerging topics, like e-cigarettes or dual use of tobacco and cannabis, and Policy Research Centers build capacity in underserved regions of the state, it will be important for health system partners to have an infrastructure for keeping up to date and collaborating on additional partnerships. Finally, health informatics will continue to be a centerpiece to enable data sharing; for example, the Helpline eReferral mechanism has been recognized as a California Department of Public Health Specialized Public Health Registry,[39] which was requested by UC Irvine during the UC Quits project to fulfill meaningful use requirements. This Registry can be a future platform for integrating and sharing individual-level tobacco treatment data across health systems and sectors. As CTCP health partnerships expand, these additional components will be integral for identifying new directions and strategies and sustaining efforts.[37]

## ACKNOWLEDGMENTS

## SUPPLEMENT NOTE

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