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Short communication

Refer2Quit: A pilot referral approach to promote treatment for parents who smoke tobacco through pediatric primary care

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HIGHLIGHTS

- A key barrier to reducing SHS exposure in children is finding a scalable way to engage all household members who smoke.
- We developed an EHR-linked system that screens parents, automates treatment, and prompts referral of household members who smoke.
- A pilot using population health and informatics to engage household members who smoke in treatment was feasible, acceptable, and effective.
- This approach may expand tobacco treatment reach, reduce SHS exposure, support whole households, and enhance public health impact.

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ABSTRACT

Objective: Evidence-based tobacco treatments are rarely provided to household members who smoke but do not attend a child's pediatric visit. This pilot study evaluated an electronic health record (EHR)-linked intervention leveraging pediatric visits to identify and engage household members who smoke tobacco in treatment remotely.
Methods: We conducted a single-arm prospective study with household members who smoke at a high-volume pediatric primary care practice. During preventive visits, the EHR system screened parents for tobacco use, automated treatment connections, and prompted referrals for household members who smoke. Referred household members were contacted, consented, and offered nicotine replacement therapy (NRT), quitline counseling, and/or SmokefreeTXT. Outcomes included feasibility (referral rate), effectiveness (treatment acceptance), and acceptability (satisfaction). A 1-month follow-up survey assessed treatment use and smoking cessation (7-day abstinence from combustible tobacco).
Results: Between April 2022 and August 2024, 3478 pediatric patients had additional household members who smoke. Of 352 (10.1 %) referred individuals, 350 were contacted; 91 (25.9 %) accepted treatment. Among these, 82 (90 %) chose NRT, 58 (64 %) chose quitline, and 64 (70 %) chose SmokefreeTXT. All participants found the referral approach acceptable. At follow-up, 54 (59 %) completed the survey; 42 (46 %) reported treatment use, and 12 (13 %) reported smoking cessation.
Conclusions: This EHR-linked intervention effectively identifies and engages household members who use tobacco in treatment, demonstrating feasibility, acceptability, and promising outcomes. These findings warrant more rigorous evaluation.

1. Background

When anyone quits smoking, they significantly decrease their risk of developing lung cancer and other smoking-related cancers and increase their own life expectancy (U.S. Department of Health and Human Services, 2014). But when a parent quits smoking, they also reduce the

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majority of their children's secondhand smoke (SHS) exposure (U.S. Department of Health and Human Services, 2006) and decrease the risk of their children smoking tobacco when they become adults (den Exter Blokland et al., 2004). Pediatricians are uniquely positioned to help parents quit smoking and protect children from SHS exposure (Jenssen et al., 2023). The American Academy of Pediatrics recommends encouraging and initiating evidence-based tobacco use treatment for parents who smoke (Jenssen et al., 2023). Nevertheless, in pediatric settings, evidence-based treatments are rarely provided to parents who smoke (Winickoff et al., 2013).

Addressing tobacco use in the pediatric setting can be systematized by clinical decision support (CDS) systems integrated into electronic health records (EHRs) (Boyle et al., 2014). CDS systems help pediatricians screen for SHS exposure, motivate parent treatment engagement, prescribe nicotine replacement therapy (NRT), and connect caregivers to behavioral interventions, such as the quitline (Jenssen et al., 2016, 2019). We created an EHR-linked system that screens parents for personal tobacco use and automates connection to treatment, as part of routine pediatric office visits (Jenssen et al., 2022; Jenssen et al., 2023) The specific screening question is "Who in your family smokes tobacco products like cigarettes, cigars like black and mild, or hookah?". The system also asks about the presence of other household members who smoke. While approximately 5 % of parents who attend the visit report tobacco use, an additional 10 % of children have other adults at home who smoke. Thus, a major barrier to protecting children from SHS exposure is identifying an efficient and scalable method to engage all household members who smoke.

An innovative approach incorporating population health principles and clinical informatics can engage household members in tobacco treatment outside of clinical encounters, while leveraging the pediatric clinical workflow to impact children's health. EHRs can create population-based registries of current individuals who smoke to whom tobacco treatment can be proactively offered independent of clinical visits. In adult healthcare settings, randomized controlled trials have shown the effectiveness of this approach for increasing treatment engagement and reducing smoking (Fu et al., 2016; Haas et al., 2015). To date, such approaches have not been developed or tested in the pediatric setting, highlighting a critical gap that, if addressed, could significantly improve children's health by reducing their exposure to secondhand smoke and lowering their risk of smoking in adulthood. Our objective was to evaluate the feasibility, acceptability, and effectiveness of an EHR-linked system that leverages pediatric visits to identify household members who smoke tobacco and then remotely engage them in tobacco treatment.

2. Methods

2.1. Study design

We conducted a single-arm prospective trial with parents/caregivers (hereafter, "parents") who attended pediatric preventive care visits to (1) assess the proportion of proactive referrals of other household members who smoke by parents accompanying children to primary care visits and to (2) assess the impact of subsequent proactive contact from our tobacco treatment team to these household members who smoke on rates of evidence-based tobacco use treatment initiation. The study was approved by the Children's Hospital of Philadelphia (CHOP) Institutional Review Board.

2.2. Setting/population

This pilot study recruited from a high-volume CHOP primary care clinic in West Philadelphia, serving approximately 32,000 pediatric patients annually, with 83 % Medicaid-insured and 84 % identifying as non-Hispanic Black. The clinic is in an area of West Philadelphia with high rates of adult smoking (25–30 %). For household members who smoke, inclusion criteria were: those referred by the parent at their child's recent preventive care visit and who are $\geq$ 18 years in age.

2.3. Study procedures

Using our system, we screened all parents who attended a pediatric preventive care visit with their children for any combustible tobacco use in the household from April 2022-August 2024. If other adults in the household were positive for combustible tobacco use, the system would prompt the parent for the name and phone number of household members who smoke and confirm permission to contact them and offer cessation services. Individual household names and phone numbers were added to a registry and sent to the study team weekly. Within 2 weeks of the initial referral, the study team reached out to the referred individual (calling twice a week, for up to 5 weeks), confirmed their smoking status, consented them, offered treatment, and completed a brief baseline survey. Additionally, all participants were asked to complete a brief survey to provide feedback about the program. The baseline survey asked about their relationship to the pediatric patient as well as their demographics (e.g., age, sex) and level of nicotine dependence (measured by the Fagerstrom Test for Cigarette Dependence (Heatherton et al., 1991; Fagerström, 2012). The feedback survey asked about satisfaction with this approach, barriers to treatment, and suggested improvements. For those who accepted treatment (see below), a 1-month follow-up survey was completed via phone or text, which asked about tobacco use treatments used, if the participant quit smoking, and any barriers to change and/or ways to improve the remote program.

2.4. Intervention

We designed the intervention – called Refer2Quit - based on the Chronic Care Model (Wagner et al., 1996) and the Social Contextual Model for Reducing Tobacco Use (Sorensen et al., 2004). The core principles involved using a combination of pharmacotherapy and community-based treatments, addressing ambivalence about behavior change regardless of readiness to quit smoking, and providing ongoing support to overcome common barriers to smoking cessation. Participants who smoked were offered three evidence-based treatment options: nicotine replacement therapy (NRT), the quitline, and SmokefreeTXT. Participants were informed that combining treatments is more effective than using a single method and that they could begin treatment even if they were not yet ready to quit. Each participant was provided combination NRT (21 mg/day patch and 4 mg gum), which is more effective than using either method alone (Livingstone-Banks et al., 2022). Most commercial insurance plans and Medicaid cover NRT with little or no co-pay.

Participants were also encouraged to accept referrals to one or both free community-based resources. The quitline provides effective telephone-based counseling, while SmokefreeTXT offers support through text message-based counseling. Connections to each treatment option were automated and adhered to specific timeframes: NRT was delivered to participants' homes within 24–48 h, the first quitline call was initiated within 24–48 h, and SmokefreeTXT messages were sent almost instantly. Participants without health insurance were encouraged to use the quitline, which provided a free one-month supply of NRT upon enrollment in the program.

2.5. Outcomes, analysis, and sample size

Primary outcomes included feasibility, acceptability, and effectiveness. Feasibility was measured through EHR data and call contact data. EHR data included the percentage of household members referred to the study team and added to the registry. Call contact data included the percentage of registry individuals who were successfully contacted. Acceptability was assessed by the system improvement survey. Effectiveness was measured by the percentage of individuals off the registry

who accepted any treatment and each treatment at the baseline call, and treatments used at 1-month follow up. As a measure of effectiveness, we assessed self-reported quit rates at 1-month follow-up. Secondary outcomes included information about barriers to program acceptance and suggested improvements through information collected on the system improvement survey.

We characterized study participants using descriptive statistics. We calculated proportions for the feasibility, acceptability, and effectiveness outcomes. We qualitatively described any barriers reported and suggestions for program improvement. We also explored variations in outcomes by participant characteristics, including sex, race-ethnicity, education level, health insurance, and nicotine dependence.

3. Results

Between April 2022-August 2024, there were 75,403 preventative care visits for children aged 0 through 18 years (81.2 % with Medicaid/Public insurance, 17.8 % with commercial insurance). The EHR-linked system, that screened for parent and household member tobacco use, was assigned at 48,277 visits and completed at 42479 visits (88.0 % completion rate). Of 29,030 unique patients/families screened, 3478 pediatric patients (11.9 %) had additional household members who smoke. Of 352 (10.1 %) household members who were referred to treatment, 350 were successfully contacted by the team, and 91 (26 %) accepted treatment and enrolled, demonstrating feasibility and effectiveness. Most enrolled participants were male (62 %), a parent to the child (71 %), had a high school education or less (59 %), had Medicaid or unknown/no health insurance (73 %), and exhibited very low (54 %) to low (37 %) nicotine dependence (see Table 1 for demographics). All participants found this referral to treatment approach acceptable. For clinical impact, 82 participants (90 %) opted for NRT, 58 (64 %) selected the quitline, and 64 (70 %) chose SmokefreeTXT. Of the 91 participants at 1-month follow-up, 54 (59 %) completed the survey; 42 (46 %) reported using the tobacco treatment, and 12 (13 %) reported smoking cessation.

Table 1
Demographic information of parent/caregiver participants.

Demographic	N (%)
Total	91 (100)
Age, mean (SD))	44 (± 11)
Race-Ethnicity	
Non-Hispanic Black	76 (84)
Non-Hispanic White	6 (7)
Hispanic	6 (7)
Other	3 (3)
Gender	
Male	56 (62)
Female	35 (38)
Relationship to Child	
Parent	65 (71)
Grandparent	20 (22)
Aunt/Uncle	3 (3)
Other	3 (3)
Education	
Less than High School	14 (15)
High School Grad/GED	40 (44)
Some College	26 (29)
Associate's Degree	3 (3)
Bachelor's Degree	6 (7)
Graduate Degree	2 (2)
Insurance	
Medicaid	56 (62)
Private	25 (27)
Unknown/No Insurance	10 (11)
Nicotine Dependence*	
0–2 Very low	42 (46)
3–4 Low	33 (36)
5 Moderate	6 (7)
6–7 High	8 (9)
8–10 Very high	2 (2)
Treatment Options	
NRT	82 (90)
SmokefreeTXT	64 (70)
Quitline	58 (64)

GED: General Educational Development; NRT: Nicotine Replacement Therapy

* Via Fagerstrom Test for Cigarette Dependence

Qualitative feedback from participants about Refer2Quit was consistently positive. Participants were asked to provide a rating on a scale from 1 to 10, where 10 indicates that the program was extremely helpful, and 1 indicates the program was not at all helpful. Over half of the respondents, (n = 30; 56 %) gave the referral program a score of 10. Additionally, 20 respondents (37 %) rated the program between 7 and 9, and 4 respondents (7 %) rated it 6 or lower. Those 4 respondents noted the referral program was helpful but that NRT, specifically, did not work for them. Participants also expressed their gratitude and satisfaction with the resources they were provided. One participant shared that the program was "actually very helpful and a blessing that it was passed down to me by my daughter and her mother. And I feel great – I've cut down from 5 to 6 cigarettes a day to 1 or 2 every few days, just using the gum." Another participant commented on the extensive list of resources they were able to select from: "You all offered a lot of resources. I have never been in contact with anyone that has offered me so many resources." These testimonials from the participants highlight the potential for the Refer2Quit program to support individuals who use tobacco on their journey to quit or cut down use.

There were high rates of treatment acceptance, regardless of participant characteristics. Most participants accepted NRT and the quitline or SmokefreeTXT, regardless of race-ethnicity, gender, relationship to the child, education, insurance or nicotine dependence (see Table 2).

4. Discussion

A pilot approach combining population health and clinical informatics that systematically identifies all household members who use tobacco and engages them in evidence-based care is feasible, acceptable, and leads to treatment receipt. One out of ten household members who smoked were referred to our team for helping with quitting smoking. One out of four household members referred to our program for support with quitting accepted at least one evidence-based tobacco use treatment. Most of those accepted combination NRT with community-based counseling. All participants found this referral to treatment approach acceptable. By conceptualizing all household members in contact with the child as needing support, the Refer2Quit intervention may extend the reach of tobacco treatment programs to comprehensively reduce childhood SHS exposure, better support entire households, and yield a larger public health impact.

Many household members who smoke who accepted treatment had a high school education or less and had Medicaid or no health insurance. Thus, this approach may help address a significant practice gap concerning tobacco treatment particularly for underserved populations. Approximately 11.5 % of US adults currently smoke cigarettes (Cornelius et al., 2023). Yet, the prevalence remains 2–3 times higher among adults with incomes below the federal poverty level and with less than a high school education (Cornelius et al., 2023). Fewer than one third of adults who smoke who tried to quit use evidence-based cessation treatments (Babb et al., 2017); these rates are even lower for adults with low socioeconomic status (SES) (Babb et al., 2017). Among those who are parents, this continues to be a major source of adverse health outcomes for children. SHS exposure affects more than 40 % of children in the US (Merianos et al., 2019). Rates of exposure are even worse for children within low SES families; SHS exposure affects 54 % of children whose household is near or below the federal poverty level (Merianos et al., 2019).

Our study has several limitations. First, we did not biologically-

Table 2
Tobacco treatment acceptance rates by participant characteristics.

	Total N	NRT N (row %)	Quitline N (row %)	SmokefreeTXT N (row %)
Total Accepted Treatment/ Enrolled	91	82 (90)	58 (64)	64 (70)
Race-Ethnicity				
Non-Hispanic Black	76	70 (92)	48 (63)	57 (75)
Non-Hispanic White	6	5 (83)	4 (67)	2 (33)
Hispanic or Latino	6	5 (83)	3 (50)	2 (33)
Other	3	2 (67)	3 (100)	3 (100)
Gender				
Male	56	50 (89)	35 (63)	40 (71)
Female	35	32 (91)	23 (66)	24 (69)
Relationship to Child				
Parent	65	60 (92)	45 (69)	45 (69)
Grandparent	20	16 (80)	11 (55)	15 (75)
Aunt/Uncle	3	3 (100)	1 (33)	2 (67)
Other	3	3 (100)	1 (33)	2 (67)
Education				
Less than High School	14	12 (86)	11 (79)	12 (86)
High School Grad/GED	40	33 (83)	28 (70)	29 (73)
Some College	26	26 (100)	14 (54)	16 (62)
Associates Degree	3	3 (100)	2 (67)	2 (67)
Bachelors Degree	6	6 (100)	2 (33)	4 (67)
Graduate Degree	2	2 (100)	1 (50)	1 (50)
Insurance				
Medicaid	56	54 (96)	36 (64)	39 (70)
Private	25	23 (92)	14 (56)	17 (68)
Unknown/ Other	10	5 (50)	8 (80)	8 (80)
Nicotine Dependence*				
0–2 Very low	42	37 (88)	30 (71)	29 (69)
3–4 Low	33	31 (94)	19 (58)	22 (67)
5 Moderate	6	6 (100)	4 (67)	4 (67)
6–7 High	8	6 (75)	4 (50)	7 (88)
8–10 Very high	2	2 (100)	1 (50)	2 (100)

GED: General Educational Development; NRT: Nicotine Replacement Therapy
* Via fagerstrom test for cigarette dependence

confirm household smoker self-reported smoking cessation rates. Participants received brief counseling and were connected to evidence-based tobacco use treatments, both strong predictors of tobacco cessation. This study was primarily focused on implementation outcomes (U.S. Department of Health and Human Services, 2020). Second, we limited tobacco use treatment pharmacotherapy to NRT. Future efforts will incorporate varenicline prescribing. In the interim, counseling via connection to the quitline combined with NRT use is effective in helping adults who smoke quit (U.S. Department of Health and Human Services, 2020). Finally, the Refer2Quit intervention was limited to a single clinic within one health system as part of a research effort, without a comparison group. There are no exact comparisons to our approach of systematically, through an EHR-linked intervention, encouraging adults to refer other adults who smoke to a service that provides medication and connections to counseling. According to surveys of individuals who smoke, of those who attempted to quit smoking in the past year, 38.3 % used counseling and/or medication (VanFrank et al., 2024). According to the National Ambulatory Medical Care Survey (based on a national sample of visits for adults > 18 years old to ambulatory medical care services in the US), of individuals who currently smoke and who visited a physician in the past year, 20.9 % received physician tobacco counseling during the visit, and only 7.6 % received a prescription or an order for a medication associated with tobacco use treatment (Jamal et al., 2012). Our preliminary results suggest that, for adults who smoke who are referred to our team, our system performed better than this patient-reported data. An appropriately powered randomized controlled clinical trial is underway to evaluate this novel approach to promote tobacco treatment engagement and smoking cessation.

Authorship

All authors have made substantial contributions to all of the following:

1. The conception and design of the study, or acquisition of data, or analysis and interpretation of data.
2. Drafting the article or revising it critically for important intellectual content.
3. Final approval of the submitted version.

All authors agree to be accountable for all aspects of the work to ensure that the questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CRediT authorship contribution statement

Grundmeier Robert W: Writing – review & editing, Methodology. **Thayer Jeritt G:** Writing – review & editing, Methodology. **Kelleher Shannon:** Writing – review & editing, Methodology. **Ramachandran Janani:** Writing – review & editing, Methodology. **Martin Hannah:** Writing – review & editing, Methodology. **Tayong Ngwi:** Writing – review & editing, Formal analysis, Data curation. **Jenssen Brian P:** Writing – review & editing, Writing – original draft. **Schnoll Robert A:** Writing – review & editing, Supervision, Methodology. **Fiks Alexander G:** Writing – review & editing, Methodology.

Declaration of Competing Interest

The authors note that there is no financial/personal interest or belief that could affect their objectivity.

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