Behavioral Health & Wellness Program

The Behavioral Health Cessation Coordination Model Toolkit

Department of Psychiatry
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

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The Behavioral Health Cessation Coordination Model (BHCCM) Toolkit
was developed by the Behavioral Health and Wellness Program
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About This Toolkit

This *Behavioral Health Cessation Coordination Model (BHCCM) Toolkit* is designed to provide a framework for organizations operating within the behavioral healthcare system to implement new or updated nicotine/tobacco dependence treatment services. The toolkit provides organizations with a blueprint for evaluating their services and implementing sustainable changes utilizing the BHCCM as a planning tool.

Introduction to the Behavioral Health Cessation Coordination Model (BHCCM)

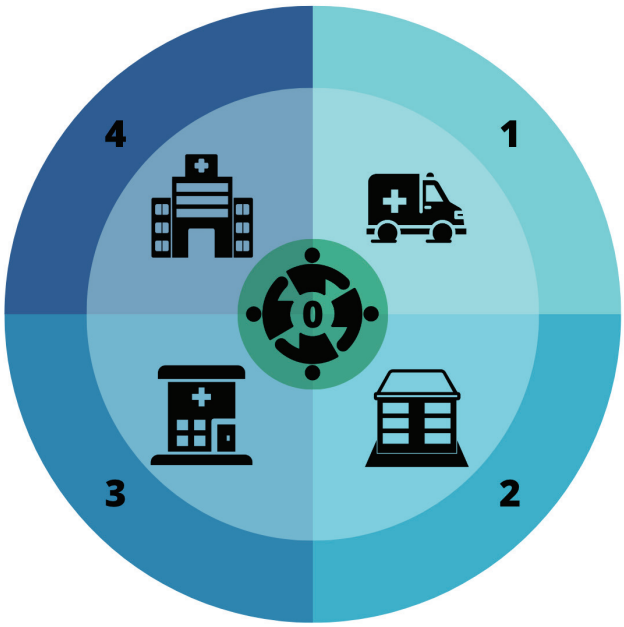
In aiding organizations to improve their delivery of nicotine/tobacco treatment services and supports, the BHCCM seeks to capitalize on the benefits collaborative quality improvement offers to both organizations and clients. Collaborative quality improvement enhances the power of individual organizations by aligning and mutually supporting the efforts of multiple organizations. At times, organizations are unable to achieve desired clinical outcomes by working alone, but in partnership with multiple organizations, such outcomes become much more feasible. The BHCCM takes the concept of collaborative quality improvement and applies it specifically to improving the delivery of nicotine treatment services, supports, and policies.

Introduction

The BHCCM was created by the University of Colorado—Behavioral Health and Wellness Program (BHWP) in 2022. The BHCCM is intended to provide a structure for learning how to engage with behavioral health systems, and within this framework, to navigate individuals to nicotine/tobacco dependence treatment. Recognizing that any behavioral health system can be challenging to navigate and daunting in its complexity, the BHCCM aims to empower organizations to better understand the system and then direct individuals to appropriate services. Moreover, the BHCCM is a tool to identify in what settings and at what stage of treatment community providers might realistically offer tobacco use treatment.

Tool 1: The BHCCM

Behavioral Health Cessation Coordination Model (BHCCM)



0 Category Zero Services
Community-Based Prevention
Early Identification and Intervention
Health Promotion

1 Category One Services
Mobile Crisis Response

2 Category Two Services
Onsite Crisis Services

3 Category Three Services
Outpatient/Ambulatory Services

4 Category Four Services
Inpatient Care
Residential Care

The BHCCM supports organizations in finding community collaborators and partners. Utilizing the model, organizations can identify areas in which they may have insufficient Tobacco Use Disorder (TUD) treatment coverage, and therefore might be best advised to refer people to external TUD resources. The model supports this organizational self-assessment, and helps organizations identify such potential external referrals. Likewise, organizations may use the model and find that they have excellent TUD treatment coverage within some care levels, and thereby may be able to position themselves as a point of referral for other organizations. Therefore, the BHCCM not only offers the ability for organizational self-assessment, but enhances the ability of organizations to identify and collaborate with external partners in the spirit of collaborative quality improvement and building an effective community care continuum.

Background for the Model

The fundamental reason this model is necessary is that the behavioral healthcare system is fragmented, complicated, and too often, difficult to navigate.

The behavioral health system includes multiple different state agencies, a vast variety of healthcare providers, insurance providers, and numerous community organizations. Collectively, these organizations play significant roles in the delivery of behavioral health services, and potentially TUD treatment. However, due to the disjointed way various organizations operate, it is generally difficult for organizations and individuals to navigate available mental health and addictions services (i.e., behavioral health services). Many treatment organizations are unable to offer a comprehensive range of services, thus making it necessary for individuals to first identify and then access needed services across multiple organizations. Complicating these matters further, the system is constantly evolving and changing, introducing new regulations, policies, and funding mechanisms. Remaining aware of and responsive to ongoing changes is challenging for both organizations and individuals and amplifies confusion and uncertainty. Alongside these issues, substantial stigma surrounding mental health and substance use conditions remains, causing many individuals to be reluctant to seek care. Often this stigma also affects the way in which healthcare providers and policymakers view TUD treatment, and the implicit assumptions made regarding who needs or desires evidence-based pharmacological or behavioral treatments. This potentially impacts relevant available funding and systemic resources.

BENEFICIARIES OF THIS TOOLKIT

The purpose of the BHCCM is to make it easier to design a Tobacco Use Disorder (TUD) treatment workflow that correctly identifies nicotine dependent individuals in need of addiction services, and which connects them to appropriate resources delivered at the proper intensity for their unique needs. Beneficiaries of this approach will include interdisciplinary providers delivering services as well as the individuals receiving substance use disorder (SUD) treatment. This model is also of high utility to public health entities and other community-based partners that offer and/or make referrals to TUD treatment. Therefore, a range of entities in the same community may initiate using the BHCCM. For instance, local public health agencies may initiate these efforts, with direct care providers being their necessary partners. Overall, this toolkit is written to aid either behavioral health or other community service organizations in constructing realistic, often inter-agency TUD treatment workflows, either as a treatment lead or as a partner.

UTILIZING THIS TOOLKIT

Public health entities, other community-based partners, and behavioral health service providers all have different missions. However, all these organizations have ample room for strategic and/or tactical alignment in working together toward lowering nicotine use prevalence rates, and thereby improving health outcomes for individuals and the public at large. How you use this toolkit will depend on your vantage point, including which type of organization you represent. Three primary groups are envisioned as potential utilizers of the toolkit: (1) public health agencies or non-profit organizations with a public health mission, (2) community behavioral health organizations or employees of government-run organizations that provide behavioral health services and medical health partners, and (3) community advocates interested in assuring robust TUD services.

Bridging the Gap Between Public Health and Behavioral Health Systems

Organizations that provide behavioral health services are embedded within a series of overlapping systems which include the familial, educational, and occupational systems of those they treat, as well as any other networks in which they may participate (e.g., hobby clubs, faith-based groups). Additional systems typically involved in the provision of behavioral health are local municipalities, state government, and the federal government. All these systems and structures can at times work together or in opposition to each other. For instance, organizations may fail to see how their own actions or inaction affect the larger behavioral health system. This is often due to the many competing demands that under-resourced and under-staffed organizations face. The BHCCM assists organizations to understand the larger context in which they are embedded. The model further asserts that coordinate, low-burden health system changes may lead to a significantly improved continuum of TUD treatment.

BEHAVIORAL HEALTH

The term "behavioral health" regards the overall wellness of an individual, including their mental and emotional health, and aspects of their physical health. Behavioral health generally refers to both mental health and mental health illnesses, as well as substance use disorders, life stressors and crises, and physical symptoms that result from such stressors and events. Behavioral health care refers to the prevention, diagnosis, and treatment of these types of conditions. Behavioral health care may encompass a range of services and treatments aimed to improve overall health and the quality of life of individuals. Among the different types of treatment options behavioral health organizations offer are individual and group counseling, medication management, and behavioral and lifestyle changes.

Before moving into the BHCCM in detail, it is worth developing our understanding of what constitutes a "system" and a "model" for our purposes. A system entails a coordinated network that integrates care planning and management across multiple levels. Ideally, systems are culturally and linguistically competent and aim to build meaningful partnerships. These elements of cultural appropriateness and relationship building can transform a typical delivery system into a system of care. Meanwhile, a model provides a means of thinking about something. Models are not simply a picture of a complex system with lines and boxes. Rather, they attempt to be reductionist in nature, thus aiming to eliminate excess detail and complications to present something in its most ideal or representative form. As a result, models are not a perfect representation of what they seek to describe and are incorrect or incomplete to various extents. Even so, models such as the BHCCM may be meaningful and useful and can help to enhance our ability to understand a system. It is our intent that the BHCCM will enable an enhanced understanding of your behavioral healthcare system.

Components of the BHCCM

Tool 2: The BHCCM Service Category Descriptions

BHCCM Service Category Descriptions

Category Zero Services

Community-Based Prevention | Early Identification and Intervention | Health Promotion

Tobacco/nicotine-free policies, tobacco-related standards and protocols (in non-behavioral health care settings)
Screening and referral to counseling, quitline, and other relevant services
Promoting cessation in schools, jails, primary care, community-based organizations

Category One Services

Mobile Crisis Response

Stabilization, co-responder services, screening and assessment services

Category Two Services

Onsite Crisis Services

Walk-in, diversion, and detoxification services, mental health and substance use disorder clinics

Category Three Services

Outpatient/Ambulatory Services

Individual counseling, group psychoeducation, medication, medication assisted treatment (MAT)

Category Four Services

Inpatient Care | Residential Care

Mental health care, substance use disorder (SUD) treatment, co-occurring addictions treatment
Case management, acute treatment unit, assertive community treatment (ACT)

Layout of the Model

The BHCCM is presented as four main categories of services arranged equally to one another around a center point comprised of population level prevention and health promotion. The model seeks to make the point that different categories or levels of behavioral health services may be offered as a continuum of care according to need, and moreover, do not represent a hierarchy or tiered system. Meanwhile, the category zero services are placed at the center of the model as these types of services do not fall in any of the four categories, but rather, represent an overarching set of services that may route individuals into the external four categories. People may access the four different categories with greatly varying frequencies and in different orders and will not necessarily engage across all these categories, though it is likewise possible that they will engage with all four categories over the course of their interaction with the behavioral health system.

BHCCM Service Categories

The BHCCM is presented utilizing four key categories of services within the behavioral health system, including one additional category that operates outside of the system, but which nevertheless plays a role in promoting and navigating people to services. Here is a breakdown of the service categories and what types of services are included within each:

Category Zero Services

This category includes the services offered outside the behavioral health system, but that are involved in connecting people to the system, and which also play a role in promoting the services offered by the system. This includes community-based prevention efforts, the early identification of diseases and health risks and associated interventions, as well as health promotion. Nicotine-free policies and nicotine-related standards and protocols that exist outside of behavioral health care settings may be part of community-based prevention. Screening for nicotine use and associated referrals to counseling, quitlines, and other treatment services are elements of early identification and intervention. Health promotion and education around the dangers of nicotine use and the benefits of abstaining from and quitting nicotine use may be offered in a wide variety of settings, including but not limited to schools, criminal justice settings, and within community-based and non-profit organizations. While none of these activities are behavioral health interventions per se, they are integral in supporting the other categories of service.

Category One Services

Mobile crisis responses fit into the Category One services designation. Services offered in this category occur at external sites in a mobile capacity, meeting client demand where it is needed, as opposed to at a centralized location. Examples of such services include stabilization, co-responder services in which a behavioral health professional is present, and potentially screening, assessment, and brief treatment for SUD. Mobile crisis services might be offered by vehicle or on foot, among other means of conveyance, and are therefore able to reach people in their communities to promote and offer TUD treatment services as a complement to other behavioral health aid.

Category Two Services

As opposed to mobile crisis responses, Category Two services are onsite crisis services which are offered in offices or other centralized locations. These services are designed to be offered to individuals who are pursuing immediate services in a crisis setting and at times to individuals who are present in recovery settings. Examples of

Category Two services include walk-in, diversion, and detoxification services, as well as mental health and substance use disorder clinics. TUD services may be offered in conjunction and in support of these types of onsite behavioral health crisis services.

Category Three Services

These types of services include those offered to individuals who are seeking treatment of nicotine dependence at outpatient/ambulatory or transition services settings. Within these settings, people may access more robust nicotine treatment services, including individual counseling for nicotine dependence, group psychoeducation promoting nicotine cessation and abstinence, the seven FDA-approved tobacco cessation medications, and medication assisted treatment (MAT). Multi-disciplinary providers, including Tobacco Treatment Specialists (TTS), may offer these services. TUD treatment might be integrated into other SUD treatment. This category does not include inpatient or residential settings.

Category Four Services

This category of services features those that are offered in inpatient and residential settings. In these settings, individuals are typically receiving treatment for other SUD and behavioral health conditions, and therefore receive TUD treatment services alongside and in conjunction with existing service offerings. Examples of such care may include mental health treatment, SUD treatment, co-occurring addictions treatment, case management, Assertive Community Treatment (ACT), and acute treatment units. As in Category Three, these services may be offered by a TTS, among other providers, and may include the use of various counseling techniques and tobacco cessation medications.

As has been discussed previously, the BHCCM is only able to provide a framework for considering a state behavioral health system and is not a perfectly nuanced representation of any specific system. Models provide a useful form for learning and self-evaluation but are limited in their ability to fully represent the ever-shifting reality of behavioral healthcare.

Getting Started

1. Identify Your Target
2. The Resource/Asset Mapping Process
3. Gathering Your Team

Getting Started

Before an organization can truly embark on the path of integrating new tobacco-related initiatives, it is vital that organizational leadership understands and approves the plan. In the best-case scenario, leadership will not merely approve of these efforts, but would be involved overtly in the related planning and action stages. This backing becomes essential when it comes time to implement real health systems changes, such as new nicotine-related policies, workflows, and TUD treatment.

With leadership approval confirmed, two initial key steps serve as a launching point in planning and outlining your tobacco initiatives: (1) identifying your target population(s) and (2) assembling the appropriate team members who will champion the work.

Identify Your Target

It may first be necessary to identify the team members who will be involved in identifying the appropriate target(s) for your intervention. That said, it may be the case that your clinical quality improvement initiative was mandated by a change in law or regulation, because of a new accreditation requirement, a newly-obtained grant commitment, or some other outside source. Examine whether any of these circumstances apply to the intervention that you are considering, as this may direct you to include certain team members and/or internal departments, while also helping to fine-tune your approach and strategies.

A "target" of a clinical quality improvement project may be a population, a process, or an outcome; we will consider each of these scenarios. In terms of a target population, your organization may have identified that a certain demographic group is not receiving care at an equitable rate, or that service outcomes are significantly less successful. When such a discrepancy exists, the underserved demographic group may be a logical target for an intervention. Processes may also be targets of an improvement project, such as the process of following up with clients who express an interest in TUD services. For example, if it is determined that an insufficient percentage of such individuals are receiving follow-up services, revitalized or new engagement processes may become the target. Finally, your organization may want to target a specific outcome related to a new TUD service. As one example, if your organization does not have the capacity to treat clients directly but values making TUD treatment referrals, it may make sense to target improving the rate at which external referrals are made.

The table below helps illuminate how different types of targets may change the intervention. The examples below are illustrative only and should not be treated as the only or best strategy. It is useful to note that these distinctions are not always clear cut. If, for example, Black patients are not screened for tobacco use at the same rates as their White counterparts, or if individuals with a behavioral health issue are not prescribed cessation medications at the same rates, then a process intervention may serve to improve outcomes within the targeted demographic. We should remain mindful that processes are only as good as the outcomes they generate; process targets assume the process as written is fine but that the process as performed needs work. Outcome targets often require new processes or the revision of existing ones.

TYPE OF TARGET	CORRESPONDING INTERVENTION EXAMPLE
Demographic Group	Hiring new staff representative of that population; redesigning marketing materials; altering the marketing strategy to reach that audience
Process	Audit fidelity to process; re-training staff
Outcomes	Adding new processes; revising old processes; adding new resources and supports

DATA COLLECTION TO SUPPORT TARGETING

In many cases it will not be possible to accurately identify a target without corresponding data to illuminate what populations, processes, or outcomes demand attention. For instance, data will be necessary to determine if a certain subpopulation is receiving sufficient care or is experiencing differential clinical outcomes. Therefore, a good first step in target identification is to learn who within your organization has the relevant data and to determine what the processes are for running necessary reports or modifying current data collection and reporting processes. It is likewise possible that multiple data sources are needed. Organizational data may be possessed by various internal departments, including Information Systems, Compliance, Accreditation, Training, and Quality Improvement. In smaller organizations, data collection and reporting may be very different, and may be consolidated in one department or under one person. Regardless of the location, data review is integral to the proper consideration and evaluation of interventions.

New projects should address a quantifiable deficiency in current organizational services. As a starting point, tobacco cessation-related improvements often start with measuring the universality of screening. If you determine that your organization is not screening close to all individuals served for nicotine use, as a next step it is wise to look for systematic bottlenecks. For example, if upon review of the data you notice that adults over the age of 65 are not being screened adequately for nicotine use, this may suggest an age-based implicit bias, in which staff members may be presuming older adults are unable to quit smoking or not interested in quitting. Systematic workflow inefficiencies may exist as well and contribute to below-desired screening rates. A workflow assessment may assist in identifying potential areas of quality improvement and ongoing evaluation.

If in performing these types of evaluations you identify a significant demographic screening differential for a certain subpopulation, then your first priority may be closing this critical gap. However, there may be other systems change targets for your program as well, such as building a strong referral network to provide external coverage for TUD services which your organization is unable to offer. Approaches to correcting systematic shortcomings will vary. In most cases, your task will not be to create new services but rather to connect your system to pre-existing service providers, within your organization or externally.

The Resource/Asset Mapping Process

Community Resource Mapping may go by various names, but the strategy is always essentially the same. For numerous reasons, many health-related vulnerabilities are geographically sourced. Today, one of the greatest predictors of your current health status and the length of your total lifespan is your ZIP code, and this phenomenon has become truer as the Internet has becomes a more ubiquitous part of our lives. As such, to best address the needs of individuals, we should examine what health-related resources (or potential resources) physically exist where the people you want to help reside.

This type of evaluation can be done by taking a walk or riding city buses through those neighborhoods and writing down every entity that provides health care, every entity that provides social services or support, and any entity that could do so. Look for health and mental health clinics, but also look for faith-based organizations, volunteer organizations, community or neighborhood advocacy groups, chambers of commerce, major employers, retail outlets, and any "third places" (i.e., areas people go to associate with others when not at work or home). Results can be listed on a piece of paper, but they are better viewed on a map—either note these resources directly on a physical map, or simply note the addresses and then later add them to a digital map.

While this exercise is strengths-based, if you happen to notice tobacco industry marketing on store fronts, bus stops, billboards, etc., it may be worth noting those as well. You can work with public health to reduce these intrusive ads, and at the very least, you may become aware of areas where you will need a stronger presence to overcome tobacco marketing.

The BHCCM also may be applied to aid organizational self-evaluation. Organizations can utilize the categories and their descriptions to identify their current TUD services, while also identifying opportunities for implementing new services. The BHCCM may reveal that certain services are not within the scope of organizational capacity and/or willingness. In such cases, the BHCCM may point to external organizations to serve as potential partners for referrals. Similarly, the categories within the BHCCM may highlight different populations of clients with which organizations are not currently engaging, enabling them to devise new means to reach these underserved populations.

Tool 3: The SAMHSA Treatment Locator

Among organizations (especially behavioral health organizations) that do not provide tobacco cessation services, often there are myths that such services are not desired by their clientele, that their clientele would not use those services if they were provided, and that they would not quit tobacco if they did use those services. As a result, such organizations may believe that choosing not to provide these services is the standard choice. In fact, of the 189 mental health organization responding to SAMHSA's 2020 Mental Health Services Survey (N-MHSS), 123 (65.1%) of them screened for tobacco use and 98 (51.9%) of them provided counseling for smoking and/or vaping. Similarly, of the 393 substance abuse treatment facilities responding to SAMHSA's companion survey—the National Survey of Substance Abuse Treatment Services (N-SSATS)—273 (69.5%) screened for tobacco use and 189 (48.1%) provided TUD counseling. While there is still room for improvement, especially in the provision of TUD treatment, it is no longer the case that choosing

not to screen and treat is the default choice. For example, behavioral health organizations that do not screen for tobacco use are part of a rapidly shrinking minority.

However, not all organizations have the capacity to provide group or individual TUD counseling or to provide (or prescribe) medication—the combination of which is considered the gold standard for treating a drug dependency referred to as Medication Assisted Treatment (MAT). A useful tool for finding potential referral sources in your area is SAMHSA's Treatment Locator, an online database of N-MHSS and N-SSATS respondents, which can be searched by state, county, or some radius from an address. Filters can be added to these databases to find those organizations that provide different types of FDA-approved tobacco cessation medications, which offer TUD counseling, and which have a facility smoking or vaping policy.

Tool 4: Blue Yarn Site Analysis

Blue Yarn Site Analysis is a technique used in urban design and architecture to assess the relationship between the physical characteristics of a setting and the social and cultural factors that influence its use and purpose, including visual and spatial analyses. The name "blue yarn" stems from the use of blue yarn or string to map and connect elements within a site or space, such as buildings, streets, natural settings, and other physical elements. By physically mapping out a site in this manner, designers and planners are better equipped to evaluate the relationships between the different elements in a setting and to consider improvements.

Blue yarn analysis can be performed for a geographical area, such as a neighborhood or city, but it can also be performed for a single clinic, hospital, or other healthcare site. In terms of offering TUD treatment services, a blue yarn site analysis may be a helpful technique to employ in evaluating the physical workflow under which these services are offered. Ideally, behavioral health services, including TUD treatment services, will have a logical layout, which will route the client in an efficient manner throughout a single treatment setting or a health system. For example, TUD screening may occur in the same office or proximity to where TUD treatment is provided, allowing for ease of access and potential warm handoffs between members of a behavioral health services team.

To perform such an analysis, print out a map, blueprint, or digital version of your site. For a geographical area, start by identifying key players in your tobacco cessation health neighborhood and use thumbtacks to place paper circles as representations of them. Use different size circles to indicate how many tobacco users they are likely to engage with regularly. Do the same for residential areas, paying particular attention to multi-unit housing settings as these are often densely populated and frequently have higher tobacco use prevalence rates per resident. Finally, indicate areas where people gather such as religious centers, community centers, grocery stores, movie theaters, shopping areas. Use different colors for residential settings, service providers, and community gathering spots. Now, using thumbtacks and your blue yarn, map the most likely routes residents will take to get from their homes to their community spots—be especially mindful of bus routes in the area. Once your map is complete, the combination of different sized nodes and their connections may illuminate potentially valuable community partners. It may also alert you to various access issues.

Consider a few questions to drive your analysis:

- Are your service providers on the bus lines?
- How would you describe the connectivity of your health neighborhood?
- If you could wave a magic wand, what would you change about your health neighborhood?

Finally, identify which providers on the map are already utilizing the 5 A's method (described in the Design Your Program section). With that focus in mind, consider the following questions:

- Who is screening for tobacco use?
- Who is advising people to quit tobacco?
- Who can provide counseling/coaching and make TUD treatment plans?
- Who on the map has the training to offer TUD treatment but is or is not performing this service?
- And finally, who could perform this work if they were properly trained?

Alternatively, if performing a blue yarn analysis for a service delivery site like an integrated health clinic, start with a blueprint or other accurate representation of the site floorplan. Use blue yarn and thumbtacks to indicate patients' pathways through the facility. Use different sized circles to indicate how long individuals spend in each of the spaces they travel through. Use this analysis to identify inefficiencies in the movement of patients, as well as to locate spaces where TUD treatment or education can be delivered efficiently.

The Asset Mapping Process

1. **Define the scope**: Asset mapping a health system begins with defining the scope of the project. This involves identifying the geographic area that you want to map, as well as the specific assets that you want to include. For example, you may want to map healthcare facilities, community health workers, medical equipment, and other relevant resources.
2. **Identify community partners**: Once you have defined the scope of the project, the next step is to identify the community partners who will be involved in the asset mapping process. This includes healthcare providers, community organizations, government agencies, and other groups that have an interest in the health system.
3. **Collect data**: Data is then collected on the assets that you have identified. This can involve conducting surveys, interviewing community partners, and reviewing existing data sources such as health facility registries, census data, and other relevant databases.
4. **Analyze data:** After collecting data, analyze it to identify patterns, gaps, and opportunities. This can involve using mapping tools and software for data visualization and identify areas of need or potential collaborations.
5. **Develop an action plan**: Based on the analysis of the data, develop an action plan. This involves identifying actionable, realistic strategies for addressing gaps and improving the overall health system. The action plan should include specific goals, timelines, and roles and responsibilities for community partners. (See the description of SMART goals in Tool 11.)
6. **Implement and monitor the plan**: The final step is to implement the action plan and monitor progress over time. This may involve ongoing data collection and analysis to track progress and identify areas for improvement. Regular communication with community partners and feedback from the community can also be helpful in ensuring the success of the asset mapping process.

Gathering Your Team

Supporting a TUD treatment initiative is best accomplished by identifying internal tobacco champions within your organization and by establishing an organizational wellness committee. Ideally, the tobacco champions will be participants in the larger wellness committee, though their work will focus on TUD treatment.

How to Find an Internal Tobacco Champion

Identifying an internal tobacco champion(s) is a critical step that behavioral health and healthcare organizations should take in promoting TUD treatment and thereby improving both client and employee health. Tobacco champions are passionate about promoting TUD treatment and are instrumental in helping to sustain organizational momentum and focus on this matter. Ideally, tobacco champions will have extensive knowledge of and experience providing and/or training others to provide TUD treatment. Champions may have completed an ATTUD-accredited Tobacco Treatment Specialist training, which will provide them the knowledge and skill to offer individual tobacco counseling services.

NATIONAL CERTIFICATE IN TOBACCO TREATMENT PRACTICE (NCTTP)

The Association for Addiction Professionals (NAADAC), in collaboration with The Association for the Treatment of Tobacco Use and Dependence (ATTUD), has established a National Certificate in Tobacco Treatment Practice (NCTTP). Upon successful completion of an ATTUD-accredited training program, TTS's can apply for the NCTTP once they meet the eligibility and application requirements. This process was created in response to the growing demand for an established set of standards to guide provision of TUD treatment for tobacco dependency using best evidence for effective treatment. ATTUD and the Council of Tobacco Treatment Training Programs defines a Tobacco Treatment Specialist (TTS) as: A professional who possesses the skills, knowledge, and training to provide effective, evidence-based interventions for tobacco dependence across a range of intensities. The TTS may have various professional affiliations and may work in a variety of settings including but not limited to hospitals, community health centers, HMOs, medical and dental practices, educational settings, social service agencies, tobacco treatment centers, telephone quitlines, drug abuse treatment programs and mental health centers. The TTS may engage not only in providing treatment but also in educating others, including other healthcare professionals, administrators, and researchers, among others. This credential also supports the ability to independently bill for TUD services.

For more information:

- *NCTTP: https://www.naadac.org/NCTTP*
- *ATTUD: https://www.attud.org/*
- *Rocky Mountain Tobacco Treatment Specialist (RMTTS) Training Program: https://www.bhwellness.org/rocky-mountain-tobacco-treatment-specialist-program/*

Organizations can take several steps to identify, engage, and sustain a pipeline of internal TUD treatment champions, including:

1. Determine the goals of your TUD treatment program. Prior to searching for an internal champion, it is worthwhile to clearly identify what the organization seeks to achieve with their programming. Using a logic model (see Tool 7), ultimate and intermediate outcomes and related measures should be considered, such as a focus on reducing tobacco use rates, generating more tobacco counseling referrals, or increasing screening and the identification of tobacco users. Outlining specific goals and outcomes that you aim to achieve via your program will help guide its development.

2. Identify potential tobacco champions. Consider individuals within your organization who have expressed an interest or passion in tobacco cessation, and/or who have an interest in promoting whole health behaviors. Potential champions may include people who have successfully quit tobacco, people with experience in counseling or health education, and those who have a general interest in preventive health. Any staff members who have completed an ATTUD-accredited TTS training program are strong candidates.

3. Approach the identified potential champions. Once you have identified potential champions, approach them with the ideas, plan, and goals for the tobacco cessation program. While explaining these goals and objectives, ask for their feedback, along with their support and involvement. Clearly align your tobacco cessation program goals with the overarching promotion of healthy behaviors and positive health outcomes among both clients and staff.

4. Provide training and resources. Once your tobacco champion is on board, it is vital that they are provided with the necessary training and resources to effectively promote the tobacco cessation program. Support may include the provision of educational materials about the health risks of tobacco use, information about the tobacco cessation services that are currently available, and further training regarding counseling techniques for tobacco cessation. If they are not already a TTS, this training would position your champions for success. Tobacco champions will also need leadership support, financial backing, and the ability to have designated work time to spend in this capacity.

5. Support your tobacco champion. Ongoing support and encouragement will help to keep tobacco champions engaged and interested. Organizational leadership and supervisors can provide regular opportunities to discuss challenges that are encountered and take the time to recognize and celebrate incremental successes. Provide feedback and recognition for their efforts, including promoting the tobacco cessation program in social media, organizational publications, announcements, and marketing materials. Informing all staff about the initiative will also help to increase general support, as well as referrals and participation in the program.

Convene Your Wellness Committee

Assembling a wellness committee is a critical starting point for effectively addressing the wellness needs of both employees and clients. A wellness committee is comprised of a group of individuals within your organization who are responsible for promoting and supporting wellness

initiatives for clients/patients and often all staff as well. These committees are primarily tasked with creating a culture of health and wellness within your organization by developing and implementing programs and policies that address burn-out and encourage positive health behaviors, including healthy eating, stress management, sleep hygiene, physical activity, and tobacco cessation initiatives. Wellness committees may be tasked with providing education and resources to staff and clients and, to be successful, must be overtly supported by senior leadership.

The tasks of the wellness committee relevant to nicotine treatment and policies include: (1) receiving input from all interested staff members; (2) adapting practices based on unique organizational needs and demands; and (3) designing, implementing, and reinforcing the organization's nicotine-free policy.

The wellness committee should be composed of administrators and other staff who will be responsible for creating and implementing the nicotine-free policy, and who may be involved in implementing TUD treatment services. The wellness committee may have representatives from various departments within your organization and include the following types of personnel: clinical director, compliance representative, environmental services representative, facilities director, health education representative, human resources direction, key clients' group, key employee groups, medical director, security representative, pharmacy representative, public affairs representative, and the organization's neighbors (residential or business). Importantly, the wellness committee should include people who may be vocal opponents to the nicotine-free policy and treatment services, such as current smokers. Including these types of individuals in a wellness committee exhibits the inclusion and consideration of all perspectives, and these people may become strong pillars of support for these initiatives over time. Finally, your identified tobacco champions are a critical component of a wellness committee.

SUPPORTING WELLNESS COMMITTEE STAFF AND TOBACCO CHAMPIONS

Beyond promoting and highlighting the work of wellness committee staff and tobacco champions, additional steps can be taken to offer further support for a tobacco cessation initiative. Offering organizational-level and/or public recognition and praise for the program may make participants feel more encouraged and supported. Additionally, providing opportunities for professional growth and development within this field can be a powerful incentive. For example, supporting participants to pursue a NCTTP can enhance their work while also serving to aid in their career development. Increasingly, this credential may also be tied to the ability to independently bill for TUD services. Consider offering more flexibility in work arrangements to program participants as well. This type of offering can encourage staff members to participate in the program, while potentially allowing them to better meet clients' scheduling demands.

Tool 5: DIMENSIONS: Tobacco-Free Policy Toolkit

The DIMENSIONS: Tobacco-Free Policy Toolkit assists organizations in implementing nicotine-free policies to create a safe and healthy work environment for their employees and the people they serve. The toolkit features evidence-based information and effective, step-by-step instructions to plan, design, implement, and evaluate a facility- or organization-wide tobacco-free policy. The recommended ten steps to follow in this process are outlined, with numerous tools to support organizations to effectively accomplish each of these steps.

External Resources

Regardless of whether or not an organization provides TUD treatment services or a nicotine-free policy, external resources are an important component to be able to offer to clients. For one, it is best practice to offer as many TUD treatment services to clients as possible, including linking people to services outside the organization. The resource/asset mapping process described previously is one of the best ways to identify potential partners and external referral sources. In addition to this approach, it can be helpful to reach out to community leaders and government agencies to identify additional referral sources.

Tool 6: Tobacco Free Colorado

Tobacco Free Colorado is a project that was created by the State Tobacco Education and Prevention Partnership (STEPP) of the Colorado Department of Public Health and Environment (CDPHE). The project aims to educate Colorado's residents and public health organizations on tobacco cessation and prevention, while supporting broad efforts to implement tobacco-related policies and services and serves as a good example of a state government resource. In addition to presences on major social media accounts, Tobacco Free Colorado hosts a website. The website features resources for health providers, offers ongoing coverage of tobacco-related news and updates, contains information on a variety of pertinent topics within a tobacco context, and encourages interaction and partnerships. There is a wide range of information regarding quitting tobacco, the impact of tobacco, learning about tobacco products, how to prevent tobacco, and many other topics. Included on the project's website is a form that interested parties may complete and submit to gain support in tobacco-related initiatives. The website also offers a portal through which statewide tobacco-related grantees can login for additional services and resources.

Visit the Tobacco Free Colorado website: https://www.tobaccofreeco.org/

Tool 7: Logic Model

A logic model is a short, visual representation of a plan's inputs and outputs. On the left side of a logic model are the organization's strengths and available resources. Examples of these include financial resources, outside community support, and wellness champions. A logic model also includes a brief description of the activities of a successful plan. Finally, a logic model lists the plan's intended outcomes. Below is a sample logic model pertaining to the implementation of a model nicotine-free policy.

POLICY-PLANNING TOOLBOX

Sample Logic Model

INPUTS/ RESOURCES	PLANNED WORK		OUTCOMES		
	ACTIVITIES	GOALS	SHORT	MEDIUM	LONG
Wellness Champions Committed members of senior leadership Pre-existing relationships with community organizations including local public health departments Free posters and other educational materials from government or non-profit agencies Tobacco cessation groups, quitlines, and other community resources	Convene the Wellness Committee Create the change plan Draft the policy Communicate the plan Build community support Provide education Provide tobacco cessation services Launch the policy Enforce the policy Program evaluation	Recruit leadership, set regular meetings Complete Logic Model, Timeline and Budget Write and approve policy Disseminate policy, describe in all-staff meeting Identify and contact community partners Disseminate educational materials, hold tobacco-free training/classes Identify/explore services, develop workflows Remove smoking shelters/ash cans, display posters Review policy violation message/ actions Conduct pre-, midway, & post-policy launch evaluations	Qualitative measure of staff attitudes Performance evaluations of staff knowledge and mastery of tobacco cessation interventions Numbers of clients asked about tobacco use Overall census and number of clients who smoke entering treatment	Changes from baseline in staff attitudes regarding tobacco use Tobacco-free policy violations Percentage of clients that leave treatment with an intent to continue tobacco product abstinence Rate of staff and client tobacco use Staff and client satisfaction	Numbers of sick days taken by staff as a whole and staff productivity Cost of care per client Clients' psychiatric and physical health symptoms, as well as life functioning Decreased overall use of emergency department care Overall census and number of clients who smoke entering treatment Rate of staff and client tobacco use

ASSUMPTIONS:

- Clients have better treatment outcomes if they quit tobacco.
- Staff provide better care if they are committed to a tobacco-free lifestyle themselves.

Strategic Partnerships

1. Investigate the Current System: Policies and Procedures
2. Investigate Current Willingness and Capacity

Strategic Partnerships

All organizations and individuals generally have unique mission statements and visions for the work they perform, and new tobacco-related initiatives are most likely to succeed when they are aligned with these organizational values. Not only will such initiatives be more likely to gain momentum and be immediately actionable, but they will have a greater chance of becoming sustained practices that become a permanent component of an organization's operations and culture.

Investigate the Current System: Policies and Procedures

Organizational self-evaluation is a powerful tool for assessing the strengths and weaknesses of current TUD treatment services and nicotine-related policies and procedures. Prior to launching and implementing new initiatives, the following organizational assessments will help to reduce workflow inefficiencies and may highlight areas that need attention. Recommended tools for organizational self-evaluation include the Model Nicotine-Free Policy (NFP), Staff Knowledge and Behavior: Tobacco Assessment (STA), and the Organizational Policy and Practice: Tobacco Assessment (OTA). These are further detailed below.

Tool 8: BHWP Model Nicotine-Free Policy

The Model Nicotine-Free Policy (NFP) is intended for use across outpatient, inpatient, and residential behavioral health settings, with applicability across a variety of other healthcare settings nationwide. The NFP was created in response to a growing need to address all forms of nicotine dependence, not simply tobacco dependence, thereby responding to the growing use of electronic nicotine delivery systems (e.g., vaping products) that may not use combustible tobacco products where tobacco is burned. To achieve a complete policy addressing all forms of nicotine use, this distinction is necessary.

The NFP is a synthesis of a policy review and best practices from leading tobacco control organizations from around the country. Key policy components are integrated to provide a template for creating an effective, comprehensive, and sustainable policy. The NFP incorporates the most current best practices for providing a healthy environment for the benefit of clients, staff, and all visitors to a facility.

While you can download the complete NFP, you can also access a web-based interface that allows users to create a customizable version of the original NFP that addresses your organization's unique characteristics. This online interface is hosted on the BHWP website and enables users to not only input their organization's name, details, and branding, but also allows users to select which components of the original policy to retain or delete based on their own specific organizational needs. Upon going through the interface, inputting organizational information, and selecting the desired components, users are then able to download a tailored version of the NFP to support policy implementation.

Access the model NFP and web-based interface: https://www.bhwellness.org/model-nicotine-free-policy/

Investigate Current Willingness and Capacity

As your organization moves toward integrating new tobacco-related initiatives and policies, it is wise to investigate the willingness and capacity of both your staff and organization at-large to

undertake these measures. In terms of your staff, knowing how people feel about potential changes is helpful in planning the rollout of your initiatives. For instance, gaining a clear understanding of your staff members' attitudes, knowledge, and behaviors toward and regarding tobacco use, cessation, treatment, and policies will inform how much education may be necessary and help design an appropriate timeline for implementing changes. Similarly, there is value in performing an assessment at the organizational level to evaluate the tobacco-related services and policies that you are already providing to identify strengths and areas of opportunity. Performing these assessments prior to implementing changes will also enable the evaluation of the ongoing impact that institutional changes have upon your staff, services, and clients. The STA and OTA will assist organizations to gain insight into the perspective and knowledge of staff as well as the use of current evidence-based practices organization-wide, respectively.

Tool 9: Staff Knowledge and Behavior: Tobacco Assessment

The Staff Knowledge and Behavior: Tobacco Assessment (STA) is designed to assess these three domains—attitudes, knowledge, and behaviors—across an organization's staff. Staff attitudes toward treating tobacco use, tobacco-related policies and procedures, and the ability of their clients to quit successfully are measured. Similarly, the survey assesses staff knowledge about the burden of tobacco, the use of evidence-based clinical cessation interventions, the benefit of these interventions, and their recognition of the importance of treating tobacco use as a chronic condition. Finally, the STA evaluates the behaviors of staff. That is, determining if they are actually employing evidence-based strategies. Ideally, the STA survey will be completed by every member of the organization to develop the most complete and comprehensive snapshot possible.

Tool 10: Organizational Policy and Practice: Tobacco Assessment

The Organizational Policy and Practice: Tobacco Assessment (OTA) is designed to assess and track an organization's current utilization of evidence-based wellness and tobacco control services and policies. Only one person per organization completes the OTA. This person should be someone who will be most familiar with the organization's tobacco and wellness initiatives. The OTA acts as baseline and enables your organization to track global progress over time. This process allows leadership and champions to rigorously identify the best opportunities for improvement, but to also acknowledge potential positive quality improvement gains.

Examples of these two surveys can be found on BHWP's website at: https://www.bhwellness.org/sample-survey-items/.

Design Your Program

1. The Ideal System: Using the Full Evidence Base
2. Putting the Pieces into Practice
3. A Learning Organization

Design Your Program

Once the preceding groundwork has been performed, and the necessary data has been collected and evaluated, an organization will be positioned to design a strategic and effective program. Such programs will require periodic evaluation and reconfiguration as needed, but regardless of their specific focuses, all should include the utilization of evidence-based approaches to address nicotine dependence.

The Ideal System: Using the Full Evidence Base

Utilizing evidence-based techniques and strategies for implementing TUD treatment services is the optimal approach. Evidence-based strategies have all been rigorously tested and proven to be effective. By following evidence-based practices, behavioral health organizations assure that they are offering their clients the most up-to-date and effective cessation treatments. Research compounded over time has found that evidence-based strategies lead to increased quit attempts, more successful quit attempts, and improved rates of long-term abstinence. As shall be described below, such treatments include a combination of standardized methods of screening, treatment, and referral, including the utilization of various counseling techniques, FDA-approved cessation medications, and the support of a robust nicotine-free policy, all with the overt backing of senior leadership. Evidence-based nicotine/tobacco cessation treatment services represent potentially cost-saving methods for offering the most comprehensive and effective treatment options possible.

The 5 A's: Ask, Advise, Assess, Assist, and Arrange

The *U.S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence* provides healthcare clinicians an onsite strategy for nicotine cessation treatment that is built around the "5 A's" (Ask, Advise, Assess, Assist, and Arrange). In recognition of the many competing demands providers face, the 5 A's were created to simplify how to address nicotine/tobacco addiction. The 5 A's are an essential component for every patient visit, *regardless of the patient's stage of readiness to quit.*

The guideline recommends that all people entering a healthcare setting should be asked about their tobacco use status and that this status should be documented. Providers should then advise all tobacco users to quit in a personalized, professional manner, and then assess their level of nicotine dependence and their willingness to make a quit attempt. Providers should then

assist people who are ready to make a quit attempt in that effort. Finally, providers should then arrange follow-up to determine the success of quit attempts. Importantly, even if clients aren't interested in quitting there is always some basic level of intervention providers should offer (e.g., asking permission to provide information on available treatments and referrals). The full 5 A's framework is best for organizations that have nicotine cessation counseling and behavioral interventions and/or nicotine cessation medications available. For organizations that do not offer such services, the recommendation is to use the first two A's (ask and advise) and then the organization can refer the client to available community resources. This abbreviated version is referred to as the 2 A's & R model. At times it is easy to get lost in the jargon of the 5 A's and 2 A's & R models. Please keep in mind that this is the same evidence-based guidance you would utilize for other SUD through Screening, Brief Intervention, and Referral to Treatment or similar clinical models.

Nicotine Dependence Treatment Services – Behavioral Treatments and Medications

Offering nicotine dependence treatment services is a critical service for organizations to include to promote the health and well-being of their clients and staff. Behavioral treatments are one of the two components that should be offered to clients seeking to quit nicotine use. Incorporating the use of a Tobacco Treatment Specialist to conduct counseling sessions is a best practice. Counseling sessions may occur in an individual (one-on-one) setting as well as in a group setting. Numerous techniques may be utilized in these counseling sessions, including the use of Motivational Interviewing, mindful strategies, Cognitive Behavioral Treatment (CBT), and tobacco-free groups. In addition to offering in-person counseling options, telephonic, and televideo counseling are useful techniques for reaching people remotely. Referring people to the state quitline for quit coaching and medications should also be a primary means of linking people to proven services as a supplemental or primary option.

As a complement to behavioral treatment strategies, tobacco cessation medications assist people with nicotine cessation in numerous ways. They provide relief from nicotine cravings and address withdrawal symptoms, while allowing people to continue to experience the effects of nicotine in the short-term, without exposure to the harmful chemicals in tobacco products. By controlling withdrawal symptoms, these medications allow people to focus more fully on changing their behaviors related to nicotine use, significantly improving their chances of a successful quit attempt. Currently, there are seven FDA-approved tobacco cessation medications, including nicotine gum, nicotine lozenge, nicotine patch, nicotine nasal spray, nicotine inhaler, bupropion SR tablets, and varenicline tablets, but the nicotine inhaler will be no longer available after 2023. These products are safe and effective for most people and have been proven to increase the likelihood of quitting.

When behavioral treatments are combined with the use of nicotine cessation medications, patients are most likely to succeed in their quit attempts. This is the standard of care for treating SUD generally and is referred to as Medication Assisted Treatment (MAT). MAT addresses both aspects of nicotine dependence– the individual's physical addiction to nicotine as well as the habit of using nicotine products.

Inclusive Nicotine-Free Policy

Implementing a nicotine-free policy is one of the best ways that organizations can promote healthy behaviors and protect the health of their staff, clients, and visitors. Nicotine-free policies create a safer and healthier environment.

Comprehensive nicotine-free policies prohibit the possession, use, manufacture, trade, purchase, and sale of all recreational nicotine products on any property owned, rented, or leased by the organizations. Ideal policies provide details about the components of the policy ban, the procedure surrounding the policy, enforcement of the policy, and the provision of supportive TUD services.

Staff Support

In offering evidence-based services for TUD treatment, it is important not to overlook the necessity of offering these services to staff in addition to clients. Staff should have the ability to access all the supportive nicotine treatment services that are available to clients. Moreover, organizations may want to consider building incentives for staff to pursue nicotine cessation, such as potential health insurance incentives for successfully quitting.

Putting the Pieces into Practice

Thus far, this toolkit has discussed in a general sense how organizations can utilize the tools provided to evaluate their nicotine treatment service and policies. In this section, the toolkit aims to provides richer detail about how to combine proven strategies and practical steps for the most complete organizational self-evaluation.

Utilizing the BHCCM

Earlier in this toolkit, we discussed the asset mapping process and the blue yarn site analysis, and in this section, we will be combining these tools. At this juncture, we will return to the grid that we used in the asset mapping section. However, the purpose of this part of the toolkit is not to identify whether or not the 5 A's are being performed, but rather, whether similar functions are being (or could be) performed at your partner sites.

To begin your analysis, create a grid similar to the one we used in the Introduction. Label your organization and your partners within the column headers. In Tool 2, you will see the various functional capabilities of Categories 1-4 of the BHCCM are listed. Identify the appropriate category for each of your partners (including your own). Remember that no organization will fit entirely or perfectly within a category; concentrate on your partners' responsibilities at each site. For example, if one of your partners is an onsite crisis center, then that partner is a Category 2 partner regardless of whether it is part of an organization that also runs a residential substance abuse program.

The category you have assigned to each organization should tell you what functions are taking place at that location (e.g., drug use screening); only you and your partners know if that is the case in practice. Check a box indicating which functions are taking place in which organizations. Use a second color (or a different symbol) to indicate whether or not those functions could take place there if additional resources were provided (e.g., training the staff to perform that function or acquiring funds to finance that function).

Finally, crosswalk these pre-existing functions to the 5 A's, and perform the following tasks to inform your next steps:

1. Return again to the BHCCM as a tool for identifying opportunities (or processes) to add an evidence-based TUD treatment service.
2. Identify gaps in the TUD treatment services that are currently being offered.
3. Deploy TUD treatment resources accordingly to the gaps you have identified.
4. Aim for the "hardest to reach" populations or gaps to amplify your impact.

A Learning Organization

Organizations do not operate flawlessly; there are always opportunities for improvement. Even when organizations are performing at a high level, changes in laws, regulations, external partners and services, and client characteristics may have negative impacts. Staff turnover and staff members moving into new roles both introduce changes and new considerations as well. Therefore, it is necessary for organizations to establish protocols to systematically evaluate their performance and to determine areas for improvement as well as the means for making those improvements. There are three critical categories to consider in assuring that your organization remains effective over time.

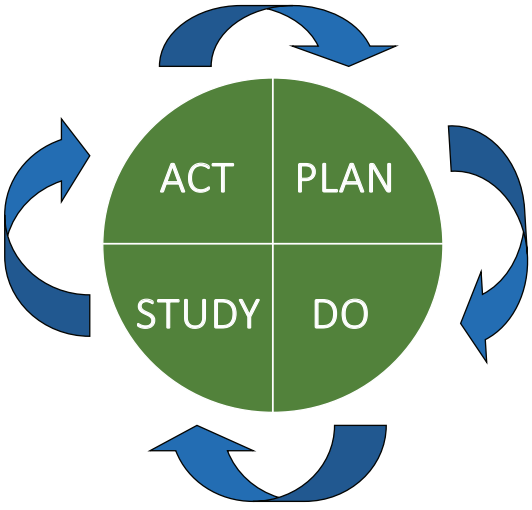
1. **Continuous quality improvement**—Recognizing that change is constant, successful organizations continuously assess the quality of their services and continuously make improvements in their provision. The effectiveness of practices will change over time—even best practices need to be reviewed continuously to assure their continued value.
2. **Evaluate your program**—Organizations must allow time for the purpose of evaluating their programming and dedicate resources for self-evaluation. In the absence of evaluation, an organization cannot know if the services being offered are effective, nor will it be able to know if changes to those services lead to organizational improvement. Program evaluation goes hand-in-hand with continuous quality improvement in the interest of continuing to offer quality services over time.
3. **Identifying new resources**—In instances where evaluation reveals shortcomings, new resources will be needed to be identified to fill service gaps. Simply performing an evaluation is insufficient. Organizations then need to take action to address any inefficiencies and shortcomings that are identified.

Tool 11: Plan-Do-Study-Act (PDSA) Process

The Plan-Do-Study-Act (PDSA) process is often referred to as a learning and improvement cycle. The PDSA process provides an established way for organizations to set short-term goals, test an implementation or change strategy, adjust that strategy based on results, and spread effective change across an organization or community. This technique provides a framework for asking three key questions: (1) What are we trying to accomplish? (2) How will we know a change is an improvement? (3) What change can we make that will result in improvement?

The PDSA process may be considered as a continuous cycle of improvement, featuring four parts as follows:

1. **Plan:** Decide what change you will make, who will do it, and when it will be done. Formulate a hypothesis about what you think will happen when you implement the change. As part of the planning process, identify information and data that you can collect (quantitative and qualitative, as appropriate) that will allow for the evaluation of the planned change.
2. **Do:** Carry out the change in a manner faithful to the original plan.



3. **Study:** Be sure to allow sufficient time for reflection about the results of the plan. Use the data collected and the experience gained by carrying out the plan to discuss what happened and to determine if you achieved the expected results.
4. **Act:** After evaluating the results of your plan, consider what to pursue for your next short-term plan. Determine whether or not the change you implemented was successful, and if you want to retain the change, modify or scale-up the change, or abandon an ineffective change.

SMART goals are a useful framework for setting short-term goals and creating rapid improvement strategies. Meeting the criteria for a SMART goal makes achievement more likely, setting up the goal for successful completion. It also is difficult to determine when a goal has been met if it is not outlined in the SMART format. The SMART goals format includes the following features:

- **Specific** – A specific goal provides information about what action will be taken and when it will be completed.
- **Measurable** – A measurable goal provides information about what will be the measure of progress and how it will be known when a goal has been achieved.
- **Attainable** – An attainable goal is one that is perceived as challenging but is achievable. Goals that are set too high may decrease motivation.
- **Realistic** – A realistic goal is one that can be achieved given the available knowledge, skills, and resources
- **Timely** – A timely goal is one that has a start and end date or features a timeline for when the goal will be accomplished.

Discovering Opportunities for Systems Change: Referrals

1. Engaging Community Partners in Systems Change
2. Strategies to Educate and Engage Community Partners

Discovering Opportunities for Systems Change: Referrals

Engaging Community Partners in Systems Change

Whether you are trying to recruit a new community partner or simply re-establish an existing one, it's important to adapt your approach to appeal to their interests and priorities. Most people are aware that tobacco use is harmful, and that tobacco use may deliver harm to everyone, not just the tobacco user themselves. However, it is not immediately clear to all organizations that their professional mission should include a TUD treatment component. The following are key considerations in making an appeal to potential partners.

The Client Case

Most tobacco users want to quit. In some surveys as high as 90% of American tobacco users regret having started. About three-quarters of tobacco users routinely say they want to make a quit attempt in the next year, and about two-thirds make at least one quit attempt every year. Given these statistics, when working with tobacco users, we hardly need to make the case for why they may want to quit. Most people likely already want to quit, and among those that do not currently want to quit, many will change their minds. However, we can use the facts above to help systems understand that providing TUD treatment will not drive clients away from treatment. In fact, most systems are unaware of the number of potential clients they lose because the client does not like the idea of receiving care from an organization that tolerates or promotes tobacco use.

The Provider Case

No group is more aware of the physical and psychiatric toll of tobacco use than medical and mental health providers. The main barriers to extending tobacco treatment often fall under two categories: (1) lack of assurance that they are properly trained to handle TUD treatment and (2) lack of awareness of good tobacco cessation resources. That said, two other categories are likely to apply as well: (3) lack of time to deal with such a complex, chronic condition and (4) the common perspective that clients are dealing with more immediate concerns than nicotine addiction. For providers, in addition to the client case above, we need to reassure them that brief interventions are effective and truly can occur in a very short amount of time. Using low-burden strategies, multidisciplinary providers can effectively engage clients during a regular visit and connect them to important resources, such as referrals to another service provider and/or medications.

The Business Case

Organizational leadership may have fears that initiating a nicotine-free policy or providing TUD treatment services will disrupt their mission or have a negative financial impact. Therefore, it is not enough to argue that TUD treatment and supports will not detract from their goals; rather, we must make the case that such programming will help them achieve their goals. Tobacco users are less productive when at work both because of tobacco breaks and because leading up to their breaks they may be suffering from decreased attention and increased irritability due to withdrawal.

Tobacco users are also more frequently sick than non-tobacco-users, and tobacco users develop chronic illnesses at younger ages and have a harder time managing those diseases. Meanwhile, tolerating tobacco use in the workplace can generate resentment between employees (e.g., those who receive additional breaks throughout the day versus those who do not). A higher prevalence of tobacco use may drive up the costs of employer-sponsored insurance plans. Allowing staff to use tobacco onsite can generate extra costs for building/site maintenance and liability insurance. Generally, senior leaders are aware of the additional stress that any policy change can generate. They often need assurance that the change in policy will be managed appropriately, that disruption to normal services will be kept to a minimum, and that the organization will reap the promised benefits related to system change.

Strategies to Educate and Engage Community Partners

Again, outreach to potential or existing community partners should be designed to appeal to their interests.

Incentives for Community Partners

In many cases, an organization's staff, leadership, and clients are all quite aware that tobacco use is detrimental to personal, occupational, and organizational health, and yet continue to fail to make the decision to provide or participate in TUD treatment. Often, this failure is due to a lack of basic incentive structures. It is estimated that roughly 5% of tobacco users in an organization will quit if an organization enforces a nicotine-free policy. This percentage can become higher if, in addition to the policy itself, the organization makes a deliberate effort to educate their staff on and connect them to TUD treatment resources. Since approximately 60% of tobacco users try to quit each year even without these efforts, supporting those quit attempts through evidence-based care could yield very high results. The benefits of quit attempts will accrue to employers, families, individuals, and the public at large. However, these benefits build over long time horizons. With that in mind, providing temporary financial incentives directly to community partners is an effective strategy for helping them overcome any initial friction they may be expressing in their willingness to participate. This approach can be even more effective when combined with non-financial incentives, such as structured training and other administrative supports, and with positive press regarding their efforts.

Engaging Non-traditional Partners

Medical and psychiatric caregivers are considered "traditional partners" in TUD treatment, and dentists and pharmacists can be considered in this way as well, as both of these professions have demonstrated their support of TUD treatment and referral for decades. Additionally, both peer navigators and lay community health workers fall under this category, as these individuals often now introduce tobacco use screening and referral programs directly to the communities they serve. "Non-traditional partners" are everyone else. These are organizations or individuals without a specific mission to care for individual or public health per se, but whose mission can be strategically or tactically aligned with a TUD treatment mission. For example, the official responsible for enrolling individuals in the Supplemental Nutrition Assistance Program (SNAP) would fit into this category. When reaching out to such partners it is important to keep their mission in mind and make a strong case that offering TUD services supports that mission. As with making the business case, it is not enough to claim that adding TUD treatment

does not interfere with their mission. Many people have heavy workloads and adding TUD questions into an intake process can potentially detract from the mission—unless screening for tobacco use also brings in its own organizational value.

To use a different example, some state prisons still allow smoking in designated areas. Prisons serve as part of the criminal justice system and therefore have a public safety mission. Within the walls of the prison, the prison staff must keep the incarcerated individuals and the prison staff safe from harm. Evidence suggests that the times before and after "smoke breaks" are the most likely times for aggression (from nicotine dependent individuals). Therefore, managing withdrawal in the early stage of incarceration and then maintaining abstinence furthers the mission of keeping incarcerated individuals and prison staff safe from harm, before even considering the health benefits.

Remember that non-traditional partners do not have a direct TUD treatment mission. Rather, they have a separate mission to which providing TUD services or supports may be a tactic they can deploy to achieve their primary purpose. Trust may be built by providing practical evidence of your commitment to shared values and by asking your potential partners how you might best help them, while also seeking their leadership, guidance, and opinions.

Overcoming Initial Friction

Staff members, especially in the context of a wellness committee, often do the bulk of the actual work in designing TUD treatment programs. This approach makes sense as staff are far more likely to agree with the character and direction of policies designed by their peers. However, staff often fear that leadership will not back them if new initiatives experience obstacles, so it is critical that senior leadership is on board. From the perspective of leadership, there may be concerns of staff backlash when new policies are introduced. Meanwhile, staff often fear that leadership is not fully in support; establishing early on that both champions and leadership will one another is critical.

Following the important step above, ongoing communication between champions and leadership is critical. Establishing early on the authority of the wellness committee is important. At the same time, communication channels for getting periodic and ad hoc approval for decisions is helpful. A communications strategy should be agreed on from the beginning including what messages are going to be shared and who will disseminate these messages. Persistent, enthusiastic support of the change should come from leadership, and substantive input related to the nature and timing of the change should come from staff. Understandings regarding the roles leadership and champions play will help to engage potential collaborators and build community partnerships.

The Behavioral Health and Wellness Program's *Behavioral Health Cessation Coordination Model (BHCCM) Toolkit* is designed to provide a framework for organizations operating within the behavioral healthcare system to implement new or updated nicotine/tobacco dependence treatment services. The toolkit provides organizations with a blueprint for evaluating their services and implementing sustainable changes utilizing the BHCCM as a planning tool. Contact the Behavioral Health & Wellness Program at bh.wellness@ucdenver.edu for more information.

Behavioral Health & Wellness Program

Department of Psychiatry
SCHOOL OF MEDICINE
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