DIMENSIONS:
Agency & Community Policies
Jim Pavlik, MA, CTTP
Sr. Program & Policy Analyst
Prerequisites

- Awareness of the evidence-based best practices for tobacco cessation
- Knowledge of the 5As (2As & R) and Stages of Change
- Recognition of the disparate burden of tobacco use in your service communities
- Basic competency in tailoring care to meet racial/ethnic, literacy, or other needs
- Familiarity with the social determinants of health behaviors
Objectives

Introduce
- the concept of the person-centered health neighborhood

Identify
- key stakeholders of the health neighborhood and their roles

Share
- the characteristics of a good “neighbor” in the health neighborhood

Outline
- strategies to sustain a tobacco cessation health neighborhood
Systemic Solutions to Systemic Problems
“A system of care incorporates a broad array of services and supports that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships....”
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<td>LEVEL 5 Close Collaboration Approaching an Integrated Practice</td>
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<tr>
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<td>LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice</td>
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Behavioral health, primary care and other healthcare providers work:

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<th>In separate facilities, where they:</th>
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<th>In same space within the same facility, where they:</th>
<th>In same space within the same facility (some shared space), where they:</th>
<th>In same space within the same facility, sharing all practice space, where they:</th>
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<td>➤ Have separate systems</td>
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<td>➤ Share some systems, like</td>
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<td>➤ Communicate in person as needed</td>
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<td>➤ Communicate consistently at the system, team and individual levels</td>
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<td>➤ Communicate, driven by provider need</td>
<td>➤ Communicate, driven by specific patient issues</td>
<td>➤ Collaborate, driven by need for each other's services and more reliable referral</td>
<td>➤ Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
<td>➤ Collaborate, driven by desire to be a member of the care team</td>
<td>➤ Collaborate, driven by shared concept of team care</td>
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<td>➤ May never meet in person</td>
<td>➤ May meet as part of larger community</td>
<td>➤ Meet occasionally to discuss cases due to close proximity</td>
<td>➤ Have regular face-to-face interactions about some patients</td>
<td>➤ Have regular team meetings to discuss overall patient care and specific patient issues</td>
<td>➤ Have formal and informal meetings to support integrated model of care</td>
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<td>➤ Have limited understanding of each other's roles</td>
<td>➤ Appreciate each other's roles as resources</td>
<td>➤ Feel part of a larger yet non-formal team</td>
<td>➤ Have a basic understanding of roles and culture</td>
<td>➤ Have an in-depth understanding of roles and culture</td>
<td>➤ Have roles and cultures that blur or blend</td>
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Constructing a Health Neighbor
Four Components of a Comprehensive Policy

The tobacco free policy itself
- Which products are covered?
- What activities are restricted?
- Who is covered?
- What area is within the jurisdiction of the policy?
- When does it take place and for how long does it last?

Client-focused tobacco cessation interventions
- Services
- Referrals
- Follow-up and care management

Staff-focused
- Supportive policies (e.g., provision of NRT during shifts)
- Information regarding benefits
- Education about the policy and its rationale
- Training regarding new tobacco-related skills, processes etc.

Neighborhood Supports
- Provide services
- Build robust referral linkages to and from other services
- Institutionalize those relationships in formal and informal ways
Convene Your Wellness Committee

Provide Education

Create Your Change Plan

Offer Tobacco Cessation Services

Draft Your Policy

Launch Your Policy

Communicate Your Plan

Enforce Your Policy

Build Community Support

Evaluate Your Program

Behavioral Health & Wellness Program
Wellness Committee Composition

- Counselors & Therapists
- Compliance
- Neighbors
- Case Managers
- Onsite Medical Providers
- Security
- Smokers
- Ex-Smokers
- Health Educators
- Human Resources

Behavioral Health & Wellness Program

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Clearly Communicate Your Intentions

- Internet, Intranet
- Paycheck messages
- Signage
- Letter from leadership
- Pamphlets for staff & clients
- Notice boards
- HR policies and procedures

- Posters and/or banners inside and outside building
- Appointment card announcements
# Message Planning

- Recruit Wellness Committee Members
- Recruit Cessation Champions
- Elicit [anonymous] feedback

- Policy draft is available for comment/revision
- Meeting/materials explaining employee cessation benefits through insurance/EAP
- Launch date

- Policy finalized
- Publication of Processes and Protocols Document
- Launch date reminder

- Success stories (staff and clients that have quit)
- Recognition of positive attention
- Reminders of staff and client cessation resources
- Recruit more Champions
Create a Change Plan

• Begins with a Needs & Resource Assessment
• Identify obstacles to successful implementation
• Three primary activities
  1. Construct a logic model
  2. Build a timeline
  3. Create a budget
The Logic Model

- A systematic and visual way to present and share relationships between resources and outcomes.
- Quickly identify resource gaps
- Utilizes and reinforces a strengths-based approach to organizational change
# Logic Model

<table>
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<tr>
<th>INPUTS/RESOURCES</th>
<th>PLANNED WORK</th>
<th>OUTCOMES</th>
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<tbody>
<tr>
<td><strong>ACTIVITIES</strong></td>
<td><strong>GOALS</strong></td>
<td><strong>SHORT</strong></td>
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<tr>
<td>What resources do we already have available? What additional items will we need to accomplish our goals?</td>
<td>If all activities are performed, what will be accomplished? What evidence will there be that the goals have been met?</td>
<td>What changes will we perceive over the following 6 months to a year? How will we evaluate those changes?</td>
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<tr>
<td><strong>MEDIUM</strong></td>
<td></td>
<td><strong>LONG</strong></td>
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Timeline

• Pick a meaningful start date that is 6-9 months out
  • Great American Smoke Out (Nov 18, 2021)
  • Valentines Day (Feb 14, 2022)
  • Independence Day (Jul 4, 2021)
• Set your initial communication to come out 6-9 months before that date

Six or Nine Months?
• Anticipated staff readiness
• Establishment of client resources
• Current tobacco-related client “rewards”
• Funding/hiring factors
Draft Your Policy

- Rationale for policy
- Complete vs. partial prohibitions
- Combustible vs. other products
- Who is included
- Where the policy is in effect
- Treatment resources
- Alignment with current policies
- Consequences of non-compliance
Nicotine-Free Policies

Nicotine-Free Policy is Not Prohibition

Nicotine users will not be required to quit. However, the policy will ensure that those who wish to continue using (non-medical) nicotine may only do so in a way that does not provide the appearance of diminishing or violating the organization’s mission and values.
Nicotine-Free Policy Philosophy

Establishing nicotine-free policies and tobacco treatment services are essential components in offering health care services.
Nicotine-Free Policy Vision

- Produce an updated nicotine-free policy for use across the country to reflect recent developments
  - Rise of ENDS products
  - Increasing presence of marijuana
  - Telehealth and COVID-19
Inclusion of Electronic Nicotine Devices

Model Language:
“E-cigarettes, electronic vaping devices, personal vaporizers, electronic nicotine delivery systems, or such devices which deliver nicotine or other substances to a person inhaling from the device.”
Guiding Principles of the NFP

- The first priority is the health and wellbeing of all clients, staff, and visitors
  - NFP framed with this intent in mind
  - Enforcement protocols alongside treatment options
- Seeks to address addiction to nicotine as a best treatment practice
Associated Policies

- Aroma/Odor, e.g., perfume policies
- Other drug use policies
- Search and Seizure/Contraband policies
- Dress codes/professionalism standards
- Shift breaks policies
- Progressive disciplinary policies
- Therapeutic termination process
Launch Your Policy

- Practice day
- Signage
- Enforcement
- Kick-off Celebration
Evaluate Your Program

- Evaluation begins during the planning phase
- Conduct regular post-implementation evaluations
- Utilize Plan-Do-Study-Act cycles
Enforce Your Policy

- Employee and client violations
  - Progressive
  - Aligned with other, already existing policies
- Ensure all employees & clients are aware of procedures and protocols
- Create and practice enforcement scripts
- Consistency is key
Make the Case

“Clients will hate it.”
“Staff will resist.”
“Leadership isn’t convinced.”

How to Implement a Tobacco-Free Policy

1. Convene Your Wellness Committee
   Your committee should consist of administrators and staff at all levels of your organization.

2. Create Your Change Plan
   Construct a logic model, build a timeline for implementation and create a budget.

3. Draft the Policy
   Include input from staff, clients and other stakeholders.

4. Communicate Your Plan
   Your messaging should include implementation processes and timeline, support available for people who use tobacco and guidelines around how the policy will be enforced.

5. Build Community Support
   Reach out to your local and state health departments, community-based organizations and neighbors to help reinforce a tobacco-free message.

6. Provide Education to Staff
   Train staff early and regularly on the policy and skills for addressing tobacco with their clients.

7. Offer Tobacco Cessation Services
   Organizations should offer tobacco cessation counseling, medication, and resources to both employees and clients.

8. Launch Your Policy
   Organize a “Practice Day” prior to the policy implementation date. Post signage in different languages, particularly in areas where staff and clients smoke.

9. Enforce Your Policy
   Enforcement should be consistent across time and equally applied to all staff, clients and visitors.

10. Evaluate Your Program
    Create an evaluation plan that includes surveying staff, clients and the community to measure the impact.

Why go tobacco-free?

- Of the total U.S. tobacco market are people with behavioral health conditions.
- Is the average cost to employers per tobacco-using employee, due to higher insurance and lost productivity.
- Nearly 70% of people who use tobacco want to quit.


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Staff Buy-In is Critical

• Brief provider training is a cost-effective way to improve patient health outcomes and quality of life.

• Staff training increases the belief in and provision of cessation services.
Provide Education

- Behavioral health and nicotine addiction
- Pharmacotherapy and counseling
- Brief screening & assessment tools
- Treatment & discharge planning
- Priority populations
- Community referrals
  - e.g., quitlines
Offer Tobacco Cessation Services

- Staff that currently use tobacco are less likely to provide cessation resources to clients
- Tobacco-free policies are an additional motivation to quit, but insufficient for many
- Offering tobacco cessation services is evidence of organizational commitment
Medication Assisted Treatment (MAT)

- Combination of behavioral interventions and medications to treat substance use disorders
- Highly effective treatment option for individuals with alcohol, opioid, or tobacco dependence
- Reduces illicit drug use and overdose deaths
Budget

• A return on investment (ROI) implies the necessity of an “investment”
• Identify potential resources to mitigate costs (e.g., billing, grants)
• Identify potential costs
• Include anticipated savings
• Consider sustainability
What is the “Return”? 

- Tobacco is unique in that leadership frequently look for a financial return to their “investment.” What is the return on investing in treatment for depression?
- Leadership must weigh the “benefit” of a treatment line against the “cost” of providing it.
- The primary costs are training and time.
- The primary benefits accrue to clients, not the organization.
Return on Investment

For Facilities:

- Reduced maintenance and cleaning costs
- Decreased accidents and fires
- Decreased health insurance costs
- Decreased worker’s compensation payments
Return on Investment

For Staff:
Decreased hospital admissions
Decreased absenteeism
Increased staff productivity
Increased staff satisfaction

For Clients:
Decreased disease and death
Decreased hospital admissions
Increased quality of life
Cost Efficiency not Cost-Benefit

- Utilize existing resources
- Use “guerilla” tactics (e.g., client poster contests)
- Strategic alignment
- Realize benefits quickly
- Amortize costs over time
- Try to measure avoided expenditures
Constructing a Health Neighborhood
Rapid Improvement Goal

Ask → Advise → ASSESS & ASSIST → Refer

IMPLEMENTATION AND DELIVERY

Quitline
ASK
ADVISE

REFER

Continuity of Care
Conclusion

• The Health Neighborhood...
  • Might require the creation of new services, but
  • Concentrates on the relationships between sites to ensure that the most in need tobacco users are accessing as many services as they need. This work focuses on....
  • Engaging community members to become tobacco cessation advocates
  • Changing attitudes about tobacco cessation by
    • Formalizing policies
    • Regularizing partner interactions (i.e., putting them on schedules)
    • Routinizing the delivery of cessation activities (e.g., including them in EHR).
  • These activities are about true sustainability over long time-horizons and lead to the creation of a Culture of Tobacco Cessation
Resources
The Person-Centered Health Neighborhood

The 5As in the Health Neighborhood: Reconceptualizing Communities as a Source of Health and Healthcare

Training the 5As

Jim Pavlik, MA, CTTS

STAGES OF CHANGE
A Framework for Guiding Health Behavior Change

Jim Pavlik, MA, CTTS
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Why go tobacco-free?

- 44% of the total U.S. tobacco market are people with behavioral health conditions.
- $5,816 is the average cost to employers per tobacco-user admission, due to higher insurance and lost productivity.
- Nearly 70% of people who use tobacco want to quit.

Logic Model Development Guide
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- **In separate facilities, where they:**
  - Have separate systems
  - Communicate about cases only rarely and under compelling circumstances
  - Communicate, driven by provider need
  - May never meet in person
  - Have limited understanding of each other’s roles

- **In separate facilities, where they:**
  - Have separate systems
  - Communicate periodically about shared patients
  - Communicate, driven by specific patient issues
  - May meet as part of larger community
  - Appreciate each other’s roles as resources

- **In same facility not necessarily same offices, where they:**
  - Have separate systems
  - Communicate regularly about shared patients, by phone or e-mail
  - Collaborate, driven by need for each other’s services and more reliable referral
  - Meet occasionally to discuss cases due to close proximity
  - Feel part of a larger yet non-formal team

- **In same space within the same facility, where they:**
  - Share some systems, like scheduling or medical records
  - Communicate in person as needed
  - Collaborate, driven by need for consultation and coordinated plans for difficult patients
  - Have regular face-to-face interactions about some patients
  - Have a basic understanding of roles and culture

- **In same space within the same facility (some shared space), where they:**
  - Actively seek system solutions together or develop work-a-rounds
  - Communicate frequently in person
  - Collaborate, driven by desire to be a member of the care team
  - Have regular team meetings to discuss overall patient care and specific patient issues
  - Have an in-depth understanding of roles and culture

- **In same space within the same facility, sharing all practice space, where they:**
  - Have resolved most or all system issues, functioning as one integrated system
  - Communicate consistently at the system, team and individual levels
  - Collaborate, driven by shared concept of team care
  - Have formal and informal meetings to support integrated model of care
  - Have roles and cultures that blur or blend
Behavioral Health & Wellness Program

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