

National Behavioral Health Summit for Tobacco-Free Recovery

ACTION PLAN

October 13–14, 2016
Dr. John R. Seffrin Executive Conference Center
American Cancer Society
Atlanta, GA



CENTER FOR
TOBACCO
CONTROL



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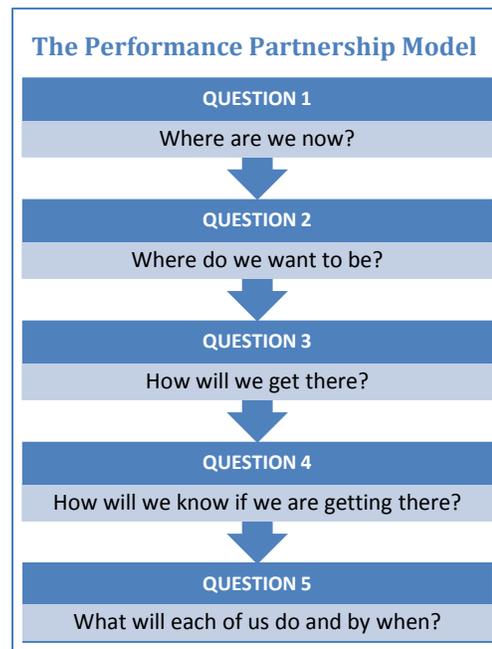
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Introduction and Background

On October 13–14, 2016, the [American Cancer Society \(ACS\)](#) and its Center for Tobacco Control, in collaboration with the [Smoking Cessation Leadership Center \(SCLC\)](#) at the University of California, San Francisco, held a national summit of a select number of public and private leaders in behavioral health, tobacco control, and public health to address the extremely high prevalence of tobacco use among people with mental illnesses and addictions. The summit produced a national action plan offering practical strategies that promise to significantly increase tobacco use prevention, increase cessation and quit attempts, and ultimately reduce the tobacco use prevalence among the behavioral health population.

The National Behavioral Health Summit for Tobacco-Free Recovery produced a call to action to reduce smoking rates among behavioral health consumers and staff nationwide, fostering an environment of cooperation and collaboration among the fields of public health (tobacco control, cancer control, chronic diseases), and behavioral health (mental health, and addiction treatment) that will serve to improve the physical health and wellness of behavioral health consumers.

This national action plan was produced using the Performance Partnership model. Jolie Bain Pillsbury, PhD, an expert in results-based facilitation, guided participants through a series of questions that framed the action plan. This action plan details the baseline, target, strategies and next steps for the partnership.



Participating Organizations

- American Academy of Family Physicians (AAFP)
- American Cancer Society (ACS) Center for Tobacco Control
- American Lung Association (ALA)
- American Psychiatric Association
- American Psychological Association
- CDC (Centers for Disease Control and Prevention)
- HUD (U.S. Department of Housing and Urban Development)
- NAMI (National Alliance on Mental Illness)
- National Association of State Mental Health Program Directors (NASMHPD)
- National Council for Behavioral Health
- North American Quitline Consortium (NAQC)
- Optum
- Pfizer
- SAMHSA (Substance Abuse and Mental Health Services Administration)
- Smoking Cessation Leadership Center (SCLC)
- Tobacco Control Legal Consortium (TCLC)
- UnitedHealth Group
- University of Wisconsin—Center for Tobacco Research and Intervention

Baseline and Target

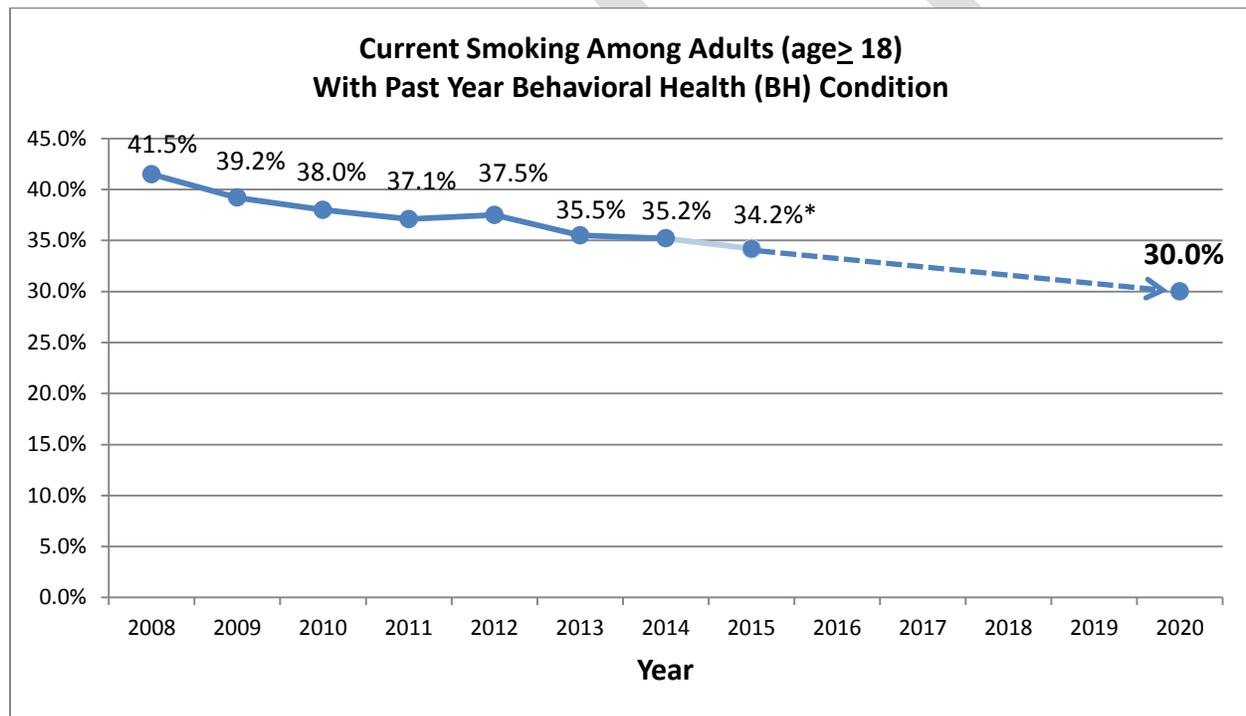
Where are we now? Where do we want to be?

	Baseline	Target
Current Smoking Among Adults with Past Year Behavioral Health Condition	34.2% (2015)	30% by 2020

Source: National Survey on Drug Use and Health (NSDUH), Substance Abuse and Mental Health Services Administration (SAMHSA), 2013–2015

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey based on interviews with individuals aged 12 and older. The survey collects data through face-to-face interviews with a representative sample of the population.

NSDUH is a primary source of statistical information on the use of illegal drugs, alcohol, and tobacco by the U.S. civilian, non-institutionalized population. The survey also collects data on mental disorders, co-occurring substance use and mental disorders, and treatment for substance use and mental health problems.



* Due to changes in survey questions regarding substance use disorders in 2015, including new questions on meth and prescription drug misuse, this data is not comparable to prior years

- **Current Smoking** is defined as any cigarette use in the 30 days prior to the interview date
- **Behavioral Health Condition** includes AMI and/or SUD
 - **Any Mental Illness (AMI)** is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)
 - **Substance Use Disorder (SUD)** is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*

Strategies

How will we get there? How will we know if we are getting there?



Five strategy areas were created, based on participants' expressed interests from a pre-summit survey: Peer Education, Policy, Provider Education, Systems Change, and Data/Research. The World Café method of facilitation fostered collaboration, and alignment and strengthening of strategies. The following matrices outline each group's strategies, commitments, contributors, process measures and timeline.

Summary of Peer Education Strategies

Implementation Team: Bill Blatt, Teri Brister, Robert Vargas, Jacqui Drope, and Roxana Said

1. Organization: NAMI			
Who Smokers with a behavioral health condition, partners and educators			
What: Develop fact sheets and educational material to disseminate to networks	With whom (contributing organizations)	By When	Process Measure
Create a designated landing page on our website where you can download these fact sheets, and incorporate into trainings. - Purpose would be to make linkages to other organizations and existing efforts.	ALA, Optum	July 2017	Gather and evaluate resources from partners
NAMI re-writing and re-building peer to peer toolkit- Overall Wellness	ALA, Optum	July 2017	Get reviews, taking subject matter experts. Teri gives Robert and Bill specific questions. -How much are you smoking? -Have your tried smoking before?
Reaching out to the ALA, and OPTUM to evaluate resources in place. Teri to collect information from Robert to review Optum's materials and integrate into NAMI's work and materials to disseminate.	ALA, OPTUM	Dec 2016	Connect and organize information
NAMI work with ALA to convince providers go tobacco free, and work with National Council to gather BH systems. NAMI, ALA and National Council can work together to gather information and disseminate.	ALA, NatlCouncil	July 2017	Connecting with ALA and National Council

Who + 2000 people- wide audience there, and the workshop can be on this becoming a national initiative, NAMI is all about becoming a movement.

What NAMI Convention	With whom (contributing organizations)	By When	Process Measure
In our exhibit hall have Optum/ALA potentially host a workshop.	ALA, Optum	June 2017	Collaborate with ALA and OPTUM and discuss plans.

Who Smokers with a behavioral health condition

What Bi-directional referral system with OPTUM	With whom (contributing organizations)	By When	Process Measure
<p>Create a bi-directional referral system with OPTUM (Quit For Life) quitline to NAMI for people who smoke and have a behavioral health condition. <i>“Hot Transfer” Referral Program</i></p> <ul style="list-style-type: none"> - NAMI can provide IT support and provide the intervention for callers. - Exchange data about do we track calls related to smoking, then what type of questions they are asking if we are tracking. - Robert will be reaching out to Teri - Teri meeting with NAMI IT team - Set up a meeting with Directors, IT, and collaborate and exchange information - Bill will get buy-in from his organization. 	ALA, OPTUM, NAMI	End of 2017	Meeting with contributing organization’s directors and IT team to create plan for referral system build and implementation.

Feedback and contributions from table:

Robert Vargas: Optum can help with developing education materials.

Interventions with people who call in to QL. We use the NAQ questions. Based off of self-reporting, we offer our program- What is the program— Incorporate, Higher Functioning vs Lower Functioning vs Diagnosed. Integrate TX: Who is their MH provider? What about the primary care physicians?

Need more people at the table including, National Jewish Medical Center and Chad Morris.

Schedule a call with John Allen, a toolkit for facilities to go smoke free. Get more insight on this process.

Voluntary vs. convinced Interventions

Bill Blatt: We have providers, we try to get them to recognize the diagnosis, and refer. *Training facilitators.*

Leverage CDC national network and take advantage- National Council First Aid Program- 6 hour educational session

2. Organization: American Lung Association

Who Behavioral health population

What	With whom	By When	Process Measure
All Community Mental Health Organizations (facilities, clubhouses etc.) to go smoke free	Optum NAMI		
Create a toolkit- Tobacco-Free Campuses for all How to help your patients quit smoking-	NAMI Club House International SAMHSA National Council	2-3 months	Fact sheets, making facilities smoke free. A “how to” sheet.
Increase cessation services for staff and clients – <i>Freedom from Smoking Program</i> : 5,000 clinics a year currently Will have a new reach #TBD	ALA	2-3 months	Promote- Freedomfromskin g.org
Train facilitators	ALA	TBD	On-going trainings

Organization: OPTUM			
Who People who smoke with a mental health condition Estimate of how many: Program reach 400,000			
What Quit for Life Program	With whom (contributing organizations)	By When	Process Measure
Promote developed program for participants who call in and have a mental health condition. - When they are eligible for the program, 40% are taking advantage.	Aim to create with NAMI and ACS, SAMHSA.	Early 2017	The acceptance rate, engagement rate, and quit outcomes. We will have data on this by the end of the year.
Quit material workbook, a tangible paper booklet.		June 2017	Reviewing process with NAMI and SAMHSA to gather behavioral strategies for coaches.
What Increase Partnerships	With whom (contributing organizations)	By When	Process Measure
Asking for more help from partner organizations and new contacts from summit	Summit attendees	Immediate	Outreach

What Create bi-directional referral system with NAMI	With whom (contributing organizations)	By When	Process Measure
Work with providers in establishing process and protocol, <i>“Hot Transfer” Referral Program</i>	NAMI, ALA	End of 2017	IT Referral to NAMI for counseling services
Connect with NAMI to discuss IT protocols and process for referrals		Nov 2016	
<p>Feedback and contributions from table:</p> <ul style="list-style-type: none"> - Work with NAMI - Robert: Understanding the complexity of the problem, or the issues that the person is going through - Customized treatment- stable housing- incentives- de-stigmatize - Leverage programs like, Mental Health First Aid 			

Summary of Policy Strategies

Implementation Team: Gregg Haifley, Marquita Sanders, Kerry Cork, Daren Sink, Catherine Saucedo
Committee Chair: Catherine Saucedo
Bridge Behavioral health & Tobacco Control to Affect Policy Change

Organization: HUD

Summit Participant: Marquita Sanders

Who: Housing industry partners – also homeless community workers, migration from homeless to health and home.
 Estimate of how many: millions

What : Technical Assistance Training for Traditional and non-Traditional partners– utilize concrete tools to accelerate social norm change and consequently behavioral change	With whom (contributing organizations)	By When	Process Measure
1. Develop messaging for staff and pilot w/ HUD– RE Asthma, Depression, Anxiety effects of smoking – myth busters – stigma – create fact sheet	TCLC, SCLC	December	# of fact sheets distributed or downloaded
2. Develop messaging for residents and pilot w/ HUD – “helps relieve anxiety, depression, and increase chances of sober” = create fact sheet a. Gain feedback on messages and tools with John Allen at NASMHPD and Consumer network for peer feedback b. Collaborate with Peer Committee	TCLC, SCLC, NASMPHD and National consumer organization	December	# of fact sheets distributed or downloaded
3. Increase access to technical assistance resources – for staff and residents a. Work within HUD communication channels to share new tools developed through summit partnership. b. Utilize new summit partners to share messages and tools with their constituents within public health communities c. Webinars – educate leaders / managers, HUD staff, public i. TCLC to choose one of 2 topics to showcase – implementation, community building, enforcement, reasonable accommodation	TCLC/SCLC/ALA	1-4 rd quarter	# of trainings and # of individuals trained

w/ ADA ii. SCLC to offer a general platform for additional outreach			
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Organization: TCLC
Summit Participant: Kerry Cork

Who: State and local health departments, Public housing authorities, in trenches in cities and small communities, and also offer legal analysis for advocacy groups
 Estimate of how many: 10,000 People and listservs, monthly newsletters

What : Legal TA & Policy Guidance for systems change and policy implementation - create educational resources to help implement cessation policy change	With whom (contributing organizations)	By When	Process Measure
1. Provide legal and policy resources to all within partnership	ALL Partners	1 st quarter	All partners aware of and using resources
2. Create a TA packet specifically with HUD to fine tune for residents and staff	HUD/SCLC	1 st quarter	# of packets distributed
3. Assist in the discussion to broaden Medicaid services to this group get coverage	ACS CAN/Provider and peer committee members	1 st quarter	
4. Offer a webinar	HUD	1 st quarter	# of participants
5. Develop a landscape Policy review of the” state of play” to be able to build in buy-in across networks we have. Work with partners like National Council and NASMPHD to identify issues with affordable care act, Medicaid/Medicare	NASMPHD/NATCON	1 st quarter	

Organization: Pfizer

Summit Participant: Daren Sink

Who: Policy makers (state and federal), 3rd parties , professional and business organizations

Estimate of how many: millions

What : Amplify message through field - Bring message to constituents via social media, and other vehicles of communication at Pfizer	With whom (contributing organizations)	By When	Process Measure
1. Take messaging from Policy summit implementation team to public affairs work at Pfizer – in person and online/social media	Gregg H- ACS CAN, Kerry Cork - TCLC	1 st quarter-2 nd quarter	message around BH and tobacco cessation policy actively promoted within Public Affairs at Pfizer
2. Incorporate BH message to Multicultural Advisory Committee - create a non-traditional outlet/partnership for HUD and others – reinforce behavioral health population of smokers as a health disparities group, note the need create equal access to cessation services	Marquita Sanders/Bill Blatt/Erika S	January 2017	–Message integrated - bridge to HUD
3. Bring issue, messaging, tools to gain commitment from providers in the field – boots on the ground a. Similar to SCLC partnership w Pfizer around Nicotrol. Pharma Pfizer representatives go into provider offices with quit kit bags, included cessation prescription pads (could be Varenicline), potential article from EAGLES study, 1 800-QUIT NOW card, info on Quitters Circle, and myth busters fact sheet.	Pfizer field reps	January 2017	% Field representatives delivering messages to % providers
4. Tailoring Quitters Circle to the BH population using social media platform (686,000 web visits, online community 175,000 people) – a. SCLC to develop curricula through RX for Peers and Psychiatry b. ALA to contribute, National council, NAMI to review, all to promote	Saucedo - SCLC, Bill Blatt - ALA, Jeannie Campbell NatCON, Terri Brister NAMI , Marquita - HUD	1 st quarter	Revised Quitters Circle available online –% of smokers with BH who join online community

Organization: American Cancer Society CAN

Summit participant: Gregg Haifley

Who : Approximately 50-60 agencies/orgs that help with policy advocacy

Estimate of how many: Through CAN advocacy arm ~ 2 million volunteers to engage in policy advocacy

What: Incorporate behavioral health component into existing efforts -Smoke free/tobacco taxes, prevention and cessation policy advocacy	With whom (contributing organizations)	By When	Process Measure
<i>Invite</i> behavioral health advocacy/leadership organizations summit participants to ACS CAN pool of advocates to engage around policy advocacy efforts	National Council, NAMI, NASMHPD	November, 2016	Add 2-3 behavioral health organizations to current ACS CAN advocacy arm
<i>Engage</i> new SUD and MH partners beyond summit circle to align priorities – consider Community Anti-Drug Coalitions of America , National Association of State Drug and Alcohol Directors , Mental Health America , Faces and Voices of Recovery Add at least one organization that focuses on SUD advocacy since addiction is currently under represented	TBD	2 nd Quarter	Add additional 2-3 organizations, include at least 1 SUD
<i>Use expertise</i> from new BH partners to find ways to tap into MH Parity and revive access to services.	NatCon, NAMI, NASMHPD and new SUD organization	2 nd quarter	Strategy developed with buy-in from BH organizations to leverage MH Parity
<i>Create</i> a global picture that includes mental illness and substance use disorder population, <i>address</i> health equity as part of this global picture – avoid strategies that are designed to reach sub-populations	National Council /NAMI/NASHMP HD	2nd Quarter	BH folded into new global message

Organization: ACS

Summit Participant: Cliff Douglas

Who: ACS constituents

Estimate of how many: 1 million

What : Establish a Roundtable to maintain ongoing communication and implementation of strategies	With whom (contributing organizations)	By When	Process Measure
<ol style="list-style-type: none"> 1. Take steps to establish a Roundtable for tobacco control to bridge all partners <ol style="list-style-type: none"> a. National Roundtable on Behavioral Health and Tobacco-Free Recovery is recommended name. b. Reach out to partners to gain buy-in c. Create a Call to Action statement d. Create a consensus statement - setting forth scientific evidence based, top level recommendations e. Do a scan of hurdles with individual treatment separate from reimbursement f. Create evidence based summary outlining what works, identifying issues for reimbursement via ACA, Medicaid/Medicare – etc. – work with NASMHPD on the white paper to summarize findings 	SCLC, NASMHPD Steering Committee TCLC, NASMHPD, APAs, AAFP, Pfizer	1 st quarter-2 rd Quarter	Roundtable established and partners actively implementing strategies
<ol style="list-style-type: none"> 2. Create basic messaging to promote at Great American Smokeout – short statement to share with all partners – to share with our individual milestones 	SCLC- steering committee	October, November 2017	# of partners sharing messages

Feedback and contributions:

Policy Strategy Themes:

- Elevating Behavioral Health Population effectively to make change – Policy, in particular, with a focus on cessation.
- Bridge BH & Tobacco Control

Cessation Policy issues:

- Payment systems are lagging behind and slowing cessation treatment process– need to work to modernize thinking re: paying for services vs. value-based treatment.
- Need to understand the population and the treatment system we are talking about and the broad spectrum that exists
- A behavioral health provider can only get one intervention to bill for.
- Suggest working with peer committee to bring the voice of the client into the process.
- When considering Access of Care reach out to the individuals being *affected*. Think about provider's point of action. Prescribe and walk away vs. prescribe and counsel.
- DSM IV cause of nicotine addiction is smoking but Psychiatrist can't bill for smoking. They can't use the billing code for tobacco. Need to come up language to make multiple billing doable
- All states hire peers for behavioral health work. Every Community Mental health Center has peer activities and all receive whole health action management training. There are currently 32 states that offer certified peers reimbursement.
- Consider reaching out to State/local policy drivers. Identify operations to better understand specific policy activity that facilitates outcomes within BH. NAMI, NatCON and NASMPHD have the ability to share this information. Only NatCon offers both mental illness and substance use disorder (SUD) advocacy. Would be wise to engage new partners that represent SUD , i.e., CADCA, Faces and Voices of Recovery and National Association of State Drug and Alcohol Directors
- ACS CAN keep partners from summit updated after election on status of Medicaid and other opportunities within state
- Because money is being cut at CDC, need advocacy now to support the above. Get Medicaid policy changed so behavioral health providers can bill under Medicaid for tobacco cessation (State x State and CMS policy).

HUD TA messaging and TA Packet:

- Peer strategy table has existing resources to bridge education and is willing to collaborate
- ALA will work with HUD to pilot – train people onsite and help smooth the transition to tobacco-free grounds
- Pfizer – Daren Sink can help by providing alignment with education and messaging first to existing leadership then to providers

Roundtable:

- Roundtable could be triggered by December 2016 but not formally established till 2nd quarter. Budget is approximately \$500K and includes full-time staff and an annual meeting.

- SCLC can work with ACS to keep partners communication going till Roundtable is official
- Partners agree this is a good solution to move forward

General:

Need more Federal counter campaigns that focus on BH. CMS needs to think about incentives. CDC and SAMHSA should offer more federal grants on BH and consider a South East strategy and identify ways to stimulate messaging.

Communication Plan:

Committee chair – Catherine Saucedo

Committee will schedule first call in November to review next steps from draft action plan

Summary of Provider Education Strategies

Implementation Team: Jeannie Campbell, Kristin Kroeger, Gil Lorenzo, Belinda Schoof, Steve Schroeder

Organization: American Academy of Family Physicians (AAFP), American Psychiatric Association, National Council, Smoking Cessation Leadership Center (SCLC)			
Who (population to be reached; e.g. constituents, providers, clients, staff): Providers			
What (specific, measurable activities that tell how the contribution will be made and with what impact)	With whom (contributing organizations)	By When	Process Measure
Growing champions <ul style="list-style-type: none"> • Determine baseline number of champions • Get buy in from leadership <ul style="list-style-type: none"> ○ Meet with district branch executives (Kristin, APA) ○ National Council board meeting (Jeannie, National Council) • Develop growth strategy 	All organizations present	December 2016 2017 November 2016	Champions identified Growth tracked
Organization: AAFP, American Psychiatric Association, National Council, SCLC			
Who (population to be reached; e.g. constituents, providers, clients, staff): Providers			
What (specific, measurable activities, strategies)	With whom (contributing organizations)	By When	Process Measure
Advocate for access to care, benefits, and reimbursement (incident 2) <ul style="list-style-type: none"> • Add new advocacy partners 	ALA, ACS, Pfizer UnitedHealth Care	ongoing	# partners increase

Organization: AAFP, American Psychiatric Association, National Council, SCLC			
Who (population to be reached; e.g. constituents, providers, clients, staff): Providers, staff, and peer specialists			
What (specific, measurable activities that tell how the contribution will be made and with what impact)	With whom (contributing organizations)	By When	Process Measure
Promotion to membership – blogs, dissemination, raising awareness <ul style="list-style-type: none"> • National listserv • Summit resources to launch across organizations (e.g., hashtag, social media, messaging, infographics) • Call to action <ul style="list-style-type: none"> ○ Establish writing committee ○ Resolve institutional vetting ○ Consider language (support vs. endorse) • National Summit on Behavioral Health and Smoking Cessation (National Council Annual Conference, Seattle, WA) • Technical assistance for communication among national summit partners 	Coordinate with SCLC and ACS Steve, SCLC and ACS Jeannie, National Council SCLC	Spring 2017 April 2017 ongoing	Listserv membership Call to Action released Summit held
Organization: AAFP, American Psychiatric Association, National Council, SCLC			
Who (population to be reached; e.g. constituents, providers, clients, staff): Providers and health systems			
What (specific, measurable activities, strategies)	With whom (contributing organizations)	By When	Process Measure
Integrate smoking cessation into routine care - content in education, training, technical assistance, webinars, best practices <ul style="list-style-type: none"> • Analysis of available curricula and residency programs • Create policy statement - American Psychological Association • Integrate cessation into behavioral health accreditation <ul style="list-style-type: none"> ○ PTAC reps from APA and National Council 	NASMHPD Lula Beatty, APA Joint Commission PTAC (Professional and Technical)	Feb 2017	Analysis and policy statement completed Inclusion of smoking

<ul style="list-style-type: none"> • Webinars – Plan as a series, promote through all organizations here, focus on peer to peer, how to talk to your patients about quitlines <ul style="list-style-type: none"> ○ Suggest speakers and content experts • Subcontracts/grants for promising strategies for non-governmental agencies 	Advisory Council) Steve, SCLC Steve, SCLC	 Launch series in Spring 2017 Q3 2017	cessation in accreditation
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Feedback and contributions:

Darren Sink, Pfizer: Our medical team has done this type of thing before; we have a lot of data over years, smoking cessation and mental health; they can do provider education, medical and research teams can provide data – set up presentations; did it with APA, medical to medical communications. *Kristin to connect with Darren.*

John Allen – NASMHPD: Set standards by which community providers have to operating, by contracting, payment method, policy; if there was a curriculum that was well developed that can be easily initiated; universally acceptable, NASMHPD can regulate and require, for community rehab agencies. Setting a standard – credentialed/training, e.g. a percentage of staff in each agency. NASMHPD can disseminate that; creating a toolkit that sets policy recommendations; provider education - % providers trained. Paraprofessional staff; non-licensed; majority of our workforce are those folks. Supported housing settings – paraprofessional staff supervised by a social worker.

Lula Beatty, APA: Promotion to membership, active on social media – hear more about the champions – similar to ambassadors? Meeting with ambassadors to find out what their interests are.

Robert Vargas, Optum: We’ve develop training for providers in states where we operate, creating a webinar, understanding each other’s limitations and development, to educate providers. CE class that is focused on tobacco cessation and mental health; elevates messaging if it is mandatory.

Marquita Sanders, HUD: Housing rule helps to spur people into action, the more mandatory, easier it is to make changes, easier for people to ask, resources will be there. Create space for national partners; give resources.

Corrine Graffunder, CDC: CDC worked with SAMHSA during 2016 tips from former smokers, Rebecca ad; advertorial, in conjunction with SAMHSA, placed in 13-16 BH/MH provider journals.

Robert Vargas, Optum: Physicians should know what patients should expect when they call the quitline; how quitlines work; clinicians should do the call with them, as part of the therapeutic relationship, supportive environment.

Corrine Graffunder, CDC: From an advocacy standpoint, quitlines are under funded; during the Tips NRT promotion, some states refused due to insufficient capacity to handle increase in call volume; get provider and behavioral health associations to advocate for quitlines.

Rosie Henson, ACS: Systems and provider education should be aligned and integrated; with growing champions, include peers in the workforce

Teri Brister, NAMI: Where in here is academia fit? APA – residency programs, where is the money going to come from? What is the pathway?

Jeannie Campbell, National Council: we run a integration center, It doesn't take a lot of money--some money, with concentrated efforts.

Nancy Kaufman, ACS: Training medical residents – RWJF invested a lot of money in training residents; palliative care, most of the programs didn't create effective practice changes. Send residents with mentor/champion in the agency, 1 to 2 weeks, not a whole rotations, residents in the behavioral health system.

How many CMHCs are there?

Jeannie Campbell, National Council: 3500-4000. 3000 are National Council members. More aligned with hospital systems, whole system, anchor is the hospital. Last year's Mental Health Excellence law, moved CMHC into CCBHC (like FQHC).

Summary of Systems Change Strategies

Implementation Team: John Allen, Linda Bailey, Christine Cheng, Corinne Graffunder, Rosie Henson, Nancy Kaufman

<ul style="list-style-type: none"> Organization: NASMHPD John 			
Who: constituents, providers, clients			
What: Create a policy statement and white paper on tobacco cessation/nicotine dependence for medical interventions in the community BH sector	With whom (contributing organizations)	By When	Process Measure
Compile and synthesize evidence	NASMHPD	Jun 2017	
Make recommendations	NASMHPD	Jun 2017	
Create implementation toolkit	NASMHPD	2017	Disseminate toolkit
<ul style="list-style-type: none"> Organization: CDC Corinne 			
Who: constituents, providers, clients, staff			
What: Systems change	With whom (contributing organizations)	By When	Process Measure
Convene meeting with organizations	CDC, ACS, ACS-CAN, NASMHPD, CTFK, CMS, NASMD, ASTHO, SCLC	Mar 2017	Meeting convened
Identify targets for systems change within Medicaid	CDC, ACS, ACS-CAN,	May 2017	Targets developed

	NASMHPD, CTFK, CMS, NASMD, ASTHO, SCLC		
Create demonstration plan to engage ACS and ACS-CAN in maximizing Medicaid benefits	CDC, ACS, ACS-CAN, NASMHPD, CTFK, CMS, NASMD, ASTHO	Jul 2017	Begin work in 5 states
Obtain funding for demo project	CDC, ACS, ACS-CAN, NASMHPD, CTFK, CMS, NASMD, ASTHO	Sep 2017	
<ul style="list-style-type: none"> • Organization: NAQC Linda 			
Who: constituents, providers, clients			
What: e-Referral pilot in 5-6 states (bi-directional exchange of information, warm transfers)	With whom (contributing organizations)	By When	Process Measure
Plan to select states, criteria, number, etc. Look at e-referral capacity (there are 16 states with capacity) and MH interest	NAQC, Optum, NJH, ACS, CDC, NASMHPD	Feb 2017	States selected
Plan for implementation and evaluation, "Go Live"	NAQC, Optum, NJH, ACS, CDC, NASMHPD	Jul 2017	
May need funding for evaluation	ACS	2017	

<ul style="list-style-type: none"> Organization: ACS Rosie 			
Who: providers, clients, staff			
What: Engage CHCs (FQHCs) and CMHCs in 3-5 pilots to increase comprehensive cessation services (systems levers – EHR, referrals, ID BH smokers, billing, Medicaid)	With whom (contributing organizations)	By When	Process Measure
Build capacity from within CHC/CMHC systems to identify, treat, and follow up with smokers (and those who quit)	ACS, HRSA, national organization for CHCs, coalition for BH centers	4 th Q 2017	3-5 pilots chosen
Obtain funding	ACS	4 th Q 2017	Initiate 3-5 pilots
<ul style="list-style-type: none"> Organization: ACS - Nancy 			
Who: providers and clients			
What: Total integration of BH and traditional health care	With whom (contributing organizations)	By When	Process Measure
Site visit Aurora Health Care (AHC) in Milwaukee to see a totally integrated system, AHC's footprint is half of the state of Wisconsin; 1 million lives impacted	ACS, SCLC, NASMHPD	May-Jun 2017	Visit completed
Develop lessons learned	ACS-Nancy	Sep 2017	Disseminate lessons learned

Feedback and contributions:

- Add a tobacco measure to state Medicaid strategy and to measure performance, like a diabetes or HTN protocol
- Utilize RIHOs (Regional Health Information Organization)
- Capturing input from consumer and family voices for the policy statement and white/position paper
- Consider looking at integration at the point of care – at the provider and client levels – one stop shop
- Look at models that use peer to peer/community health worker
- Use Million Hearts as sample policy statement
- Accreditations? Joint Commission tobacco measures? State MH licensure for CMHCs as policy leverage?
- Overarching paper/position statement from this summit’s participants
- Accountability of action items
- Engage VA?
- Engage DoD?
- Finding tobacco user “hiding in plain sight”; be able to count the number of smokers in any system, including insurers, etc.
- Peer leaders in the CMHCs, working with CEOs and consumers, certified peer specialists, community health workers
- SCLC to host webpage for all resources from this summit’s participants
- Para-professionals are the ones who are smoking, day to day interactions – provide resources to help those who want to quit
- ACS-Optum partnership – Optum QIs with ACS brand
- Tap into 6-18 initiative with CDC and RWJF
- Make sure there is help and resources for BH staffers to quit

Summary of Data/Research Strategies

Implementation Team: Lula Beatty, Monica Feit, Michael Fiore, Lew Sandy, Bidisha Sinha, Lee Westmaas

1. Organization: University of Wisconsin, Center for Tobacco Research & Intervention			
Who (population to be reached; e.g. constituents, providers, clients, staff): mental health patients and providers			
What (specific, measurable activities that tell how the contribution will be made and with what impact)	With whom (contributing organizations)	By When	Process Measure
100% of outpatient and inpatient MH treatment health facilities are SM and offer cessation and other medications	Payers, state and fed regulators that make reimbursement and certification contingent	2020	Survey
2. Organization: SAMHSA, HHS			
Who (population to be reached; e.g. constituents, providers, clients, staff):			
What (specific, measurable activities, strategies)	With whom (contributing organizations)	By When	Process Measure
Keep doing data collecting through NSSDA or generating a special report and make it more accessible; Office of Chief Medical Officer can do grand rounds Can offer technical assistance to other similar activities Main: Ask Chief Medical Officer to do grand rounds Joint webinar with APA/NCI	Office of CMO; provider groups, Wisconsin (Mike's group) With APA/NCI	2017 Q1 FY 2017	Webinar

3. Organization: American Psychological Association			
Who (population to be reached; e.g. constituents, providers, clients, staff): providers (have a practice directorate), BH; approximately 100			
What (specific, measurable activities that tell how the contribution will be made and with what impact) Identify research	With whom (contributing organizations)	By When	Process Measure
1) Present and meet with health leadership team (head of psychology health) and get them to sharpen focus on this intersection of mental health and smoking 2) Identify research that is missing 3) Identify planned social media activities (what can we do via social media) 4) Main: Webinar to membership, perhaps in collaboration with SAMHSA	This group With SAMHSA/NCI	By December 2016 or Jan 2017 Q1 2017	
4. Organization: United Health Group			
Who (population to be reached; e.g. constituents, providers, clients, staff): American Psychological Association Optum behavioral services that serves united healthcare			
What (specific, measurable activities, strategies)	With whom (contributing organizations)	By When	Process Measure
Main: Assess the current state (focusing on Optum Behavioral Health Solutions and United Health’s contracting networks) of what’s included in contracts re: tobacco and see if/how contracting language can be incorporated (@ minimum referral to QITLINE). 2) What is the impact post ACA – any change of use of NRTs, etc? Lew will contact HCCI about this question Want to find/conduct research showing that it’s less costly to treat people who don’t smoke	United Health Group/Optum	End of 2016 End of 2016	Self-report

Feedback and contributions:

Corinne

Need to identify better ACA info- evaluating what is happening due to ACA's policies.

Is there any evaluation on what's being implemented through/because of ACA?

Guidance to health plans was not very strong in the FAQs

Survey methodology – consistency in standards in surveys not on population side but on the systems and practice side – is that needed? Lew: yes, it's needed

Nancy: may be a place for ENDS within this population

Do research with people who are chronically mentally ill (harm reduction models) in which we offer ENDS as a cessation tool; ACS/NIH/FDA fund a trial? NHS in UK has done this.

Observe already existing practices within this group (qualitative studies)

Mike: FDA has approved E-cigs for research – can use for the research with ENDS suggested.

NIDA has budgeted and put out for bid any company that would make an e-cig for standard use. In 2017 there will be standard e-cigs with standard doses that can be used for research.

Access to cessation treatment that is accessible without barriers is a general issue. Should we advocate for insuring that smoking cessation treatments are available in treatment settings may be easier than trying to find specific facilities that treat MH patients.

Get clarification on ACA provisions b/c even with the FAQ, the coverage isn't clear. When somebody goes in to quit smoking there can't be any barriers.

Mike: there's going to be an update for the FAQs and they may ask for comments

FAQs: flesh out broad definitions...

Bill blatt: benefits do exist. People have to know about it. Plans are bad at making them available

Data/Research Main theme: Mental Health Treatment Facilities

Broader goals: 1) Increase smoke-free policies 2) increase comprehensive cessation treatment delivery

Levers to Promote our Goals

- 1) ACA
- 2) Influence Provider Attitudes and practices
- 3) Private sector/Payer policies
- 4) Accrediting bodies

Milestones:

- 1) SAMHSA will conduct a webinar Q2 FY 2017 and engage their CMOs in grand rounds for providers (towards #2 above)
- 2) American Psychological Association: conduct a webinar for members along with NCI and SAMHSA by Q1 FY 2017 (towards #2 above)
- 3) United Health Group will assess the current state (focusing on Optum Behavioral Health Solutions and United Health’s contracting networks) of what’s included in contracts re: tobacco and see if/how contracting language can be incorporated (@ minimum referral to QUITLINE). (towards # 3)

Staying Connected:

Email established in the next two weeks

Monthly check-in phone-calls to update each other about specific goals and also to continue other steps towards our main goal

Emergent Questions/Data Requests:

- 1) Since there is a variability of coverage of cessation services...is there a way to target facilities that don’t have services to have them provide the services? How well are the coverages for cessation being implemented? What are the gaps in provision? Barriers to access? How much does it cost for the patient? What’s covered? How does this have to be different for the population with behavioral health issues?

- 2) There was a question about providers being worried about losing clients if you ask them to quit smoking. Is there data available to show if that's true? Does anyone from this group have this information?
 - I. Getting information on the level of smoke-free policies at the range of institutions and centers that the behavioral health populations might access for treatment for behavioral health, ranging from primary care facilities, to centers where peers are the ones providing treatment, and who may themselves be smokers. Michael Fiore was able to dig up SAMHSA data pertinent to this which he showed us. I can't recall whether it included non-traditional facilities where peers may be the ones providing treatment for behavioral health.
 - II. Data on whether any smoking cessation treatment is available at the range of institutions/facilities mentioned in (i), and what that treatment is (meds?, counseling? Etc.).
 - III. Whether more people are taking advantage of cessation counseling since the ACA, and its recent FAQ to address questions about coverage. Lew said he could look at claims data from HCCI (Health Care Cost Institute) to address this.

- 3) Data on % of HUD residents that have BH issues and who smoke.

Next Steps

What will each of us do and when?

STRATEGY	NOV-DEC 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017
DATA/ RESEARCH	<p>Strategy group will communicate via email (ongoing)</p> <p>Webinar to APA membership, perhaps in collaboration w/ SAMHSA</p> <p>Assess the current state of what's included in contracts re:tobacco and how contracting language can be incorporated</p> <p>What is the impact post ACA – any change of use of NRTs, etc? <i>Want to find/conduct research showing that it's cheaper to treat people who don't smoke</i></p>	<p>Present and meet with APA health leadership team (head of psychology health) and get them to sharpen focus on this intersection of mental health and smoking</p> <p>Ask SAMHSA Chief Medical Officer to do grand rounds</p>			100% of outpatient and inpatient MH treatment health facilities are SM and offer cessation and other medications (2020)
PEER EDUCATION	Evaluate resources in place; review Optum's materials and integrate into NAMI's work and disseminate	<p>Create a toolkit- Tobacco-Free Campuses for all</p> <p>Quit for Life - Promote developed program for participants who call in and have a mental health condition.</p>		<p>Create landing page on NAMI's website</p> <p>Re-write NAMI toolkit, Overall Wellness</p> <p>Work w/National Council to convince providers to go tobacco-free</p>	Create a bi-directional referral system with OPTUM (Quit For Life) quitline to NAMI for people who smoke and have a behavioral health condition. <i>"Hot Transfer" Referral Program</i>

				Workshop at NAMI convention	
POLICY	<p><i>Invite</i> behavioral health advocacy/leadership organizations summit participants to ACS CAN pool of advocates to engage around policy advocacy efforts</p> <p>Develop messaging for staff/residents and pilot w/ HUD</p> <p>Create basic messaging to promote at Great American Smokeout</p>	<p>Take messaging from Policy summit implementation team to public affairs work at Pfizer</p> <p>Incorporate BH message to Multicultural Advisory Committee</p> <p>Bring issue, messaging, tools to gain commitment from providers in the field</p> <p>Tailoring Quitters Circle to the BH population using social media</p> <p>Increase access to technical assistance resources – for HUD staff and residents (throughout 2017)</p> <p>Provide legal and policy resources to all within partnership</p> <p>Assist in the discussion to broaden Medicaid services to this group get coverage</p> <p>Take steps to build a Roundtable for tobacco</p>	<p><i>Engage</i> new SUD and MH partners beyond summit circle to align priorities</p> <p><i>Use expertise</i> from new BH partners to find ways to tap into MH Parity and revive access to services.</p> <p><i>Create</i> a global picture that includes mental illness and substance use disorder population, <i>address</i> health equity as part of this global picture – avoid strategies that are designed to reach sub-populations</p>		

		control to bridge all partners			
PROVIDER EDUCATION	<p>Hold first strategy group call</p> <p>Determine baseline number of champions</p> <p>Meet with APA district branch executives</p> <p>Discuss topic and get guy in at National Council board meeting</p> <p>Develop growth strategy</p> <p>Release Call to Action</p> <p>Technical assistance for communication among national summit partners</p>	<p>Advocate for access to care, benefits, and reimbursement (incident 2) – ongoing</p> <p>Summit resources to launch across organizations (e.g., hashtag, social media, messaging, infographics)</p> <p>Analysis of available curricula and residency programs</p>	<p>Launch National Listserv</p> <p>Launch webinar series</p> <p>National Summit on Behavioral Health and Smoking Cessation (National Council Annual Conference, Seattle, WA, April)</p>	<p>Subcontracts/grants for promising strategies for non-governmental agencies</p>	<p>Integrate cessation into behavioral health accreditation</p>
SYSTEMS CHANGE	<p>Hold first strategy group call</p>	<p>Convene meeting with organizations</p> <p>Plan to select states, criteria, number, etc. Look at e-referral capacity and MH interest</p> <p>Site visit Aurora Health Care (AHC) in Milwaukee to see a totally integrated system, AHC's footprint is half of the state of Wisconsin; 1 million lives</p>	<p>Identify targets for systems change within Medicaid</p> <p>Create demonstration plan to engage ACS and ACS-CAN in maximizing Medicaid benefits</p>	<p>Obtain funding for demo project</p> <p>Plan for e-referral pilot implementation and evaluation, "Go Live"</p>	<p>Create NASMHPD Toolkit</p> <p>Build capacity from within CHC/CMHC systems to identify, treat, and follow up with smokers (and those who quit)</p>

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Call to Action and Steering Committee

The Steering Committee will help keep lines of communication open between partners and monitor progress. A Call to Action for the partnership will be drafted; Steve Schroeder will compose an initial draft based on the following: *building and engaging a coalition of stakeholders to achieve a reduction to 30 by 20*. A writing team composed of at least 5 members will collectively edit the Call to Action and propose it to the larger group.

Among other activities, the Steering Committee will decide on process on how to involve new organizations to this initiative. Those volunteering for the committee are: John Allen, Jeannie Campbell, Bill Blatt, Robert Vargas, Cliff Douglas, Bidisha Sinha and Catherine Saucedo.

The following organizations were recommended for growing the group:

Campaign for Tobacco-Free Kids, American Heart Association, CMS State and Medicaid Directors Association, FDA, VA, National Association of Community Health Centers, NIDA, CVS Health, Community Anti-Drug Coalitions of America, Faces and Voices of Recovery, other potential health insurers, National Association of Social Workers.



Participants of the National Behavioral Health Summit for Tobacco-Free Recovery