GLOBAL BRIDGES AND SCLC CAPACITY-BUILDING PROJECTS WORLDWIDE

2016

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

Smoking Cessation Leadership Center

Mayo Clinic

American Cancer Society

Pfizer

GLOBAL BRIDGES AND SCLC CAPACITY-BUILDING PROJECTS WORLDWIDE

2016

Table of Contents

J. Taylor Hays, MD

Chair, Global Bridges: Healthcare Alliance for Tobacco Dependence Treatment
Director, Mayo Clinic Nicotine Dependence Center

Tobacco use and dependence remains the number one preventable cause of premature death in the world. The tobacco control community, including healthcare professionals, can help turn this tide by increasing the accessibility and affordability of tobacco dependence treatment.

Partnerships for Global Bridges and the Smoking Cessation Leadership Center (SCLC) with Pfizer Independent Grants for Learning and Change have expanded training for healthcare professionals from many U.S. states and countries around the world in evidence-based tobacco dependence treatment – and helped to mobilize them as advocates. On May 22, 2016, Global Bridges and SCLC were proud to co-sponsor the CONNECT: Sharing and Sustaining Success meeting for our grantees in Rochester, Minnesota at Mayo Clinic. We thank the North American Quitline Consortium for expert facilitation of the meeting.

The Global Bridges effort began in 2007 with a small international meeting of healthcare professionals focused on tobacco dependence treatment. Today, we support 30 international grantees, including regional partners, regional networks and many projects in low and middle income countries. In addition to training healthcare professionals in tobacco dependence treatment and advocacy, Global Bridges advocates for Article 14 of the WHO Framework Convention on Tobacco Control, the global standard for integrating treatment into comprehensive tobacco control.

At the CONNECT meeting, SCLC and Global Bridges were privileged to witness knowledge sharing between countries, states and professional disciplines. This booklet of posters presented at the meeting is an invitation to join our community. Please consider how you can support tobacco dependence treatment, strengthen our network and disseminate the knowledge you'll find on the following pages.

Together with our organizations, Dr. Steve Schroeder of SCLC and I thank each of our stellar grantees for their dedication. It has been our privilege to help nurture their work.

Steven A. Schroeder, MD

Director, Smoking Cessation Leadership Center, University of California-San Francisco
Emeritus President and CEO, Robert Wood Johnson Foundation

We at SCLC and Global Bridges are proud of the collaborations we have made with Pfizer IGLC and the >70 organizations that have been funded to expand healthcare professional training, implement policy and system changes on their campuses, and increase the reach of individuals who suffer from tobacco use and dependence.

The Smoking Cessation Leadership Center was founded in 2003, under funding by the Robert Wood Johnson Foundation to work with leaders of American health professional organizations and health care institutions to increase the cessation rate for smokers. It has expanded the types of clinician groups that support cessation, developed an alternative cessation message (Ask, Advise, Refer), created new ways to market toll-free telephone quit lines, and engaged the mental health and addictions treatment community for the first time. SCLC works collaboratively with SAMHSA, HRSA, the CDC, and multiple health professional groups to provide technical assistance to help strengthen smoking cessation capabilities. The Center has also facilitated summit meetings involving 18 U.S. states that conduct tobacco cessation summits enabling states to achieve targeted reductions in smoking rates among behavioral health populations.

Many of the grant programs aimed to reduce smoking prevalence among the general population, but most of the domestic grants address the disproportionate burden that smoking exerts on the behavioral health population. This population with either mental health conditions, substance use disorders, or both, smokes at double to triple the rate of the general population. Persons with these conditions die much earlier, and many of their fatal diseases are caused by smoking. It is crucial for the tobacco control community to drive down smoking prevalence in the U.S. and other parts of the world by addressing both the general and behavioral health populations.

While smoking is an equal opportunity killer, no matter the nation, race or ethnicity, there are major differences in rates of smoking across these dimensions. Our conference showcased hardworking champions in smoking cessation. It was a pleasure to meet you and to be a part of your work!

Steven A Schroeder

Capacity building for smoking cessation training in Latin America: expanding the work of Global Bridges

InterAmerican Heart Foundation, Latin America Region
Gustavo Zabert, Beatriz Champagne, Esteban Cruz

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

Fundación InterAmericana del Corazón

Background and Project Overview

Global Bridges & the InterAmerican Heart Foundation (IAHF) have successfully trained over 1,358 healthcare providers on the importance of smoking cessation, the tools to aid smoking cessation, and techniques in applying smoking cessation skills. Although initial goals were met, and even tripled for Latin America, the impact of smoking cessation training on public health outcomes was limited.
To maximize the impact of the training, the project was refocused to build capacity in Latin American healthcare organizations and to promote smoking cessation training by focusing on a Train-the-Trainers approach, the principal objective being to strengthen health systems for treating tobacco dependence through improving healthcare workers' (HCW) knowledge, skills and confidence to routinely identify tobacco use and provide brief advice to assist cessation, in accordance with Article 14 of the WHO FCTC guidelines using the WHO training package "Strengthening health systems for treating tobacco dependence in primary care."

Project Objectives:

1. Develop a smoking cessation Train-the-Trainers (TtT) curriculum adapted to the Latin American region and consistent with the WHO's Building Capacity for Tobacco Control training packages
2. Provide face-to-face TtT courses and develop a Global Bridges Latin America (GBLA) smoking cessation Trainer's team with partner organizations.
3. Provide smoking cessation training (SCT) sessions in partnership with healthcare organizations.

IAHF

InterAmerican Heart Foundation is the official representative of the World Heart Federation in the Americas. IAHF's mission is to reduce heart diseases and stroke, and related non-communicable diseases (NCDs), in Latin America and the Caribbean and promote health through research, advocacy, public awareness and education. Tobacco control has been one of IAHF's main priorities since its creation in 1994.

Key objectives are:

- ♦ Promote an environment throughout the Americas that is conducive to the prevention of heart diseases and stroke, and NCDs more generally,
- ♦ Promote the growth and development of organizations that will take active roles in public education, professional education, public advocacy, and fund raising,
- ♦ Foster partnerships between health professionals, governments, business, industry, and other sectors of society for the accomplishment of its mission and goals.

Faculty of First Smoking Cessation Training, Puebla 2011
Global Bridges &
InterAmerican Heart Foundation

Global Bridges and IAHF

Global Bridges & the IAHF have reached more than 2,000 healthcare professionals from 70 healthcare organizations and successfully trained over 1,358 healthcare providers between 2011 to 2014 in Latin America and the Caribbean.
In this project, organizations and countries were approached with the objective of building training capacity and to promote smoking cessation training in their affiliates.

Outcomes

TtT: competent trainers to provide training for treating tobacco dependence in primary care settings.
SC training: competent healthcare providers that routinely deliver brief interventions to help tobacco users quit and protect others from exposure to second hand smoke.
Training sessions provided by partner organizations*

TRAIN THE TRAINERS (TtT)
ATTENDEES: 62 Experts
Certification
Trainers (Level 3) 12
Trainer Assistant (Level 2) 31

SMOKING CESSATION TRAINING (SCT)
ATTENDEES: 180 health care providers
Attendees to SC session after TtT 91
Attendees to SC session by partners 89

TRAINING SESSIONS
TtT 4
SCT 8
SCT by partners 4

***Partner organizations**
Mexico: Instituto Nacional de Enfermedades Respiratorias (INER)
Uruguay: Fondo Nacional de Recursos (FNR)
Bolivia: Servicio Departamental de Salud Santa Cruz (SEDES) and Instituto del Torax (La Paz)
Costa Rica (consultation): Caja Costarricense del Seguro Social (CCSS)

Lessons Learned

The mechanism of working with established institutions is promising. Agreeing to activities and outcomes helped involved high level authorities. However, changes in decision makers or focal points sometimes contributed to discontinuity.

Partner organizations were required to identify tobacco experts for TtT based on Key Criteria: background knowledge, SC experience, communication skills, teaching abilities and emotional stability.

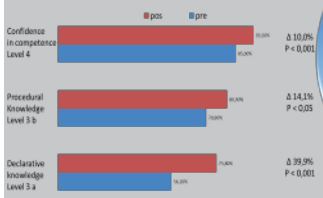
TtT participants' competences were found to be very variable therefore a two-step approach was instituted to improve trainers' expertise.
1. Accreditation at 3 levels, supported by performance on day 2 SCT
Level 1: **TtT Attendee**, endorsed as facilitator in SCT case presentation or role playing
Level 2: **Assistant Trainer**, endorsed as facilitator in case presentation or role playing and to lecture but cannot chair SCT
Level 3 **Trainer**, fulfills competence and performance requirement therefore is certified to chair a SCT and to be included in the GB-IAHF Trainer´s team
2. On line follow-up and continuous training for TtT in LMS (Blackboard)

Intervention design and methods

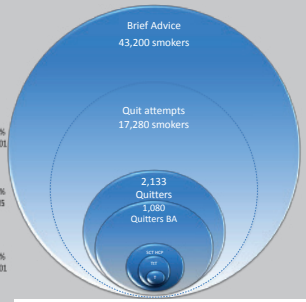
The intervention strategy was to approach organizations to partner with GB & IAHF to build capacity for smoking cessation training within their organizations. Organization and country selection was based on previous partnership and interaction with GB & IAHF as well as feasibility to achieve goals.

We offered a two day training session:
Day 1 - Train the Trainer module and **Day 2** - Smoking Cessation program. Day 2 was based on Part III and IV of the WHO training package "Strengthening health systems for treating tobacco dependence in primary care." TtT module was led by our team expert in medical education. Partner organizations were requested to sign a letter of agreement with IAHF for the project, to select and propose SC candidates to attend TtT module, and schedule at least 2 SC sessions in the following year.

Moore's outcomes taxonomy**
Pre and post test GB-IAHF 2011-2014
(Level 3a n=1358 Level 3b n=443)



**Moore D, Green J, Gallis H. Achieving Desired Results and Improved Outcomes: Integrating Planning and Assessment Throughout Learning Activities. Journal of Continuing Education in the Health Professions. Winter 2009;29:1–15.



What would be the impact if each HCW trained offer ONE brief advice (BA) every working day and NRT plus intensive intervention (IT) to 20% of smokers in the year after training?
GB-IAHF 2014-2016

Next Steps

Evaluation forms of WHO's training package Part III and IV propose to explore attendees' self-report of Moore´s Level** 2 and Level 3. In our experience, all dimensions reported positive answers in more than 90% for both modules. Objective evaluation of TtT for Level 4 (Competence of P³E strategy) and Level 5 (Performance on Day 2) disclosed outcome gaps that required amendment to ensure trainers expertise. So far, for SCT there is no clear relationship between attendees' self assessment and performance in clinical scenarios.
GB-IAHF project is currently in the evaluation process for qualitative outcomes for TtT and institutional outcomes and commitment to change for SCT in three dimensions (brief advice, register in clinical files and refer to SC specialists)

Building Tobacco Treatment Capacity in Medical Universities and Affiliated Hospitals in China

Center for Tobacco Control Research, China

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

Challenge and Project Overview

Many people would rather choose the treatment of disease than intervention of pathogenic factors, considering smoking cessation is beyond a physician's duty in China. Such prevailing cognitive bias could not be changed in a short time. Health professionals play a critical role in the success of tobacco control by providing services, advocating for policies and serving as role models for social change. It is necessary to first raise physicians' awareness of the significance of smoking cessation.

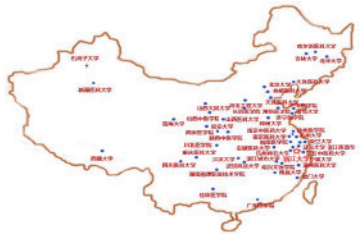
This capacity building project involves 50 medical universities. We developed culturally relevant materials for a tobacco control and tobacco treatment course to be implemented in medical faculties. About 10,000 medical students and 250 medical teachers will be trained through our project, and their tobacco control and tobacco treatment knowledge, skills and behavioral capacity will be developed. The experience also develops our technical expertise in treatment development and dissemination, as well as an extensive network of contacts throughout the country.

Many smoking cessation clinics have been developed in China in recent years as part of the government's tobacco control programs, but only a small number of smokers have visited them. While hotlines have been the great hope for the embarrassing situation, the result turns out to be exactly the same - people barely asked the hotline for help. These may reflect that Chinese culture, to a large extent, still adheres to agrarian social mores that make Chinese people unaccustomed to dealing with problems such as smoking by means of rational and instrumental methods. Smokers who want to quit would rather believe in their will than using professional assistance. This makes it difficult to attract smokers to clinics specializing or hotline in smoking cessation. A more promising alternative is to introduce smoking cessation treatment during routine care, when patients come to a hospital or visit physicians. In our project, 10 university affiliated hospitals (AHs) were recruited and began to implement the nicotine dependence treatment program in routine clinical care; about 200 trained physicians will provide smoking cessation assistance to about 5,250 smokers.

Broad dissemination is also an important part in this project. We conduct advocacy to raise awareness of public, policymakers, and medical professionals concerning the importance of tobacco treatment.

Who

Prof. Tingzhong Yang, the principal of this project trained 50 local principal investigators (PIs) and 12 physicians from 10 affiliated hospitals to conduct our project normatively through two-day training workshops organized by the project team. Then, the PIs and physicians delivered the same training to other project participants in their own institution. All kinds of trainers including Prof. Tingzhong Yang, PIs, physicians and all of the project participants are heroes in this part, they spread tobacco control and tobacco treatment skills and knowledge to medical students, physicians and the public directly or indirectly.



Where and When

The 50 universities and 10 affiliated hospitals involved in this project covered 24 provinces, municipalities and autonomous regions of 34 in the whole nation. Although these partners seem a bit imbalanced in geographic distribution through this map, the distribution of selected universities is basically consistent with population distribution in China. This project's duration is Sep. 2015 - Dec. 2016.

Results

Result 1
A total of 35,000 medical students have received face-to-face training and another 510 students and health professions have completed an online training.

Result 2
238 medical teachers and 147 physicians have finished training and practiced teaching through workshop and peer education.

Result 3
At least 700 smokers have received nicotine dependence treatment in nine affiliated hospitals and a community health center.

Highlighted Impact

Smoking treatment in China still lacks maturity and the most important thing is raising awareness and support. We did a lot for it. The workshop we held in last August, received intensive media attention. The reports of this workshop were released by at least 21 news agencies. The image was a screenshot with the news released by "The State Council Information Office of the People's Republic of China," which was then forwarded to more than 200 news agencies and other websites.

It should be also mentioned that during the project period, our report about Global Health Professions Student Survey (GHPSS) in Tobacco Control in China was published and the core information was released by United Nations. These positive effects are so useful for our current project implementation.

We take every chance to advocate smoking cessation treatment with all available resources: share experiences in related conferences, add smoking cessation skills into national standard textbooks and participate in tobacco control legislation.

Methods

A main goal is to have all participating universities implement the newly revised curricula in medical courses within their own school or department. A critical issue in this process is gaining agreement by each university to incorporate tobacco control into their curriculum plan. Such agreements are being cemented under our current project; we only need to introduce the new and improved material under existing agreements. The course follows multiple formats of teaching: lecture, problem-based learning, group discussions, debate and case studies. The primary aims are to equip students with basic theories, methods and skills of tobacco treatment. We deliver the course in three contact hours and three non-contact hours. Contact hours will focus in teaching pharmacological and behavioral treatment methods; non-contact hours will have students go to hospitals to observe the practice or go to community to conduct smoking quitting counseling. Besides, to raise awareness of public, PIs have to gain media attention in their cities/municipalities though project events and "World No Tobacco Day."

Methods

To have all participating AHs to implement tobacco treatment within their respiratory department. We will build systems and infrastructure to ensure tobacco dependence treatment is given to all patients who smoke and access services in respiratory department of the 10 AHs. We will urge and assist our primary contact at each hospital to lobby and convince key stakeholders to implement tobacco treatment in their hospital, which take smoking cessation as an integral part of the treatment of disease.

Contact Information (email): tingzhongyang@zju.edu.cn; shuhan_Jiang@163.com
Corresponding Authors: Tingzhong Yang; Shuhan Jiang; Zhejiang University, School of Medicine, Center for Tobacco Control Research

Implementing evidence-based smoking cessation treatment in addiction/mental healthcare units in Brazil

Centro de Estudos em Saúde Mental do ABC (CESM-ABC), Brazil

Challenge and Project Overview

Motivation: The population of mental health and addiction (MHA) patients has received little help to combat smoking. However, the prevalence of smoking among MHA patients is 2-4 times higher than it is in the general population. Recent Brazilian studies show that success rates in quitting smoking and retention in the treatment are at least comparable to the general population, since the treatment of smoking is incorporated into ongoing treatment for mental disorder or other addiction. Considering this, specialized MHA care units are strategic locations for such processing. However, in Brazil, such as in other countries, such units that are engaged in the fight against smoking are the exception.

Approach: Our team trained the staff of 17 MHA units within 10 cities – which included 184 health professionals – that have not been running specialized treatment for smoking. Our curriculum included the following topics focused on the implementation of treatment for MHA smokers: management; epidemiology; medications; psychotherapy; and smoking/mental health assessment instruments. This project enabled the implementation of a smoking treatment protocol in at least 1 MHA care unit in each of the 5 Brazilian administrative regions.

Where and When

186 professionals from Mental Health/Addiction care units within the 5 Brazilian regions:
CAPS-AD Continente (Florianópolis, South region)
CAPS-AD Guará (Brasília, Middle-West region)
CAPS Infantil Manaus (Manaus, North region)
CAPS Sul (Manaus, North region)
CAPS Iranduba (Iranduba, North region)
CAPS-AD Manacapuru (Manacapuru, North region)
CAPS-AD Mané Garrincha (Rio de Janeiro, Southeast region)
CAPS-AD Cachoeirinha (São Paulo, Southeast region)
CAPS Alvarenga (São Bernardo do Campo, Southeast region)
CAPS Farina (São Bernardo do Campo, Southeast region)
CAPS 3 Centro (São Bernardo do Campo, Southeast region)
CAPS-AD Centro (São Bernardo do Campo, Southeast region)
CAPS-AD Norte (Natal, Northeast region)
CAPS-AD Leste (Natal, Northeast region)
CAPS Infantil Natal (Natal, Northeast region)
CAPS 2 Oeste (Natal, Northeast region)
CAPS 3 Leste (Natal, Northeast region)

Who

Up to now, this project has trained 186 health professionals (including 19 managers within them), around 75% female, 50% aging 30-39 years, among those: 32 Doctors; 38 Psychologists; 48 Nurses; 21 Pharmacists; 15 Social Workers; 6 Dentists; 25 Other professionals.

Results | Lessons Learned

- Give clinicians an opportunity to explore how they feel/think about treating their clients' tobacco dependence before diving into how to do it
- Avoid the red flag term of CBT and focus on "supportive" counseling. Include in training professionals who aren't so tied to psychoanalysis.
- Discuss the strengths that MHA units have in helping their smokers quit

We changed the training structure, in order to address the need to change provider attitudes, increase knowledge and develop adopting a mixed approach with lectures, small-group discussions and role-plays.

We customized the training content for physicians (more focused on pharmacotherapy) and licensed healthcare professionals (more focused on behavioral therapy.)

We also adapted the training content to best meet MHA unit's needs, which were assessed in a pre-training survey with key professionals.

Next Steps

- To develop and implement a web survey with trained professionals making use of the Portuguese-language Global Bridges website. The purpose of this survey will be to assess the Moore's levels 2, 3, 4, and 5: "Satisfaction"; "Learning – Knowledge"; "Learning – Competence"; and "Performance."
- To expand this project to Portugal, improving the health and wellness of the Portuguese by increasing tobacco cessation among those diagnosed with MHA disorders who are receiving treatment in MHA care units there.

Table 2. Learning outcomes evaluation measures for the MHA Tobacco Cessation Project in Portugal, 2016-2018.

Target Level		Moore's Levels				
		1 (Participation)	2 (Satisfaction)	3 (Learning - Knowledge)	4 (Learning - Competence)	5 (Performance)
Champions	Measure	Individual attendance records	Post-training questionnaire	Pre- and Post-test of knowledge	Self-report of competence and intention to change questionnaire	Websurvey for self-report of performance in patient care setting
	Target	15	90% of satisfaction	75% of increase	90% of self-report of competence and 90% of intention to change	90% of performance
Individual	Measure	Individual attendance records	Post-training questionnaire	Pre- and Post-test of knowledge	Self-report of competence and intention to change questionnaire	Websurvey for self-report of performance in patient care setting
	Target	135	50% of satisfaction	50% of increase	50% of self-report of competence and 50% of intention to change	50% of performance
CRI	Measure	Number of CRI units reached	Aggregated individual data per CRI unit	Aggregated individual data per CRI unit	Aggregated individual data per CRI unit	Aggregated individual data per CRI unit
	Target	15	50% of satisfaction	50% of increase	50% of self-report of competence and 50% of intention to change	50% of performance

Workshop Content

1) Management – To enable the CAPS-AD units: (i) for getting support from INCA for the treatment of smoking by receiving specific medications (bupropion and nicotine patches); (ii) for storing and accounting the medications received; (iii) to calculate the number of vacancies available based on equipment and staff available; (iv) to inform the public about the availability of treatment and management of the waiting list.

2) **Epidemiology** – Smoking in Brazil and in other countries, in sub-groups of interest such as women, elderly, adolescents, individuals with psychiatric disorders and other types of dependency, and individuals with clinical diseases; the consequences of smoking within the human body systems; the neurobiology of smoking.

3) **Pharmacological Treatment** – To enable the practitioners for prescribing medications provided (bupropion and nicotine patch) and not provided (varenicline, nortriptyline and other forms of NRT) by INCA for the treatment of smoking in a classic 12-week treatment.

4) **Psychotherapy Treatment** – To explain the implementation of specialized group psychotherapy for the treatment of smoking in 12 sessions.

5) **Instruments** used to: (i) evaluate smoking habits, to enable practitioners for using all the Portuguese validated-scales for smoking habits during the first visit of the patient; and (ii) evaluate psychiatric morbidity: to enable practitioners on the use of Questionnaire for Adult Psychiatric Morbidity.

João Mauricio Castaldelli-Maia, MD
jmcmaia2@gmail.com

Building Capacity for Illness-Specific Tobacco Cessation Among Nurses & Clinical Psychologists in Turkey

University of Arizona, USA & Kadir Has University, Turkey

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

Background

Turkey has often been presented as a tobacco control success story since it has been able to implement ALL of MPOWER.

However, smoking prevalence rates remain high: 41% for men and 13% of women, with rates in urban areas even higher.

As part of MPOWER, a number of cessation clinics were established, offering primarily NRTs & medication.

Project Overview & Objectives

The **overall goal** of the project is to extend the reach and depth of smoking cessation training within the Turkish healthcare system. We are creating a cadre of nurses and psychologists trained in tobacco cessation who are able to introduce illness-specific as well as general cessation training within their own practice-based communities and sub-specialties. We are building on over a decade of cessation experience gained during Project Quit Tobacco International conducted in India and Indonesia.

Our **specific objectives** are:

- To conduct formative research as a first step in adapting evidence-based cessation training to Turkish culture
- To raise consciousness & expand clinicians' knowledge of the many harms of smoking as a means to promote cessation in clinical settings & assist them in establishing relevance for cessation advice to patients
- To produce illness-specific, culturally sensitive cessation educational materials and videos modeling tobacco cessation skills for use in trainings & quit guides for laypersons;
- To provide assistance to health professionals to train other professionals in both their own clinical settings & in their professional organizations as a means of promoting cessation as a normative part of clinical practice in Turkey

Work Completed

Trainings of Health Professionals:

- Three trainings have been conducted on the harms of tobacco and cessation counseling skills with nurses (n=44) and psychologists (n=6).
- Following training, participants conducted BIs & were debriefed as part of continuing education. Feedback on challenges faced and lessons learned are being used in future trainings and to improve cessation materials.

Materials Development:

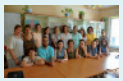
- Existing cessation materials in clinics are largely promotions for NRTs and medications. We are in the process of developing educational pamphlets & posters for general and illness-specific cessation. These are are being developed, pretested, & adapted to laypersons' level of understanding and perceived acceptability of cessation messages.
- Video scripts modeling cessation skills are being developed and shooting/editing is underway.
- Once completed, all materials will be available on our website: www.sigarasiz.org

Research:

- Interviews with hospital administrators, nurses working in existing cessation clinics, doctors and nurses in sub-specialty clinics, and smokers.
- Review of existing cessation materials available in clinics.
- Focus groups with smokers about cessation guides and posters under development.
- Surveys on smoking prevalence of nurses and doctors.
- Mining patients' responses to brief interventions.

Project Assumptions that were Challenged

- We assumed that Turkey's proactive national tobacco control policies would result in widespread acceptance & receptivity to cessation trainings for nurses as well as support for cessation counseling as routine practice in clinical settings.
- These assumptions have not proven correct. We identified several systemic challenges to introducing tobacco cessation in clinical settings & motivating nurses to conduct brief interventions.



Challenges

Systemic Level

- Turkey has recently implemented a for-profit business model in the government health sector. Emphasis has been placed on increasing efficiency and the number of patients seen per day.
- At Government Hospitals, doctors are scored for performance: given 4 credits for seeing patients, but only given 1 credit for work in cessation clinics.
- Doctors are no longer motivated to work in the first wave of cessation clinics; the for-profit business model has resulted in disincentives to counsel patients.
- Several cessation clinics in Istanbul have closed.

Doctors

- 24% of general practitioners in Turkey are smokers.
- Status as smokers impacts doctor's willingness to counsel patients; many are skeptical about the harm of moderate tobacco use.
- Most doctors have little experience with conducting brief interventions.
- Doctors' focus is on treatment of disease, not prevention.

Nurses

- 21-49 % of nurses are smokers in Turkey.
- Hospitals are understaffed & nurses are overworked.
- At present, there is little incentive for nurses to gain new skills as this will not result in career enhancement or salary increase.
- High prevalence of smoking among nurses affects both their interest in learning about smoking cessation & undermines their ability to counsel patients.

Patients

- Turkey is a good example of a country with a literate population who challenge expert information about the harm of tobacco.
- Many patients, even those with serious respiratory and heart problems, challenge doctors who talk about the harm of tobacco and the importance of quitting.
- Some patients are concerned that quitting will be more harmful to their body than smoking & emphasize how smoking helps with their daily stressors.
- Motivational interviewing has to be adapted to deal with common doubts & challenges linking smoking to Turkish culture.

Lessons Learned

Emphasize Suffering Not Mortality

- Increased chance of mortality does not appear to be a powerful motivator to quit smoking in Turkey.
- Illness-specific counseling plays up suffering, and exacerbation of current illness as a means of establishing relevance of quitting at a teachable moment.
- This approach is being tested in our project.

Medical Education

- Our project started "downstream" due to the assumption that health care providers in Turkey would be on board with cessation.
- However, the importance of counseling patients to quit smoking has not been sufficiently emphasized upstream in Turkish medical & nursing education.
- Upstream intervention is necessary to make cessation a normative part of best practice. Knowledge about tobacco harm and cessation skills need to be part of medical and nursing examinations to be taken seriously.
- Medical and nursing students need to practice brief interventions with patients, not just learn about skills on line or from classroom lectures.
- Health care providers need credible, culturally appropriate educational materials to use in clinical settings to increase their credibility and support patient quit efforts.

MATERIALS

OUR PARTNERS

KOÇ UNIVERSITY SCHOOL OF NURSING

AMERİKAN HASTANESİ

MEDİPOL

CONTACT INFORMATION

Prof. Mimi Nichter
mimi.nichter@gmail.com

Assoc. Prof. Aslı Çarkoğlu
asli.carkoglu@khas.edu.tr

Nurses

- Nurses should receive training about the harm of tobacco and conducting BIs during their *nursing education,* rather than once they are practicing on the ward. At present, this is not the case.
- Conducting BIs needs to be part of nurses' performance evaluation so they will take it seriously; they need to be rewarded for doing cessation.
- Nurses need to see that doctors are invested in tobacco cessation.

Conclusion

- Until systemic issues are addressed it may be hard to promote and sustain cessation in clinical settings.
- It is essential to introduce cessation training as part of nursing and medical education so it becomes a normative part of clinical practice.

Development and Dissemination of a Tobacco Cessation Training Program in Spanish for Healthcare Professionals in three Latin American countries

Catalan Institute of Oncology (Spain)
Instituto Oncológico del Oriente Boliviano (Bolivia) ; Instituto de Cancerología (Guatemala); Ministerio de Salud Pública (Paraguay)

Challenge & Project Overview

- Tobacco consumption is shifting to low and medium income countries such as some countries in the Latin American and Caribbean (LAC) region. (120 million of smokers live in these countries).
- Half of them will develop a tobacco-related disease and they will need of hospital care.
- Smokers who are hospitalized have an excellent opportunity to quit in a favorable environment.
- However, evidence-based cessation programs are hardly available in LAC countries.

CHALLENGE

The most common barriers to incorporating tobacco cessation interventions involve:

- Lack of training
- Absence of expertise, time, and
- Organizational constraints

GOAL

This research is designed to disseminate and evaluate the adoption, implementation, and maintenance of an evidence-based tobacco cessation training program addressed to health care professionals of three Spanish-speaking low and middle income countries in the Americas

Aims

- To adapt the course to the reality of three Spanish-speaking low and middle income countries (Bolivia, Guatemala, and Paraguay) and;
- To evaluate the effectiveness of the program among the participant hospitals and workers

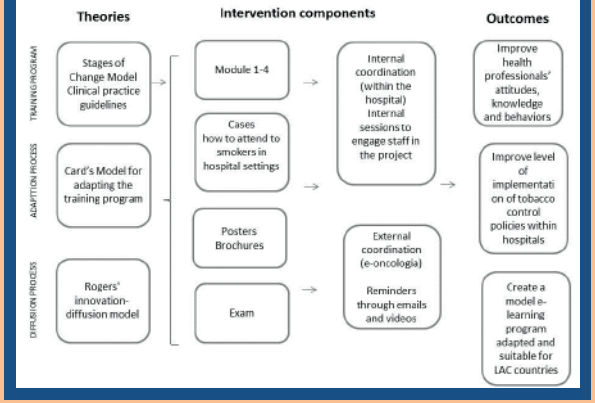
Study Design

- Mixed methods study (qualitative and quantitative)
- Quantitative methods: pre-post design.
  - Participants' attitudes, knowledge, and behaviors
  - Level of implementation of tobacco control policies
- Qualitative methods: focus group and in-depth interviews of participants and key person.
  - Evaluate the experience of adapting the training program in each of the participant hospitals
  - Evaluate the experience of undertaking the training program.
  - Evaluate the opportunities and barriers of undertaking the distance-learning program.

Participants

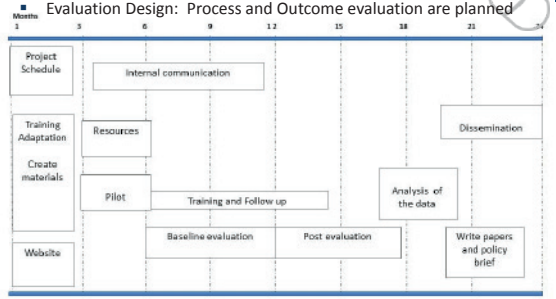
- Three hospitals in Bolivia , Guatemala, and Paraguay
- All health providers in the selected hospitals, including nurses, doctors and other health professionals, will be trained.

Conceptual Framework Model



Procedure and timeline (Cards' model)

- Select a suitable effective program:
  "Brief Intervention for Smoking Cessation" online course (10 hours)
- Gather the original program materials;
- Develop a program model;
- Identify the program score components;
- Identify and categorize mismatches
- Adapt the original program model; and
- Adapt the original program materials.
- Implementation (Internal and External coordination)
- Evaluation Design: Process and Outcome evaluation are planned



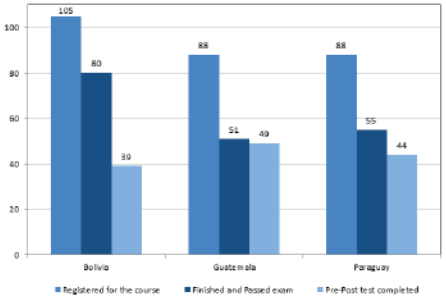
Results

The adaptation was done with local partners/stakeholders.

DETECTED MISMATCHES INCLUDED:

- Language background and literacy level in some of the terms in Spanish from Spain differ from the Spanish used in Bolivia, Guatemala, and Paraguay.
- Differences in the epidemiology of smoking across countries
- Availability of tobacco cessation pharmacological treatment
- Tobacco prevention and cessation services (primary care, hospitals, quitlines, etc), in each country;
- In case studies, clinical simulations and demonstrations the cultural characteristics of each country;
- Questions and answers of the assessment and evaluation were also changed according to the adapted contents;
- Mismatches were modified in a version that was pilot-tested by 8 to 10 volunteers in each country.

Registration and compliance with the course per country (number of trainees)



Lessons learned

- Organizational support and resources are needed:
  - top managers commitment is a must
  - champions should support students in the online learning and completion of tasks (exams, questionnaires)
  - internal communication using posters, sessions
  - external communication: post, videos, etc
- Computer skills and Internet usage could affect enrollment and progression, especially among:
  - less qualified health care professionals, and
  - trainees >50 years old
- Baseline and post intervention evaluations
  - Pros: evaluation
  - Cons: reduce the completion
- Comparison among countries is stimulating

- Capacity building activities:
  - activate other tobacco control actions (ex: signposting)
  - encourage leadership in LAC countries

CONCLUSION

- Online education might be the way to provide evidence-based tobacco cessation training in LAC countries
- It requires devices for its use (computers, tablets or smartphones) and high speed Internet connection
- It may provide online and in person technical support

FUTURE

- Disseminate this smoking cessation training among other organizations in these countries
- Support of other National entities will be necessary in each country (Ministry, Professional Organizations, etc)
- Extend this approach to other LAC

Contact: Cristina Martínez Catalan Institute of Oncology
: cmartinez@iconcologia.net : CrisMarMar

To strengthen healthcare capacity for the implementation of Article 14 of the FCTC in Mexico by advocating for a more strategic approach to extend treatment for tobacco dependency

InterAmerican Heart Foundation Mexico / ALIENTO National Alliance for Tobacco Control Mexico

In Mexico, 72% of adult smokers wish to stop smoking, but only 24% among them seek treatment and from those, only 16% receive short term counseling to quit smoking. In 2008 there were 325 tobacco cessation clinics, but by 2015 their number had decreased to 231. In any case, this type of service is centralized, outdated and limited to a few cities. It is not accessible at the primary care level and its availability is not made public. There is lack of information about health professional experts in smoking cessation treatment. Together with the National Commission Against Addictions [Comisión Nacional contra las Adicciones] and the National Office for Tobacco Control [Oficina Nacional para el Control del Tabaco] the project is currently assessing the situation regarding the treatment for tobacco dependency in order to produce, together with the leading organizations in the field, a concept paper to analyze the situation in the country at a national level [Análisis de la Situación Nacional (ASN)] and to support the development of a comprehensive policy in accordance with the guidelines of Article 14 of the FCTC. The strategy is expected to increase the number of Mexican professionals that provide treatment, expand access and affordability, promote the recording of tobacco use in medical histories, and broadly provide brief advice in all primary care settings.

Who

15 government agencies participate in the project: The National Commission Against Addictions, the National Center for the Prevention and Control of Addictions, the National Office for Tobacco Control, the National Social Security Institution, the Institute for Security and Social Services for State Workers, the Ministry of Defense, the Ministry of the Navy, the National Oil Company, the Youth Integration Centers, the National Cancer Institute, the National Institute of Respiratory Diseases, the General Hospital of Mexico, the National Polytechnic Institute, the Faculty of Medicine at the National Autonomous University of Mexico (UNAM); 2 private entities: The clinic Aida in Sonora and "Thank you, I do not Smoke" in Querétaro. The InterAmerican Heart Foundation Mexico and the National Alliance for the Control of Tobacco (ALIENTO) are project leads.*

Where and When

The project is implemented at the Public Institutions of the Health Sector in Mexico, in some institutions of higher education and in private clinics. It was originally scheduled to be executed between October 2014 and March 2016; however, due to administrative changes in the lead government agencies on addictions, the deadline was extended to December 2016.

Results

Leading health professionals on the treatment of tobacco dependency participated in an *Analysis of the National Situation*. This step was essential to develop a National Cessation Strategy that is well-grounded in the realities of Mexico. We are already involved in the design of a comprehensive policy within the framework of the National Program against Tobacco Use 2015-2018. With their participation, treating professionals have assumed a leadership role that is hoped will help in the implementation of the national strategy.

The establishment, in collaboration with the National Office for Tobacco Control, of the Interagency Group for the Cessation of Tobacco Consumption [Grupo Interinstitucional para la Cesación del Consumo de Tabaco], which will be a permanent working group focused on cessation.

Increased efforts to build capacity among healthcare professionals for implementing Article 14 of the FCTC and expanding the treatment for tobacco addiction. The National Institute of Respiratory Diseases has been a key partner.

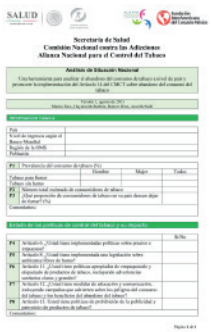
The updating of key concepts and characteristics of cessation services regarding tobacco consumption in order to incorporate them into the Mexican Official Norm 028-SSA2-2009 this same year.

Next Steps

To organize a meeting with the project's leading international consultants on tobacco treatment to review the results of the National Situation Analysis and identify major findings;
To draft the report resulting from applying the *National Situation Analysis* tool;
To complement the catalog of smoking cessation services in the country, stressing their scope and limitations, and to define the relevant profiles of the healthcare personnel in charge of this task;
To gather information regarding the number of tobacco treatment services and other indicators of progress;
To broadcast the existence of the Coalition of Professionals on Nicotine Dependency Treatment, and
To make the most out of the World No Tobacco Day, on May 31, 2016, in order to increase public awareness on smoking cessation.

Additional Accomplishments

Releasing statements from the InterAmerican Heart Foundation (IAHF) to the different heads of the National Commission Against Addictions; a personal interview by the executive director of the IAHF with the National Commissioner on Addictions; and in parallel, drafting and sending initial communications to the successive heads of the National Office for the Control of Tobacco and the well-known professionals on tobacco treatment, besides sending them Internet messages, calling them on the phone and interviewing each one of them to explain the details of the project, its importance, scope and potential participants. It is noteworthy to underline that there is constant communication with the people who agreed to participate.



Methods

The project team sent the National Situation Analysis tool, the corresponding instructions and the Guidelines of Article 14 of the FCTC to participants. Meetings were held at the InterAmerican Heart Foundation (FIC/Mexico), the National Commission against Addictions, and the National Office for the Control of Tobacco. The project was presented at the premises of the Ministry of Health. The members of the Interagency Group for the Cessation of Tobacco Consumption were incorporated on a permanent basis in the updating of the National Program against Tobacco Use 2015-2018.

incantab@gmail.com
María Elma Correa-Acevedo, Juan Nuñez-Guadarrama, Erik Antonio Ochoa, Martin Raw and Beatriz Champagne.

Strengthening healthcare capacity for Article 14 by developing a strategic approach to analysing need and planning a strategy in Bolivia

InterAmerican Heart Foundation – FIC Bolivia

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

InterAmerican Heart Foundation
Fundación InterAmericana del Corazón
Fundação InterAmericana do Coração

Challenge and Project Overview

Bolivia has 2.2 million tobacco users and, at the start of this project, almost a complete absence of tobacco dependence treatment. There was no support, no facilities or services, no involvement of health care providers, no medications, no national cessation strategy, and no national treatment guidelines.

With the Bolivian Ministry of Health we conducted a National Situation Analysis (NSA) following Dr. Martin Raw's recommended process for Art. 14 implementation. After numerous discussions with government authorities and key opinion leaders (KOLs) we reached agreement on the current situation and began developing a National Cessation Plan to treat smoking cessation.

The aim was to increase the number of people who quit smoking by improving the frequency and effectiveness of treatment interventions provided by health professionals, in an environment that supported cessation. Even prior to the completion of the Plan, a number of actions were taken to advance tobacco cessation, particularly training of health professionals in Santa Cruz and La Paz and drafting Treatment guidelines. Bolivia was chosen precisely because of the absence of support and the challenge of increasing awareness about the need to implement the Framework Convention for Tobacco Control (FCTC) Article 14 using the Art. 14 Guidelines.

Objectives

Overall Goal: To help Bolivian government officials and healthcare KOLs assess the current situation with regard to tobacco cessation and develop a strategic plan to scale up tobacco dependence treatment.

Objective 1. Assist government officials and healthcare and cessation KOLs to work together to assess the current situation in the country and develop a strategic plan.

Objective 2. Involve key healthcare professional groups in the implementation of the strategic plan.

Methods

We identified all relevant parties to address tobacco dependence treatment in Bolivia, with support of the Ministry of Health: healthcare agencies, medical centers, NGOs and professional societies.

These KOLs assessed the national situation and available resources for tobacco dependence treatment. The analysis was conducted using the tools developed by Dr. Martin Raw, who participated in the process. Using the NSA, a Plan was drafted and discussed in numerous venues to reach consensus.

Finally, there was an effort to increase awareness and initiate training of healthcare professionals.

Results

The main results of the project were:

Result 1: A National Situation Analysis (NSA) to assess the current states of tobacco control and cessation support in the country, including available infrastructure and resources. Stakeholders came together for the first time.

Result 2: A National Cessation Plan and draft National Guidelines developed with consensus from key stakeholders. The Plan is in the process of approval by the Ministry of Health.

Result 3: Draft Effectiveness and Affordability Review (EAR) to help prioritize interventions appropriate for Bolivia by estimating their effectiveness and affordability based on the country's income level and available resources.

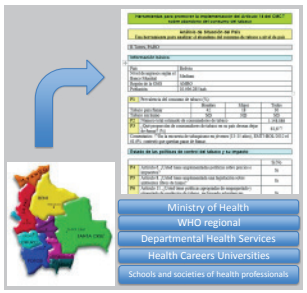
Result 4: Involvement of key healthcare professional groups in implementing the National Cessation Plan. Building alliances to form groups of trainers who will train the rest of the health personnel to offer help to quit smoking.

Next Steps

- Approve and launch the National Cessation Plan.
- Develop regulatory and technical support instruments to implement the National Cessation Plan.
- Continue awareness efforts among the health community and the public about tobacco cessation.
- Propose a strategy for the acquisition of accessible and affordable medicines for quitting smoking.
- Implementing brief advice and mandatory recording of use in primary care.
- Train and update health personnel to provide treatment and train trainers to provide sustainability.
- Provide the necessary conditions for specialized treatment.
- Design a strategy for monitoring and evaluating the implementation of the National Cessation Plan.
- Complete Treatment Guidelines with consensus from key parties and disseminate.

Phase 1 – Start-up

Prepared a plan of action for the project, including mapping, and contacted government officials and KOLs in relevant healthcare professional societies and organizations to elicit engagement and participation for tobacco cessation, exploring potential activities in order to organize events and identify leadership capacities.

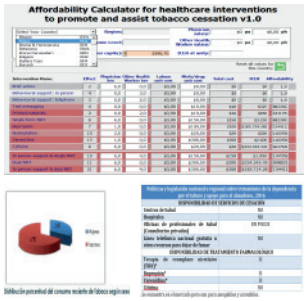


Phase 2 – Capacity Building

In this phase the project contributed to developing and improving capacity for government and healthcare professional groups on FCTC Article 14 implementation through workshops.

Phase 3 – Needs Assessment

The project oversaw the process to conduct the National Situation Analysis, using Dr. Martin Raw's approach and tools. An initial NSA draft was discussed in the cities of Santa Cruz, La Paz, Oruro and Cochabamba to increase awareness and consensus about the situation.



Phase 4 – Planning

During this phase the stakeholders worked together, led by the Ministry of Health, to develop a national cessation strategy based on the NSA.

An alliance was made with the "Capacity building for smoking cessation training in Latin America" project to build capacity and train people to train health workers who provide tobacco cessation treatment.

Phase 5 – Monitoring and wrap-up

We established a healthcare professional monitoring group to support the strategic plan by monitoring implementation and provide public accountability.

The monitoring mechanism was developed by consensus of the participating healthcare groups, based on their institutional capacities.

Contact Information: pamelacortez@ficbolivia.org
Corresponding Authors: Pamela Cortez – Beatriz Champagne – Martin Raw – Karina Garrón

"TOBACCO CESSATION THROUGH USE OF ORAL HEALTH CARE PROVIDERS AS AGENTS IN KENYA":

Dimba EAO, Njiru AW, Mutave RJ, Gathece LW
School of Dental Sciences, University of Nairobi, Kenya

Challenge and Project Overview

Although 70% of patients who smoke want to quit, only 7.9% are able to do so without help. One of the strategies to reduce morbidity and the number of smoking-related deaths is to encourage multi-disciplinary involvement of health professionals in tobacco use prevention and cessation (TUPAC) counseling.

Oral health care professionals (OHCP) can contribute significantly to increasing tobacco cessation rates when TUPAC is effectively integrated into the context of routine diagnosis, advice/treatment and referral of patients. The World Health Organization (WHO) Global Oral Health Programme identified TUPAC counselling as a priority goal in dentistry.

However, it has been reported that dentists are less active than other health professionals in counselling patients on tobacco cessation, mainly due to inadequate training in providing tobacco cessation counselling to their patients. Other barriers include low confidence levels in their own ability to help their patients to quit, doubts about effectiveness of quitting advice and anticipated negative reaction from patients.

The aim of this study is therefore to evaluate the effect of a training program in tobacco use prevention and cessation (TUPAC) counselling on the uptake and participation of oral health care workers in tobacco control.

Training of trainers at the School of Dental Sciences.

Who

A **multidisciplinary team** from the School of Dental Sciences (SDS), University of Nairobi with experience in research and policy matters provided the technical expertise for this project. Our heroes were the **oral health care professionals (OHCP)** who participated actively in the workshops and dedicated their time and energy to TDT thereafter.

The second group of heroes were the clients who came forward, ready to **stop tobacco consumption** with the help of our team. They taught us that the modes of delivery of NRTs were important (transdermal patches were not popular with many male clients). They also showed us that with courage and determination, even those who could barely afford NRTs could stop using tobacco.

The project headquarters in Nairobi, Kenya.

Where and When

The study population comprised of 175 trainees randomly selected from over 60 different healthcare institutions distributed in the 47 counties in Kenya. These 175 trainees attended 3-day intensive residential workshops at University of Nairobi School of Dental Sciences (UoN-SDS) and Moi Teaching and Referral Hospital (MTRH) in 2015 and thereafter are using logbooks to record the practice of TUPAC in their respective centers.

Results | Lessons Learned

This was an intervention study where a representative sample of all cadres of OHCP were trained in TUPAC in a total of 5 workshops. Changes in competence levels are assessed immediately before and after training, followed by an on-site review of tobacco cessation practices 3 and 6 months after the training. This project has resulted in the establishment of 2 new TUPAC clinics to date, with more to come.

Results 1 (FIGURE 1)
Provision of formal training significantly increased the awareness of the 5 A's among OHCP, with high rates of retention of these principles after 3 months.

Results 2 (FIGURE 2)
Awareness of effective methods of pharmacotherapy for tobacco dependence treatment improved significantly after training.

Results 3
Perceived barriers to TDT reduced after training and trainees developed positive attitudes towards short interventions for TUPAC in the clinic/community.

Next Steps

The study will provide an evidence base for the justification of involvement of oral health care providers in reduction and control of tobacco use in the African Region. The TDT program will target specific modes of tobacco consumption in different communities.

The UoN-SDS team has received numerous requests from the larger College of Health Sciences to provide this training for MBChB, Nursing and Pharmacy students and we plan to continue organizing both pre-service and in-service workshops to achieve this goal. Emphasis will be placed on training of trainers to establish tobacco cessation clinics nationally and entrench the use of mhealth in tobacco control.

Dr. Dimba engages the press.

Methods

Tobacco use prevention and cessation (TUPAC) is a program in which qualified medical professionals/counsellors provide tobacco cessation therapy to help clients in their attempts to quit. The therapy involves a brief intervention based on the 5A's and 5R's, motivational counselling and pharmacotherapy.

Our TUPAC modules encourage face to face interviews with the clients, supported by **mobile health (mhealth),** which is medical and public health practice supported by mobile communication devices, such as mobile phones, tablet computers, patient monitoring devices, personal digital assistants and other wireless devices.

Focus group discussions during the workshops.

Data

FIGURE 1.

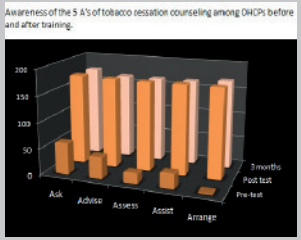
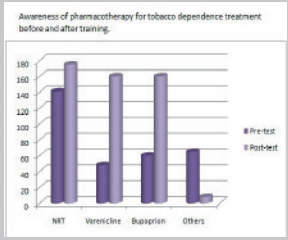


FIGURE 2.



Methods

The training workshops focused on patient assessment and counseling techniques for **tobacco dependence treatment (TDT).** Participants were educated on options for both prescription and over the counter nicotine replacement medications. Our trainers customized the Global Bridges training content for both English and Kiswahili speakers.

Integration of brief interventions into clinical practice was practically demonstrated, to change the OHCP attitudes. Follow up of clients after the brief interventions was emphasized as an ideal method of preventing relapses. Trainees were provided with internet links to access online resource materials.

Capacity building of primary care physicians for treatment of tobacco dependence in Bangladesh

National Heart Foundation Hospital & Research Institute, Dhaka, Bangladesh

Challenge and Project Overview

- Bangladesh is one of the high tobacco consumption countries of the world
  - About 45% of males and 1.5% of females smoke, and 26% of males and 28% of females use smokeless tobacco, i.e. about 40.1 million adults use tobacco regularly
- Tobacco cessation service has not yet been evolved in Bangladesh
  - Only 53% of tobacco users who have visited the hospital received quitting advice (GATS, 2009)
- Health care professionals' knowledge on cessation is also poor
  - 92% of physicians have never been trained in smoking cessation
- Objectives of the project are:
  - To develop a core group of health professionals with expertise for treatment of tobacco dependence
  - To motivate and increase the knowledge for treatment of tobacco dependence among primary care physicians of Bangladesh
  - To establish model tobacco cessation clinics in selected tertiary care hospitals in divisional cities of Bangladesh

Who

- National Heart Foundation of Bangladesh (NHFB) is a non-governmental organization established with the aims of prevention and control of cardiovascular diseases
- National Heart Foundation Hospital & Research Institute (NHFH&RI), a project of NHFB, is a tertiary care cardiac hospital providing modern cardiac care at affordable costs
- Tobacco control is one of the major preventive activities of the NHF
- NHFH&RI has been running a tobacco cessation service since 2013

Where and When

- NHFH&RI, Dhaka has strengthened tobacco cessation services by organizing training of physicians and establishing cessation services in five hospitals and in a community in different parts of the country from October 2014
- Hospitals / community currently running cessation services are-
  - National Heart Foundation Hospital, Sylhet
  - Faridpur Heart Foundation Hospital, Faridpur
  - National Institute of Cancer Research & Hospital, Dhaka
  - Zia Heart Foundation Hospital, Dinajpur
  - Gazi Medical College & Hospital, Khulna
  - Ekhlaspur Center of Health (ECOH), Chandpur (Community based)

Results

- A core group of health professionals (14 physicians and 4 community health workers) were trained as trainers for organizing local level trainings
- 200 primary care physicians and 359 nurses were trained on tobacco cessation
- Seven tobacco cessation clinics were established throughout the country
- Tobacco cessation trainings institutionalized

Number of subjects quit after receiving health professionals' intervention (6 month follow-up)

	No. Tobacco user	Quit (%)
Physician based intervention	338	11 (3.3)
Nurse based intervention	178	21 (11.7)
CHW based intervention	210	16 (7.6)
Total	726	48 (6.6)

Lessons Learned / Challenges

- Lack of knowledge related to techniques of behavioral and drug therapy among health care professionals
- Referral from consultants to cessation clinics is not satisfactory
- Hospital authorities are reluctant to setting a separate clinic for tobacco cessation
- Sustainability of the established clinic depends on the resources from external grant
- Unavailability and high price of NRT and other tobacco dependence treatment drugs

Next Steps

- Advocacy meetings will be done with medical education curriculum authority for introduction of tobacco cessation treatment in undergraduate medical curriculum
- More emphasis will be given to organize trainings for general practitioners instead of establishment of independent clinic
- Steps for establishment of a national quit line will be taken
- Operational research will be done to identify effective interventions, especially for smokeless tobacco cessation

Methods

- A guideline on tobacco cessation for health professionals was developed in Bengali following WHO and other regional guidelines
- A central training of trainers (TOT) was done at NHFH&RI in July 2015.
- Designated outdoor clinics and physicians were assigned by the authority of the participating hospitals by December 2015.
- All nursing staff of NHFH&RI went through one day training on documentation of tobacco use habit, brief advice to users and follow-up after discharge in Jan 2016.
- Local level trainings of physicians and CHWs were conducted in Sylhet Heart Foundation Hospital & in ECHO Chandpur in Feb 2016.
- Tobacco cessation is introduced as one of the topics for certificates course on cardiovascular diseases for general practitioner conducted by NHFH&RI.

Tobacco cessation trainings

A success story of smokeless tobacco quit by community health worker intervention

Monowara Begum, a smokeless tobacco (SLT) user since 32 years residing in a village served by CHW of ECOH. In 2011 at age 46, she developed high blood pressure with abnormal heart rhythm. She was treated and advised to quit tobacco, but she didn't realize how tobacco added to her blood pressure problem and continued to take tobacco. CHW trained through our project advised her intensively in 2015 resulting in successful quitting. She is now acting as a change agent in the community.

Court yard meeting by CHW

Monowara in a program

Contact Address: Dr. Sohel Choudhury, National Heart Foundation Hospital & Research Institute, Dhaka, Bangladesh, sohel_ r_ choudhury@hotmail.com, www.nhf.org.bd

Implementing the FCTC Article 14 in Armenia through Building National Capacity in Smoking Cessation Training

School of Public Health, American University of Armenia

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

Challenge And Project Overview

Smoking prevalence rate among the Armenian adult male population is one of the highest in the European region (63%). Smoking is also remarkable among Armenian physicians (48.5% M, 12.8% F) and medical students (50.0% M, 7.7% F).

Armenia was the first former Soviet Union country to accede to the WHO FCTC (November 2004), with following adoption of a national tobacco control law to ban smoking in healthcare, education, culture facilities and public transport. Armenia also banned tobacco advertising on TV and radio (2002) and on billboards (2006) and introduced larger (30%) health warnings on cigarette packs.

One area where Armenia's progress was less than satisfactory is the FCTC Article 14. To achieve reductions in smoking rates, it is critical to reach smokers with effective cessation interventions.

Inadequate training on tobacco dependence and its treatment is one of the major obstacles to getting consistent and effective treatment of tobacco dependence. Studies suggest that trained physicians are about twice as likely to offer assistance to their patients who smoke compared to non-trained physicians. Yet no such training courses and/or cessation clinics are available in Armenia. The goal of the project is to contribute to developing a national capacity in implementing the FCTC Article 14 in Armenia through:

a) building smoking cessation training capacity on evidence-based methods and tools for teaching physicians the basic skills for working with smokers and supporting them to do so,
b) training of primary healthcare physicians to provide them with knowledge and skills to provide brief advice and assistance to smokers.

Who

The American University of Armenia (AUA) School of Public Health (SPH) is affiliated with Johns Hopkins Bloomberg School of Public Health and is a member of the Association of Schools of Public Health in the European Region (ASPHER). SHP has been involved in tobacco control research and advocacy projects through its Center for Health Services Research and Development (CHSR).

AUA SPH has a strong record of sustained linkages with the Ministry of Health (MoH), local and international agencies and NGOs.

The current project is conducted in cooperation with the Yerevan State Medical University (YSMU) that provides graduate and postgraduate (including continuing medical education) education for medical students and practicing physicians.

Where and When

The project was implemented among primary healthcare physicians from two Armenian cities:

- Yerevan, the capital of Armenia,
- Gyumri, the second largest city (located in Shirak region).

Project timeline: 1 November, 2014 - 31 October, 2016

Results | Lessons Learned

- A new training program to provide an evidence-based training course on smoking cessation for practicing physicians has been developed
- Strengthened support from key stakeholders, including the policy and decision making community and the institutions of medical education to sustain the project outcomes and advocate for a system-wide change.

Comprehensive situation analysis
- Qualitative research
- Pharmaceutical Market Research
- White Paper: Mapping the FCTC Article 14 Implementation in Armenia

Built smoking cessation training capacity in Armenia
- Trained faculty members
- Developed and accredited curriculum

Evidence-based smoking cessation training program for health professionals
- Around 55 primary healthcare professionals participated in 2-day training

Next Steps

- Advocate for:

a) adoption of a system-wide screening for tobacco use and recording of the smoking
b) integration of the smoking cessation training into medical curricula;

- Develop and launch an online Smoking Cessation Training and Resource Center (a web portal)
- Monitor project indicators, analyze outcomes, produce reports and discuss the project activities through regular meetings with staff and partners
- Disseminate results of the project

Methods

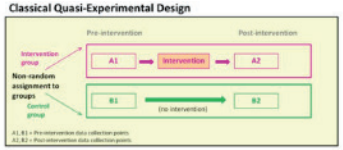
Formative Research

- Qualitative research
- Semi-structured guide for moderating the FGDs developed by research team
- 5 focus group discussions in Yerevan and Gyumri
- Pharmaceutical market research
- Desk review
- Cross-sectional survey in pharmacies
- Qualitative research among representatives of pharmaceutical companies
- Affordability of smoking cessation healthcare interventions

Project evaluation

- Quasi-Experimental design

Classical Quasi-Experimental Design



Formative Research

- Qualitative research
to identify primary healthcare physicians' baseline knowledge, attitude and practices regarding smoking cessation, as well as to clarify their perceived needs for training and support for addressing tobacco use among their adult patients.

- Pharmaceutical market research
to assess the current situation of the availability, affordability, and the price of tobacco cessation products in Armenia.

Trainings

- Training curriculum
- didactic sessions on the smoking-caused disease and death; nicotine addiction and treatment; the role of healthcare providers in motivating patient to quit (5As);
- interactive sessions (role play, case studies)
- Accreditation
- accredited by the Ministry of Health and designated 5 CME credits.
- Participants
- primary healthcare physicians from Yerevan and Gyumri (n=55)
- control group will receive training materials after completing the post-intervention survey (n=55)

Evaluation

Training expectation measurement
Training evaluation survey

Training improvement measurement
Pre-post training survey

Training effectiveness measurement
KAP survey
(before and 3 months after training)

Corresponding Author: Arusyak Harutyunyan, MD, MPH
Co-Authors: Varduhi Petrosyan, MS, PhD and Armine Abrahamyan, MS, MPH
Contact info: aharutyunyan@aua.am

EPACTT Project
"EuroPean Accredited Curriculum on Tobacco Treatment" Project
European Network for Smoking and Tobacco Prevention (ENSP)

Gap and Aims

Tobacco use is the largest threat to European Public Health. According to the Special Eurobarometer 385 published in 2012, nearly one in every three citizens smoke and 61% of current smokers have already tried to quit smoking.[1] In light of the above, there is an increasing consensus that tobacco dependence is a disease that must be treated by health professionals.

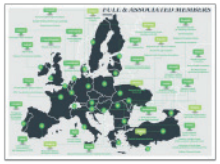
Strong evidence shows that multi-component interventions that combine practice-based, provider and patient-level intervention strategies are the most effective method for increasing provider performance in the delivery of smoking cessation treatment and improving cessation rates among patients.[2] Smoking cessation is one of the main strategies suggested by the World Health Organization's (WHO) MPOWER package against the tobacco epidemic.[3]

The aim of EPACTT is to increase the number of healthcare professionals committed to treating tobacco dependence in Romania, Armenia, Georgia, Ukraine and Russia. The project had two main objectives:

1) To develop a hybrid training (hands on and pilot e-learning course) with CME accreditation for healthcare professionals, based on best practices of tobacco treatment and policy.
2) To further develop the European Guidelines for Treating Tobacco Dependence, as noted in FCTC Article 14, and to translate and adapt the Guidelines into Romanian, Armenian, Georgian, Ukrainian and Russian.

ENSP

ENSP is a non-profit organization whose mission is to develop a strategy for coordinated action among organizations working in tobacco control throughout Europe. ENSP is comprised of member organizations from each of the 28 EU Member States plus Switzerland, Norway, Iceland, Georgia, Ukraine and Russia. **ENSP has observer status at the WHO FCTC** and is perfectly positioned to enhance FCTC 14 activities and provides alliance building to its members and others, including the European Commission.



Task 1 – The training

Hands on training was conducted in Brussels on the 5-6 April 2016, and focused on tobacco control and tobacco treatment. The programme included key note presentations, case study presentations, guidelines for smoking cessation & hands on workshops. The audience of **170 registered participants** included clinicians, health care workers and policy makers from a number of European Countries with a focus on health care professionals from Eastern European Countries. The training programme **was fully accredited by the European Accreditation Council for Continuing Medical Education (EACCME) with 11 CME credits**.

Task 2 - Guideline Development

Guidelines **in accordance with FCTC Article 14** were developed so as to create a complete range of tools to support smoking cessation strategies for healthcare professionals, working in the field of smoking cessation that would be also culturally and linguistically adapted/translated.

Key Actions and Results

Hands on training

Pre-post evaluations indicated that:

- ✓ The percentage that correctly answered what are the most effective treatments that increase quitting dramatically increased from 1% to 37% (p<0.001)
- ✓ Knowledge of how long a craving lasts increased from 18% to 38% (p=0.007)
- ✓ Awareness of the most common side effects for pharmacotherapy increased from 25% to 43% (p=0.017)
- ✓ Awareness of the impact of the physicians advice on quit rates increased from 16% to 32% (p=0.03)

Pilot e-learning

A pilot e-learning platform with 7 training modules was developed based on the different domains within the ENSP European Guidelines for Treating Tobacco Dependence. www.elearning-ensp.eu

Guidelines

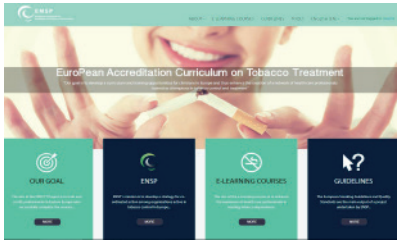
Guidelines translated and culturally adapted by regional champions in tobacco cessation, are now available in OPEN ACCESS in the following languages: English, Romanian, Ukrainian, Georgian, Armenian and Russian

E-learning

Our future goal is to continue the development and expansion of an accredited curriculum for tobacco cessation clinicians in Southern and Eastern Europe, and to enhance the formulation of a network of healthcare professionals that will be accredited in smoking cessation and dedicated to advancing evidence-based tobacco dependence treatment.

ENSP had created an e-learning course designed to empower healthcare providers how to identify, treat, and follow up with patients who smoke.

The e-courses can be accessed through any computer or mobile device and upon successful completion of each module, participants will receive a certificate of completion. The e-learning will provide formal CME.



Evaluation Methods

Hands on training

Quasi-experimental design with one-group pretest - posttest design was the preferred method to compare participant groups and measure the degree of change occurring as a result of intervention.

The study was divided into three phases. The participants filled out the 64-item questionnaire (divided into 4 sections) before and after the training with the same set of questions concerning comprehensive tobacco knowledge, attitudes and opinions. At the end of the smoking cessation workshop, all participants completed the second questionnaire. Only clinicians who had pre-registered and completed all other aspects of the training and preregistered were included in the analysis (N= 44). In the third phase the participants will be invited to complete a third questionnaire, about one month after the April intervention. (May 2016).

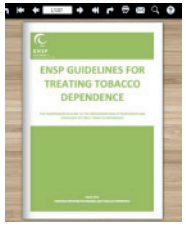
Guideline Content

The guidelines are in open access and free to use as an ebook. Available via www.epactt.eu and www.elearning-ensp.eu

2016 Editors: C Vardavas & S Papadakis. ISBN: 978-618-82526-0-8

Chapters include:

C1: Assessment of tobacco use and dependence
C2: Recommendations for the treatment of tobacco dependence
C3: Brief advice on stopping tobacco use
C4: Standard tobacco treatment interventions
C5: Research and recommendations for evaluating cessation.
C6: Standards for tobacco cessation specialists and services



Future steps:

To translate/adapt the guidelines into another 6 languages (Greek, French, Polish, Spanish, Serbian, Bulgarian).

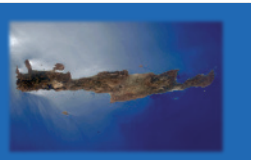
References

1. Available at: http://ec.europa.eu/health/tobacco/docs/eurobaro_attitudes_ towards_ tobacco_2012_en.pdf (accessed 10 April 2016)
2. Papadakis, S., McDonald, P., Reid, RD., Pipe, AL., Mullen, K., and K. Skulsky. Strategies to improve the delivery of smoking cessation treatments in primary care: A systematic review and meta-analysis. Preventive Medicine 2010; 51:199-213.
3. World Health Organization, 2008. WHO Report on the Global Tobacco Epidemic, 2008: The MPOWER Package (Geneva).

Corresponding Author: Constantine Vardavas MD, RN, MPH, PhD, FCCP
Email: vardavas@tobcontrol.eu
ENSP President: Francisco Lozano
ENSP General Secretary: Cornel Radu Loghin
ENSP Staff: Dominick Nguyen, Andrea Glahn, Sissi Peleki
Armenian Focal Point: Arusyak Harutyunyan
Georgian Focal point: George Bakhturidze
Romanian Focal point: Antigona Trofor
Russian Focal Point: Andrei Demin
Ukrainian Focal Point: Otto Stoyka

TiTAN CRETE – Tobacco Treatment Training Network in Crete

C. Vardavas[1], S. Papadakis[1,2], C. Girvalaki[1], A. Pipe[2], C. Lionis[1]
[1]Clinic of Social and Family Medicine, Department of Medicine, University of Crete
[2]Division of Prevention and Rehabilitation, University of Ottawa Heart Institute



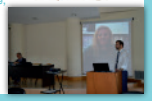
Background & Introduction

- Rates of tobacco use in Greece are amongst the highest in Europe (38%) and are responsible for an enormous burden of CVD and other smoking-related illnesses.
- The World Health Organization's MPOWER initiative has called for increased rates of tobacco treatment delivery in clinical settings, in particular Primary Care.
- Clinical practice guidelines recommend all patients be screened for tobacco use (ASK), ADVISED to quit smoking and ASSISTED with cessation, which includes counseling and pharmacotherapy.
- There is a well-documented 'Practice Gap' in the rates at which evidence-based smoking cessation treatments are delivered to patients in primary care settings.
- The 'Ottawa Model for Smoking Cessation' is a multi-component intervention designed for use in busy primary care practice setting. The program was adapted as part of the present project for use in primary care practices in Greece.
- This project involves a partnership between the Clinic of Social and Family Medicine at the University of Crete and the University of Ottawa heart Institute.

TiTAN CRETE

The goal of the capacity building, TITAN Crete project is to develop a network of trained primary health care (PHC) providers in Crete, Greece that will integrate treatment of tobacco dependence into daily clinical practice and become champions of tobacco control policy.



Aim #1: To develop a multi-factorial tobacco treatment training program for PHC providers.

Activity 1.1: Develop a faculty of tobacco treatment experts, PHC providers, and stakeholders who will deliver tobacco treatment training to the PHC providers.
Activity 1.2: Create a curriculum/training program on tobacco treatment for PHC based on national and international experience and best practice guidelines.

Aim #2: To adapt and deliver the provider/practice resources to ensure maximal sustainability among PHC providers in Crete, Greece.

Activity 2.1: Conduct a needs assessment with PHC providers in Crete.
Activity 2.2: Produce a set of tools in Greek which are designed to support the 3As model of tobacco treatment.
Activity 2.3: Deliver advanced tobacco treatment training to the existing practice-based research network within PHC in Crete.
Activity 2.4: Perform program evaluation to inform program refinement.
Activity 2.5: Engage PHC practice networks in Greece for continued expansion of the Global Bridges tobacco treatment network.

The TiTAN CRETE Intervention Program

The TiTAN Crete program has adapted the existing curricula and resources originally developed at the University of Ottawa Heart Institute and which are specific to primary practice settings. To facilitate maximum uptake the intervention program was adapted to reflect: language; cultural appropriateness; local patient beliefs and attitudes regarding tobacco-use and cessation; local primary care practice. The TiTAN-Crete intervention includes a 1-day tobacco treatment training program, dissemination of provider and patient resources, and two booster training sessions. The intervention was delivered between September 2015 and January 2016.

Components	Description
Tobacco Treatment Training Program	A one-day core session tailored to cessation intervention in primary care practice setting. The curriculum includes 2/3 theory and 1/3 practical. The program employs teaching techniques including role-play and case-study approaches known to enhance practice change. Local faculty and international faculty delivered the training curriculum.
Tool-Kit	A "toolkit" of resources was distributed to providers which includes: Waiting Room Tobacco Use Screener; Provider Smoking Consult Form; Patient Quit Plan Booklet; Quick Reference Sheets; Waiting Room Posters.
Booster Sessions	Two booster 3-hour sessions were delivered 1- and 3-months after the core training. The booster sessions are designed to reinforce the adoption of new practice behaviors and offer practical skills-based training.
Website & Video Series	The TiTAN website houses training material and tools as well as 6-part video series was created to support the program. www.titan.uoc.gr

Results

51 GPs and Family Medicine Residents participated in the TiTAN Crete training program. Post-assessment data collection is currently partially completed (75%) and will conclude at the end of April 2016. We report here on the interim results of the evaluation based on evaluation activities among 15 GPs and 768 patient from their practice (n=436 pre-intervention and n=336 post-intervention).

Provider Tobacco Treatment Satisfaction & Knowledge

- ✓ High rates of satisfaction with the training program and tools were reported by GPs.
- ✓ Significant improvements in rates of provider tobacco treatment knowledge were documented in 6/13 of the knowledge domains at the post assessment.

Tobacco User Characteristics

- ✓ Tobacco use prevalence was 38% among patients seen in primary care clinics sampled.
- ✓ The majority (64.1%) of tobacco users reported a readiness to quit smoking in the next 6-months, with 24.7% of patients reporting an interest in quitting in the next 30-days.
- ✓ However the majority (63.4%) of tobacco users reported not having made a quit attempt in the past year.

RATES OF TOBACCO TREATMENT DELIVERY

- ✓ While rates of ask and advice were delivered at moderate rates (slightly more than half of patients), rates at which assistance with quitting was delivered was very low.
- ✓ Significant increases were documented in rates of 5As delivery between the pre- and post-assessments: "ask" (17%, p<0.001); "advise" (23.7%, p<0.001); "assist" with cessation (46.2%, p<0.001).
- ✓ Fig.1 presents preliminary results of the pre and post assessment conducted as part of the TiTAN Crete project.

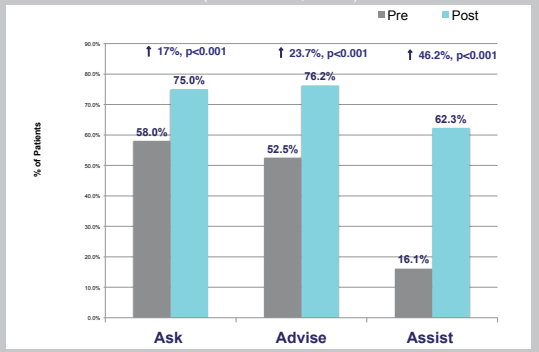
Evaluation Methods

A two-arm pre-post control group evaluation design was used to examine the impact on the program on: 1) health care providers satisfaction, knowledge and self-efficacy in tobacco treatment delivery, and 2) rates at which providers deliver evidence-based tobacco treatments to patients who smoke identified in their practice.

Fifteen General practitioners (GPs) from the Heraklion region in Crete participated in the intervention arm and 10 General Practitioners from Rethymnon region served as controls. Both providers and a sample of 36 patients who reported daily tobacco use from their practices were surveyed.

TiTAN Toolkits

Fig. 1: Rates of Ask, Advice, Act Pre-and-Post Implementation of TiTAN at Index Visit (Provider = 15, n=768)



Future Expansion Of The Global Bridges Network

TiTAN CRETE Greece & Cyprus

Building on the positive results and assets of the TiTAN Crete project, our team has partnered with the Medical Faculties of five different Universities in Greece and Cyprus, the University of Ottawa Heart Institute, and national and international tobacco control experts to develop a plan to expand the tobacco treatment training network to more than 300 Primary Care Providers (GPs, RNs, Medical Residents) in Greece and Cyprus

Contact Information (email): vardavas@tobcontrol.eu
Corresponding Author: Dr. Constantine Vardavas
Website: www.titan.uoc.gr

Develop and disseminate an evidence-based healthcare professional training program tobacco use treatment in Viet Nam

Bui T[1], Nguyen N[1], Nguyen L[1], Nguyen T[1], Phuong N[1], Phan H[2], Shelley D[3]

[1]Institute of Social and Medical Studies (ISMS), Viet Nam; [2]VINACOSH – MOH, Viet Nam; [3]NYUSchool of Medicine (NYUSOM), USA

Funding source: Global Bridges and Pfizer Independent Grants for Learning & Change (IGLC)

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

Challenge and Project Overview

Challenges

- Almost half of adult men are current smokers. Smoking prevalence is the second highest among South East Asian countries (GATS, 2010);
- Services to treat tobacco dependence are not readily available to smokers or integrated into the health care system (GATS, 2010);
- Study conducted by Shelley & Nguyen in 2013 in one district of VN showed only 23% of providers reported routinely screening for tobacco use, 33% offered advice to quit to smokers, and less than 10% offer cessation assistance (i.e., counselling referral or medication);
- Over 90% agreed or strongly agreed that advice from a provider is one of the best ways to help people stop smoking but 60% were not aware of the best treatment to help patients stop smoking (Shelly & Nguyen 2013);
- 94% reported having never received training related to tobacco treatment and less than a third reported they had training needed to help smokers to quit;
- A lack of training was the most commonly reported barrier to offering cessation interventions (70%);
- To increase provider-delivered cessation interventions, training for physicians and allied health professionals working in commune health centers (CHCs) and hospitals is urgently needed.

Project overview:

Goal: To develop and disseminate an evidence-based health provider training program on the treatment of tobacco use in Viet Nam and build capacity for widespread dissemination through a network of professionals and organizations committed to tobacco control, including the Ministry of Health and other public health stakeholders in Viet Nam.
Objectives: 1) develop an evidence-based health provider core training curriculum for tobacco use treatment; 2) develop and test a train-the-trainer (TTT) program in one province; 3) disseminate the TTT program nationwide via the Viet Nam Steering Committee on Smoking and Health, and Ministry of Health.
Four deliverables: i) evidence-based core training curriculum for tobacco use treatment; ii) train the trainer (TTT) manual and training materials; iii) 300 health providers trained on tobacco use treatment; iv) report on results from 3-month follow up surveys.
Evaluation: 1) evaluation of the initial core curriculum trainings among 100 health providers and of the master trainer's training of health providers in 3 districts (TTT), and 2) a 3 month post training assessment of sustained practice changes.
Dissemination plan: 1) seeking approval of TTT training curriculum by MOH; 2) developing strategy for dissemination; 3) conducting dissemination workshop; 4) developing a plan to implement the dissemination strategy; and 5) conducting web-based training courses.
Program partners: Ministry of Health, Viet Nam, Steering Committee on Smoking and Health (VINACOSH-the MOH's tobacco control program), the MOH Tobacco Cessation Technical Group, Ha Noi Medical University, School of Public Health, Bach Mai Hospital, New York University School of Medicine (NYUSOM), and Global Bridges.

Who

- 300 health care providers in 92 communes of 5 districts in Thai Nguyen province;
- 8 master trainers from ISMS;
- 30 master trainers from health system at national and provincial levels;
- Policy makers from MOH, VINACOSH, and People's Committee of Thai Nguyen province;
- Members of MOH Tobacco Cessation Technical Group;
- Other stakeholders working in Tobacco Control in Viet Nam.

Where and When

- In Thai Nguyen province (project site): 92 commune health centers in 5 districts, from 2015-2016
- At central level: Ministry of Health, Steering Committee on Smoking and Health (VINACOSH-the MOH's tobacco control program), the MOH Tobacco Cessation Technical Group, Ha Noi Medical University, School of Public Health and Bach Mai Hospital
- At provincial level: HCM city, Hue city and Ha Noi city

Results | Lessons Learned

Outputs

- The curriculum been implemented and updated after 3 training courses in 3 districts;
- The TTT manual and training materials developed and implemented;
- 8 Master Trainers of ISMS' Training Center, ISMS trained. In addition, the project has Trained 30 master trainers, who are from hospitals and universities across Viet Nam
- Developing web based training. Video taped trainings in 3 districts which are available at VQUIT website (www.vquit.vn) for nation-wide health providers online training;
- 3 training courses conducted by ISMS master trainers for 187 health providers in 49 commune health centers of 3 districts and for 7 counsellors of Tobacco Cessation Counselling Center of Bach Mai hospital;
- 182 pre post training surveys and 94 3 months follow up surveys completed

Evaluation Results (see table and figures below)

- Pre-post training surveys showed increase in knowledge and self confidence (N = 187)
- 3 month follow up showed changes in cessation treatment practices (N = 94)

Impact level

- Gained in awareness of the necessity and relevance of tobacco cessation of MOH, VINACOSH, local authority, health provider and other stakeholders working in Tobacco Control in Viet Nam;
- Obtained policy commitments and support: MOH will approve the core curriculum and the TTT training material for nation-wide implementation; Thai Nguyen People's Committee, Department of Health in Thai Nguyen and Health Center of the districts in Thai Nguyen will continued supporting to the project implementation; and the implementation of post-training plan in the community;
- Obtained policy commitments from MOH, VINACOSH, People's Committee and extended Tobacco Cessation Network to make changes in healthcare system enabling for Tobacco Control in general, and for tobacco cessation in particular;
- Expanded Tobacco Cessation Network from the central level to the community levels. ISMS is now a lead member of the MOH Tobacco Cessation Technical Group, which consist of members from MOH, VINACOSH, Bach Mai Hospital, University of Medicine and Pharmacy in HCMC, Hospital of the University of Medicine and Pharmacy in HCMC, and WHO in Viet Nam;
- Created practices of healthcare providers working in healthcare system in screening for tobacco use and delivery of cessation assistance using 4As framework.

Integration of the project with NIH-funded project (VQUIT)

- Staff working for NIH-funded project are key players for Pfizer project;
- Training materials were developed based on the NIH-funded project training materials;
- Good working relationship with Thai Nguyen provincial people's committee, department of health and Pho Yen district and experience of working with health provider in the community from NIH-funded project, has facilitated smooth implementation of Pfizer project activities;
- Leveraged tobacco cessation network from NIH-funded project to support implementation and integration of Pfizer's project activities with the Government activities in tobacco cessation;
- Policy environment and commitment from the Government's stakeholders created during the NIH-funded project is facilitated the implementation of the Global Bridges project activities.

Lessons learned

- Engaging policy leaders from the MOH and provinces early in the process through formal and informal discussion and consultation increased potential for scale up and dissemination;
- Winning support and collaboration with tobacco cessation networks through formal and informal technical and operation discussion and consultation;
- This project was very labour intensive and required human resources, and expertise from NIH-funded project staff, the support from MOH, VINACOSH, Thai Nguyen People's Committee, and the Tobacco Control network during the implementation of the project.
- Working in parallel on system changes in community health centres, created credibility and alignment with larger goal of disseminating tobacco use treatment guidelines.

Next Steps

- Conduct 2 trainings (by master trainers) for health providers in 2 remain districts: Phu Binh and Song Cong Districts;
- Conduct 3-month follow up survey with participants attending trainings in 3 districts;
- Finalize the core training curriculum and TTT training;
- Finalize the e-training materials, make it available to all health providers nation-wide;
- Get approval from MOH on the TTT;
- Disseminate the results;
- Distribute TTT nation-wide.

Methods

1. Develop, implement, evaluate, revise and finalize a core curriculum
- based on ATTUD, NCSCT core competencies;
- based on strengthening health system for treatment tobacco dependence in primary care material (WHO), VQUIT/ISMS training materials, and VINACOSH training materials;
- adapted based on consultation with expert advisory group;
- based on interview results with health providers at commune health centers;
- evaluate, revise and finalize a core curriculum.

2. Develop and implement a train the trainer (TTT) model

a. Develop a train the trainer model and conduct the training of master trainers
- developed 5-day TTT training program, self-help training materials and training manual;
- conducted training of master trainers;
- master trainers conducted training for 200 health providers at CHCs.

b. Develop and implement a web-based program
- Develop and upload online training materials and make those materials available for all health providers nationwide via www.vquits.vn, and lms.etraining.vn designed by ISMS;

3. Evaluation

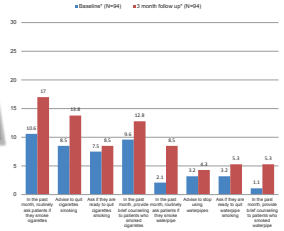
a. Evaluation of the initial core curriculum training among 100 health providers in one district, and of the master trainer's training of health providers in 3 districts
- training session observations using assessment form with note-taking instructions;
- pre-and-post tests of participants using self-administered questionnaire;
- employed EpiData software for data entry and SPSS for data analysis

b. Assessment of post training sustained practice changes (a baseline pre-training survey and a 3-month follow-up phone survey)
- to measure increased rates of screening for tobacco use and delivery of cessation assistance using 4As framework, and improvements in knowledge, attitudes and confidence of health providers to screen for tobacco use and assist smokers in quitting;
- used survey tool which was tested in over 100 health providers (Shelley & Nguyen 2013);
- conducted baseline (pre training test) survey all participants attended training at the first day of the training
- conducted phone survey at 3 months after trainings all participants attended the trainings
- employed EpiData software for data entry and SPSS for data analysis

c. Disseminate the evidence-based training curriculum and evaluation results

Data

Figure 1 shows increased rates of screening for tobacco use and delivery of cessation assistance by health providers using 4As framework*



*Provided half/more than half/all or most

Table 1: Characteristics of health providers participated in 3-month follow up

Characteristic	N =94	%
Gender		
Male	30	31.9
Female	64	68.1
Age (mean years)	94	40.5 ±10.1
Years working as health provider	94	15.1±9.4
Position/staff grade		
Physician	22	23.7
Nurse	10	10.7
Midwife	2	2.2
Physician's assistant	56	60.2
Other	3	3.2

Figure 2: shows increased confidence of health providers in their knowledge, skills and ability to provide smoking cessation counseling

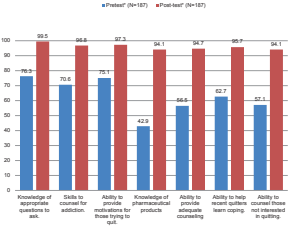


Table 2: shows improved knowledge about harm of smoking, positive changes in opinions, and gained confidence of health providers in smoking cessation after training

	Pre-test (N=187)	Post-test (N=187)
Mean score of knowledge about harm of smoking cigarettes (range: 0-52)	37.7±4.2*	43.1±3.6
Mean score of knowledge about tobacco counseling and treatment (range: 0-10)	4.9±1.3*	7.0±1.6
Mean score of opinions about tobacco use treatment (range: 10-40)*	32.4±3.9*	35.7±2.8
Mean score of smoking cessation confidence (range: 7-28)**	18.5±4.4*	24.9±3.2

* Cronbach's alpha = 0.62
** Cronbach's alpha = 0.89
* P<0.001

Contact Information: bdthu@isms.org.vn / Corresponding Author: Thu Dai Bui, MD, MSc

Improving tobacco cessation practices among physicians in tertiary hospitals in Nigeria

College of Medicine, University of Lagos, Nigeria.

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

Challenge and Project Overview

In Nigeria, there are 4.7 million Nigerian adults who currently use tobacco products: 10.0% of men and 1.1% of women.[1] Nigeria signed the FCTC in 2004 and ratified it in 2005 however efforts at implementing Article 14 have been sparse. Many Nigerian smokers desire to quit smoking and often make unassisted and unsuccessful quit attempts. In 2012, almost half (45.4%) of Nigerian adult smokers reportedly made unassisted and unsuccessful quit attempts in the past year.[1] There is considerable evidence that physician-led tobacco cessation interventions increase quitting among smokers however poor knowledge has been cited as the major barrier to physician-led smoking cessation interventions and few teaching hospitals in Nigeria have effective systems for the identification and treatment of tobacco-using patients.[2]

Short messaging systems (SMS) and internet-based technologies are increasingly being used to promote health and to prevent disease.[3] Mobile phone and internet use is particularly high among Nigerian physicians opening up a window of opportunity for the use of mobile and internet-based technology to promote behavioural change among health care workers. In addition, these technologies are comparatively low cost and have a wide reach. These interventions may therefore have an additional cost advantage in low-resource settings like Nigeria.

Project goal and objectives

Overall goal of the project: To increase physician-assisted tobacco cessation among patients in tertiary hospitals by identifying, reaching, training and working with emerging leaders (resident doctors) in medical and dental teams to prioritise and practice tobacco cessation within their local work settings.

Project objectives:

Identify and recruit 20 physicians in each of the three collaborating institutions as primary tobacco cessation change agents (PTCCA)

Motivate and train these primary change agents as focal persons for tobacco cessation within their respective departmental units using a traditional intensive two-day face-to-face training session followed by informative text messages and emails over a six-month period.

Support the PTCCA's to promote tobacco cessation among other physicians in their respective departmental units (Secondary Tobacco Cessation Change Agents-STCCA) using informative text messages and emails over a 3-month period.

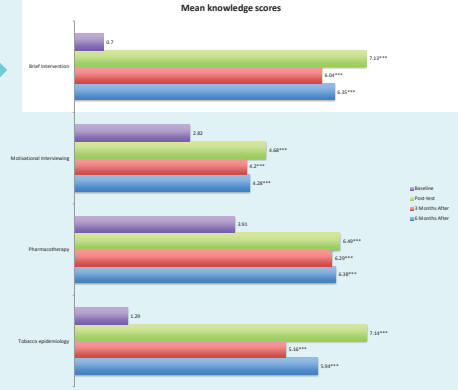
Who, Where and When

The study was conducted among physicians in three geographically distinct teaching hospitals in 2015.

The Intervention

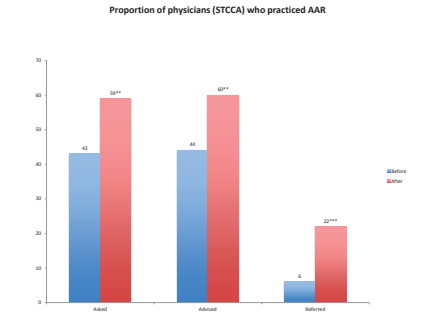
Primary target: 94 Physicians (PTCCA) received a 2-day intensive training followed up with informative text messages and email reminders over a three month period. (Two messages every week)

Secondary target: 1,242 physicians (STCCA) received informative text messages and emails only.(Two per week over a three month period)



Next Steps

- Research to determine the possibility of extending this intervention to physicians in primary or secondary care settings.
- Using lessons learned to develop and test similar intervention for other non-physician health care workers like nurses and community pharmacists.



Methods:

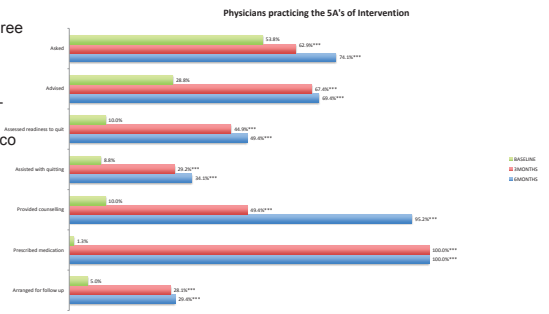
We used a non-randomized controlled intervention study design involving three intervention sites and three control sites within Nigeria.

Main activities

- Identification, recruitment and training of primary tobacco cessation change agents (PTCCA).
- Development and delivery of informative text messages and emails reminders to PTCCA's over a six-month period.
- Delivery of informative text messages and e-mails to a larger network of physicians to facilitate tobacco control within their clinical practice over a three-month period.

Primary target: Resident doctors in teaching hospital settings. (We recruited at least two physicians in each relevant department. (PTCCA)

Secondary target: The wider network of physicians in the teaching hospitals. We communicated with them using text messages and emails only. (STCCA)



Output indicators:

- Mean knowledge scores for tobacco epidemiology; brief intervention; pharmacotherapy; motivational interview among PTCCA's
- Proportion of PTCCA's who practiced brief intervention techniques using the 5A's approach on at least 50% of patients after the intervention.
- Proportion of STCCA's who practiced tobacco cessation using the AAR approach after the intervention.

*=P<0.05, **=p<0.01 ***p<0.001

References:
1. National Bureau of Statistics. Nigeria GATS country report 2012. Available at nigerianstat.gov.ng/pages/download/157. Accessed May 2014
2. Desalu OO. Knowledge of and practices related to smoking cessation among physicians in Nigeria.J Bras Pneumol. 2009;35(12):1198-1203.
3. Githinji S, Kigen S, Memusi D, Nyandigisi A, Wamari A, Muturi A, Jagoe G, Ziegler R, Snow RW, Zurovac D. Using mobile phone text messaging for malaria surveillance in rural Kenya. Malar J. 2014 Mar 19;13(1):107. doi: 10.1186/1475-2875-13-107.

Contact Information : drolukemiodukoya@yahoo.com
Corresponding Authors: Odukoya OO, Jamda M, Uguru NK, Onigbogi OO, James OW, Faseru B, Ayo-Yusuf OA

Capacity building of healthcare professionals to create a workforce trained in tobacco dependence treatment at different levels of healthcare settings

Salaam Bombay Foundation, Mumbai, India

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

LifeFirst
Yes to Life. No to Tobacco.

Challenge and Project Overview

Challenge:

- Tobacco treatment not part of the existing public healthcare system
- India faces unique challenges in controlling the tobacco epidemic - 275 million current tobacco users equating to 35% of adults in India
- In spite of willingness to quit, healthcare professionals (HCP's) have not been identifying a majority of tobacco users and a very small proportion have been advised to quit
- High rates of smokeless tobacco use and a uniquely diverse array of tobacco products - 21% adults in India use smokeless tobacco
- Data from the India Global Health Professional Students Survey (GHPSS) showed a general lack of training among health professional students.
- To meet the widespread need of tobacco cessation services, stronger efforts are needed to equip all types of healthcare providers in various settings with trainings on tobacco dependence treatment

The goal of the project is "to build a team of competent healthcare professionals with skills to provide evidence-based tobacco dependence treatment in a variety of healthcare settings across Maharashtra, India."

Our Heroes

LifeFirst training program was fortunate enough to have heroes who helped in successful implementation of the project.

Why they are our heroes?

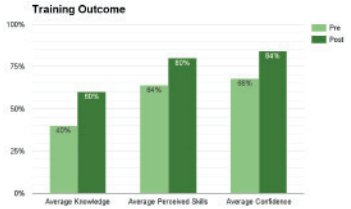
- Worked as advocates and promoted the training program in various settings
- Were decision makers who influenced their own staff to undergo the trainings
- Acted as catalysts and enabled the entire workforce to attend trainings in their own settings
- Included LifeFirst trainings as part of routine staff induction training
- Had a vision of setting up tobacco cessation service and considered the trainings as a first step.

Where and When

From September 2014 to November 2016. LifeFirst trainings are to be conducted all over Maharashtra in variety of healthcare settings. Trainings have been conducted in about 10 multispecialty tertiary care hospitals, 1 police hospital, 5 medical and dental schools, all HCPs from public health system of a municipal corporation and healthcare professionals working with 11 not-for-profit organisations.

Results

- Over 2,000 healthcare professionals were provided Level 1 training
- Over 80% participants who attended Level 1 trainings showed interest in undergoing level 2 training
- Level 2 trainings launched in Jan 2016 and 106 healthcare providers were provided a two day intensive training



Next Steps

Short Term

- Continuing Level 1 Trainings for more healthcare settings
- Taking Level 2 trainings to healthcare institutes where Level 1 is already accomplished.
- Helping Level 2 participants in setting up cessation services in their own practices
- Launch of online training module
- Continued professional development

Long Term

- Applying to Association for the Treatment of Tobacco Use and Dependence (ATTUD) for accreditation
- Exploring paid training models

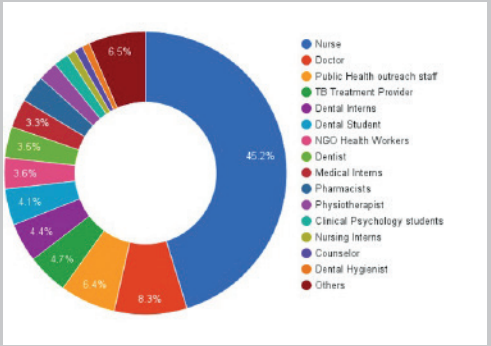
Methods

Development of training modules

Developing framework and learning objectives → Curriculum, pre post test, trainer notes, exercises, role plays and handouts → Testing of modules with pilot groups → Making revisions as necessary → Conducting Train the trainer for LifeFirst team → Providing training to different HCPs

Implementing trainings

Database of Govt. and private institutions → Individual and foundations contacts to approach institutions → Cold calls for appointments → Meetings with MDs, CEOs and Govt. officials → Presentation on LifeFirst trainings → Planning and setting up trainings → Conducting Level 1 trainings → Level 2 trainings for interested participants



Level 1 trainings

An educational session on basic yet essential topics such as types of tobacco products in India, forms and patterns of tobacco-use, all about tobacco dependence, health effects of using tobacco, and benefits of quitting.

Level 1 online version

A great option for busy healthcare professionals.

Registered trainees will have access to presentations and relevant resource material

On successful completion, they will receive an e-certificate.

Level 2 trainings

Modules developed on the basis of ATTUD guidelines

All aspects of nicotine dependence, evidence-based techniques of providing cessation services in Indian healthcare settings,

Oppurtunity to be a part of a network of trained tobacco treatment counsellors

Contact Information: himanshu@nsfoundation.co.in
Corresponding Authors - Dr. Himanshu A. Gupte, Dr. Vaibhav Thawal, Ratandeep Chawla, Dr. Priyamvada Todankar, Leni Chaudhuri

Expand availability of tobacco dependence treatment (TDT) services in the Eastern Mediterranean Region (EMR) through building sustainable evidence-based in-country training programs

Hawari FI, Bader RK, Hatoqai AA, Obeidat NA, Ghonimat IM
King Hussein Cancer Center (KHCC), Jordan

Challenge And Project Overview

Despite their proven value and smokers' interest in quitting, TDT services are limited in the EMR and are not yet integrated within the health care system. Such a shortage may be attributed to several barriers including the shortage of trained healthcare providers (HCPs) and the lack of access to evidence-based resources.

FCTC Article 14 highlights training of HCPs as a key low-cost strategy towards a TDT-supporting infrastructure. Training enhances HCP confidence and readiness to offer services, which in turn leads to improved patient health. Yet in the EMR, TDT training continues to be lacking. Thus, availing resources and developing capacity of faculty facilitates institutionalizing TDT training.

In order to bridge this gap, this project ultimately seeks to increase the number of trained HCPs in the EMR who can integrate TDT into their practice. Project aims will be achieved through establishing four self-sustaining training hubs in addition to the one existing at KHCC.

Who and Where

The project engages:

1. King Hussein Cancer Center (Jordan)
2. Ain Shams University (Egypt)
3. Ministry of Health (Tunisia)
4. Sidi Mohamed Ben Abdellah University (Morocco)
5. Sultan Qaboos University (Oman)

Partners serve as hosts of the established training hubs and support each other in addressing knowledge gaps, developing curricula, sharing best practices, and providing a 'go-to' reference group.

The five training hubs were selected to provide maximum geographical coverage across the region

When

The project spans the duration of November 2014 – October 2016. Strengthening the network and collaborations extend beyond the official closing of the project.

Results | Lessons Learned

Functioning hubs:
- Egypt: Several TDT clinics already launched
- Tunisia: Training for occupational health practitioners conducted in April 2016
- Oman: First workshop to be fully delivered by in-country faculty during May 22-24, 2016
- Morocco: Two clinics per participating city to be established by end of 2016

Potential to practice and train:
- 88% reported the ToT workshops to have enhanced their confidence to train on TDT
- More than 68% believe they will have the opportunity to practice and train in the coming 6 months

Networking:
- Value of staying in touch with the network: 3.4 (self-reporting on a scale of 1-4)

Next Steps

- Continue to strengthen capacity of faculty in delivering training
- Reinforce the learning: remotely engage faculty through the Virtual Clinic (Facebook group) to practice and share developments in the field of TDT
- Continuously update content: through creation of a central repository with specific responsibilities among faculty for updating materials
- Complete translation of materials into Arabic

Methods

At project completion, each hub will be capable of offering TDT training programs through local in-country faculty. TDT curricula and content will be developed and made available in all three languages that are in use the region; Arabic, English, and French.

Phase I

Preparatory work:
- Sign MoUs with host organizations
- Document and share KHCC's experience
- Generate country assessments of TDT training needs
- Conduct a kick-off workshop for host organizations
- Define country-specific target audiences
- Design country-specific training programs
- Develop criteria for selection of in-country faculty

Phase II

Developing content:
- Translate content used by KHCC and customize it to fit needs of countries
- Develop additional content necessary for the region or for specific countries
- Develop additional interactive exercises, cases, and tools

Phase III

Building capacity:
- Select faculty-to-be by host organizations
- Remotely engage faculty-to-be in preparatory reading and post-reading knowledge assessment
- Conduct in-country training of trainers (ToT) workshops covering:
  - ✓ TDT knowledge and skills
  - ✓ Establishing TDT services
  - ✓ Training skills
  - ✓ Continuous professional development

Global Bridges
Healthcare Alliance for Tobacco Dependence Treatment

Strengthening Cessation Capacity of Primary Care Professionals (SCCoPE)

Public Health Foundation of India (PHFI), India

PUBLIC HEALTH FOUNDATION OF INDIA

SCCoPE
Strengthening Cessation Capacity of Primary Care Professionals

Setting the scene

- Tobacco cessation is a key intervention required to attain the Sustainable Development Goals target of one third reduction in mortality due to non-communicable diseases worldwide.
- In India, less than half of smokers who visited health care providers were advised to stop smoking (GATS 2009-10).
- Studies from India have reported lack of skills in delivering brief intervention and counseling for tobacco cessation. Despite a compelling evidence recognizing the strengthening of cessation services, capacity building for tobacco cessation has been slow.
- Through this project, we aim to build the capacity in physicians working in primary and secondary health care for providing evidence-based tobacco cessation interventions

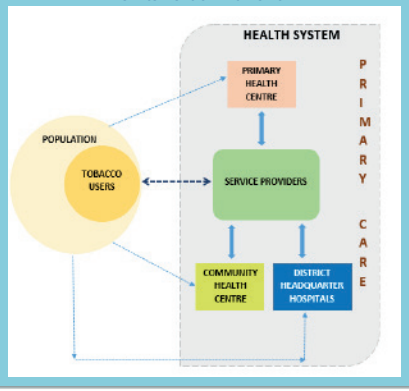
Project Setting

•The project covered was undertaken in 13 districts from 2 states of India – Odisha and Rajasthan (covering a total population of 32.5 million)

•The sampling frame comprised of physicians working in Primary and Secondary healthcare facilities (District Headquarter Hospitals, Community Health Centers and Primary Health Centers)

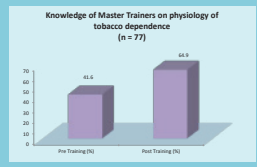
•The time span of the project is September 2014-September 2016. The result dissemination, networking and collaboration will extend beyond the scope and duration of the project.

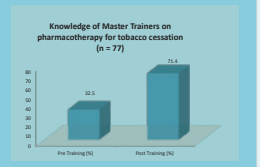
The Intervention Framework

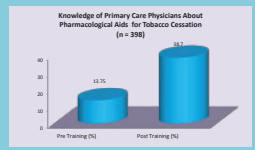


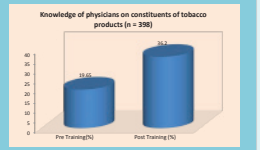
Media coverage for SCCoPE Training Programme

Evaluation of Training of Primary Care Physicians









Quotes of Physicians

"Workshop very good, was based on scientific evidence" ***In charge, Community Health Centre, Koraput***

"It was pretty good, Scientific contents were incredible" ***Primary care Physician, Primary Health Centre, Kendrapada***

"Audio/visual film about side effect of tobacco use should be incorporated" ***Dental Surgeon, Community Health Centre, Jaipur***

"Availability of Hindi language module for tobacco cessation" ***Primary care Physician, Primary Health Centre, Churu***

Methods

Phase I (September 2014 – June 2015)

- Obtaining ethical approval from the state governments as well as institutional ethics committee
- Obtaining permission letters to conduct the study from respective state departments
- Development of training resource packs through consultations and contributions from cessation experts nationally and internationally
- Creation of an online learning management system for imparting training
- Development of context specific IEC materials

Phase II (June 2015 – December 2015)

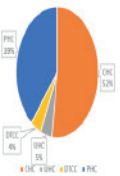
- Launch of project in Odisha and Rajasthan
- Conduct of training of master trainers in the two intervention states
- District level training of the primary care physicians from selected districts of two intervention states
- Assessment of effectiveness of training programs through robust evaluation measures

Phase III (Ongoing; January 2016 – September 2016)

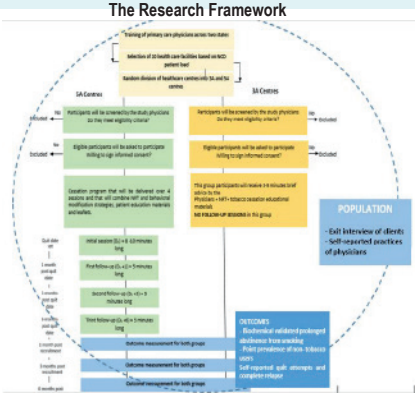
- Development and deployment of a tobacco user register at selected panel facilities for patient follow up.
- Undertaking exit interviews to evaluate the effectiveness of overall intervention
- Dissemination of the project learnings and identifying opportunities for upscaling and nationalizing the capacity building intervention for facility based tobacco cessation

An Innovative Hybrid Training Model adopted

Graph showing: Distribution of trained Primary Physicians in various facilities



The Research Framework



Key Challenges

- Building confidence of officials on the online/hybrid mode of training
- Maintaining the compliance of participants post training

Way Forward

We are developing a Hub and spoke model, where we serve as a Hub (centre of excellence in tobacco cessation) and develop spokes around us (empowered facilities for tobacco cessation regionally in premier institutes, already recognized for their clinical care.)

Project Team: Dr. Rajmohan Panda, Dr. Manu Raj Mathur, Dr. Sanghamitra Pati, Dr. Hayden McRobbie, Dr. Sandeep Mahapatra and Mr. Kumar Gaurav

Contact us at: raj.panda@phfi.org

The China-U.S. Smoke-Free Workplace Initiative
Build the bridge: from capacity building to practice

ThinkTank Research Center for Health Development, China
Chinese Center for Disease Control and Prevention

Goal

To promote and support the development of smoke-free workplaces by providing training, technical assistance and smoking cessation services to private companies.

Background

- Over 60% of nonsmoking adults are regularly exposed to secondhand smoke in the workplace in China.
- There is an existing network of companies and local health officials established under the China-U.S. Smoke-Free Workplace Initiative (CUSW). A needs assessment conducted by CUSW expressed the need for assistance in helping employees to quit smoking.
- A pilot study found that health professionals cooperating with companies could bring a feasible and stable way of providing cessation intervention.

What if we embed this model in an intracompany operation?

- If we could provide training and support to staff from the health sector and HR inside the company, then they may provide cessation services inside the company with convenience.

Activities

Recruiting companies	Providing training	Intra-company activities	Promotion
Recruiting 30 companies from CUSW network in Beijing, Shanghai and Shenzhen respectively	Dangers of smoking and secondhand smoke, nicotine dependence treatment, different cessation services, etc.	Trained staff should conduct motivational interviews to increase quit attempts.	To summarize experiences of each company.
2 staff will be trained (one from Human Resource sector, one from health sector)	3 training classes will be conducted by tobacco control professionals.	Providing long-term intervention to smokers who want to quit.	To promote successful experiences nationwide.

36 companies participated in the training.
Beijing, April 19, 2016

Next Steps

- Training workshop in Shenzhen will be conducted in May 2016
- Training workshop in Shanghai will be conducted in June 2016
- Companies promote cessation service to their employees after training
- Project team provides long-term support to companies

For more information, please contact:
WANG Lili
Email: wanglili711@hotmail.com

Training Community Health Workers in Rural Uganda to Introduce Stop Smoking Interventions in a Context of a Lung Health Awareness Campaign

International Primary Care Respiratory Group, Uganda

Chronic lung disease is common, but under-reported, despite its impact in sub-Saharan Africa. Following a survey in rural Uganda which found 16.2% of the adult population had COPD, we developed a lung health awareness programme to raise awareness of the diseases and their risk factors with emphasis on tobacco smoking and biomass smoke. In this two year project a cascading training and awareness campaign was conducted.

This project targeted to increase awareness and knowledge of tobacco smoking and lung health of health care workers (HCWs), community health workers (CHWs) and community members in Masindi district in Uganda.

In the train-the-trainer program we trained 12 HCWs and developed an education package. The education materials were tested in the field. These 12 HCWs then trained 47 HCWs and the 47 HCWs would train CHWs.

The CHWs training is ongoing with 100 CHWs so far completing. Ultimately the community members would be sensitized by the HCWs.

The project was conducted in Masindi District in rural Uganda starting in March 2015. Masindi District is a rural area of a low income country with poor health infrastructure and tobacco growing is an important source of income. It is located in the mid-western part of Uganda with a predominantly rural population with only 5.4% of the residents living in urban areas. The project is ongoing.

This project grew out from the FRESH AIR Uganda survey in which we found 16.2% of population above the age of 30 years had COPD. HCWs working on the FRESH AIR Uganda survey wanted to educate the community about the dangers of tobacco and biomass smoke.

The involvement of the District Health Officer and his team, and the local health service was critical for the success of this project. They felt ownership of the materials

There is significant national and international interest in the materials and the program especially after they were approved by the Ministry of Health, Uganda.
Survey of baseline knowledge among 2000 community members conducted

The lung health awareness campaign is continuing with radio talk shows and radio adverts.

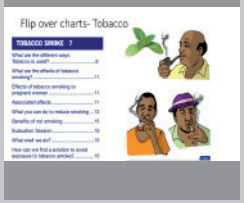
Masindi District Health Team are promoting lung health in their day to day activities in all health care facilities. To support CHWs, we are developing the use of mobile telephone technology in form of SMS messages.

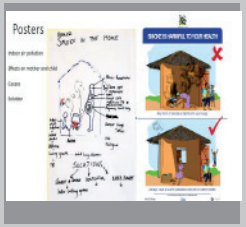
Working with patients, local HCWs and experts we developed a slideset covering:

- Lung health
- Biomass smoke
- Tobacco smoke

The initial slideset was shown to 51 stakeholders in 14 interviews ranging from the Ministry of Health to the villagers. Then we developed draft training materials. The draft materials were piloted with select HCWs, CHWs and communities members. We then conducted a trainer the trainer course. To facilitate training of CHWs we developed a flip book and posters which the HCWs used to train CHWs. CHWs used the same flip books to train their community members.

Look after your lungs and they will look after you





We developed and tested knowledge questionnaires for use before and after training. We have done a survey of 2000 people to measure the effects of this awareness campaign.

We designed radio messages and hits through a participatory approach as the training and IEC materials. A 6 week radio campaign comprising talk shows by project staff and radio hits was undertaken.

Contact Information (email) / brucekirenga@yahoo.co.uk
Corresponding Authors: Bruce Kirenga, Rupert Jones and Frederik van Gemert

A STATEWIDE IMPLEMENTATION OF THE TREATING TOBACCO in MENTAL HEALTH SETTINGS TRAINING

Jill M Williams, MD[1,2], Nina Cooperman, PsyD[1,2], Patricia Dooley, MA[1], Jose Cruz, MBA[1] and Marc L Steinberg, PhD[1,2]

[1]Rutgers-Robert Wood Johnson Medical School, [2]The Cancer Institute of New Jersey

Introduction

• Smokers with mental illness have less access to tobacco dependence treatment across the health care spectrum, and specifically in the behavioral health setting

• Studies have shown that training other health professionals in tobacco dependence treatment results in increased treatment, including more counseling and helping smokers set quit dates

•We developed a curriculum for training behavioral health professionals but never implemented it on a large scale in NJ

Study Objective: To conduct a statewide implementation of a 3-day tobacco training for mental health professionals in New Jersey.

Methods

Subjects:

We targeted all 76 New Jersey Division of Mental Health and Addictions Services (DMHAS) funded outpatient programs in New Jersey to provide training in evidence based tobacco dependence treatment and motivational interviewing. These sites serve nearly 300,000 outpatients per year who are usually considered to have serious mental illness (SMI) and are treated in the public sector.

The training was held three times during the project period to facilitate attendance. (October 2013, December 2013 and March 2014)

The training curricula was developed by the RWJMS Division of Addiction Psychiatry (based on similar prior trainings) and contained current evidence-based practice strategies.

The faculty included 1 physician, 2 doctoral level psychologists, and 2 Masters level counselors who were also Certified Tobacco Treatment Specialists.

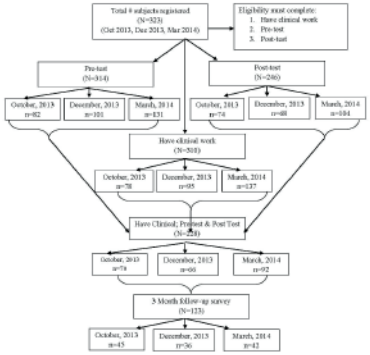
Evaluation Procedures:
Participants subjects completed an 11-item survey addressing general knowledge about effectiveness of treatment interventions, barriers to treatment implementation, and attitudes about tobacco users

Subjects also completed an identical 15-item pre- and post-test with topics from all the training modules

Subjects completed an additional survey of personal and institutional tobacco practices at baseline and 3 months after attending. Subjects given $10 gift card to complete 3 month follow-up online survey.

Results

Figure 1. Participants and Eligibility for Follow-Up

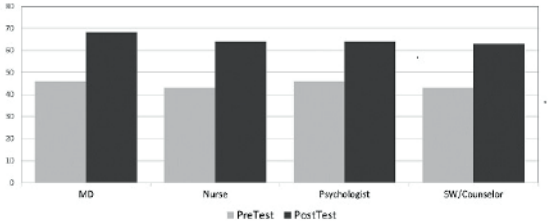


Three hundred twenty three attended
Oct 28,29,30, 2013 N=82
Dec 9,10,11, 2013 N=101
March 10,17,24, 2014; N=140

19 MDs
44 Nurses
9 Psychologists
79 Social workers
117 Counselors
32 Other (non credit seeking)

57% (176) never smoker
34% (106) former smoker
6 % (18) current smoker

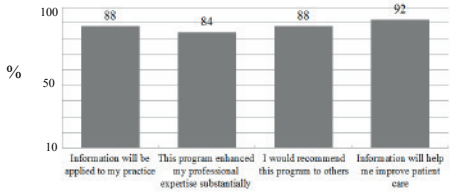
Figure 2. Pre Test and Post Test Scores



Two hundred nine completed a pre test and post test
Mean pre test scores 0.43 (SD 0.15)
Mean post test scores 0.63 (SD 0.16)

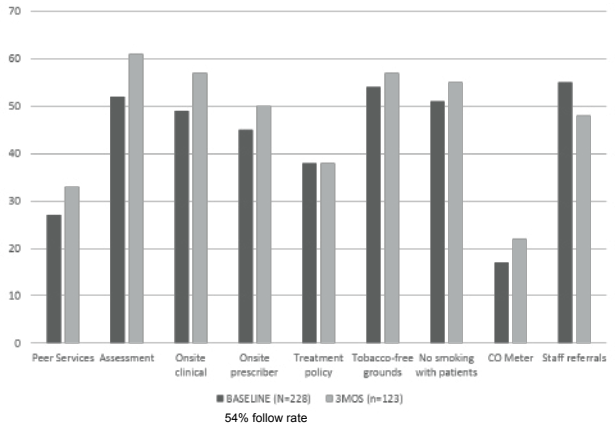
Significant increase in test scores
(paired sample t test; t -16.63; df 208; p < 0.001)
No differences between professional groups

Figure 3. Training Evaluations



Two hundred fifty completed a training evaluation

Figure 4. Tobacco Practice Baseline and 3 Months after Training



54% follow rate

Discussion

• Participation was good with more than 300 NJ behavioral health care professionals attending

•Participants rated the training activity highly in terms of usefulness and applicability

•Baseline knowledge of treatment of tobacco dependence was poor among trainees

•Knowledge increased significantly after training

• Tobacco practices increased at 3 month follow-up in nearly every area surveyed

This work was supported by an unrestricted educational (CME) grant from Pfizer.

RUTGERS
Robert Wood Johnson Medical School

linician Training on Tobacco Dependence for Respiratory Therapists

Shawna Strickland[1], PhD, RRT-NPS, RRT-ACCS, AE-C, FAARC,
Georgianna Sergakis[2], PhD, RRT, TTS, FAARC, Sarah M. Varekojis[2], PhD, RRT, FAARC
1-American Association for Respiratory Care, Irving, TX; 2-The Ohio State University, Respiratory Therapy Division, Columbus, OH

Challenge And Project Overview

A limited number of respiratory therapists (RTs) have training in tobacco dependence treatment. The practice gap addressed relates to the cadre of RTs available yet ill equipped to recommend pharmacotherapy and provide assistance to current tobacco users. Approximately 14% of RTs are trained for these conversations.

The overall goal of this project was to increase the proficiency of RTs in the AAR model and in pharmacotherapy recommendations by utilizing the Rx for Change materials and supplemental specialized RT modules created with grant funding. Utilization of an on-line training platform promotes access to the training by all practicing RTs.

Background

This project was designed for respiratory therapists who have successfully completed entry-level respiratory therapy education and earned either the Certified Respiratory Therapist or Registered Respiratory Therapist credential. The target demographic qualifies for state licensure to practice as a respiratory care practitioner. As licensed respiratory care practitioners, this population has contact with patients who are current tobacco users and can benefit from the cessation conversation conducted by the respiratory therapist and subsequent referral to a formalized tobacco cessation program.

Recruitment/Participants

Participants were enrolled in the online training beginning in late August 2015 through January 2016. Participants were recruited from the top 6 states for tobacco use as identified by the Centers for Disease Control and Prevention: Indiana, Kentucky, Mississippi, Missouri, Oklahoma, and West Virginia. Data collection was completed in April 2016.

Results

Sixteen of 48 participants completed both the pre and post evaluation measures. Fifteen of 16 indicated the course would increase the number of tobacco cessation counseling sessions they conducted with patients, and all participants indicated that the course would increase the quality of these counseling sessions.

Pre to Post:
- 53.9% increase in patients asked about smoking
- 64.5% increase in patients advised to quit
- 136.6% increase in patients referred to counseling
- 267.6% increase in patients referred to quit-line

Pre to Post:
- 57.1% increase in participants that discuss and provide patients with materials for calling quit-line
- Slight increases in counseling competency, overall ability to help patients quit, overall self-efficacy

Barriers to using AAR:
Rated Very Important:
- Lack of available time
- Lack of training
- Lack of confidence for counseling about quitting

Next Steps

The RT training improved knowledge, self-efficacy and self-reported counseling behaviors. Participants continue to identify time, training and confidence as potential barriers to implementing AAR. This pilot data suggests that RTs trained in brief tobacco dependence interventions can contribute to a reduction in tobacco use through increased evidence-based advice and referral, thereby possibly effecting overall cessation rates. Future efforts need to build on the successes of this pilot and directly address the slight increases in ratings of counseling skills and confidence.

Course

The training intervention included the AARC Clinician's Guide to Treating Tobacco Dependence as required reading along with 3.5 hours of video content including epidemiology of tobacco use; nicotine pharmacology and principles of addiction; non-nicotine pharmacology; nicotine replacement therapy; assisting patients with quitting; motivational interviewing; special populations: teens, patients with cardiac disease, and pregnancy; difficult questions; reimbursement; and systems and pharmacology. The training also included a pre-course knowledge test, in-course self-assessment quizzes for every video chapter, and post-course knowledge test.

Methods

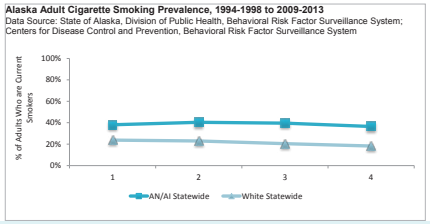
Successful completion was defined as completion of all course artifacts and at least a 70% passing score on the post-course knowledge test. Prior to completing the training, the study participant completed a pre-study survey regarding current practices in tobacco cessation. The participant was also invited to complete a post-study survey 30 days after completion of the course to determine what, if any, changes in practice were noted.

Data

In the past week, how many patients did you…	Pre mean (SD)	Post mean (SD)	% change
Ask whether they smoke?	11.13 (16.5)	17.13 (16.0)	53.9%
Advise to quit smoking?	7.94 (10.0)	13.06 (11.8)	64.5%
Refer to smoking cessation counseling?	3.25 (5.5)	7.69 (10.4)	136.6%
Refer to the national tobacco quit-line (1-800-QUIT-NOW)?	2.38 (5.1)	8.75 (12.1)	267.6%

Increasing Capacity to Treat Tobacco Use in the Alaska Tribal Health System

C. Dalena, BS, CTTS; D. Diehl, BA, TTS; C. Meade, BS, CTTS
ANTHC Tobacco Prevention Program, Anchorage, Alaska

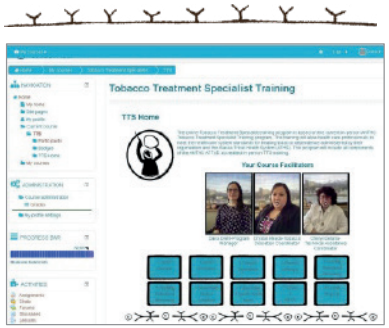


Challenge and Project Overview

In Alaska there are approximately 153,000 Alaska Native beneficiaries who receive services within the Alaska Tribal Health System (ATHS). Tobacco use is the number one cause of preventable death and disease among Alaska Native people. American Indian/Alaska Native people have the highest tobacco use rates in the United States. While overall tobacco use rates among adults in the U.S. and Alaska are decreasing, since 1996, the tobacco use rate among Alaska Native adults has remained steady and has not decreased significantly (42%). The goal of this project is to create an online tobacco treatment specialist training program that increases the accessibility and ease for healthcare providers and professionals to be trained on how to help individuals quit tobacco.

Target Audience

Physicians, mid-level providers, nurses, behavioral health clinicians, community health aides and a number of other healthcare professionals have a prime opportunity to intervene with individuals who use tobacco and the U.S. Public Health Service - Best Practice guidelines (2008) indicate that these professionals make the most impact in encouraging a tobacco user to make a quit attempt. This project will start by targeting the 12 main tribal health regions in Alaska to support at least one provider or healthcare professional to take the online training during the regional pilot session in October 2016. Once the regional pilot is complete, the course will be open to healthcare professionals from across Alaska and the US.

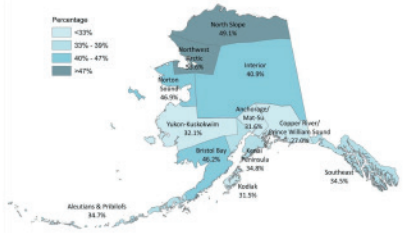


Motivating and Mobilizing Healthcare Professionals

Expected Results

Since 2006 there have been 245 participants that have completed the in-person TTS course. The goal of the online training is that at least 400 additional healthcare professionals will be trained within ten years of the April 2017 training launch, almost doubling the number of currently trained TTSs in the ATHS. By increasing the number of TTSs in Alaska, and promoting other evidence based strategies such as smokefree workplaces, tobacco tax increases and educational campaigns, we hope to eventually see a decline in the percent of Alaska Native adults that report using tobacco.

Figure 9: AN/AI Adult Smoking Prevalence by Tribal Health Region, 2009-2013
Data Source: State of Alaska, Division of Public Health, Behavioral Risk Factor Surveillance System



Lessons Learned

1) Translating a 5 day (35-40 hour) in-person curriculum to an engaging, online format is very tedious, time consuming, and requires support from experts in online learning.

2) Incorporating fun, interactive activities is challenging yet crucial to keeping learners engaged.

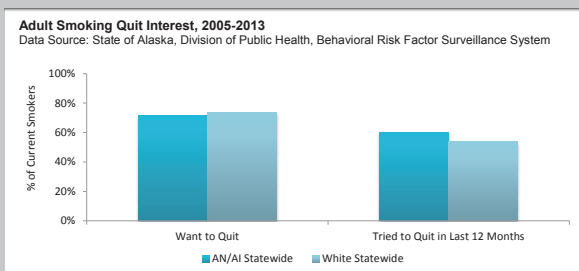
3) Setting up a plan for how the online course will be facilitated at the beginning of curriculum development is important. Planning for capacity and resources to facilitate in the future is necessary.

4) Incorporating quizzes throughout modules ensures that participants are learning. Providing detailed feedback in the answers section of the quizzes keeps the participant engaged.

5) Hosting an online learning program can be costly.

Project Activities

- Adapt the in-person tobacco treatment specialist (TTS) training curriculum into an online TTS training program based on the USPHS Best Practice Guidelines for Treating Tobacco Use and Dependence.
- Conduct an initial pilot of the Alaska Native Tribal Health Consortium (ANTHC) online TTS training program with pre-selected staff from the Alaska Native Medical Center and ANTHC by July 2016.
- Conduct a regional pilot of the ANTHC online TTS training program for at least one healthcare professional in each of the 12 tribal health regions of Alaska by January 2017.
- Promote the online training program on two statewide, and three national websites in order to increase future and sustained participation in the online training program.
- Launch an ATTUD accredited, user-friendly, interactive online learning platform by April 2017.



Materials/Methods

- Identified baseline number of TTSs in Alaska through the ANTHC Tobacco Treatment Database System
- Identified current smoking rates through the Alaska Behavioral Risk Factor Surveillance System
- Adapted the ANTHC Tobacco Treatment Specialist in-person Training Curriculum to an online format
- Utilized Moodle, an online learning system to draft and host the curriculum

Project contacts: Cheryl Dalena, cadalena@anthc.org, Dana Diehl, dadiehl@anthc.org, Crystal Meade, cdmeade@anthc.org.
Acknowledgements: This project is funded through Grant ID: 16766717 from Pfizer.

Texas Smoking Cessation Integration Project

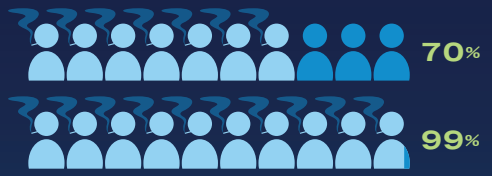
ASSOCIATION OF SUBSTANCE ABUSE PROGRAMS (ASAP), TEXAS

CHALLENGE & PROJECT OVERVIEW

CHALLENGE

Clinicians are not fully addressing tobacco addiction in substance abuse treatment.

- In Texas in 2013, 70% of the individuals entering DSHS state-funded treatment were current tobacco users and 99% of Texas treatment clients continued to use tobacco products at discharge from treatment.



- Smoking tobacco causes more deaths among clients in substance abuse treatment than the alcohol or drug use that brings them to treatment.

PROJECT OVERVIEW

In 2012, the Association of Substance Abuse Programs (ASAP) of Texas, in partnership with the Texas Department of State Health Services (DSHS) Tobacco Prevention and Control Program, received a smoking cessation initiative grant from Pfizer Independent Grants for Learning and Change.

The grant's funding provided no-cost training, outreach, and educational materials for treatment program clinicians, administrators, and clients.

WHO

The Texas Tobacco Cessation Integration Project was constructed by the alliance of ASAP and DSHS. Its mission is to improve the health and wellness of Texans by increasing tobacco cessation among adults and young people diagnosed with a substance use disorder. Through this grant, the initiative impacted:

85 DSHS-funded Substance Abuse Treatment Programs (200 programs)

40,000 Clients who enter DSHS substance abuse treatment as tobacco users

28 Local Recovery-Oriented Systems of Care (ROSC) communities

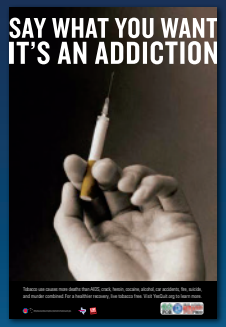
WHERE & WHEN

Seven regional trainings were held from April through June 2014 in San Antonio, El Paso, Corpus Christi, Houston, Longview, Dallas, and Lubbock.

RESULTS

PROCESS RESULTS

- Conducted 8 regional Smoking Cessation Integration Workshops, giving 6 hours of CEUs
- Held a Smoking Cessation Integration Train the Trainer Workshop
- Distributed 200 toolkits for substance abuse treatment providers
- Distributed 2,020 posters



OUTCOME RESULTS

9,300 Clients impacted by information monthly.

33,886 Unique clients served—65% were tobacco users.

82% Increase in calls to the Texas Quitline from people self-reporting drug or alcohol abuse.

42% Increase in DSHS treatment provider implementation of smoking cessation treatment strategy.

Increased the number of substance abuse treatment clients who used tobacco at intake to being tobacco-free at discharge.

LESSONS LEARNED

Address tobacco use as a **REAL** addiction.

- Address perceived barriers based on current research.
- Increase training in Motivational Interviewing specific to quitting smoking.
- Use skilled trainers and pay them a stipend.
- Advocate for DSHS funding for NRT in residential treatment programs.
- Advocate and educate for tobacco-free facilities systems change.

NEXT STEPS

Secure additional funding to continue the collaboration and develop evidence-based sustainability strategies that will further the project's objectives among recovery-oriented DSHS programs.

METHODS

- Key stakeholders and leadership developed a training plan targeting clients and staff through a peer-driven commitment to changing the status quo.
- Via strategic communication and motivational messaging, provider receptivity was improved, and substance abuse services were expanded to integrate tobacco cessation.
- A comprehensive dissemination approach was used to deliver outreach materials directly to DSHS-funded treatment facilities. Multimedia tools such as "Yes Quit," "Share Air," and "Ask, Advise, Refer" were distributed.
- Two types of training were implemented, a Train the Trainer (TOT) workshop and regional workshops for DSHS clinicians.
- Efforts were made at DSHS to improve data collection for tobacco cessation activities and outcomes.
- A provider questionnaire was developed to survey provider attitudes and status of integrated tobacco cessation protocols and policies.

The Association of Substance Abuse Programs

GO FOR DRUGS, ALCOHOL & TOBACCO FREE

Smoking Cessation Leadership Center

Texas Recovery-Oriented Smoking Cessation

ASSOCIATION OF SUBSTANCE ABUSE PROGRAMS (ASAP), TEXAS

WHO

The Texas Recovery-Oriented Tobacco Cessation Integration Project is a collaboration between:

- Association of Substance Abuse Programs (ASAP)
- Department of State Health Services (DSHS), Substance Abuse Services Unit and Tobacco Prevention and Control Program
- The University of Texas at Austin, Tobacco Research and Evaluation Team

WHAT

The Texas Recovery-Oriented Tobacco Cessation Integration Project received a 2015 Pfizer Independent Grant for Learning and Change (IGLC).

This enables ASAP to narrow the focus of the previous IGLC smoking cessation initiative to DSHS-funded substance abuse treatment providers who were not prepared to take advantage of the previous IGLC grant funding education and training.

The project aims to:

- Increase implementation of integrated smoking cessation treatment strategies by 10%.

▲10%

- Increase support for adopting tobacco-free campus policies.
- Increase the percentage of clinical professionals and peer leaders trained in evidence-based tobacco cessation treatment.
- Increase referrals to the Texas Quitline.

WHEN & WHERE

Through the 2015–2017 Pfizer IGLC Grant, education and training will be provided for the following DSHS-funded programs:

87 Outpatient (31,981 adults & 4,322 youth)

19 Pregnant Post-Partum Intervention (PPI) (Female Clients: 1,925 adults & 5,484 youth)

9 PADRES Intervention (Male Clients: 427 adults & 16 youth)

28 ROSC recovery communities with 300 DSHS trained recovery coaches

21 Recovery Support Services (RSS)

27 Oxford House (421 residents)

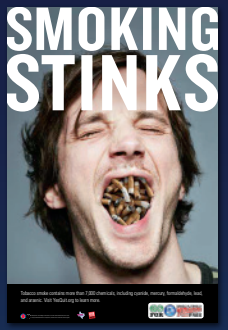
WHY

- The tobacco use rate of adults and youth served in DSHS-funded treatment programs is at least triple that of the general population in Texas.

- Only 1% of clinicians trained by ASAP in cessation integration strategies were identified within the target group of DSHS providers.
- Only 1% of youth and 13% of adults who reported tobacco use at intake in DSHS outpatient treatment programs had quit tobacco use at discharge.
- In 2014, 5% of callers to the Texas Quitline reported having a substance abuse problem.

HOW

1. Stakeholder & Peer Leadership Engagement: A stakeholder workgroup provides the overall direction for the project.
2. Health Communications:
   - Posters, websites, manuals, and testimonials.
   - Presentations at statewide conferences and contractor meetings.
   - Social media, parcel post, Go For Three Listserv, ASAP e-newsletters and meetings.
   - DSHS "Yes Quit," "Share Air," and "Quit for your Child" media.
3. Tobacco Cessation Module for ROSC Peer Recovery Coach Curriculum: ASAP has collaborated with DSHS to add a one-hour tobacco cessation integration module to the curriculum. ASAP recruited current peer coaches and other trainers to help develop the module.
4. Training:
   - 8 Regional Go For 3 workshops tailored for recovery-oriented programs on evidence-based tobacco cessation.
   - A Rocky Mountain Tobacco Treatment Specialist Certification training (Train the Trainer) facilitated by ASAP and DSHS.
5. Technical Assistance: Trainers, experienced peer recovery coaches, and DSHS regional tobacco coordinators will provide ongoing technical assistance to providers about how to plan and implement an integrated treatment program and smoke-free campus policy.



DATA COLLECTION

Efforts will be made at DSHS to improve data collection at ROSC communities, Oxford House, and PPI programs.

ASAP will work with the DSHS Tobacco Prevention and Control Program to enhance the Texas Quitline data reporting system. Only aggregate data will be collected to protect confidentiality.

REFERENCES

Clinical Management for Behavioral Health Services (CMBHS) (2014)

Texas Quitline monthly reports (2014)

Texas Behavioral Risk Factor Surveillance System (BRFSS) (2014)

ASAP Smoking Cessation Provider Survey (2014)

DSHS Texas School Survey of Substance Use among Students (grades 7-12) (2014)

The Association of Substance Abuse Programs

GO FOR 3 DRUGS ALCOHOL & TOBACCO FREE

SMOKING CESSATION LEADERSHIP CENTER

Managing Nicotine Withdrawal for Comfort and Cessation in Medically Ill Smokers

Audrey Darville, PhD, APRN, CTTS; Angela Dearinger, MD, MPH, FAAP; David Mannino, MD; James Norton, PhD University of Kentucky, UK HealthCare, Lexington, KY

http://www.cecentral.com/ManagingNicotineWithdrawal

Challenge And Project Overview

Goal 1: To develop specialty-specific web-based training modules presented by providers within each targeted specialty to provide current evidence-based and best practice information for the management of nicotine withdrawal and the promotion of tobacco use cessation.

Goal 2: To provide a forum for providers to discuss concerns specific to managing nicotine withdrawal and treating tobacco dependence subsequent to the module, moderated by clinical experts in the treatment of tobacco dependence.

Goal 3: To monitor withdrawal management prescribing and tobacco dependence treatment practices of providers by specialty at UK HealthCare pre- and post-intervention.

Who

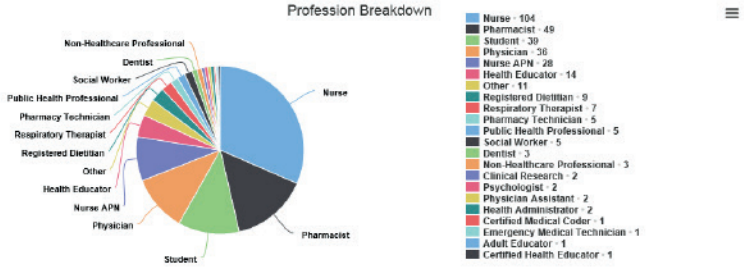
Projected reach: To train at least 300 providers, and provide at least 200 continuing education (CE) credit

Actual: 678 total downloads, 441 CE certificates to date

The majority of participants were direct care clinicians (197)

Participants were primarily from Kentucky (172) but also from 35 other states, 8 foreign countries and 3 Canadian provinces

.



Results | Lessons Learned

- The project had broad reach and appeal within our institution, nationally and internationally
- An infrastructure supporting professional quality CE was essential to the project success
- Marketing was an ongoing concern
- 26% of participants made an initial commitment to change
- There was no interest in the extended Learning Community

Results Goal 1

Average increase in knowledge from pre to post testing was 15-20% across modules

Nearly all 'strongly agreed' (70%) or 'agreed' (30%) the materials were useful, relevant to practice and clearly presented

Results Goal 2

115 commitments to change from 92 participants were made, with only 9 completing the first follow up and 1 the second

No one participated in the Learning Community

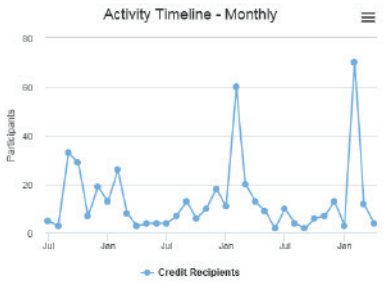
Results Goal 3

A significant ($p<.0001$) increase in NRT provided for all patients from a period of 6 months pre-launch to 6 months post; increases were limited to neurology, trauma and orthopedic providers

Next Steps

CE credit for the project is set to expire 6/1/16 for the majority of modules with the Urology CE extending to 1/31/18.

Nursing students viewed the modules during a course in February of 2015 and 2016 (participation spikes below). Updating the modules and target distributing the link to relevant course instructors/service lines may be an effective way to increase reach among students & professionals in healthcare settings.



Methods

- Employ an established web-based, user-friendly format with targeted training to various provider groups (cardio-pulmonary, orthopedics and trauma, oncology, neurology, surgery, and urology)
- Provide free CE credit for a general overview module plus at least one specialty module
- Pre- and post-test for each module with embedded survey questions
- Provide a 'Commitment to Change' vehicle to track one and three month follow up performance-based outcomes
- Provide access to an online Learning Community after module completion
- Track NRT use for 12 months pre and post launch as an indicator of the influence on prescribing behavior for UK HealthCare service lines

Timeline

Jan-Mar 2013	Mar-July 2013	Aug 2013-June 2016
Recruit providers; develop module/ survey content; apply for IRB	Module production Urology module added Feb 2015	Module launch, marketing, learning community, commitment to change, data collection and analysis

Data*

- Greatest improvements in pre to post test knowledge were related to medication use and potential side effects
- Pre-polling revealed 90% of participants felt smoking reduction was a valid treatment goal for persons with medical illness

* All data as of 2/21/2016 and do not include recent urology module

Module (N)	Mean % Increase Pre to Post Test Scores (SEM)
Overview (283)	18.66 (1.3)
Cardio-pulmonary (72)	22.5 (2.7)
Orthopedic/Trauma (65)	15.4 (3.3)
Oncology (57)	15.4 (3.5)
Neurology (50)	20.8 (3.3)
Surgery (53)	18.1 (3.1)

Commitments to Change (N=115)	
Ask	20% (23)
Advise	37% (43)
Assess	9% (9)
Assist	31% (36)
Arrange	3% (4)

Expanding Provider Education and Resource Training Tobacco Cessation Program

Maria Feo, BSN, RN-BC, CTTS, Geralyn M. Prosswimmer, MD, FAAP & Rose Puelle, PhD

INTRODUCTION

- Tobacco use is the leading cause of preventable death, chronic disease, healthcare crisis, economic burden, cause of loss productivity, and source for poor health outcomes and quality performance measures.
- Hunterdon Healthcare is a mature integrated delivery system, encompassing a large primary care network, including 25 Level 3-NCQA , Patient Centered Medical Homes (PCMH), specialist care, and a Magnet ® designated, community hospital. ACOs include commercial contracts with the six major payers in our area, plus two public innovation programs from the Centers for Medicare and Medicaid Innovation (CMMI). Ten Primary Care Practices and one Cardiovascular Specialty practice participate in the Million Hearts®: Cardiovascular Disease Risk Reduction Model (MH Model). Practice gaps identified the lack of provider education and standardized protocols to prompt and guide providers through cessation counseling, leading to missed opportunities for "teachable moments."
- The 2010 countywide Behavioral Risk Factor Surveillance Survey (BRFSS) data revealed: Percentage of smokers who reported they had NOT been advised by a health professional to quit smoking had increased from 61% to 74%, and only 9% of Hunterdon County smokers reported a healthcare provider had advised them to quit within the past 12 months, compared to 24% in 2001 .

GOALS & OBJECTIVES

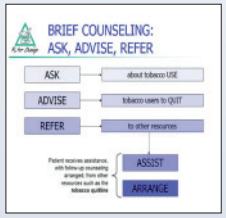
- Educate healthcare providers about evidence-based, effective strategies to increase patient tobacco cessation rates.
- Integrate standardized tobacco cessation treatment protocols into patient care in a way that can be replicated throughout Hunterdon Healthcare.
- Increase the percentage of patients who are offered evidence-based methods of cessation treatment and counseling.
- Align with The Joint Commission Tobacco Measure Set, NCQA-PCMH-Behaviorally Based Condition Management, Meaningful Use, and the Physician Quality Reporting System (PQRS).

SUSTAINABILITY

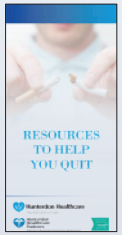
- All interventions were designed to be practical and sustainable in our Integrated Delivery System through internal and external continuing education and training with our collaborative partners, as well as embedding tobacco cessation projects into our Population Health Program.

INTERVENTIONAL DESIGN

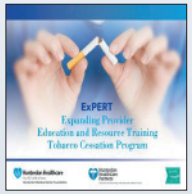
- Phase 1/Phase 2/Phase 3- Recruitment/ Certified Tobacco Treatment Specialist Training /Certification: Thirteen "super-users" attended the UMDNJ/Rutgers Tobacco Dependence Program. Clinicians were recruited from the following specialties: Nursing, Primary Care, Behavioral Health, Maternal/Child Care, Surgical Services, Cardiopulmonary Rehab, Oncology, Community Outreach, and Pharmacy. After completion of the program and post practicum, these clinicians obtained their CTTS and act as "change-agents". They effectively treat patients for tobacco dependence, provide organizational services, and educate providers, based on culturally competent, evidence-based protocols which are population specific.
- Phase 4 - Electronic Health Record (EHR) Enhancement/Workflow Development: Our electronic health record tobacco template was revised and enhanced to allow for easier use by the healthcare team. Correct documentation of cessation counseling was reviewed during training. We have recently added e-cigarettes to the tobacco template.
- Phase 5 - Training/Process Improvement: Development and implementation of training programs, educational sessions, speaker events, conference and webinar offerings via ExPERT project staff, continue indefinitely. Our ExPERT training manual was created and implemented, and is utilized in both the hospital and out-patient settings.



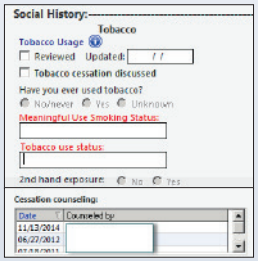
Even brief tobacco dependence treatment is effective and should be offered to every patient who uses tobacco.



Patient Education



ExPERT Training Manual

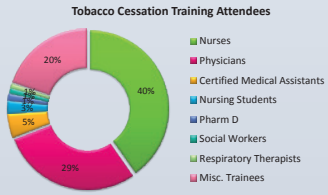


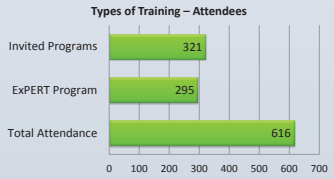
Tobacco Screening Template

OUTCOMES

Objective - Increase the % of healthcare providers reporting improved knowledge of tobacco cessation options.

Since 2012, over 600 Hunterdon Healthcare providers have received training on tobacco use, treatment and counseling options.





Objective - Increase the % of patients who are screened for tobacco use and documented in the EHR.

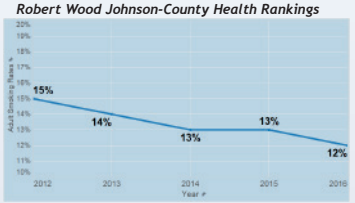
EHR data is reviewed at the system Population Health Committee meetings. In November we gather stakeholders in conjunction with the Great American Smoke-Out. Practices receive their tobacco status and cessation metrics on a monthly dashboard along with patient tobacco registries for outreach.

Objective - Increase the % of patients who are offered evidence-based methods for counseling/treatment for tobacco use.

We looked at the number of tobacco cessation counseling CPT codes (99406, 99407, G0436, and G0437) submitted before and after training sessions were provided throughout 2013 and 2014. Codes were extracted from the NextGen EHR for 10 primary care practices that had been on the system for at least 2 years. Counts are for unique patients seen at least twice within 2 years as of the last day of the reporting year.

HUNTERDON COUNTY POPULATION HEALTH DATA

Robert Wood Johnson-County Health Rankings



CHALLENGES

- Maintaining enthusiasm in the face of competing demands on providers
- Turnover of Certified Tobacco Treatment Specialists
- Under-reporting of counseling efforts due to clinical documentation

COLLABORATIONS

Association for the Treatment of Tobacco Use and Dependence-ATTUD

Hunterdon & Mercer County Chronic Disease Coalition

Hunterdon Population Health Committee

Mom's Quit Connection-MQC

Rutgers- Tobacco Dependence Program

Rutgers- Treating Tobacco Dependence in Mental Health Settings Training Program

New Jersey Prevention Network-Tobacco Free for a Healthy NJ

Smoking Cessation Leadership Center (SCLC)

REFERENCES

County Health Rankings & Roadmaps
http://www.countyhealthrankings.org/

Fiore MC, Jaén CR, Baker TB, et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service.

Hunterdon County Behavioral Risk Factor Surveillance Survey (BRFSS) 2010.
http://www.co.hunterdon.nj.us/pdf/health/BRFSS/2010-BRFSS.PDF

Rx for Change: Ask-Advise-Refer
http://rxforchange.ucsf.edu/

CONTACT

Maria Feo, BSN, RN-BC, CTTS-Project Director, ExPERT
Heart & Vascular Care Coordinator-Hunterdon Healthcare
feo.maria@hunterdonhealthcare.org

Improving Access to Counseling Tools and Increasing Competence, Confidence and Frequency of Smoking Cessation Interventions among Retail Clinicians

Jennifer Keith, MPH, CPH and **Janene Brown, MPH** (Public Health Management Corporation, Research and Evaluation Group); **Kimberly Houston** (The Foundation for Health Smart Consumers); **Sarah Rosenberg** (Convenient Care Association/National Nursing Centers Consortium)

For more information: visit **smartcarepro.com** or contact **Kimberly Houston** at khouston@healthsmartconsumers.org or **Joseph McGovern** at jmcgovern@healthsmartconsumers.org

Inspire Background

Partnership

- The **Foundation for Health Smart Consumers** and the **Convenient Care Association** partnership
- Grant provided by the **Pfizer Independent Grants for Learning & Change** and supported by the **Smoking Cessation Leadership Center** at the University of California at San Francisco

Inspire Smoking Cessation Training Program

- **Program** – Tailored training and patient counseling toolkit for the retail clinic setting
- **Goal** – Increase smoking cessation interventions in retail-based clinics by providing nurse practitioners and other attending clinicians with training and counseling resources

Launching Inspire

Training

- Face-to-face Training – Retail Clinician Education Congress (May 2013 and May 2014)
- Online Training – Web-based on-demand training (July 2013 – June 2015)
- Toolkit Support (ongoing)

Evaluation Methods

- Training records
- Pre/Post training survey
- 3-month follow up survey

Change in Confidence

Helping to Obtain Services (n=250, p=0.000)

- Pre-training mean – 7.43
- Post-training mean – 8.86
- 98% expect to be more comfortable making cessation-related referrals

Helping to Quit (n=236, p=0.000)

- Pre-training mean – 6.83
- Post-training mean – 8.49

Note: Paired Samples T-Test, 95% CI, Sig. (2-tailed)

Buy-In

Training Use

- Utility – helpful with practical application (73%) and ideas/tools for consideration (26%)
- 97% will share ideas/tools discussed in training
- 96% will recommend training to others

After Training

- 99% see AAR as a useful tool for retail clinicians
- 99% see AAR as part of their job

Feasibility

- 76% rate feasibility 8 or higher (1-10 scale) to consistently use AAR with patients (Mean 8.5, Mode 10)
- A little less than half rate as 10 (absolutely feasible) (43%)

Behavior

Intent

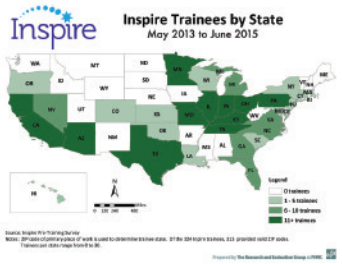
- 95% intend to refer clients as part of Inspire
- 93% expect to use the Inspire Toolkit

3-Month Follow Up (pre-n=324, follow up n=36)

- 88% regularly ASK (always or often)
- From 74% to 85% regularly ADVISE (always or often)
- From 54% to 76% regularly REFER (always or often)

Moving in the Right Direction

- Reduced drop off from Ask to Advise to Refer



Lessons Learned

Tailored Trainings/Unique Environments

- Provide options for utilizing tools/assets:
  - ✓ As a link
  - ✓ As a clinic system enhancement
  - ✓ As a hard copy resource if clinic is paper-based
  - ✓ Etc.
- Consider work flow
- Access from clinics can be a challenge

Reach

Demographics (n=791 trainees)

- Primarily Nurse Practitioners (74%)
- Variety of clinic settings
  - » Retail-based clinic (43%)
  - » Pharmacy-based clinic (25%)
  - » Grocery (18%)
- Mostly full time employees (87%)
  - » Most trainees spend more than half (60-100%) of their time with patients (66%)
  - » Two fifths are 100% direct service (40%)

Knowledge Change

Ask, Advise, Refer (AAR)

- 43% are familiar with AAR prior to training
- 99% have the information they need to refer patients as part of Inspire

Cessation Aids

- 56% are familiar with at least 5 tobacco cessation support options prior to training
- 99% are more comfortable discussing cessation aids because of the review and/or new information provided during training

Face-to-Face vs. Online Training

Similarities

- Overall, very similar
- Confidence and feasibility ratings are consistent
- 92% have requested/plan to request CEUs post-training

Differences

- Reach
- Types of trainees
- More clinic managers at face-to-face
- More "other clinicians" online

Data Collection

- Post-training survey completion
- Follow up survey response rates need improvement

Patients Impacted

Inspire Smoking Cessation Training May 2013 - March 2016

Clinicians Trained	911
Potential Number of Patients Impacted	1,366,500
Follow-up Survey with Trained Clinicians: 88% Regularly Ask; 74% to 85% Regularly Advise; 54% to 76% Regularly Refer	75%
Number of Patients Impacted (Projected)	1,024,875

The Foundation for Health Smart Consumers

Access Inspire Smoking Cessation Program at smartcarepro.com

01.12.12.04

CREATION AND IMPLEMENTATION OF AN EHR QUIT SMOKING TOOL IN SAFETY NET CLINICS

Jyothi N. Marbin, MD[1]; Cathy McDonald, MD MPH[2], Ryan Hensler[3], Deborah Fernandes MD[3], Eric Henley MD[3], Kathleen Tebb PhD[1]

[1]Department of Pediatrics, University of California, San Francisco;
[2]Alameda County Alcohol, Tobacco & Drug Treatment Provider Network; [3]Lifelong Medical Care

BACKGROUND

- Tobacco use and secondhand smoke (SHS) exposure continue to cause significant morbidity and mortality, especially in low-income populations
- Providers need support to connect patients who use/are exposed to tobacco to resources to help them become tobacco free
- Electronic referrals are a promising strategy to simplify referral pathways to state Helplines
- Integrating tobacco cessation support tools into electronic health records (EHR) may improve provider treatment of tobacco use and referrals to Helplines

METHODS

- LMCC randomly assigned to intervention group, which received tobacco cessation template, or control group, which received standard of care
- Champions from intervention clinics met to provide input into design of tobacco cessation tool
- Experienced NextGen design team member built tobacco template based on provider/champion input
- 2 way e-referrals to Helpline built using "direct messaging" platform
- Intervention and control clinics trained in "ask, assist, connect" framework. Intervention clinics also received training on new EHR tools
- Reports built to pull tobacco metrics from NextGen
- All clinics receive monthly tobacco reports. Champions lead rapid cycle quality improvement with clinic teams
- Collect data for 6 months, analyze data, then disseminate tobacco EHR tool and direct messaging tool to all clinics

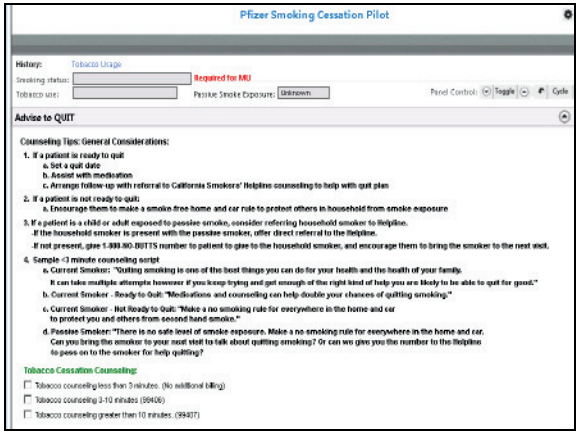
OBJECTIVES

- Build tobacco cessation order set in NextGen EHR that includes the tools for identifying smokers and household smokers and helping them quit
- Build a bidirectional e-referral between the NextGen EHR and the California Smokers' Helpline.
- Deliver order set and e-referral with a brief training to 11 Lifelong Medical Care Clinics (LMCC), which serve a high number of patients living at or below the federal poverty level in Alameda/Contra Costa Counties
- Evaluate the impact of the order set and e-referral on proportion of patients screened for tobacco use, referrals to helpline, number of NRT prescriptions provided, and quit rate among counseled smokers.

Funding Source: Pfizer Independent Grants for Learning & Change/UCSF Smoking Cessation Leadership Center
Corresponding Author: Jyothi N Marbin MD, jyothi.marbin@gmail.com

EHR TOOL INCLUDES

- Active, passive smoke exposure screening questions
- Provider alert for active/passive smoke exposure
- 2 way e-referral to Helpline for active/passive smokers
- Household Smoker nicotine replacement therapy rx
- Tobacco treatment order set



OUTCOME MEASURES

- Proportion of patients screened for tobacco use, identified as smokers
- Proportion of patients screened for SHS, identified as passive smokers
- Proportion of identified smokers referred to Helpline
- Smoking cessation support provided (tobacco cessation medication prescriptions written and counseling); and
- Smoking cessation rates for patients receiving Helpline counseling

TIMELINE

- **April 2015-February 2016**: Champion meetings, EHR tool development, testing
- **February 2016 – August 2016**: Data collection, monthly QI reports shared with sites
- **August 2016 – April 2017**: Analysis, dissemination

Smoking Cessation Initiative "One Step at a Time"
Hope Health Clinic
LaGrange, Kentucky

Janet Warren jwarren@hopehealthclinicky.com 502-225-6711 Kara Sanders, kara.sanders01@gmail.com 502-387-8969

SMOKING CESSATION LEADERSHIP CENTER

Introduction

Overall Goal

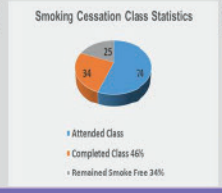
- Increase the number of individuals successfully quitting smoking through effective systems change.
- Provide local and accessible smoking cessation classes using the Cooper Clayton Method to Stop Smoking program throughout the four county region.
- Pairing personal advocates to offer additional support to those participating in the program.
- Create partnerships with key providers in local community to promote and refer patients.
- Target smokers reaching a special population, including mental health and the criminal justice system.

Methods

- ✓ Developed a referral system with local key physicians and dentists.
- ✓ Worked directly with Dr. Richard Clayton and learned how to effectively teach his method of smoking cessation.
- ✓ Created Network Partners
  - Newspapers
  - Health Departments
  - Prison Ministry
  - Chamber of Commerce
  - Parks and Recreation Department
  - Local School System
  - Extension Offices

Results

1



2

3

Each year more than 8,000 Kentuckians die of illnesses caused by tobacco use. Some die of lung cancer, while others fall victim to cardiovascular disease. Annually, Medicaid and Medicare costs exceed an estimated $1.2 billion for treatment of Kentuckians suffering smoking-related diseases and conditions. This equals $300 for each of the four million people living in Kentucky.

4 Community Impact

- The success of this program is providing smoking cessation programming at no cost to local communities.
- Since October 2015, we have hosted 10 Cooper Clayton Method to Stop Smoking Classes and introduced the process of smoking cessation over 60 local smokers.

5 Lessons Learned

POSITIVE

1. Successful weekly support groups.
2. Incentive= Zero cost to participants

NEGATIVE

1. Noncompliant to program
2. Personal commitment versus key provider referrals.

6 Challenges

- Accessibility
- Low Cost, KY averages $5.45 per pack of cigarettes
- Behavioral changes
- Stigma of substance abuse
- NRT cost
- Insurance plans forcing people to participate
- Rural Community/ Tobacco Crops

Georgia Bowling, Carrollton, Kentucky

"I think the class was great. I don't think I could have become a non-smoker without the support of the Cooper Clayton Class. I am so proud of my accomplishment.

Wilma & Steve Taylor Carrollton, Kentucky

"With your help and support we quit smoking. We feel better and can breathe now. You taught us how to get through stressful times without cigarettes. We are so proud of ourselves".

Conclusions

Areas to Focus:

- ❖ Expanding advocacy for participants
- ❖ Sustaining class attendance
- ❖ Continue engaging key providers
- ❖ Breaking barriers with substance abuse counselors/criminal justice system

Acknowledgements & Resources

The AWL – August 28, 2015

www.americashealthranking.org

Pfizer Pharmaceuticals & Smoking Cessation Leadership Center

CVS

Enhancing eReferral Capacity: From "pilots" to "institutionalized practices"

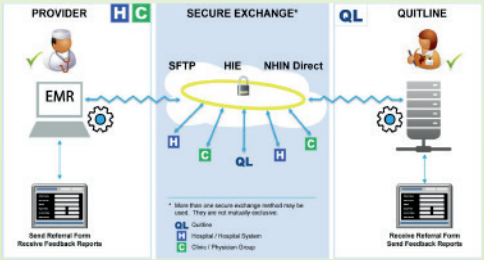
North American Quitline Consortium, Phoenix, Arizona

PROJECT OVERVIEW

EHRs represent an important new way for tobacco cessation quitlines to receive referrals electronically from the healthcare sector. Electronic referral or e-Referral provides the opportunity for quitlines to deliver effective cessation services to more smokers, especially those in priority populations. Through a collaboration with the Smoking Cessation Leadership Center and with funding from Pfizer, North American Quitline Consortium (NAQC) launched a project to establish national capacity to implement eReferral systems between state quitlines and healthcare organizations. The project aims to go beyond educating health professionals to address the system changes needed within healthcare organizations to identify smokers and refer them electronically to quitlines, as well as the system changes needed within quitlines to receive an eReferral and provide an electronic feedback report. This project extends work on eReferral to an additional four service providers in the United States that currently do not have capacity. Success, challenges and lessons learned will be documented and resources developed to inform future efforts.

BACKGROUND

Since 2012, a NAQC workgroup comprised of quitline service providers, state managers and health care institutions has been engaged in developing eReferral capacity from health care institutions to quitlines through the health care institution's electronic health records (EHRs). To date, of the 11 service providers that operate the 53 state quitlines, only five have the capacity to conduct eReferrals. This project engages four quitline service providers that do not have the capacity for eReferral in an 18-month project to develop capacity. Four state state teams from Arizona, Illinois, Mississippi and South Dakota comprised of a quitline service provider, the state quitline funder and a healthcare organization that serves priority populations were formed to participate in this project.



GOAL

The overall goal of the project is to establish national capacity among state quitlines for engaging in eReferral with healthcare organizations. This capacity will greatly increase the quit attempts and cessation success, especially among tobacco users from priority populations; strengthen partnerships and collaborative endeavors between quitlines and the healthcare sector on cessation treatment; and advance system changes in the healthcare sector and quitlines.

METHODS

PHASE 1 (months 1-3):
Foundation and assessment activities

PHASE 2 (months 4-12):
Building eReferral capacity

PHASE 3 (months 13-18):
Demonstration period

PHASE 4 (months 17-18):
Dissemination and evaluation

RESULTS | LESSONS LEARNED

The four state teams are in Phase 3 of the project. Some of the initial outcomes include:

- ✧ Strengthened communication and partnerships between healthcare organizations and quitlines.
- ✧ Established prior experience on both the provider and quitline platform developer side with HL7 and CCDA exchange of patient information.
- ✧ Improved access to care for physicians making the process of Quitline referral quicker and easier.
- ✧ Large volume of new data offers an opportunity to improve data integrity and internal operations.
- ✧ Increased awareness of and interest in healthcare organizations partnering with state quitlines for tobacco cessation services.

DISCUSSION

States that have successfully achieved eReferral with one health care organization are now looking to embark on the next step…scaling up capacity. Scaling up presents a new set of opportunities and challenges, the magnitude of which are just beginning to become unveiled. One key topic that has surfaced with regards to scaling up is the issue of cost. As quitlines seek to enhance capacity and engage additional healthcare organizations, they are confronted with a new set of costs that are sometimes greater than those initially invested to establish eReferral capacity. Quitlines at this juncture are seeking guidance on costs in particular, the costs involved with maintenance, additional development to add a healthcare organization as well as the magnitude and categories of cost, who pays for which costs and in what way. The NAQC eReferral Workgroup is beginning to investigate the elements and dynamics involved with the cost of scaling up to better understand what it entails in hopes of developing best practices, resources and guidance on the topic.

ACKNOWLEDGEMENTS

The North American Quitline Consortium gratefully acknowledges the contributions provided by the eReferral Workgroup and the following technical consultants: Evan Frankel, *Frankel Healthcare Consultants* and Robin Daigh.

CONTACT INFO:

Tasha B. Moses, MPA
Program Manager, eReferral
tmoses@naquitline.org

Opt-to-Quit: Linking low SES and racial/ethnic minority populations to evidence-based cessation treatment through health system changes

Hannah Wilson[1], Christina Kyriakos George MPH[1], Deepa Prasad MPH[1], Michael Schuman[2], Donna Shelley MD MPH[1]

[1]New York University School of Medicine, [2]New York City Department of Health and Mental Hygiene

For more information, contact: deepa.prasad@nyumc.org

Background

Telephone Quitlines are an evidence-based tobacco cessation intervention. With adoption of electronic health records, the New York State Smokers' Quitline developed a new referral system to replace the paper-based Fax-to-Quit program. Opt-to-Quit (OTQ) is a policy-driven solution that facilitates referrals through electronic data exchange between a referring health care organization and the Quitline. To date, few health care organizations in New York City have adopted OTQ due to a number of system and organizational challenges.

Goals

1. Implement Opt-to-Quit (OTQ) in two Federally Qualified Health Centers (FQHCs) in New York City.
2. Evaluate the process of implementing OTQ.
3. Develop and disseminate an easily adoptable step-by-step protocol for implementing OTQ.

What is Opt-to-Quit™ (OTQ)?

Clinical Workflow

ID tobacco user → Refer patient to OTQ unless he/she opts out → Document in EHR → Generate registry and transfer data to Quitline → Quitline calls patient within 72 hours to offer services

Where is OTQ being implemented?

2 FQHCs in New York City: Betances Health Center and Upper Room AIDS Ministry-Harlem United

- Populations are: racial/ethnic minorities (>90%) with low SES status (>90% at or below 200% of Poverty line and >60% Medicaid or uninsured) and with disproportionately high smoking rates.
- Both sites have been using the paper-based Fax-to-Quit program and use eClinicalWorks (eCW) as their electronic health record (EHR).

Process | Lessons Learned

Create OTQ Quality Improvement Team
We formed teams at each FQHC consisting of a champion, medical director, IT staff, and clinical staff.

Modify Electronic Health Record (EHR)
We integrated OTQ referral fields into Social History (see screenshot below).
We automated the EHR to generate a registry of smokers and we set up a data exchange system between the EHR and NYS Smokers' Quitline.

Redesign Clinical Workflow
We, along with the OTQ QI team, decided who/how/when OTQ referral is offered to the patient and transmitted to the Quitline.

OTQ implementation varies depending on the EHR so we cannot use a one size fits all approach. However, there are necessary steps that will apply to all health systems and will form the basis for our blueprint/protocol for implementation.

Imminent Next Steps

1) Train providers to use OTQ
2) Launch OTQ by going live with EHR changes
3) Track referrals to Quitline and get feedback
4) Conduct interviews with OTQ teams and staff offering referrals to get feedback on their experience developing and using OTQ
5) Make changes to optimize OTQ program

Further Down the Line

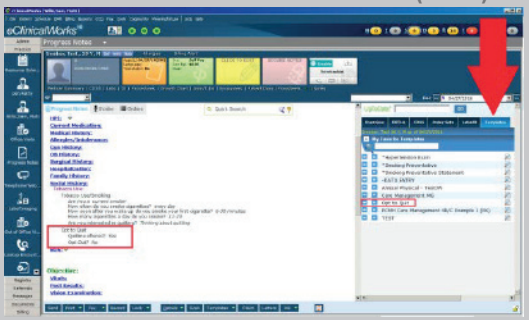
1) Create highly replicable, step-by-step protocol for implementing OTQ to disseminate to other FQHCs
2) Use Regional Health Information Organization (a type of health information exchange) to close the data exchange loop between the Quitline and health care org to allow bidirectional data exchange

Scalability of OTQ

The implementation and evaluation of this project have been designed to create a scalable and sustainable model for setting up an electronic referral system to the Quitline.

- The **RE-AIM model** by Glasgow et al. (1999) has been used as an intervention design and evaluation framework to ensure that OTQ will reach the intended population, is effective in FQHCs, and is easily adopted, implemented, and maintained over time.
- Roger's **Diffusion of Innovations theory** (2003) has been used to emphasize OTQ's relative advantage, adaptability, compatibility, and complexity, which are essential to the diffusion and scalability of OTQ.
- The culminating **step-by-step protocol** will facilitate widespread implementation in the real world by providing clear definitions of staff and resource needs to implement OTQ; estimated costs and budget impact; templates for adaptations required in the EHR and other data systems to facilitate data exchange between the FQHC and the Quitline; and a clear clinical pathway that defines roles and responsibilities related to the new system.

Screenshot of eClinicalWorks (eCW)



Barriers

- eCW is not easily amenable to OTQ integration because smoking status is documented in a form that is too costly to edit.
- Our temporary solution is a workaround that requires navigation to a different EHR section and add-on software to generate a smoker registry.
- Currently, OTQ is a one way communication platform. The QL cannot transmit data directly back to the sites to provide feedback on the patient encounter.
- Competing priorities and lack of time made it difficult to set up meetings/calls with OTQ teams.
- FQHCs are highly sought to engage in Quality Improvement (QI) projects, which has led to "QI fatigue", making engagement more difficult.

Improving Tobacco Cessation among Smokers with Mental Health Conditions Using a State Quitline

Arizona Smokers' Helpline (ASHLine)

Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, AZ

THE UNIVERSITY OF ARIZONA

ASHLINE
an affiliate of the University of Arizona

Mel and Enid Zuckerman College of Public Health
Canyon Ranch Center for Prevention & Health Promotion

Project Overview

- Smoking continues to be the leading preventable cause of death and disease globally
- Smokers with mental health conditions have disproportionately high smoking rates
- Clients with mental health conditions experience increased barriers to quitting
- Quitlines are efficient, cost-effective strategies to provide services to hard-to-reach populations
- Cessation services (quitline coaching) may need to be tailored to specifically serve this high-risk population
- In 2014, through the Pfizer IGLC grant funds, the Arizona Smokers' Helpline (ASHLine) developed tailored materials for clients with mental health conditions who utilized our quitline services

Methods

- Survey of mental health clients enrolling into ASHLine (N=277) was conducted between April- August, 2014 showed:
  - Only 11.3% reported using the ASHLine website
  - 68% reported using NRT; greater uptake may benefit tobacco behavior change
  - 73% indicated quit coach and NRT services were helpful
- ASHLine developed tailored client educational materials based on:
  - Survey findings
  - Collaborations with faculty at University of Arizona's College of Public Health and College of Pharmacy
  - Feedback from coaches who work specifically with smokers with mental health conditions
- Client educational videos and handouts were developed by the University of Arizona's Dept of Biomedical Communications

Additional content provided by The University of Arizona College of Pharmacy; Materials produced by AHSC Bio Communications
This project was supported by Pfizer Independent Grants for Learning & Change in collaboration with the Smoking Cessation Leadership Center.

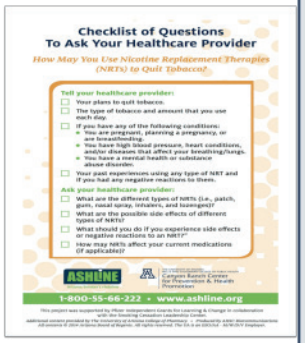
Outputs

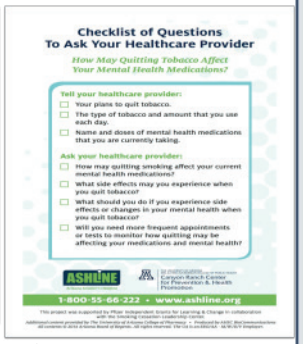
A comprehensive list of audio-visual and educational materials:

- 3 animated video-clips (each 1.5 minutes) on ASHLine's website
- Flyers (4) and checklists (2) for clients to take to appointments with health care providers
- Tailored coaching protocols for clients reporting mental health condition

Coaching Protocols For Clients with Mental Health Conditions

- Use of the 5Rs (Relevance, Risks, Rewards, Roadblocks, Repetition), an evidence-based technique when working with mental health clients
- Clients are encouraged to talk to their providers about quitting tobacco, using pharmacotherapy
- Assessments of current level of functioning are introduced during sessions: "How often are you in touch with your health care provider?' or, "Since working with ASHLine do you notice changes in mental health symptoms?"
- Evaluation of past experiences with quit attempts in relation to changes in mental health symptoms
- Use of directed questions rather than using open-ended questions
- Increased messaging around quitting smoking during every call
- Discussion of common reasons for non-adherence (e.g., increased side-effects of medications, attitudes about quitting)
- Directing clients to their mental health care providers for additional support, medication dosage, and side-effects monitoring





NOTE: All handouts and videos can be found at www.ashline.org

Next Steps

- Partnerships between ASHLine and regional behavioral health service providers to refer clients to ASHLine services using "AAR" brief interventions have been ongoing
- Targeted educational efforts that are tailored for mental health providers treating clients with tobacco addiction are needed
- Multi-level strategies (clinic-level interventions + tailored counseling protocols) that influence quitline service utilization, readiness to quit, quit outcomes, and relapse prevention will be developed

Arizona Smokers' Helpline • 1-800-55-66-222 • ashline.org

Asking the Right Questions: Clinicians and Tobacco Cessation in the Clinical Encounter

Janet Brishke, MPH[1], Karen Wilson, MD, MPH, FAAP[2], Kiran Patel, MPH[1], Julie A. Gorzkowski, MSW[1], Regina M. Whitmore, MPH[1], Jonathan D. Klein, MD, MPH, FAAP[1]

[1]American Academy of Pediatrics, Elk Grove Village, IL; [2] Children's Hospital Colorado, Aurora, CO

American Academy of Pediatrics Julius B. Richmond Center of Excellence

BACKGROUND

The Julius B. Richmond Center of Excellence is the home for tobacco control initiatives at the American Academy of Pediatrics (AAP). The mission of the Richmond Center is to improve pediatric health by eliminating children's exposure to tobacco and secondhand smoke (SHS). The Richmond Center aims to ensure that all pediatric clinicians are aware of the consequences of tobacco and SHS exposure, and have the skills and tools needed to protect children and families.

In 2014, the Richmond Center hosted two clinical practice trainings, entitled *"Asking the Right Questions: Clinicians and Tobacco Cessation in the Clinical Encounter."* The trainings were designed to help child healthcare clinicians implement clinical practice change to incorporate effective tobacco screening and counseling protocols into their day-to-day work.

Participants, recruited through the AAP, were encouraged to attend the training in pairs: each pair consisted of a pediatrician and another member of the practice clinical staff (eg, nurses, medical assistants). After the training, the pair was tasked with championing tobacco control practice change efforts in their office.

WHY PEDIATRICIANS?

Tobacco use and exposure is a pediatric disease. The majority of smokers smoke their first cigarette before age 18, and 2012 data from the Centers for Disease Control and Prevention indicate that 40% of young children are regularly exposed to SHS. Tobacco use and exposure have serious health effects for children and families.

Although tobacco use is a critical child health priority, many pediatric clinicians do not screen consistently or effectively for tobacco in practice. This creates missed opportunities to intervene with smokers to aid cessation and protect families from SHS exposure. In order to accurately address tobacco, clinicians should use consistent, comprehensive screening protocols and evidence-based interventions in practice.

Pediatricians are well-poised to address tobacco use in practice. Pediatricians see a majority of the US child population for clinical visits, and parents of young children often see their child's pediatrician more frequently than they see their own doctor. As such, the pediatric visit is an important opportunity to address tobacco use and SHS exposure with both youth and parents.

TRAINING CONTENT

Training content included a mix of keynote lectures, presentations of lessons from the field and small breakout sessions. In order to support sustained change after the trainings, **participants were asked to complete an online quality improvement (QI) module to guide implementation of practice change after the training.** The QI module reinforced information discussed during the in-person training, and allowed clinicians to track their success in making clinical practice changes around tobacco control.

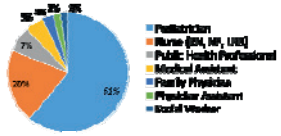
Training topics included:

- Screening and counseling patients about tobacco use and SHS exposure
- Screening and counseling parents about tobacco use and SHS exposure
- Strategies to address electronic cigarettes and vaping devices in practice
- Prescribing nicotine replacement therapy (NRT) to help parents quit smoking
- Revising electronic health record (EHR) systems to capture information about tobacco use and SHS exposure in each patient's chart
- Billing and coding for time spent addressing tobacco in practice
- Measuring quality of care and QI in pediatric practice
- Identifying opportunities for clinicians to advocate for tobacco change at the community, local, or state level

CLINICAL TRAININGS OVERVIEW

In total, 59 participants from 22 states participated in the trainings:

Participants came from a variety of clinical backgrounds:



Over the course of the two-day training, participants heard lectures from expert faculty about incorporating tobacco screening and counseling into clinical practice and learned strategies for implementing practice change successfully. They worked with their peers to identify opportunities for improving delivery of tobacco screening and intervention in practice and ways to advocate for tobacco control initiatives in their local community or state. Finally, colleague pairs from each practice worked closely together to form concrete plans for incorporating tobacco screening and counseling systems into their practice.

Lectures from Tobacco Control Champions

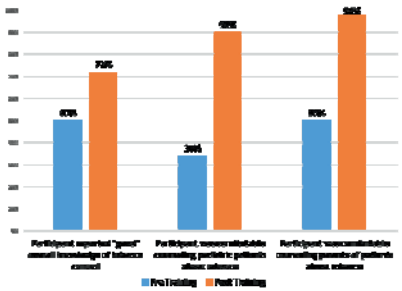
Discussions and Workshops with Peers

Planning for Practice-Change at Home

PARTICIPANT RESPONSES

Participant feedback, along with surveys administered pre- and post-training, revealed both satisfaction with the training content and an increase in overall tobacco knowledge, along with an increase in comfort with counseling both patients and parents about tobacco cessation.

Participant-Reported Knowledge and Comfort with Addressing Tobacco:



Participant Feedback:

"My third patient of the morning had a mom who smoked. I led the smoking cessation discussion very skillfully and confidently and she accepted NRT, so I gave her two prescriptions! Thanks to the wonderful faculty and the training. I learned a lot and I will be putting my skills to use."

"I am happy to report that I enrolled my 14th parent this week in Michigan's quit line, enrolled them in the "I-QUIT" text program, helped them set quit dates, and gave them NRT. Thank you for including me in this training program. I feel it is going to greatly benefit my community."

"I actually got another family (a grandparent) agree to try to quit just yesterday. One person at a time quits and many will benefit from a smoke free environment. I have seen too many die from lung cancer. I plan on doing my part."

SUSTAINABILITY

Follow up surveys at 6 weeks and 6 months post-training showed continued tobacco control efforts in participants' practices and communities, including:

Clinical Practice Changes

- Practice-wide screening for tobacco use and SHS exposure
- Changes to EHR system to better incorporate tobacco and SHS data
- Development of system to refer patients to hospital tobacco-cessation group
- Creation of comic-strip-themed resource to train colleagues in screening and referral procedures
- Changes to medical student/resident training within their health system

Advocacy and Dissemination Efforts

- Op-Ed encouraging raising legal purchase age for tobacco products
- Submission of testimony to state legislature about raising legal purchase age for tobacco products
- Presentation of results from practice-change efforts at 2015 AAP National Conference and Exhibition

Reach of Trainings

At 6-month follow-up, participants completed chart reviews to track their tobacco control performance since the training. These reviews revealed that they had screened over 60,000 patients and families for tobacco use/exposure and provided 321 families with NRT prescription and/or referral to quit resources.

LESSONS LEARNED

Participant satisfaction and sustained efforts: Training participants reported high satisfaction with the clinical trainings and sustained tobacco control efforts in their institutions and communities. Through these efforts, tobacco control protocols have been permanently integrated into existing systems and clinical processes, allowing practices to intervene consistently and appropriately with patients and families.

Success of the "pair" approach: Encouraging participants to attend the trainings in pairs, with both a pediatrician and another clinician from the same practice, was well-received by attendees. The approach ensured that there were multiple champions for tobacco control efforts at different levels of the organizational structure, which helped those champions secure buy-in from their colleagues and successfully implement practice change.

Content evolution: The educational content of each training was systematically evaluated by participants, allowing staff and faculty to improve upon the program. Participant suggestions that have been incorporated into the program include adding more content on electronic cigarettes and other alternative tobacco products, increasing the amount of time for group discussion workshops, and adding details about how to appropriately bill for time spent on tobacco control efforts during clinical visits.

Future trainings: Two additional trainings are planned for August and September of 2016. Trainings will be held in North Carolina and Georgia, and will draw many participants from states where the tobacco use rate is higher than the national average.

ACKNOWLEDGEMENT

These clinical trainings were supported by a Pfizer Medical Education grant. In addition, the American Academy of Pediatrics Julius B Richmond Center of Excellence receives core support from the Flight Attendant Medical Research Institute.

SMOKING CESSATION LEADERSHIP CENTER

Integrating Tobacco Use and Dependence Treatment into Perinatal Substance Abuse Services

Janis Dauer, MS, CSAC and Sandy Kanehl, MEd, CSAC
Alliance for the Prevention and Treatment of Nicotine Addiction, Norfolk, VA

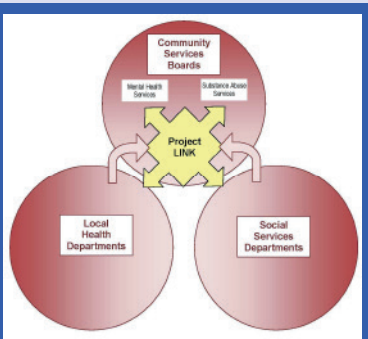
Challenge and Project Overview

Main goal: facilitate integration of Screening, Brief Intervention and Referral to the state quitline for tobacco Treatment (SBIRT) into the standard, routine case management practices of eight regional substance abuse prevention programs serving pregnant women in Virginia. Secondary goal: assist those programs in advocating for tobacco SBIRT integration within other programs at their agencies as well as among local health districts and social services agencies in their operating networks, with a focus on perinatal women.

Who

We partnered with the state department of behavioral health (DBHDS) to recruit the Coordinators of the eight Regional Project LINK (PL) programs in Virginia. PLs are funded by DBHDS and managed by Prevention Services staff at local Community Services Boards (CSBs).

PLs provide intensive case management services to women and children affected by substance abuse. They serve residents of 38 counties, assessing needs and referring for services within their own CSBs and among a network of local community resources, health departments and social services in particular.



Where and When

Between December 2012-August 2014, we conducted onsite consultations with each PL Coordinator (see yellow regions on map) in order to assess needs and provide resources and technical assistance to assist them in achieving these objectives: develop an action plan tailored to their region; provide a training event for members of their referral networks; implement an SBIRT protocol for tobacco within their programs and advocate for expansion to other CSB programs, especially those serving perinatal women; increase referrals to and utilization of the free state quitline by pregnant tobacco users in their communities; and, collect data related to PL client tobacco use, including quitline fax referrals.

Lessons Learned

A sample SBIRT plan was preferred by the PL Coordinators over customizing a plan, staff motivation varied and admin support for their efforts was lacking, connections to key community agencies were not well-established, and more skill in the using Motivational Intervention techniques were needed to maximize effective fax referral to the state quitline.

Lesson 1: Site Champions are Key

Implementation of tobacco SBIRT within the Project LINK program relied mostly on having a sample plan and on the personal motivation of the Coordinator

Lesson 2: Admin Support is Key

Lack of upper administrative support was a barrier to systems change, expansion to other programs within the CSBs, and sustainability after staff turnover.

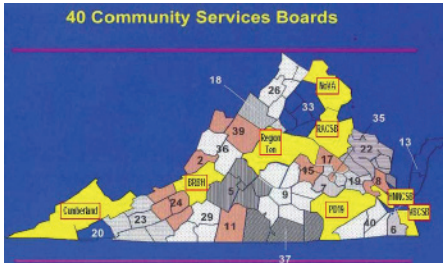
Lesson 3: Effective MI Skills are Key

Low rates of quitline fax referral usually reflected an inability to move perinatal clients from a stage of "no interest" in quitting to a willingness to speak with a Quit Coach.

Next Steps

With major changes taking place now in the behavioral health field, from billing & reimbursement to the use of Peer Coaches, along with growth in cessation resources tailored to their clients, we feel the next step in Virginia will be to create peer-based services that can be offered to CSBs as in-house resources.

These may be single-purpose or comprehensive programs that fully integrate tobacco recovery and are delivered in a manner that will enable the CSBs to meet mandates such as those set out by the ACA, Joint Commission and CMS.



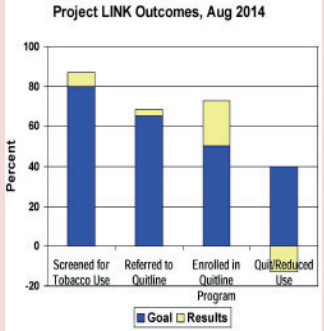
Methods

Onsite assessments were conducted with PL Coordinators, TA and resources were provided (including a supply of baby items and a cash stipend), along with encouragement to develop their own plan so it matched the community's needs and the program's capacity for: tobacco SBIRT by PL staff; educating/training other CSB programs and community organizations and advocating for tobacco SBIRT; and, increasing access to the state quitline by clients.

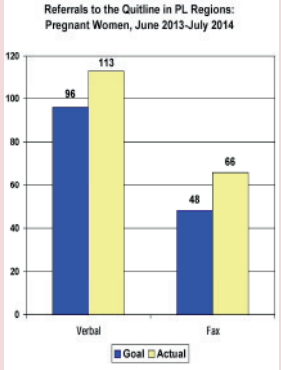
Emphasis was placed on *fax referring* perinatal women to the quitline as a key service available at no cost was a 10-session program of proactive phone counseling, plus print materials, designed especially to assist both pregnant and post-partum tobacco users.

Phone, e-mail, online Google Group access, and participation at DBHDS' quarterly PL meetings were all used to facilitate resource distribution, progress updates and sharing among the Coordinators. Each PL hosted a regional training on tobacco SBIRT and recruited attendees from community organizations.

Data



Percent of PL clients who quit/reduced use may be higher as two Coordinators did not report that data



Methods

DBHDS revised the PL service delivery data collection tool to add two questions about client tobacco use and attempts to quit. Each PL registered their program to fax refer clients as part of their SBIRT plan, promoted fax referral with other CSB programs and community organizations, and distributed quitline materials.

All staff involved in PL (27) and staff from 14 organizations in the community (179) received training on doing tobacco SBIRT with perinatal tobacco users. In addition to the eight in-person regional training events, two webinars were conducted, one on tobacco SBIRT and one on MI-based tips for intervening with pregnant women. Lastly, a database of resources tailored to addressing tobacco use among perinatal women with substance use disorders was created. The focus was on sources of free or low cost materials and additional education/training.

SMOKING CESSATION LEADERSHIP CENTER

Integrating tobacco cessation interventions in the routine of care in a rehabilitation hospital serving rural patients in WA State, USA.

UNIVERSITY of WASHINGTON
ADAI | ALCOHOL & DRUG ABUSE INSTITUTE

St. Luke's Rehabilitation Institute

Challenge And Project Overview

The primary goal of this project is to implement a tobacco cessation program to ensure that smokers admitted to St. Luke's Rehabilitation Institute (SLRI) receive evidence-based tobacco cessation interventions during their hospitalization and after discharge.

When this project started (May 2015):

- Tobacco use status was asked during admission but no clear protocol or policies existed to address tobacco cessation.
- The hospital had a smoking area for patients and staff.
- No staff were trained or assigned to address tobacco use among patients.
- There were no protocols in place to assure tobacco users had access to continued cessation support after discharge.

The key objectives of the project are to:

- Educate clinical staff on evidence-based tobacco dependence screening, advice and assessment, and cessation support for hospitalized patients.
- Modify inpatient medical record systems to prompt and document tobacco cessation interventions during and after hospitalization.
- Implement an evidence-based, pharmacist-assisted inpatient tobacco use treatment program.
- Implement a discharge protocol that includes the provision of prescriptions for medication and a referral for continued cessation support after hospital discharge

Where and When

St. Luke's Rehabilitation Institute (SLRI) is the largest free-standing physical rehabilitation hospital and the only level 1 trauma rehabilitation hospital in the Inland Northwest (Spokane, WA).

- 102 beds and had over 1500 inpatient admissions in 2015
- Stroke, brain injury, spinal cord injury, neurological, cardiac, pulmonary, and orthopedic conditions are the most common inpatient diagnoses.

Project duration: May 2015 to October 2016

Who

Beatriz Carlini, University of Washington **(bia@uw.edu)**
SLRI Team: Gregory Carter, Medical Director, **Chris Greer,** Manager, Pharmacy and Inpatient Respiratory Therapy departments and **Douglas Weeks,** Research Director

Results

- A clinical system to address tobacco use was developed and implemented (Figure 1)
- Pharmacists (and pharmacy students) have been trained as tobacco cessation specialists and are responsible for counseling, medication management and referrals after discharge
- Clinical protocol (medication dosing, bedside counseling) was developed and approved by the hospital
- In January 1st, 2016 SLRI implemented a tobacco-free campus, closing down their smoking area

Next Steps

Ongoing QA and improvement:

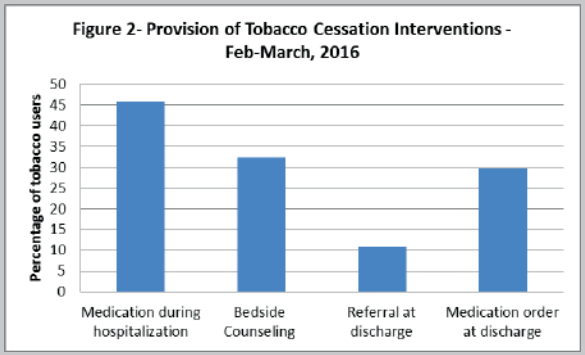
- Improve reporting capability of EHR system ;
- Increase rates of tobacco cessation interventions through booster trainings and re-organization of roles (inclusion of pharmacy students)

Evaluation: Employ an Interrupted time-series design to analyze the impact of clinical and systems change on hospitalized tobacco users' care

Sustainability: Work toward full implementation of Joint Commission Tobacco Measures

Lesson Learned:
Improvement is a constant process.

Figure 1: System implemented to address tobacco use among SLRI's patients



Methods

Team approach: Site team has been highly involved in decision making and problem solving through weekly meetings and regular site visits.

Flexible capacity building strategy: Training content was defined as challenges were identified. Training delivery methods varied from face-to-face to webinar and online tutorials.

Iterative Electronic Health Records modification: The patient documentation system utilized by SLRI allowed a multiple-step process on deciding best ways to collect and document tobacco use and cessation variables.

PROACTIVE POPULATION HEALTH STRATEGY TO OFFER TOBACCO DEPENDENCE TREATMENT TO SMOKERS IN A PRIMARY CARE PRACTICE NETWORK

Nancy A. Rigotti, MD, Jennifer Kulesa Kelley, RN, MA, Sara Kalkhoran, MD, Elizabeth Inman, BA

Tobacco Research and Treatment Center, Massachusetts General Hospital and Harvard Medical School, Boston, MA

BACKGROUND

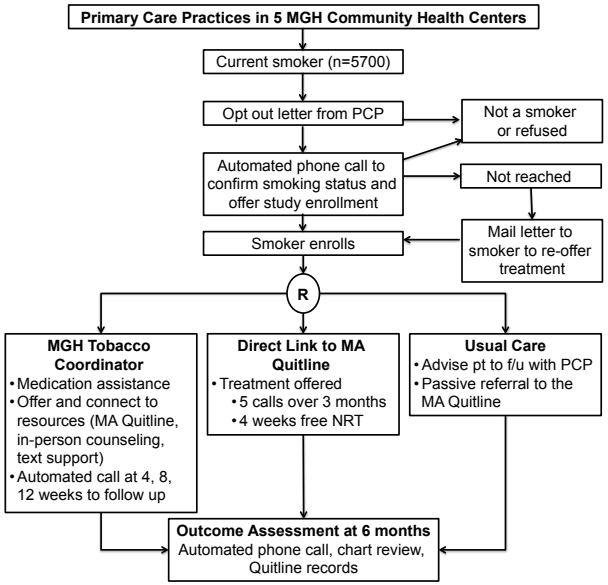
- Health care systems currently use reactive strategies which require busy clinicians to initiate treatment during a clinical encounter
- Success rate is greater when patients are proactively offered several interconnected smoking cessation resources
- Healthcare systems have a strong financial incentive to manage tobacco smoking as a chronic disease; however, the optimal way to implement a proactive population health strategy for tobacco users is unclear

RESEARCH OBJECTIVE

- Test a novel population health strategy to increase the delivery of tobacco dependence treatment to smokers in a primary care practice network
  - **Aim 1**: Determine the feasibility of a proactive outreach program that engages smokers independent of healthcare visits
  - **Aim 2**: Determine if the program increases the proportion of smokers who use tobacco cessation treatment, compared to usual care

be tobacco free

STUDY DESIGN



METHODS

- **Setting**: Five community-based primary care practices in the Boston area that are affiliated with Massachusetts General Hospital (MGH)
- **Study Design**: A pragmatic RCT of 2 smoking cessation interventions vs. usual care for documented smokers within a large health care system
- **Subjects**: Adults (≥18 years old) enrolled in primary care at 5 MGH community-based primary care practices
  - **Inclusion criteria**:
    - Smokers seen at participating MGH Primary Care practice in the past year, identified as a current smoker, and have a listed telephone number
  - **Exclusion criteria**:
    - Patients excluded by their primary care physicians (PCPs), non-English speaking, or who do not have a listed telephone number in the electronic health record (EHR)
    - Problem list has a diagnosis of severe cognitive or emotional disorder
- **Recruitment:** Smokers receive an automated call using interactive voice response (IVR) technology, which offers tobacco cessation assistance and participation in a research study and requests verbal informed consent
- **Randomization:** Consenting patients are randomized (1:1:1) to 3 study arms
  - Intervention 1: MGH Tobacco Coordinator calls smoker to explain treatment options, offer help to access counseling and medications
  - Intervention 2: Patient completes IVR call, then remains on the phone while the IVR service transfers them to the Quitline
  - Usual care control: Patient is encouraged to make PCP appointment and given telephone number for MA Quitline
- **Outcome Assessment**: 6 month survey by automated call, MA Quitline records, medications in EHR
  - **Primary Outcome Measure**: Proportion of smokers with any documented use of evidence-based tobacco cessation treatment
  - **Secondary Outcome Measures**: Documented use of pharmacotherapy, cessation counseling; self-reported smoking status and quit attempt(s)

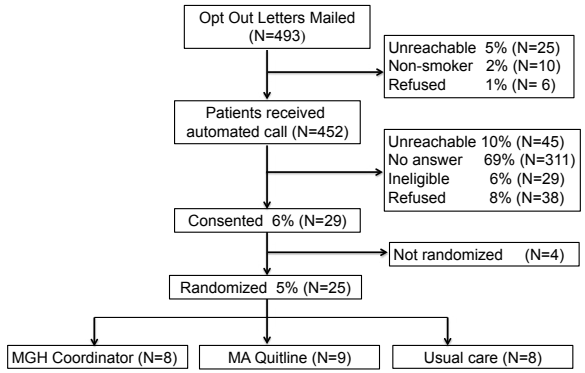
Funding: Pfizer Independent Grant for Learning and Change

CROSS-SECTOR COLLABORATION

- The health systems partnered with these groups:
  - **TelASK**: a health communications technology firm that specializes in automated calls using an interactive voice response (IVR) system
  - **Quitworks**: the MA Smoker's Quitline run by the MA Department of Public Health in association with National Jewish Health, offering free telephone-based smoking cessation counseling and free nicotine replacement samples

PRELIMINARY RESULTS

1st month of recruitment (March 2016)



LESSONS LEARNED

- Gaining PCP approval to contact patients directly as the IRB requires takes time
- Accuracy of EHR reporting patient address, phone number, and smoking status is imperfect and limits reach
- Patients screening calls limits uptake of IVR calls
- Building an automated system is labor-intensive but ultimately doable

INTERIM CONCLUSIONS

- The automated outreach system appears feasible: it recruited 5% of patients from the 1st monthly mailing
- All 5700 smokers identified by the EHR will be offered study participation over 10 months (through end of 2016)
- The extent to which the program engages smokers in tobacco cessation treatment is not yet known

A Tobacco Cessation Continuity-of-Care Model for the Reentry Population

Behavioral Health & Wellness Program, University of Colorado Anschutz Medical Campus

Chad D. Morris, PhD, Cindy W. Morris, PsyD, and Rebecca M. Richey, PsyD

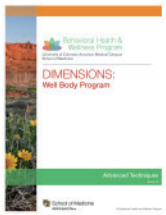
Chad D. Morris, PhD

Dr. Chad Morris is an Associate Professor at the University of Colorado Denver, Department of Psychiatry, and Director of the Behavioral Health & Wellness Program. Dr. Morris has led a number of initiatives to study and implement effective organizational, psychosocial, and pharm-acologic wellness strategies across the age range. He has provided clinical, public policy and program evaluation consultation across more than 30 states and internationally. His extensive expertise in the field of tobacco cessation for at-risk populations and tobacco-free policies for community health facilities led him to found the Behavioral Health & Wellness Program in 2006.

Contact Dr. Morris at Chad.Morris@UCDenver.edu

Resources

The DIMENSIONS: Tobacco Free and Well Body Advanced Techniques Programs instruct providers and peers on effective community education, providing tobacco cessation, nutrition and weight management services for individuals and groups, and ways to promote positive behavior change through motivational engagement and behavior change strategies.



Continuity of Care Model for Tobacco Cessation

Description of Problem

Smoking among justice involved individuals is a largely ignored public health epidemic resulting in smoking rates that are approximately **3 times higher** than the general population. Many of these individuals want to and can quit.

Project Description

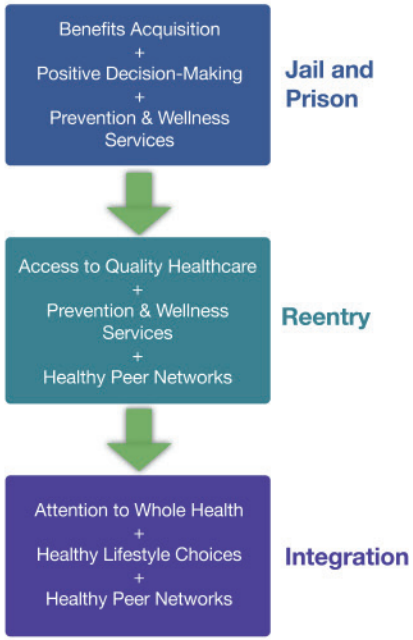
The Behavioral Health & Wellness Program along with the Colorado Governor's Office, Department of Corrections, and prison and jail reentry programs, and the Substance Abuse and Mental Health Services Administration (SAMHSA) created tobacco cessation programming for offenders re-entering the community. This programming included a "continuity-of-care" model that complimented existing services. The model piloted "in-reach" services designed so that parolees' tobacco cessation, healthcare, and housing needs were not lost in the gap between incarceration and community integration.

Continuity of Care Flow Chart

Tobacco Recovery and Healthy Decision-Making Training

Resources	Activities	Reach	Impact
Infrastructure • Fully staffed for start-up • Denver County Jail and reentry program access • Evidence-based provider and peer toolkits, treatment manuals, training modules, and system redesign resources • University & Community Reentry Program offices **Partners** • Colorado Governor's Office • Colorado Office of Community Corrections • Colorado Department of Corrections, Division of Adult Parole • The Gateway Program - Red Rocks Community College & Denver Criminal Justice Renetry Programs • SAMHSA Regional Office	**Train-the-Trainer Program** Gateway trainings → Over 60 peers trained Community Reentry Program → Over 20 peers and providers trained Metro Denver Homeless Initiative → 6 peers established at MDHI Youth offenders in Utah → 5 youth peer leaders; 50+ youth offender group members **Whole Health Approach to Inmate Care** • Tobacco recovery & healthy decision-making at pre-release reentry → 300+ inmates, students, & staff of the Gateway program, jail staff • Gateway program, jail, and reentry offsite/onsite technical assistance **Impact Evaluation** • Recommendations & future directions for partners and community organizations → Resources disseminated broadly across the above organizations, providers, & peers		• Standardized training evaluations • Utilization of evidenced-based strategies • Lay preliminary foundation for sustainable tobacco cessation & healthy decision-making programming for partner agencies • Increased use of peer-to-peer networks • Decreased number of youth offenders in Utah • Decreased tobacco use/ increased cessation among criminal justice population • Increased healthy decision-making skills leading to more successful community reintegration • Contribute to scarce literature base on tobacco cessation among criminal justice population • Qualitative case studies of community progress

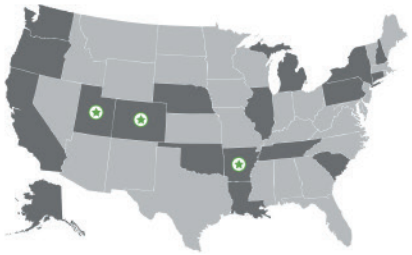
Continuity of Care Model



Available at www.bhwellness.org/fact-sheets-reports/Continuity-of-Care-Model-for-JI-Population.pdf

Sustainability

Based on the work in Colorado, several states are adopting and scaling up this model. In Utah, the DIMENSIONS Program is used for youth with tobacco-related misdemeanors. In Arkansas, the state made DIMENSIONS part of its mandatory programming throughout the community corrections system.



Tobacco Recovery and Wellness for the Behavioral Health Community

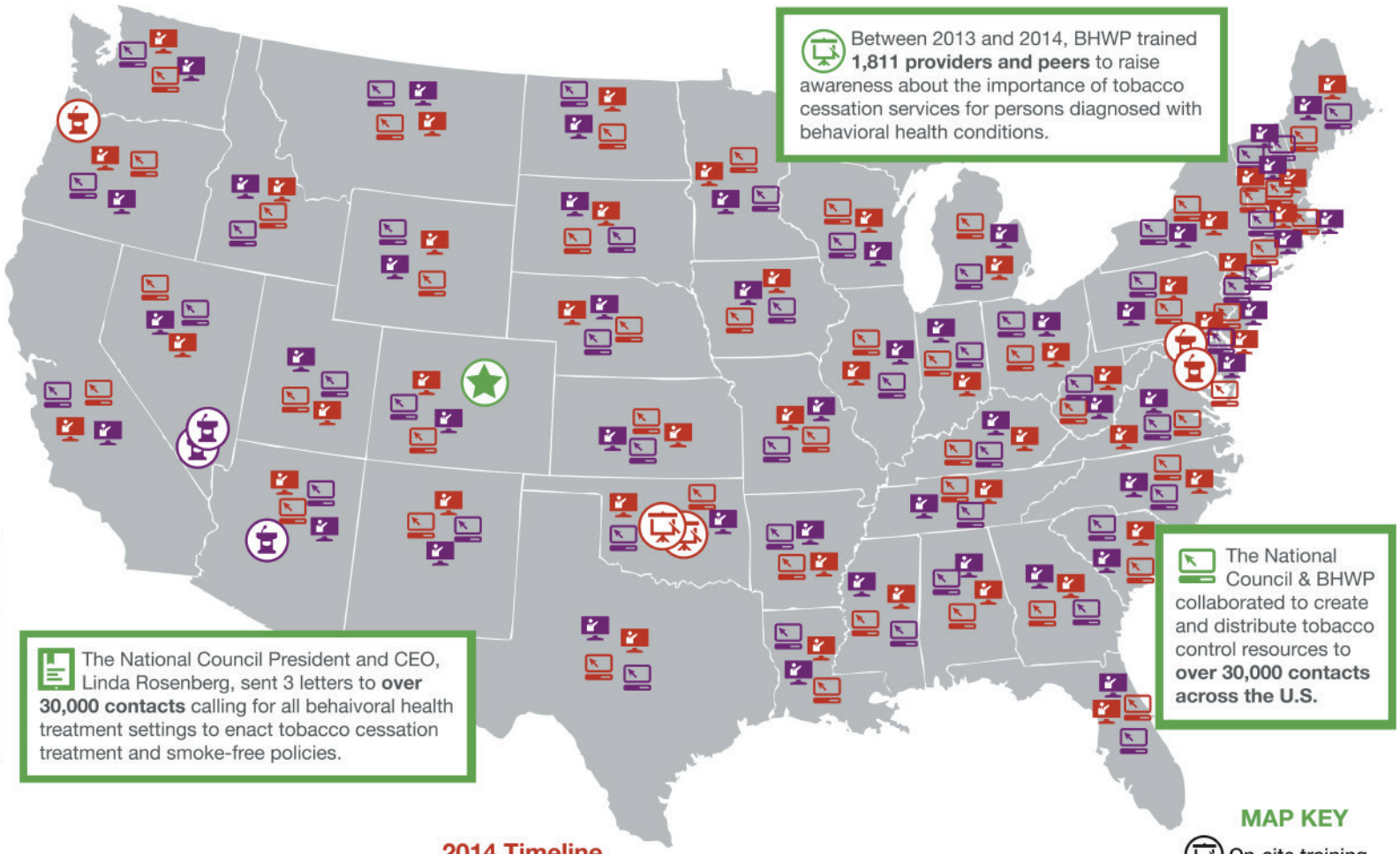
Behavioral Health & Wellness Program
University of Colorado Anschutz Medical Campus
Cindy W. Morris, PsyD & Chad D. Morris, PhD

The National Council for Behavioral Health
Shelina Foderingham, MPH, MSW
Margaret Jaco, MSSW

Cindy W. Morris, PsyD

Dr. Cindy Morris is a clinical psychologist and the Clinical Director for the Behavioral Health & Wellness Program as well as directs the Wellness Leadership Institute at the University of Colorado Anschutz Medical Campus, School of Medicine. She has developed many training programs and educational materials for administrators, healthcare providers, and peer specialists focused on health behavior change for whole health, work and well-being, tobacco cessation, and weight management. Dr. Morris also works with organizations to create systems that support the overall health of the organization, its employees, and the people they serve.

Contact Dr. Morris at Cindy.Morris@UCDenver.edu



Between 2013 and 2014, BHWP trained **1,811 providers and peers** to raise awareness about the importance of tobacco cessation services for persons diagnosed with behavioral health conditions.

The National Council & BHWP collaborated to create and distribute tobacco control resources to **over 30,000 contacts across the U.S.**

The National Council President and CEO, Linda Rosenberg, sent 3 letters to **over 30,000 contacts** calling for all behaivoral health treatment settings to enact tobacco cessation treatment and smoke-free policies.

MAP KEY

- On-site training
- Presentation
- National webinar
- National resources

2013 Timeline

April - National Council Conference Presentation - Las Vegas, NV - "Smoking Cessation Summit: Reducing Unnecessary Death and Disability" & "Workforce Wellness: Introduction to the Peer-to-Peer Tobacco Recovery Program," 46 attendees

May - Oklahoma Department of Mental Health and Substance Abuse Services Training - Three-day intensive course on tobacco cessation treatment for persons with behavioral health conditions, 54 attendees

June - National Webinar on "Building the Case to Support Tobacco Cessation," 234 attendees

July - Hawaii State Department of Health Training - one-day training titled "Tobacco Recovery Program: Practical Strategies for Providers and Peers," 52 attendees

October - National Webinar on "Treating Tobacco Dependence in Individuals with Substance Use Disorders," 287 attendees

November - Beyond the 5A's Conference - Phoenix, AZ - Presented to plenary panel of SCLC/Pfizer grantees

2014 Timeline

January - National Council Letters from CEO - "Tackling Tobacco Use in Substance Use Treatment Settings" & "Surgeon General's Report Points to Anti-Smoking Needs in Mental Health," sent to 30,000 contacts

April - National Webinar on "Ending Tobacco Use in Criminal Justice Settings," 300 attendees

May - National Council Conference Presentation - Washington, D.C. - "Peers and Tobacco Cessation: The Tool Up Your Sleeve" & "Tobacco in Integrated Health Settings," 123 attendees

November - National Webinar on "Reducing Tobacco Use in Young Adults," 630 attendees

November - Leadership Symposium Presentation - Portland, OR - Attended by CEOs and other senior leadership, presentation focused on strategies to increase organizational buy in for tobacco cessation treatment in behavioral health agencies, 35 attendees

December - National Council Letter from CEO - "E-Cigarettes: Harmful or Helpful?" sent to 30,000 contacts nationwide

Enhancing systems-level tobacco interventions in substance abuse treatment programs

Shadi Nahvi, MD, MS, Erica D'Aquila, MPH, Julia Arnsten, MD, MPH
Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, New York

Challenge And Project Overview

- Substance abuse treatment program (SATP) patients have high rates of tobacco use, and tobacco-related disease and mortality
- Low levels of tobacco cessation treatment in SATPs
- Limited staff capacity to address tobacco use is a major barrier
- Project builds capacity for multi-disciplinary tobacco cessation treatment at both provider- and system- levels
- Goals include: increase identification of tobacco use, provide evidence-based cessation treatment, and improve cessation rates

Who

Approximately 3,500 adults, 18 years or older, who present with substance use disorders to Division of Substance Abuse (DoSA) clinics in the Bronx, NY

- 83% report current tobacco use
- 70% report interest in quitting

Multidisciplinary treatment team:

- Substance abuse social workers, counselors, nurses, physician assistants, physicians

Where and When

Three DoSA clinics in the Bronx, NY offering co-located medical and addiction treatment services

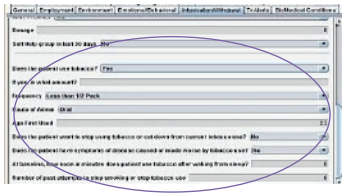
- Prompts in electronic medical record (Epic) 11/2015
- Prompts in counselor forms 12/2015
- Provider trainings 2/2016, 4/2016

Results

Participant characteristics

n=596	n, %
Male	383 (64.3)
Mean age, years (SD)	51.8 (10.3)
African American	110 (18.5)
Hispanic	419 (70.3)
White	67 (11.2)
Current tobacco use	491 (82.4)

Documentation of smoking status



Lessons Learned

Counselors significantly increased tobacco cessation counseling with forms that prompt tobacco use assessment

Medical provider tobacco cessation treatment was unchanged by transition to electronic health records

Next Steps

Continue smoking cessation trainings for all clinical staff

Develop DoSA-specific electronic health record (EHR) prompts that facilitate

- Referral to the NY State Smokers' Quitline
- Prescription of smoking cessation medication treatments

Methods

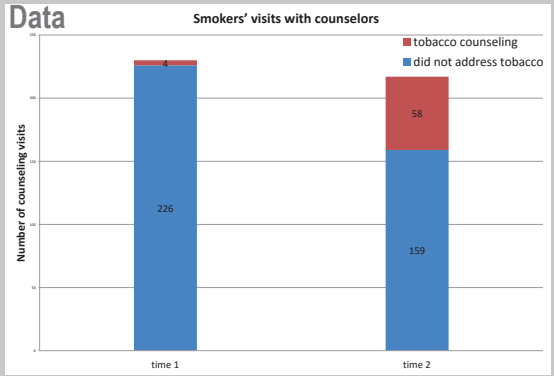
Charts of a random sample of 100 patients at each of the three DoSA clinics were reviewed by a trained research assistant

- Two time points: September/October 2015 and March/April 2016
- **Data collected:** demographic characteristics, smoking status, number of medical and counseling visits, provision of smoking cessation counseling, quitline referral or medications, tobacco cessation

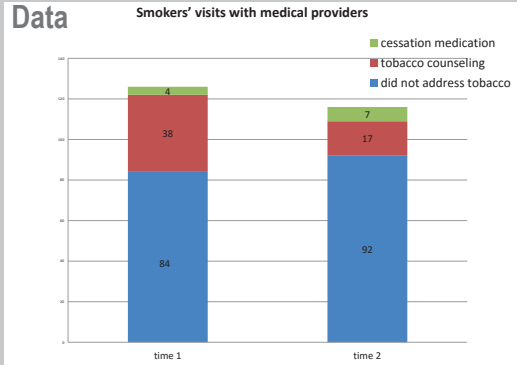
Smoking cessation trainings for counselors, clinical supervisors and medical providers on:

- Burden of tobacco use
- Tobacco use assessment
- Evidence-based smoking cessation treatments

Data



Data

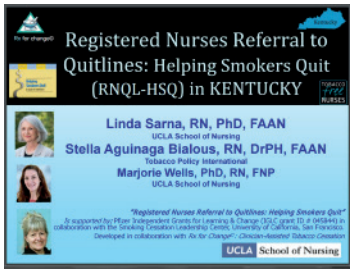


Impact of a webcast on nurses' delivery of tobacco dependence treatment

UCLA School of Nursing, Los Angeles, CA

SMOKING CESSATION LEADERSHIP CENTER

UCLA School of Nursing



Challenge And Project Overview

Background: Healthcare professional's knowledge about evidence-based tobacco dependence treatment using the **5As** framework (**A**sk about tobacco use, **A**dvise users to quit, **A**ssess willingness to quit, **A**ssist in making a quit plan, and **A**rrange for follow-up, including referral to a quitline) is essential in order to increase quit attempts and smoking cessation rates in the United States.

Aims and objectives: To evaluate an educational program about nurses' role in tobacco dependence treatment, and the value-added of its webcast component, on the frequency of nurses' self-reported delivery of smoking cessation interventions

Who:

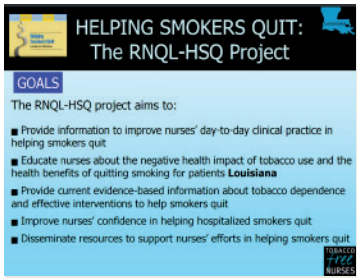
Investigators:

Linda Sarna, PhD, RN, FAAN, Interim Dean & Professor, UCLA School of Nursing

Stella Aguinaga Bialous, RN, MScN, DrPH, FAAN, Associate Professor in Residence, UCSF School of Nursing

Marjorie Wells, PhD, RN, Project Director, UCLA School of Nursing

Jenny Brook, MS, Statistician, David Geffin School of Medicine, UCLA



Where and When:

A pre-post, descriptive, correlational design with a cross-sectional sample of hospital-based Registered Nurses from two states with high smoking prevalence, Kentucky (25.6%) and Louisiana (22.1%), from December 2012 – December 2014.

Results/Lessons Learned

An online educational program plus printed toolkit about tobacco dependence treatment increased nurses' consistent delivery of smoking cessation interventions. Incorporating a webcast and web resources to the program significantly increased the proportion of nurses who provided evidence-based tobacco dependence treatment.

Results 1: At 3- & 6-months all nurses were significantly more likely to consistently (usually/always) provide smoking cessation interventions to patients who smoked

Results 2: Nurses who viewed the webcast were more likely to implement aspects of the 5As, including providing resources, reviewing barriers to quitting, and arranging for follow-up.

Results 3: If nurses viewed the webcast, they were more likely to refer smokers to the Quitline (3X at 3-months and 4X at 6-months).

Next Steps

This web-based program resulted in the increase of nurses' involvement in tobacco dependence treatment over six-months in 8 hospitals. Ongoing monitoring as well as system reinforcement of these interventions is needed for long-term sustainability.

Another strategy to change practices of nurses in these states would be to engage with State Nurses Associations (SNAs) for wider dissemination of the e-learning.

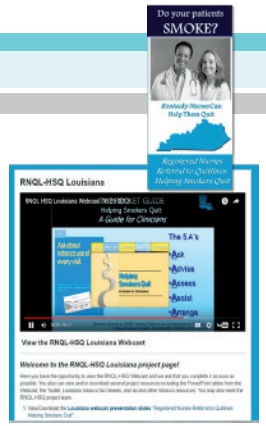
SNAs could be partners in disseminating an educational program that has demonstrated a positive impact in increasing nurses' smoking cessation interventions.

This would allow us to link the webcasts and resources on the Tobacco Free Nurses website (www.tobaccofreenurses.org) with the website of each association.

Methods:

Nurses from 8 hospitals (4/state) with ≥ 100 beds. CNOs used email, meetings, intranet, etc. to invite nurses to participate. Nurses accessed the project on the REDCap™ (Research Electronic Data Capture) survey website, completed informed consent and a 32-item, valid & reliable instrument assessing self-reported performance of tobacco dependence interventions. After the baseline survey nurses were provided access to the webcast and printed toolkit.

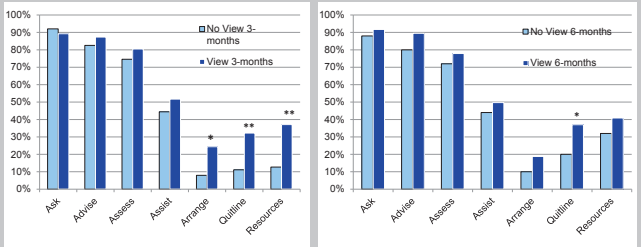
Toolkits included a printed tri-fold highlighting the positive impact nurses could have in addressing tobacco dependence, the author-developed pocket guide, '*Helping Smokers Quit: A Guide for Clinicians*', and their state's quitline card.



Funder: Smoking Cessation Leadership Center/Pfizer Independent Grants for Learning and Change (IGLC), Award #045844

Data

Impact of viewing a webcast on changes in consistently (usually/always) delivering tobacco cessation interventions at 3- & 6-months post-baseline



* $P \leq 0.05$, ** $P \leq 0.001$; **5 As: *Ask*** about tobacco use, ***Advise*** to quit, ***Assess*** willingness to quit, ***Assist*** with quit plan, ***Arrange*** follow-up, ***Quitline*** refer to quitline, ***Resources*** refer to quitting resources

Methods:

Webcast included state-specific data on tobacco prevalence, burden of tobacco use, behavioral and physiological aspects of nicotine addiction, FDA-approved medications, the quitline and the state's tobacco control program. The website also included other national and state-specific tobacco control resources. Web traffic was monitored during the study.

A convenience sample of nurses (*N* = 283) completed the baseline survey and had either 3- (n=269) or 6-month (n=231) data. The 3- or 6-months post educational program data on changes in frequency of delivery smoking cessation interventions were analyzed to determine the value-added benefit of a webcast to the printed materials and online resources.

SBIRT (Screening Brief Intervention Referral to Treatment) for Tobacco Cessation in Healthcare Settings: Targeted Multidisciplinary Training for Medicaid Providers

Krystle F. Nickles, M.P.P. [1], Carlo C. DiClemente, Ph.D. [1], Shayla T. Thrash, M.A.[1]

[1] MDQuit Resource Center, University of Maryland, Baltimore County

Challenge and Project Overview:

Medicaid (MA) enrollees are significantly more likely to use tobacco than the general population. In Maryland, 29.7% of MA enrollees are current smokers vs. 14.2% of the general population (2014 BRFSS). Individuals with lower incomes (34.7% earning less than $15,000) in Maryland reported current smoking (2013 BRFSS). Overall, smokers with low SES (typically characterized by low income and education attainment, lack of social supports, neighborhood disadvantages, negative affect/stress, and low self-efficacy) are less likely to quit smoking compared to those with higher SES, albeit they share a similar likelihood to try to quit. It is critical to engage MA providers to address tobacco cessation with their patients with Medicaid as the largest health insurance provider in the U.S. Engaging Managed Care Organizations (MCO), provider organizations/practices, and individual providers aims to enhance efforts to disseminate and sustain primary care interventions and enable the reach of tobacco control efforts to this neglected group of hard to reach smokers, especially those with mental health, substance abuse, or other serious somatic health problems. MCOs are uniquely positioned to reach their providers and to raise their awareness about the need to provide targeted cessation interventions to MA enrollees who use tobacco. Training for both clinicians and non-clinical staff regarding tobacco use and cessation challenges, efficacious interventions such as quitlines and brief interventions (e.g., 5 A's), guidance for smoking cessation medication assistance (e.g., NRT), and targeted communications from MCOs to provider networks serve as key mechanisms for enhancing healthcare providers' skills for reaching and intervening with the MA population.

Who

State Medicaid representatives and the MCO Board of Medical Directors were consulted regarding project aims and the need for addressing tobacco cessation efforts within the Medicaid (MA) population. Contacts were established at the organizational level of all (total 8) Maryland Managed Care Organizations (MCOs), including Human Resources, Provider Relations, communications, healthcare, and provider and consumer network representatives. Individual MA providers, non-clinical staff, and primary care practices who received training, and by extension their patients, were our target audience.

Where and When

In-person training for MCOs spanned from September 2013 to December 2014. Online trainings were launched in June 2015 and remain free and accessible. Seven (7) "Connect to Quit Corner" newsletter messages aimed at MA providers (provider newsletter) and three (3) aimed at MA enrollees (consumer newsletter) were distributed to each of the MCOs throughout the project period (shown in box above). Over the project period these messages reached a conservative estimate of 7,437 providers and over 72,000 consumers affiliated with one or more of the eight (8) MCOs.

Results | Lessons Learned

MDQuit approached tobacco cessation efforts with Medicaid (MA) enrollees in Maryland by creating and delivering training and targeted messaging to clinicians and non-clinical staff of MA practices within all Maryland Managed Care Organizations (MCOs), coupled with evaluative methods to measure impact.

Project Outputs & Outcomes

- Tailored and delivered training on the A3C brief intervention model and basic motivational enhancement skills to a total of 181 MA personnel across all eight (8) Maryland MCOs. Created and delivered consistent provider and consumer newsletter messaging to MCOs.
- Created flexible, self-paced online modules for MA providers. Modules mirror in-person training content, including: overview of tobacco use in the MA population; conducting brief interventions for tobacco use; cessation medications; and motivational enhancement strategies.
- MDQuit worked with all eight (8) MCOs to ensure that tobacco cessation counseling visit CPT codes were opened to providers for reimbursement for both intermediate (3-10 minutes, CPT 99406) and intensive (>10 minutes, CPT 99407) cessation interventions. This was a critical step in promoting provider use of the A3C intervention taught in our trainings.

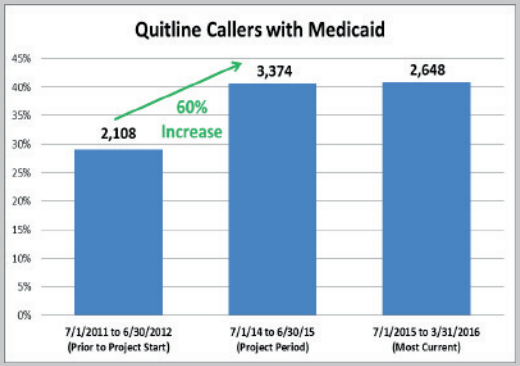
Next Steps

- Encourage state tobacco control programming to provide the fullest extent of support available under Medicaid.
- Increase marketing for online training to MCOs and Medicaid providers.
- Educate health departments and their providers to address the available treatments and services for smoking cessation.
- Investigate interested network of statewide supporters and partners to disseminate materials and communications regarding smoking cessation to reach the Medicaid population.
- Investigate feasibility of adding prompts in EHRs that provide Quitline participant feedback, alerting providers that their patient is a Medicaid recipient and to offer targeted advice and treatment.
- Target promotions during Medicaid enrollment periods.
- Create and send communications and other media highlighting the importance of addressing SHS with families, especially those with children, to MCOs, provider practices, and patient touch points (e.g., WIC offices).

Approaches

- Addressed MCO Board of Medical Directors and consulted with Maryland Medicaid Representatives
- Obtained lists of practices and individual providers serving Medicaid patients to understand the landscape for reach and contact for communications and training
- Met with Medicaid representatives from all 8 Maryland MCOs
- Sent prepared communications to MCOs, provider practices, and individual providers
- Shared materials and resources, including Quitline materials, with MCOs and practices
- Developed and launched in-person and online training for multidisciplinary Medicaid providers, focusing on intervention processes (SBIRT & 5A's) and use of Fax-to-Assist program

Data



Acknowledgments

This project was supported by an independent medical education grant for learning and change from Pfizer, Inc., along with a contract with the Maryland Department of Health and Mental Hygiene.

Special recognition is given to the center specialists and staff of the MDQuit Resource Center at the University of Maryland, Baltimore County.

Incorporating smoking cessation into behavioral health treatment protocols: flexible and tailored support for behavioral health providers and agencies to provide smoking cessation interventions

Carlo DiClemente, PhD [1], Catherine Corno, MA [1], Meagan Graydon, MA [1], Daniel Knoblach, MA [1], Shayla Thrash, MA [1], Angela Petersen, MA [1], Alicia Wiprovnick,BS [1], June Sutherland, MS [1]

[1] MDQuit Resource Center, University of Maryland, Baltimore County

Challenge and Project Overview: Mental Health and Substance Abuse treatment programs should provide smoking cessation in their programs by the staff. Staff myths, knowledge, attitudes, skills and knowing what to do are significant barriers. The challenge is to create materials and training programs that are flexible, portable, easily implemented, evidence-based, and achievable. This project developed and disseminated targeted intervention/training materials to be used in a comprehensive approach to tobacco control in Maryland treatment agencies.

Who

This project aimed to address the disproportionately high smoking rates among individuals with mental health and substance abuse disorders in the State of Maryland by equipping behavioral health providers with critical evidence-based smoking cessation tools. In a state-wide survey of Maryland behavioral health agencies, nearly two-thirds of mental health providers and nearly half of substance abuse providers indicated a need for staff materials and training to address tobacco use in their settings. To meet these needs, we developed and disseminated tailored smoking cessation intervention materials and comprehensive trainings targeting Maryland mental health and substance abuse treatment providers. Further, in an effort to address agency-level barriers to successfully implement our smoking cessation intervention, we developed and implemented specialized trainings targeting administrators and support staff working in Maryland behavioral health treatment settings.

Where and When

Materials and trainings were developed and piloted in the first year of the project. In-person training for mental health and substance abuse treatment providers and agencies across the state of Maryland began in February 2014 and is on-going. On-site and regional trainings were offered to expand reach across the state.

Approaches

Overview of "Breaking the Habit in Behavioral Health (BH2)":
BH2 is a comprehensive intervention and training program developed to assist mental health and substance abuse agencies in supporting client smoking cessation, utilizing CBT and motivational enhancement strategies.

- Single session smoking cessation manual and training (2.5 hour in-person training)
- Multiple session smoking cessation manual and training (6 hour in-person training)
- Staff training (1.5 hour in-person training)
- Administrator training (1.5 hour in-person training)
- Long-term agency technical support
- Evaluation: Pre, Post, 2-mo & 6-mo follow-up; Assessing barriers, knowledge, attitudes, importance, and confidence

Acknowledgments

This project was supported by an independent medical education grant for learning and change from Pfizer, Inc., along with a contract with the Maryland Department of Health and Mental Hygiene and Maryland Behavioral Health Administration.

Special recognition is given to the center specialists and staff of the MDQuit Resource Center at the University of Maryland, Baltimore County. This initiative is part of as statewide initiative to reduce smoking in the behavioral health population.

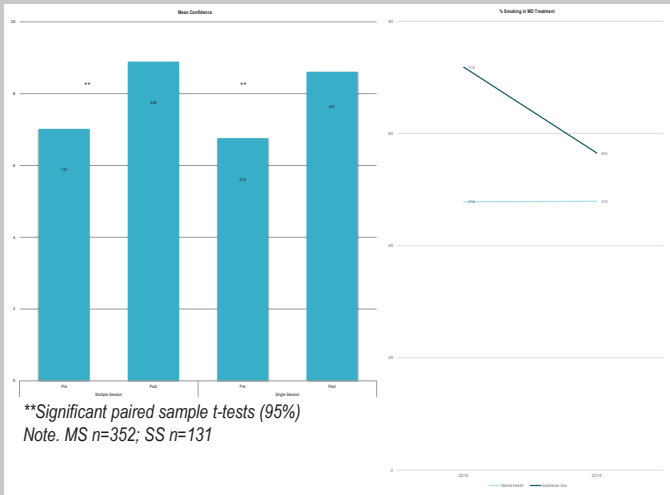
Training Evaluation Data

	Multiple Session	Single Session	Staff/Admin
Agencies	126	44	4
Trainees	389	221	114
Trainings	30	17	7

Note: Reflects trainings conducted from February 2014 through March 2016

	Multiple	Single
Training Satisfaction	9.51 (.99)	9.24 (1.13)
Materials Helpful	9.69 (.89)	9.62 (.98)

Note: MS n=378; SS n = 151 (only collected pre- & post-data on 13 trainings)



***Significant paired sample t-tests (95%)*
Note. MS n=352; SS n=131

Lessons Learned & Next Steps

- From conducting the trainings we've learned:
  - Training and materials need to be comprehensive yet flexible to meet unique needs of each agency, and consider client, provider, and setting factors.
  - Providers have more confidence they can provide smoking cessation interventions after they receive training and "plug-and-play materials".
  - Successful implementation is a process and requires ongoing contact. Technical assistance is being offered with follow-up phone calls.
- Challenges identified by providers: provider turnover, access to medications, and staff smoking.
- Next Steps: On a state-level, the smoking rate among consumers in substance abuse treatment decreased, yet remained stable among consumers in mental health (MH) treatment; efforts targeting MH consumers are necessary.

SMOKING CESSATION LEADERSHIP CENTER

Bribery Didn't Work: Implementation of TelASK Quit Connection IVR System in South Carolina Hospitals, Medical University of South Carolina, Charleston, SC

Background

The Medical University of South Carolina implemented an automated *"opt out"* tobacco cessation system. The program delivered smoking cessation support to adult smokers with a bedside consult and IVR phone follow-up calls for 30 days after hospital discharge consistent with the Joint Commission's tobacco measurement set. Data show that the "opt out" program was well accepted by patients and effective.

Between: February 2014-May 2015

- 42061 adult admissions screened
- 8423 current smokers identified
- 5843 eligible for the service
- 85% accept the service
- Post-discharge quit rates nearly doubled
- Readmission rates lower

Goal

To implement the "opt out" Tobacco Cessation Service in 5 additional hospitals in the Charleston, SC region.

Methods

- $10,000 offered as an incentive to install the IVR "opt out" service
- In 2013 meetings are held with the leadership of 3 hospital systems in the Charleston region
- In 2014/15 the incentive was offered to 5 additional hospital systems in South Carolina, but outside of the Charleston area.

Results

- Only 1 of 8 hospital systems approached accepted the incentive to install the IVR "opt out" service.
- The hospital system that installed the service had 3 hospitals, but limited the service to respiratory care patients which restricted the reach of the service to 2% of eligible smokers .

Lessons learned

- We grossly under estimated the resources needed to incentivize hospitals to adopt the service.
- Lack of assurance of sustained revenue to support the program was a concern mentioned repeatedly by hospital administrators.

Office Champions in Tobacco Cessation: Results from an AAFP Project

Sarah Mullins, MD & Pamela Rodriguez, CAE
American Academy of Family Physicians

This project was supported by Pfizer Inc in collaboration with the Smoking Cessation Leadership Center

Challenge And Project Overview

In order to facilitate change in clinical culture and practice patterns, the AAFP recruited and trained office champions to provide a leadership role in implementing systems changes and encourage a tobacco-free culture in their clinics. Federally Qualified Health Centers (FQHC) are nonprofit private or public entities that serve medically underserved populations or areas. FQHC patients are more likely to be uninsured and live below the poverty level, and they have tobacco use rates much higher than the national average.

This project profoundly affected populations in critical need of health intervention. Stress, depression, and anxiety were commonly associated with nicotine dependence. The quality improvement (QI) project was based on the framework of the AAFP's successful Ask and Act program. Ask and Act encourages family physicians to ASK their patients about tobacco use and then ACT to help them quit.

Who

The AAFP selected 22 Federally Qualified Health Centers (FQHC) that had an AAFP member on staff to fill the role and perform the duties of the physician champion. In an effort to target populations with high smoking prevalence, practice selection was based on tobacco use prevalence from local Uniform Data System (UDS) reports. Fifteen of the 22 selected FQHCs had a patient population smoking prevalence higher than the national average. More than 40% of FQHC patients use tobacco.
Pictured: Office Champions project staff at Lincoln Community Health Center in Durham, NC.

Where and When

Criteria used for selection of the 22 practices sites in 18 states ensured a wide geographic representation and variety in size of practice. The practice settings included: 59% urban, 23% rural, and 18% suburban. Three site visits were made to FQHCs located in Durham, NC; Birmingham, AL, and Columbus, OH. The Office Champions project timeline was from March 2013 to January 2014.

Results | Lessons Learned

- AAFP members love Office Champions.
- Quality improvement plays an important role in all family medicine offices.
- The Office Champions model is a proven approach to implementing quality improvement in a clinical setting.
- Patients benefit from improved, coordinated team care and better health outcomes.

Results 1
Post-project chart review indicated a 4.5% increase over baseline in the percentage of patients that had tobacco use documented [91.1% to 96.1%].

Results 2
Post-project chart review indicated a 48.1% increase over baseline in the percentage of patients for whom cessation assistance was documented [50.3% to 74.5%].

Results 3
A majority of practices (95%) indicated that all or most of the changes made were still in place at the end of the project, and 91% of practices were confident they would be able to sustain the changes made.

Next Steps

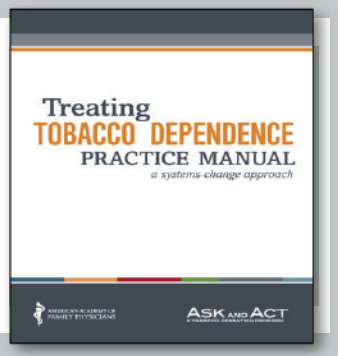
- The Population Health team is seeking funding to expand the Office Champions project across the nation, with an emphasis on FQHCs and community health centers where the need is greatest.
- The AAFP is working on broader implementation of the Office Champions model via an online QI tutorial for all patient-centered medical homes.
- The AAFP developed a free Tobacco and Nicotine Toolkit with comprehensive resources to help physicians support a healthy tobacco-free culture.
- Staff are working to expand the online toolkit to engage "Tobacco-free Champions" in community and advocacy efforts.

http://www.aafp.org/patient-care/public-health/tobacco-nicotine.html

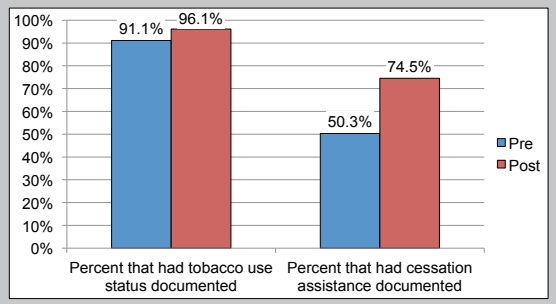
Methods

Selected practices' office champions, physician champions, and supportive staff did the following:

- Completed the office champions training program (online course, IRB training, attend a teleconference, and review the practice manual).
- Presented an overview of project to their practice's physicians and staff at a staff meeting.
- Completed a pre- and post-project chart review of 20 randomly selected patient charts.
- Implemented systems changes to better integrate tobacco cessation activities into daily office routines.
- Participated in all phases of program evaluation, including the final evaluation survey at the end.



Data



Methods

Common themes for implementation plans included:

Training/Education
- Train staff on motivational interviewing
- Educate on coding and billing

Resource Materials
- Display visual cues (lapel pins, posters) and patient education materials in the clinic

Electronic Health Record (EHR) Changes
- Add prompts or templates to record intervention
- Create patient registries of tobacco users

Policy/Finance
- Enforce a tobacco-free policy
- Establish a fund to offer cessation medications for patients in need

"Opportunities for Individuals Who Experience Severe Mental Illness to Collaborate with Healthcare Providers in Reducing Tobacco Consumption"

Mental Health America of Licking Co., Newark, OH

Kristen Frame, CTTS, CPS
kframe@mail.com
614-209-2665

Challenge

People who experience severe and persistent mental illness in the U.S. die, on average, 25 years earlier than their peers. The leading cause of death of this population is directly or indirectly related to tobacco usage. (SAMHSA, 2006)

Individuals reporting a mental disorder consume 44.3% of all cigarettes smoked in the U.S., spend 27% of monthly income on tobacco, and are 2-3 times more likely to become addicted. (Lasser, K.; et al, 2000; Steinberg ML et al, 2004) In mental health settings, about 30% to 35% of staff smoke. (Schneider, Stephen, 2009)

The tobacco industry promoted smoking in psychiatric settings by providing cigarettes and supporting efforts to block hospital smoking plans. (Prochaska, 2001) It monitored or directly funded research supporting the myth that individuals who experienced schizophrenia **were less susceptible** to the harms of tobacco and **needed** tobacco as self-medication. (Prochaska, Hall, Bero, 2007).

Tobacco cessation has no negative impact on psychiatric symptoms and may even lead to better mental health and overall functioning. (Baker et al., 2006; Lawn and Pols, 2005; Prochaska et al., 2008)

Peer Wellness Conference

Hosted a 1-day, state-wide peer conference to encourage participation in training. 80 participants from 8 locations across Ohio and the Veterans Administration received full scholarships.
Creating a serene environment with stress-relieving techniques for engaging in tobacco cessation process, the conference offered a 5 mi. walk on park trails and Tai Chi in the Japanese Garden. Participants received educational materials, Quitline referral cards, pedometers and water bottles.

Method

Using a multi-pronged approach: direct outreach to providers through education opportunities with providers and professional associations, direct outreach to Consumer Operated Services (COS) staff and Certified Peer Specialists (CPS), directed social media targeting consumers and providers, peer-to-provider initiated conversation, and peer-to-peer services, we sought to promote tobacco cessation for individuals with severe and persistent mental illness in Central Ohio. An "Ask-Advise-Refer" and recovery-based curriculum was developed for staff trainings. Funding was provided by a Pfizer Medical Education grant.

Consumer Operated Services

Grantee contacted 20 Consumer Operated Service (COS) locations in Central and Northern Ohio for telephone interviews. 16 locations, 3 serving metropolitan , 12 small cities and 2 rural locations agreed to participate in visits. Visits to COS took place May 2013-Aug. 2013 and included an educational presentation about tobacco and individuals who experience mental illness, meetings with COS peer staff, one-on-one conversations with clients, and distribution of resource materials. Presentation focused on tobacco myths and empowerment. Staff Clients and staff voiced concerns and preferences for future actions. Follow-up letters were sent to 16 COS summarizing the visit and suggesting actions based upon the conversations with staff and clients, along with mini-grants of $500 or $1,000 to jump-start cessation awareness programs. COS were contacted again by mail after 6 months to determine what actions had been taken towards implementing tobacco cessation efforts and to respond to requests for additional educational resources.

Social Media

We utilized social media, including: agency website, Facebook, and blogs, to reach health professionals, care providers and individuals who experience severe mental illness with information about tobacco cessation and this population. A contact list of 711 area providers received posts and links to our websites, newsletters and Facebook page.

Jan.-July 2013, 980 newsletters on project were sent, 286 website posts on tobacco project/ tobacco issues, 425 Facebook posts on tobacco project/tobacco issues with over 17,067 hits.

Educating Providers

Feedback from peers was utilized to plan presentations for health professionals from the Ohio Chapt. of Society of Public Health Educators (SOPHE) and the Tobacco Free Ohio Alliance (the state coalition on tobacco professionals representing over 40 state associations, agencies and organizations). A national webinar by the grantee for 150 attendees was posted on the national SOPHE educational website. Additional presentations included two state-wide conferences, and a local Tobacco Coalition.

There were 1,503 participants from Dec.-Aug. 2013, not including presentations at two regional conferences and Promising Practices to Promote Tobacco-Free Living 2014 National Conference.

This project targeted public health educators, COS staff and other health professionals through professional associations meetings and conferences.

Recommendations

Providers of community cessation resources need to be educated about the unique cessation needs of, and trained to work with special populations including individuals who are homeless, low-literacy, those with severe and persistent mental illness. Grant providers should prioritize success with these populations. All staff need to be committed to cessation. COS staff should include cessation in recovery plans, and document tobacco use of COS members at intake and in counseling interactions. Provide NRT and quit aids. Provide education to peers about the history of tobacco industry manipulation and institutional complicity with patient tobacco addiction. Enforce tobacco-free campus policies for COS organizations and client housing. Provide phones and mail addresses for Quitline access.

"Teen Peer Advocacy"

Sixty-five teen peer mental health educators were introduced to tobacco-free advocacy through a 4-class training, including Advocacy 101 and tobacco education. Students participated in "National Kick Butt Day" workshops, marched at the Statehouse, met state legislators and attended a press conference about tobacco marketing to youth.

"Men's Smoker" & "Spa Night"

Two gender-specific educational events at our home COS targeted members in sheltered housing. The 1st was focused on women's health and tobacco cessation. Guests were provide with a spa-like experience. The 2nd was a twist on a men's "Smoker" with a poker tournament, grill-it-yourself meal. Both received incentive gifts.

References

Baker, A. et al. A randomized controlled trial of smoking cessation intervention among people with a psychotic disorder. American Journal of Psychiatry, 163, 1934-1942. 2006.

Lasser, K; et al. Smoking and mental illness: a population based prevalence study. Journal American Medical Association. Nov 22-29; 284(20): 2606-10. 2000.

Lawn, Sharon and Pols, Renee. Smoking bans in psychiatric inpatient settings? A review of the research. Australian and New Zealand Journal of Psychiatry, Volume 39, Issue 10, pages 866 – 885. 2005.

Prochaska, JJ, et al. Tobacco Use Among Individuals With Schizophrenia: What Role Has the Tobacco Industry Played? oxfordjournals.org. Schizophrenia bulletin, MPRC. 2008.

SAMHSA. The 10 By 10 Campaign: A National Wellness Action Plan to Improve Life Expectancy by 10 Years in 10 Years for People with Mental Illness: A Report of the 2007 National Wellness Summit for People with Mental Illness. U.S. Dept. Health and Human Services. 2010.

Schneider, Stephen; et al. Understanding Tobacco's Deadly Toll: Responding to the Call to Help People with Mental Illnesses and Addictions Live Smoke-Free. Seminar, Smoking Cessation Leadership Center, March Journal of American Medical Association 2009 article: http://jama.ama-assn.org/cgi/content/full/301/5/522/

Steinberg ML, et al. Financial implications of cigarette smoking among individuals with schizophrenia. Tobacco Control Jun;13 (2):206. 2004.

Vida Sana QUITS

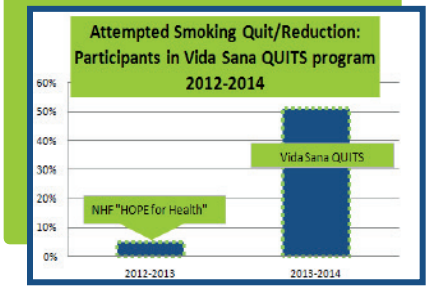
Mary Lynne Knighten, DNP, RN, NEA-BC marylynneknighten@verity.org
St. Francis Medical Center, Lynwood, CA, USA

Results

89 Trainers taught MI skills
526 Health professionals taught A-A-R
39 Physicians attended CME
344 Community members educated
86% cumulative gain in knowledge following smoking cessation modules

Spanish smoking cessation class for community members/champions at a local Middle School in Lynwood, CA

Results



Lessons Learned

#1 "Ask-Advise-Refer" strategy integrated mid-way through project; simpler, easier and more likely for clinicians to use
#2 PFAs most receptive to motivational interviewing techniques of all disciplines trained—they had no previous assessment framework bias as seen in health professional disciplines
#3 "Incentives" provided for community health classes improved attendance and program compliance

Challenge And Project Overview

Smoking is the leading cause of preventable morbidity and mortality in the United States[1]. While residents in the Western U.S. smoke less than other areas in the country, several significant risk factors for smoking—low income, low educational attainment and large numbers of recent immigrants[2] are prevalent in the communities served by SFMC. The aim of the *Vida Sana* QUITS (**QU**ality **I**nterventions to **T**ransition **S**mokers) Project was to improve clinical outcomes by training health professionals and community health promoters to apply proven smoking cessation strategies in a culturally competent manner, utilizing discipline and population specific curricula, and creating infrastructure and sustainable systems. The project, implemented December 2012 to 2014 built on the successful 2011 Los Angeles County (LA) Pioneers Smoking Cessation project.

Reference: [1,2] Vital Signs: Current Cigarette Smoking Among Adults Aged 18 years [and older]—United States 2009. Morbidity and Mortality Weekly Report. The Centers for Disease Control and Prevention. September 10, 2010 / 59(35); 1135-1140 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5935a3.htm

Where

Established in 1945, SFMC is one of the nation's largest Disproportionate Share Hospitals and is the only comprehensive, non-profit health care facility serving Southeast Los Angeles. A former member of the Daughters of Charity Health System, SFMC operates a 384-bed acute care hospital, high volume private Emergency and Level II Trauma Center, Family Life Center, Health Benefits Resource Center, and Behavioral Health Service Line for adults and children. Numerous community health fairs and screenings, and programs for schools, seniors, homeless families, and those with chronic illnesses are provided.

Training our PFAs

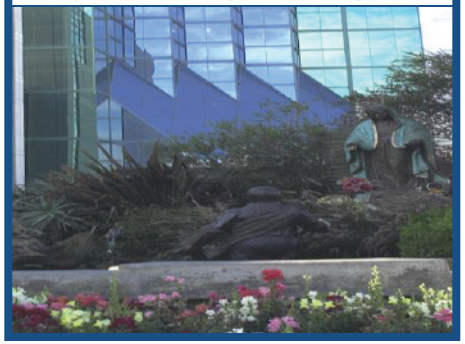
Who

The *Vida Sana* QUITS curriculum was used to train a core group of SFMC health professionals— physicians, direct-care nurses, educators, parish nurses, *promotoras*, patient family advisors, respiratory and physical therapists and mental health professionals— in a variety of locations including the hospital, community centers, churches, and pre-operative teaching classes.

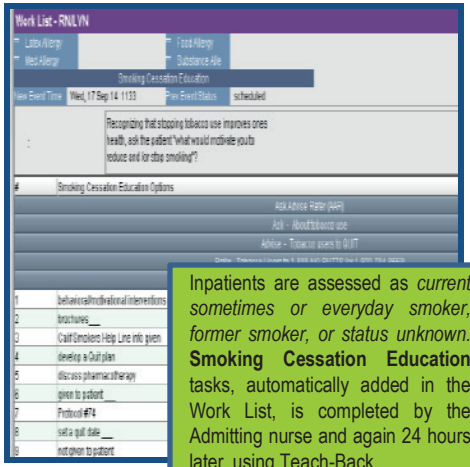
What & How

The original evidence-based smoking cessation curriculum included training on six topics: 1) Healthy Behaviors; 2) The Truth about Tobacco; 3) Changing Behaviors; 4) Coping with Cravings; 5) Managing Stress; and 6) Planning Ahead. The revised curriculum allows health practitioners to customize patient messaging to the recipient's socio-economic, cultural, and health literacy level, includes the most effective strategies and approaches, and employs motivational interview techniques designed to elicit accurate information about smoking. The interventions range from providing passive education, information, and messaging—building awareness of the dangers of tobacco use; to offering more intensive lifestyle intervention and support networks with 4 smoking cessation modules integrated in the existing *promotora*-taught disease prevention and health promotion classes. Hospital staff and physicians were taught how to use the "Ask-Advise-Refer" technique for high risk patients (e.g. Stroke & CHF) with short hospital lengths of stay, with a hard-coded Electronic Health Record framework, Patient/Family Teaching Protocol #74, and nurse-driven protocols for Nicotine Replacement.

St. Francis Medical Center
A part of Verity Health System



SFMC's *Vida Sana* team lobbied the city of Lynwood for successful passage of the **"Healthy Parks Resolution"** at the February 16, 2016 City Council Meeting. The Resolution establishes a No Smoking Policy in public parks, Healthy Food/Drink choices in vending machines, & Physical Fitness opportunities.



Inpatients are assessed as *current sometimes or everyday smoker, former smoker, or status unknown.* **Smoking Cessation Education** tasks, automatically added in the Work List, is completed by the Admitting nurse and again 24 hours later, using Teach-Back.

Closing the Loop: Assessing & Documenting Smoking Status After Discharge

Melissa Gray, CHES ● Melissa.Gray@providence.org

Project Overview

Providence Health & Services Oregon, has a long history of addressing and treating tobacco use. Our comprehensive tobacco program had inpatient processes in place to assess tobacco use, order bedside interventions and fax cessation referrals to the state quit line. However, in 2012 it was announced that the current EMR Centricity would be replaced by EPIC.

At the same time, Joint Commission (JC) announced the formation of a new Tobacco Measure Set. Providence met all requirements except one: assessing and documenting smoking status after discharge. This was the perfect opportunity to develop and implement a multidisciplinary approach to meet the JC Tobacco Measure Set.

Who: **Health Education Services** (HES) led this work. HES is the administrative department for the Tobacco Prevention and Cessation program led by Medical Director, Meera Jain, M.D. HES coordinated a multidisciplinary team to create this new process. Members from the outpatient setting included: Tobacco Program Medical Director, Providence Medical Group (PMG) Referral Operations, PMG Health Literacy and Innovation and Diabetes Education. Members from the inpatient setting included Nursing Informatics, Nursing Clinical Education, Hospitalists, Care Managers and Respiratory Care. This work was generously supported by a Pfizer Medical Education Grant.

Project Focus: **Creating a referral in EPIC** to connect the inpatient tobacco user to outpatient resources allowing us to assess and document smoking status after discharge.

Results:

1: Health Education REF 145 Tobacco Cessation Referral was created and implemented into the outpatient referral list and the inpatient discharge navigator.

2: Developed an "inbasket" and work process for referrals to be sent to HES for follow-up.

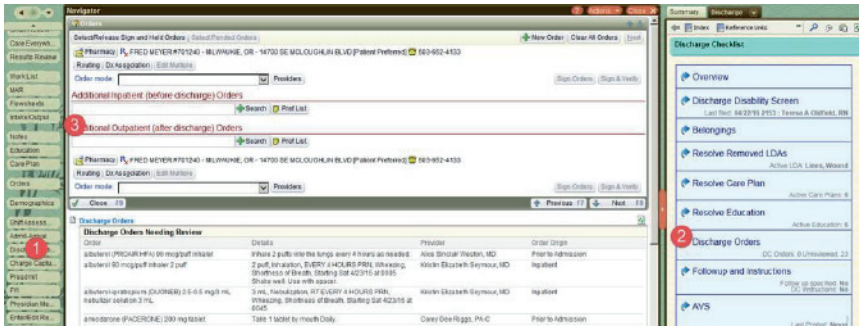
3: Developed a workflow for HES to assess and document tobacco status in EPIC.

4: Developed a script and follow-up procedure for HES staff.

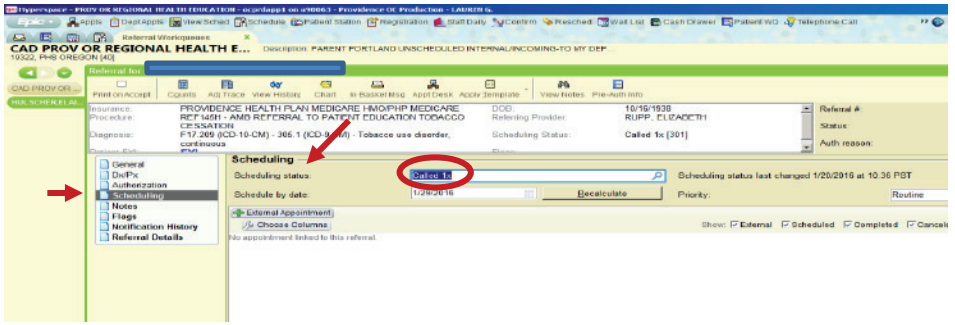
Next Steps | Lessons Learned :

1. **Optimize physician engagement.** We learned that physicians do not view outpatient referrals as part of the discharge process. We are working on a plan with clinical services to address this.
2. **Automate referrals** to outpatient services at time of discharge. Ideally, once a patient is identified as a tobacco user the outpatient order would automatically load into the discharge navigator. Until we can do that, we are working to load the referral into the RN preference list so they can process it.
3. Once this process is optimized, we will **document it as a Providence best practice**. This will allow our work to be spread to five states impacting 34 acute care hospitals serving 4,000 patients daily.

Ordering the outpatient referral at discharge



Scheduling patient follow up



Bringing EX to a Million Hearts

Georgetown University Medical Center, Washington, DC
Contact: Kenneth Tercyak, PhD (*tercyakk@georgetown.edu*)

Challenge and Project Overview

Tobacco use remains the leading cause of preventable disease, disability, and death nationwide and globally. Evidence-based resources are freely available to the public to assist tobacco users in stopping smoking, but many smokers remain underserved by the health care system in assisting them with accessing these resources.

The goals for this project are as follows: 1) develop a partnership between the national "Million Hearts Initiative" at MedStar Health's ambulatory points of care and the BecomeAnEX.org (EX) online smoking cessation program of the Truth Initiative; 2) advance point of care provider capacity across MedStar Health ambulatory care practices in tobacco use assessment, brief quit advice, and connection to evidence-based smoking cessation; 3) collaborate with the institutional Million Hearts Initiative team to develop and implement a tobacco control protocol within the electronic health record (EHR) connecting smokers to EX; 4) evaluate impact by monitoring population-level tobacco control outcomes and workflow within the ambulatory care system.

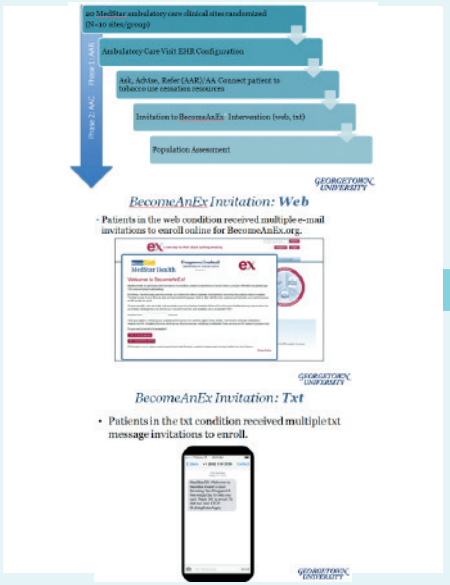
Our ultimate goal is to reduce barriers and increase patient access to well-established tobacco control resources within the ambulatory care environment at the point of care and beyond.

Who

MedStar Health is a network of 9 hospitals and 20+ health care entities located in more than 100 rural, suburban, and urban communities across the Maryland/Washington, DC region. MedStar Health joined the federal "Million Hearts Initiative"--a nation-wide partnership of health care systems convened by the US Department of Health and Human Services. Million Hearts operates under the premise that a dedicated and consistent focus on four primary and secondary interventions can help prevent 1,000,000 new heart attacks and strokes over five years. These four interventions are framed simply for patients and health care providers as "Remember the ABCs": A = determining cardiac risk and encouraging aspirin use for those at risk; B = blood pressure screening and appropriate blood pressure control for those diagnosed with hypertension; C = cholesterol screening and appropriate cholesterol control for those diagnosed with hyperlipidemia; and S = determination of smoking status, coupled with aggressive efforts at smoking cessation for those who smoke. With this as the backdrop, our team consisted of population scientists and health care providers dedicated to improving the quality of tobacco control services and addressing systemic barriers to the delivery of evidence-based care for smoking cessation.

Where and When

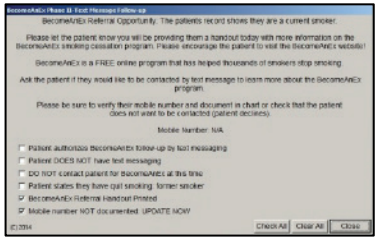
MedStar Health ambulatory care practices that served large numbers of diverse patients were enrolled in a point of care tobacco control quality improvement initiative that was developed and implemented in multiple phases across two years of study, centered around partnership, collaboration, best evidence, and a common EHR system that was centrally managed by clinical bioinformatics and clinical use teams.



Next Steps

We are currently in the process of working with the team's clinical bioinformatics experts to extract all data related to the trial and plan to analyze both process and outcome data to determine impact.

Data are reported herein as provisional and descriptive only, with information extracted by limited EHR query functions.



Methods

This quality improvement initiative was designed as a two-phase cluster-randomized trial. We sought to evaluate if a standardized clinical workflow within the EHR (Centricity product) that systematically Asked all adult patients (age 18+) about their tobacco use, Advised them to quit if they were tobacco users, and Connected them (AAC Model; Vidrine et al., 2013) with evidence-based smoking cessation resources, including the Truth Initiative's "Become an EX" no-cost web-based smoking cessation program (Graham et al., 2013), was impactful. Connection occurred via a paper-based referral to the EX website that was generated as part of patients' exit paperwork (Phase I), and then via e-mail or SMS text message invitation (Phase II). Providers (MD, RN, PA, MA) receive tobacco control training in the new workflow and education about EX: we selected, sampled, and randomize large group ambulatory care practices to receive either no change in their EHR configuration (usual care) (Control Condition: N=10 practices, N~56k patients) or our intervention (Intervention Condition: N=10 practices, N~58k patients). Usual care included patient education and counseling about tobacco use and pharmacologic therapies (OTC or RX) at providers' discretion, and as determined by clinical use team to be populated within the EHR's resources section and/or formulary. Primary outcomes include the number of patients successfully receiving the AAC cascade and population-level smoking prevalence.

Preliminary Data – To Be Verified as Extracted from the EHR

Health Care Providers Trained: Across 20 ambulatory care sites were 81 unique MD's who underwent online systems training in the AAC Model. Other provider (RN, PA, MA) total estimate was 162.

Smokers Impacted: Baseline cohort contained 112,590 patients. Of these, 12,855 were identified by EHR values as 'smokers' (11%). We estimate that 8,045 (63%) of these smokers were seen for care.

Asked: Of the 112,590 patients, ~72,300 (64%) were seen during the project: 67,801 (93.8%) were Asked and had a smoking status recorded during an appointment. Of the 8,045 smokers, 7,728 (96.1%) were Asked about their smoking status.

Advised: A total of 6,922 (86.0%) of the 8,045 baseline smokers seen were advised to quit during at least one of their appointments.

Connected: During Phase I, 740 smokers were actively referred to the BecomeAnEx intervention by participating providers. During Phase II, 611 patients were actively referred to the BecomeAnEx e-mail or text message invitation by providers. The remainder of smokers were passively referred to the quit smoking program via visit exit paperwork.

Mobilizing Capacity and Training of Health Professionals to Reduce Smoking During Pregnancy: The Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) Program

Nakita Kanu, MPH[1]; Elaine Auld, MPH, MCHES[1]; Deborah Gordon-Messer, MPH; Jennifer Schindler-Ruwisch, MPH[2]

Society for Public Health Education (SOPHE)[1], George Washington University School of Public Health[2]

Introduction

Washington, D.C.'s infant mortality rate is higher than the national average and its pre-term birth rate is the 6th highest in the nation.

Smoking during pregnancy is a major risk factor for infant mortality and morbidity, including pre-term birth and low birthweight. D.C. identified smoking cessation during pregnancy as a priority.

Comprehensive smoking cessation services are not available for low-income pregnant smokers. **SOPHE** is filling this service gap by working with **Community of Hope** and **Strong Start partners** to provide training and capacity building to implement a comprehensive, evidence-based smoking cessation program for pregnant women.

Goals

Enhance capacity to:

- Provide comprehensive, evidence-based smoking cessation screening and treatment as part of routine prenatal care
- Implement health care system changes and improve quality of smoking cessation services for pregnant women

Objectives

- **75% increase** in number of pregnant smokers with access to evidence-based smoking cessation screening and counseling
- **15% increase** in number of pregnant smokers who quit or reduce smoking during pregnancy
- **Train 100 prenatal care staff** to provide SCRIPT counseling as part of routine prenatal care
- Strong Start partners incorporate **50% or more** of SCRIPT policy/organizational changes

What is SCRIPT?

SCRIPT is an **award-winning, evidence-based** program effective in helping thousands of pregnant women quit smoking. Cited by the Agency for Healthcare Research & Quality's Smoking Cessation Clinical Practice Guidelines, SCRIPT is designed to be a component of a **patient education program** for prenatal care providers. SOPHE is the national provider of SCRIPT training and materials.

Intervention Components

- ***Pregnant Woman's Guide to Quit Smoking*:** 31-page guide outlines a self-evaluation process to help build women's smoking cessation success over a 7-day period
- ***Commit to Quit Smoking During and After Pregnancy*:** 8-minute motivational DVD with testimonials of pregnant smokers who quit
- **Comprehensive Counseling:** helps pregnant smokers quit or significantly reduce smoking during pregnancy; evidence-based approaches include the "5 A's"
- **Counseling and encouragement:** tips to establish a non-smoking home; follow up components prevent smoking relapse

Community of Hope

Community of Hope, a nonprofit, community-based organization, serves 450-500 prenatal care patients per year across its 3 clinic sites:

- Marie Reed Health Center (Ward 1)
- Family Health and Birth Center (Ward 5)
- Conway Health and Resource Center (Ward 8)

16% of Community of Hope's prenatal care patients are self-reported smokers, though national studies indicate that self-reports underestimate true numbers of smokers.

Train-the-Trainer Workshops

SOPHE offered 2 workshops to provide insight and skills on how SCRIPT could become part of Community of Hope's routine prenatal care. Participants learned how to:

- Integrate intervention into routine prenatal care
- Educate colleagues in clinical settings on how to implement intervention components
- Integrate continuous program evaluation for quality improvement

Training workshops are **one day, interactive sessions** that include substantial role play, counseling practice and planning techniques, such as patient flow mapping and practice using SCRIPT screening forms and carbon monoxide monitors.

Performance Measurement & Evaluation

Mixed-methods approach with key inputs, outputs and outcomes, and rigorous research methods for process-oriented formative evaluation and summative impact evaluation.

- Health professional knowledge of SCRIPT and self-efficacy with training
- Number of health workers trained to deliver SCRIPT
- Implementation fidelity index
- Number of patients receiving intervention
- Self-reported smoking prevalence
- Exhaled carbon monoxide levels

Primary Outcomes to Date

- **Trained 22 prenatal care staff**
- Community of Hope modified its **electronic health records** to incorporate SCRIPT forms to collect smoking status and SCRIPT tools usage
- Systems established to securely **transfer monthly data** from Community of Hope to evaluation team

Challenges and Limitations

- **Smoking history study** took longer than expected to complete
- Difficulties **navigating patient flow** to determine which providers will implement intervention and at what point during patient visit
- Modifying **electronic health records** requires technical expertise and understanding of record capabilities and processes

Lessons Learned

- Incorporating **policy and organizational changes** are important for sustainable and fluid intervention delivery, but can take time
- **Allow sufficient time** to determine baseline levels of smoking to evaluate outcomes
- **Open communication** with community partners is vital

Conclusions

Given the prevalence of pregnant smokers and the readiness of healthcare providers to have a tailored smoking cessation protocol for pregnant smokers, Community of Hope was an ideal site to demonstrate how SCRIPT can complement Strong Start programs and be implemented across multiple clinic environments.

For more information and a list of upcoming training opportunities, visit:
www.sophe.org/SCRIPT.cfm

Expanding Tobacco Treatment through Technology

Anna Schulze, MSW,[1] Thomas Ylioja, MSW,[1] Hilary Tindle, MD, MPH,[2] Antoine Douaihy, MD,[1] Esa Davis, MD, MPH[1]

[1]UPMC Tobacco Treatment Service, [2]Vanderbilt University Medical Center

TobaccoTreatmentService@upmc.edu

Background

- Hospitalization provides a 'teachable moment' (Fiore, et al., 2008) to educate patients on the impact of tobacco use on their disease and recovery, and provide evidence-based tobacco cessation counseling and medication.
- Treatment that begins in the hospital and continues for 1 month after discharge increases the likelihood of long-term cessation by 37% (Rigotti, et al., 2012).
- The electronic health record (EHR) is used to facilitate patient care in hospitals across the U.S. EHRs offer an opportunity to increase the reach of tobacco treatment in hospitals and health systems (Boyle, et al., 2014).
- The Tobacco Treatment Service (TTS) was established in 2012 with the goal of improving the number of patients receiving bedside counseling and medications while admitted to UPMC Presbyterian hospital.
- Members of the TTS team (HT, TY, AS, ED) worked with the North American Quitline Consortium (NAQC) eReferral Working Group to implement a technologically-advanced eReferral to enhance care following hospital discharge.

Objective

- To develop infrastructure within the electronic health record to improve the identification and treatment of tobacco users admitted to UPMC Presbyterian.

Method

- UPMC TTS, in collaboration with the UPMC Information Services Division, created an electronic TTS consult form, tobacco medication alert, order set, and electronic quitline referral to enhance treatment of hospitalized tobacco users.

Results

Documentation of Treatment Provided to Everyday Smokers Admitted to Hospital and seen by the TTS (2015)

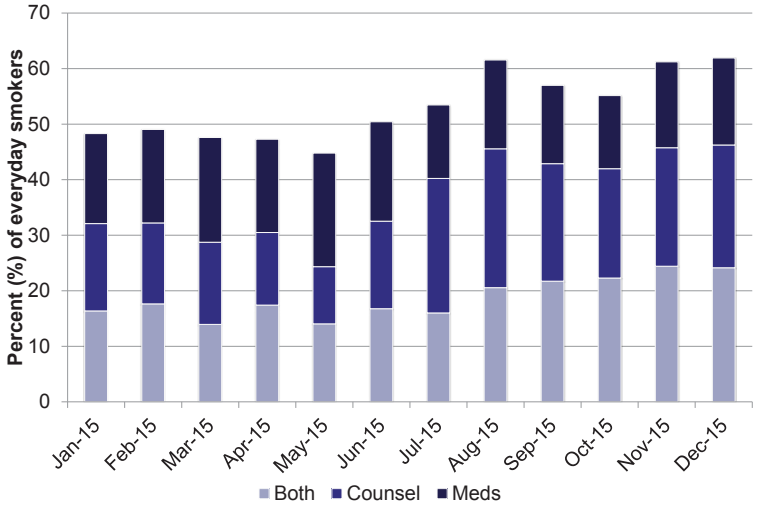


Table 1. Characteristics of hospitalized current smokers

Age, mean (SD)	48.8 (15.1)
Sex, % female	43.3
Race, %	
White	71.5
African American/Black	21
Other	7.5
Discharge disposition, % home	80.4
Length of stay, median (IQR)	3 (5)
Insurance, %	
Commercial	28.5
Medicare	30.2
Medicaid	33.9
Other	1
Uninsured	6.5
Smoking related primary diagnosis, % yes	14.9
Received TTS counseling, % yes	30.5

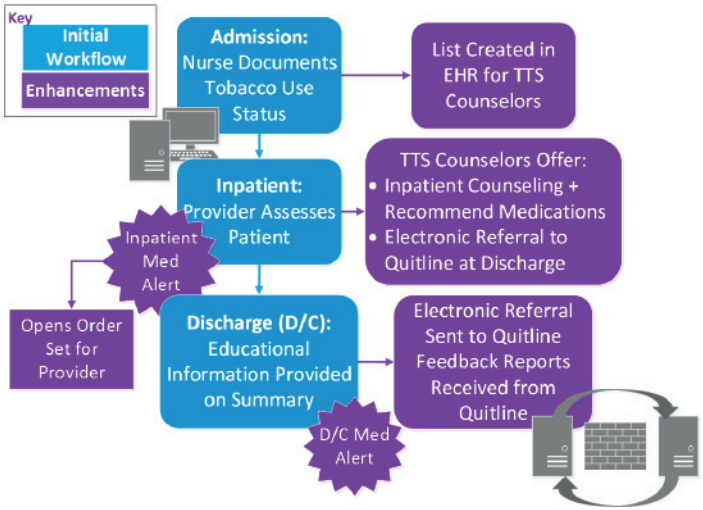
Patients admitted April 1, 2012-March 31, 2016. N=39,006, 23.9% of all admissions

Table 2. Characteristics of counseled smokers

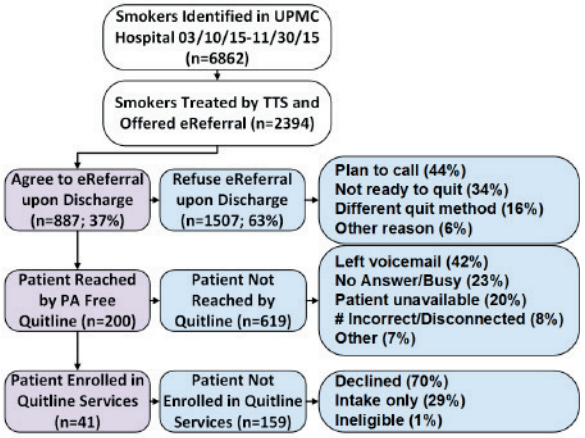
Minutes of counseling, median (IQR)	10 (9)
Referral method, %	
Opt-out from RN admission assessment	85.6
Provider consult	14.3
Time to first cigarette, % within 30 minutes	58.7
Cigarettes per day, % 10 or more	69.8
Ever used electronic cigarette, % yes	25.5
Plan to quit, % try/stay quit on discharge	60.8
Accepted follow-up, % yes	20.9
Medication recommended by TTS, % yes	55.5
Reason medication not recommended, %	
Refused	80.2
Already on a medication	14.4
Other	5.4
Medication ordered for everyday smoker, % yes	
No TTS involved	22.4
TTS involved	47.2

N=10,128 current smokers seen by TTS (Jan/2013-Mar/2016). NRT or varenicline recommended and ordered for identified everyday smokers (N=9710).

UPMC Presbyterian Tobacco Treatment Electronic Infrastructure



UPMC Electronic Referral (eReferral) Reach



Conclusions

- The EHR infrastructure has allowed the TTS to expand tobacco treatment across the hospital and document offers of treatment during admission.
- Future plans include increasing reach of TTS in all UPMC hospitals, including medication orders and electronic referrals to the Quitline.
- Additional strategies are needed to improve initial and sustained engagement of recently-discharged smokers to maximize the delivery of quitline services.

Sources of Support

- The TTS is directly funded by the UPMC Health Services Division.
- TTS received an Independent Grant for Learning and Change from Pfizer and the Smoking Cessation Leadership Center.

References

- Fiore M, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service;May 2008.
- Rigotti NA, Clair C, Munafò MR, Stead LF. Interventions for smoking cessation in hospitalised patients. Cochrane Database of Systematic Reviews 2012, Issue 5.
- Boyle R, Solberg L, Fiore M. Use of electronic health records to support smoking cessation. Cochrane Database of Systematic Reviews 2014, Issue 12.
- North American Quitline Consortium (2015). Guide for Implementing eReferral Using Certified EHRs. (R. Daigh, MBA). Phoenix, AZ

SMOKING CESSATION LEADERSHIP CENTER

"Smoke Free Giant Eagle-- Driving Smoking Cessation Among Customers of a Regional Supermarket Chain": Purdue and PVI Pittsburgh PA

PURDUE COLLEGE OF PHARMACY

Giant Eagle is a regional supermarket chain with 229 stores throughout Western Pennsylvania, Ohio, West Virginia and Maryland that serves 4.6 million customers annually. Among Giant Eagle's employees are 900 PharmDs who work in pharmacies embedded in most of their supermarkets. Prior to our initiative, Giant Eagle conducted a Pharmacist-driven, employee-targeted tobacco cessation program that yielded positive results. The initiative utilized a mix of PharmD-led small group and individual cessation counseling sessions.

70-85% of participating Giant Eagle employees quit smoking within 30days of their final counseling session with 45-55% continuing to abstain after 3 months. The success of this PharmD-driven counseling, coupled with the demographic similarity between Giant Eagle's employee population and its customer population encouraged Giant Eagle to expand their tobacco cessation effort to their customers.

Where and When

Funded by a Pfizer IGLC grant we created an ASK-ADVISE-REFER curriculum specifically for Giant Eagle pharmacists. Two live training sessions were held in conjunction with regional Giant Eagle pharmacy meeting as well as four live webinars to disseminate the training. The presentation was then taped and placed on Peerview's website where pharmacists could access the training at any time. **For more information contact Frank at vitalefm@msn.com**

The theme "Motivating and Mobilizing Healthcare Professionals" is exemplified in this project as we created an easy to use cessation protocol for community pharmacists and showed them an effective way to implement it in their daily practice.

712 Giant Eagle Pharmacists participated in this training. Per the 3-month follow-up survey, responding Pharmacists reported asking an additional 1-2 customers each week about their smoking habits. That is an additional 50-100 patients per year per pharmacist.

If all 712 Pharmacists individually inquire about the smoking habits of 50-100 patients each year, the total potential annual patients impacted from this training will be between 35,600 and 71,200.

Trainees

Giant Eagle Pharmacists

Live in-person:	235
On Line:	462
Webinars:	15
Total:	712

Additional Health Professionals

Students:	121
Pharm Techs:	26
Dieticians:	15
Others:	39
Total Trained:	**913**

After participating in the training, the Giant Eagle Pharmacists were given time to implement what they learned at their retail pharmacy locations. A follow-up survey was fielded 3 months post-training to assess behavior change and barriers to implementing the training. The following key trends were noted:

As a result of participating in the training, Giant Eagle Pharmacists…

… were more likely to:

- Ask their customers about tobacco use
- Refer customers to the tobacco quit line or other tobacco cessation resources

…were less likely to view the following as barriers to providing cessation counseling

- Their own lack of training on tobacco cessation counseling

…were equally likely to view the following as barriers to providing tobacco cessation counseling to customers:

- Lack of space in the pharmacy to hold a private conversation
- Lack of time
- Customer resistance

Frank Vitale also trained 105 second-year University of Pittsburgh Pharmacy Students in the ASK-ADVISE-REFER protocol as part of a service project related to the Great American Smokeout.

29 of these students volunteered to staff smoking cessation stations set up in Giant Eagle stores on the day of the Smokeout.

In subsequent months, another 19 students conducted 5 "Ready to Quit" days at various Giant Eagle stores where they staffed counseling stations near the pharmacy counter and spent over 6 hours during each session engaging customers in cessation discussions.

Pharmacist Feedback/Change in Practice

* "I asked a patient if she was interested in quitting and she explained to me that she was but felt uninformed about the products. I showed her what we had in the store and she said she would consider a future purchase."
* "The customer said he was happy we offered advice and counseling but would come back when he was ready. I gave him a quit line card."
* " I have a customer who I encouraged to continue with his quit attempt. I gave him a quit line card when he said he wanted to give up on the attempt. He seemed encouraged and said he was going to keep trying."
* "I do wear my 'ASK ME' pin on my smock and customers have asked me questions in the store when I didn't even know they smoked."

Change from Within

Increasing cardiologists' engagement in tobacco cessation and control

Project Overview

Tobacco use and SHS exposure significantly reduce CVD patients' chances of survival. Globally, tobacco use accounts for over 10% of premature mortality from CVD. World Heart Federation (WHF) is working with member organizations and partners (including the World Health Organization, the NCD Alliance and Ministries of Health) to reduce premature CVD mortality by 25% by 2025, Increasing cessation rates globally is a top priority for reaching this overall CVD goal, but many of its member organizations do not give interventions to address this critical risk factor (tobacco dependence treatment and tobacco control law) the attention that they merit. Aiming to build WHF member organizations' capacity to reduce premature CVD mortality by addressing tobacco use and SHS exposure in clinical practice and training, this two-year project (2013-2014) was designed to: increase cardiology society's commitment and capacity to train members in clinical interventions for tobacco use and SHS exposure; establish a network of trainers on treating tobacco dependence within the cardiology/CV community; engage leaders of national and regional member organizations in improving the CVD community's capacity in tobacco cessation and control; and keep tobacco control and cessation high on the global agenda for NCD advocacy. Consulting cardiologists and tobacco cessation experts from around the world, WHF developed a cessation curriculum that was tailored to health professionals treating people with CVD. Based on a curriculum developed by the Rx for Change project (UCSF) to train US cardiologists, The three-hour curriculum covered basics of counselling and medication and focused on the cardiovascular effects of tobacco; it was designed to be used within existing cardiology events and programs to strengthen its sustainability, piloted the training and conducted trainer training in events in China and the Middle East.

What

Curriculum development, including regional adaptation, translation into Chinese and Spanish and piloting.

Trainer training, held during cardiology training conferences and events.

Key opinion leader meetings, to develop high-level buy-in for action on tobacco cessation and control among leading cardiology organizations and individual KOLs.

Webinars, to share results of the project and curriculum regionally.

Who/Where

The WHF advocacy group, chaired by Eduardo Bianco (Uruguay) oversaw project implementation. Alice Grainger Gasser (WHF Geneva) coordinated. Judith Prochaska (Stanford) and Sarah Hitchman, adapted the curriculum in consultation with an international expert group that included Richard Hurt, Robert West, Dongbo Fu, Neal Benowitz, Catriona Jennings, Harry Lando, Nancy Rigotti, Tom Glynn, Mira Aghi, Stanton Glantz, Martin Raw and Lisa Kroon. The project was implemented in China and the Middle East by Prof. Dayi Hu and Ding Rong Jing of the Chinese Society of Heart and Brain Disease and Georges Saade of the Lebanese Cardiology Society. Trainer training was held in UAE, Lebanon, Tunisia, Iran and Egypt as well as in 3 Provinces in China.

Results

- Trained over 2000 health professionals in 7 countries
- Trained 35 trainers in China and 7 in the Middle East
- Engaged CVD leaders from 15 cardiology societies/heart foundations
- Integrated tobacco dependence treatment into Chinese national cardiac rehabilitation training

Lessons Learned

Training health professionals is not enough; can only have limited impact in LMICs without addressing "upstream" barriers:

- Lack of time of health professionals;
- Lack of access to basic health services;
- Lack of availability/affordability of medications
- Low priority for health policymakers

There are no magic bullets for culture change.

Next Steps

WHF CVD roadmap on tobacco

- Anchor tobacco as priority for reducing premature CVD mortality
- Integrate tobacco dependence treatment into basic treatment for CVD
- Identify Priorities for addressing upstream problems (health system and policy)
- Seek solutions with other sectors

WHF Emerging Leaders:

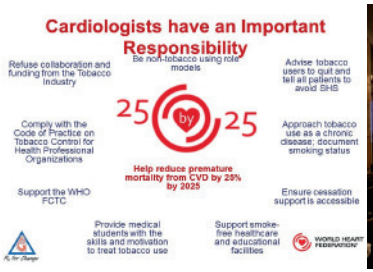
- Developing cadre of emerging leaders and expand heart health community's capacity in tobacco cessation and control

World Congress of Cardiology and Cardiovascular Health 2016 4-7 June 2016:

- Cessation training workshop
- Raising public awareness of CVD and heart disease (CTFK: Lupita the Broken Heart)
- Advocacy on Mexican smoke-free law.

WHF members:

- Promote use of curriculum in events
- Develop advocacy capacity of members
- Raise awareness of tobacco use/SHS exposure (WHD, events, Lupita)



Smoking Cessation Intervention with Trauma Patients

Rita K Cydulka, MD, MS, Steven Bernstein, MD, Kevin Hopkins, BA, for the American College of Emergency Physicians

What

Challenge And Project Overview

Prior studies have demonstrated that (1) the prevalence of tobacco use among trauma patients is higher than that of the general population; (2) Emergency Department (ED) patients typically have moderate levels of nicotine addiction and 61-79% are in the contemplation or preparation stage of change; (3) many trauma patients lack access to a primary care provider and are therefore unlikely to receive cessation messages from another source of medical care. We sought to examine the effect of an educational intervention on trauma care providers' knowledge base, attitudes and behaviors regarding screening for tobacco use on patients with traumatic injuries who present to the ED for treatment. The overall aim of the project was to improve the rate of smoking cessation interventions among these providers.

Who

n = 375

Sex, (% female)	43
Ethnicity (%)	
White	82
African American	4
Hispanic	3
Asian	8
Other	3
Provider Type(%)	
Physician	75
Emergency Medicine (% of physicians)	70
General/Trauma Surgery (% of physicians)	17
Orthopedic Surgery (% of physicians)	13
Nurse	21
Nurse Practitioner/Physician Assistant	1

Where and When

Six Sites: MetroHealth Medical Center/ Case Western Reserve University (coordinating site), Denver Health Medical Center,/ University of Colorado, Oregon Health and Science University, University of Missouri- Kansas City, University of Pennsylvania, University of Texas Houston;

Study Period: 2013-2015

How

1.Stake holders task force meeting -Representatives from the American College of Emergency Physicians, American College of Surgeons, American Academy of Orthopedic Surgeons, Emergency Nurses Association, and Society of Emergency Medicine Physician Assistants met to share organizational approaches and policies regarding smoking cessation interventions, develop consensus on roles and timing of such interventions and understand existing barriers to implementation of such interventions in trauma patients.

2. Recruit Level 1 Trauma Centers for participation.

3. Develop and test educational materials, provider and patient surveys.

4. Administer surveys- Gather baseline data assessing provider knowledge, attitudes, beliefs and practices about tobacco control.

5. Interview 50 adult tobacco-smoking trauma patients who are at each site→25 in ED +25 requiring hospitalization. Review medical record for documentation of ask-advise-refer interventions.

6. **Educational intervention** – PowerPoint lecture presentation

7.Stock ED, SICU, surgical and orthopedics units with "quit cards".

8. Administer surveys- Gather post-intervention data assessing provider knowledge, attitudes, beliefs and practices about tobacco control 2-4 weeks after intervention.

9. Interview 50 adult tobacco-smoking trauma patients who are at each site→25 in ED +25 requiring hospitalization. Review medical record for documentation of ask-advise-refer interventions.

Results

n = 375

Provider surveys	Baseline	Post-intervention	P-value
During the past month how often did you… (% always/usually)			
Ascertain smokng status?	77	80	< .001
Advise to to quit?	50	52	< .001
Ask patient if they've considered quitting?	28	36	< .001
Provide brief counseling to assist quit attempt?	20	29	< .001
Document assistance in record?	7	12	< .001
Refer to quitline or other program?	11	15	< .001
Smoking Cessation intervention is part of my role as a health care provider (% definitelly agree)	39	40	< .001

Conclusion

A brief educational intervention among trauma care providers resulted in a significant increase in smoking cessation intervention when caring for trauma patients.

Next Steps

- Ascertain patient recall and perception of intervention
- Ascertain best timing of intervention
- Implement ongoing educational program for trauma care providers

CEASE California: Implementing a Pediatric Clinical Intervention to Reduce Secondhand Smoke Exposure

Jyothi N. Marbin, MD; Cindy Nelson Purdy, PNP, MPH; Gena L. Lewis, MD; Kathleen P. Tebb, PhD
[1]Department of Pediatrics, UCSF Benioff Children's Hospitals Oakland & San Francisco

BACKGROUND

- Secondhand smoke (SHS) has a number of well documented negative health outcomes in children
- CEASE (Clinical Effort against Secondhand Smoke Exposure) is an evidence based intervention to offer smoking cessation assistance to parents
- This study evaluated dissemination of the CEASE program to Northern CA pediatric practices

OBJECTIVES

- Disseminate CEASE program to 20 clinics in Northern CA
- Track pre/post changes in CEASE implementation practices and Quitline referrals
- Identify barriers and facilitators to dissemination of CEASE intervention

METHODS

•Delivered in-person trainings to busy pediatric clinics in Northern CA
•Conducted post survey training to assess ability to improve knowledge and practice
•Conducted 6 month post training survey with clinic champion
•Tracked referrals to state Quitline

RESULTS

- Trained 24 practice sites with 279 staff
- High rating of training quality
- 95% reported an increase in ability to screen for SHSE, refer patients to Quitline, provide nicotine replacement therapy (NRT)
- 588 Quitline referrals generated; 37% of smokers reached by Quitline; 78% of those reached accepted help
- CEASE implementation resulted in significant improvements in provisions of NRT and referrals to Quitline

FACILITATORS TO IMPLEMENTATION

- Strong physician champion leadership
- Resident training
- Buy in of ancillary staff
- Systems to manage clinic referrals

BARRIERS TO IMPLEMENTATION

- Lack of EHR integration
- Lack of consistent insurance coverage for NRT
- Lack of time for intervention

CLINICIAN REPORTED BEHAVIOR CHANGE PRE/POST TRAINING

	Pre	Post	p-value
SHS screening	3.15 (SD .80)	3.54 (SD .52)	.054
NRT Prescriptions	1.23 (SD .44)	2.54 (SD .66)	<.001
Quitline Referrals	2.00 (SD .58)	2.70 (SD .58)	.013

CONCLUSIONS

The CEASE California training is a practical, replicable, model for pediatric providers seeking support to help parents quit smoking. Implementation of CEASE resulted in significant improvements in NRT prescriptions and referrals to the state Quitline. This study identified practice change strategies and support tools to increase providers' ability to implement CEASE in busy pediatric primary care settings. To strengthen implementation, sites must ensure adequate systems to support the intervention and strong support from champions and ancillary staff.

Funding Source: Pfizer Independent Grants for Learning & Change & UCSF Smoking Cessation Leadership Center | **Corresponding Author:** Jyothi N Marbin MD, jyothi.marbin@gmail.com

Tobacco Interventions for People with Behavioral Health Conditions: If you build it, how do you keep them coming?

Debra R. Hrouda, Ph.D.
Center for Evidence-Based Practices at Case Western Reserve University
Cleveland, Ohio

Background / History

2007 Partnership between Center for EBPs at Case; Ohio Tobacco Prevention Foundation and Ohio Departments of Mental Health; Alcohol and Drug Addiction Services; and Health to identify/ develop and disseminate evidence-based approach for tobacco with people with SPMI
- Development of ***Tobacco: Recovery Across the Continuum (TRAC)*** model, principles, and fidelity assessment
- Readiness Assessments with potential providers (n=39)
- Selection of Pilot sites (n=12)
- Fidelity assessment and implementation

2009 Ohio Department of Health: Tobacco Use Cessation Project
- Cessation only
- Required TTS
- Three implementation sites

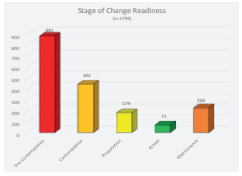
SAMHSA Primary and Behavioral Health Care Integration (PBHCI)

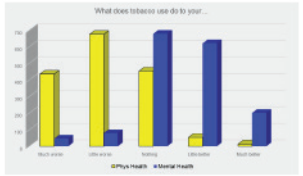
2011 CMS – Health Homes for People with SPMI
- Phase 1 Health Homes (n=5)
- Target: state-wide in 1 year (full roll-out delayed)

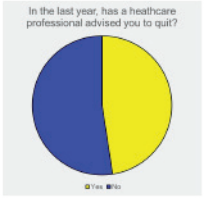
2012 Smoking Cessation Leadership Center at UCSF and Pfizer Medical Education Group grant
- All-Day training events (n=13)
- Group consultation "Tobacco Tuesday" (n=9)

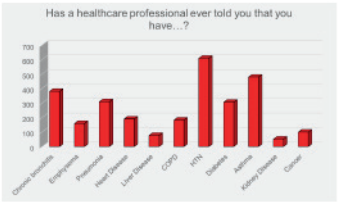
2014 Ohio Behavioral Health System Redesign

2015 SAMHSA Tobacco Policy Academy
OhioMHAS Tobacco Summit









What motivates people to change?

- Knowledge
- Ownership / responsibility
- Data
- Reward for positive change
- "Punishment" for negative or no change
- Fit with workflow
- Fit with personal mission / values / attitudes
- Money

Progress…

- > 2,400 people trained
  - Doctors, APRNs, nurses, counselors, social workers, care coordinators, hospital staff, managed care providers, peer support specialists, housing staff, local- and state-level policy-makers, local Department of Health cessation providers
  - Clinicians, supervisors, managers, educators, funders, decision-makers
  - Participants very pleased with training – mean=4.2 (5-point scale)
  - Knowledge acquisition: Post-test score – average 90 (median 93) with 90% of respondents scoring 80 or higher
- 1,220 hits to YouTube Channel

- Over 7,000 patients were assessed
- 42% identified as "tobacco users" (lower than expected)
- Of "tobacco users"
  - 63% Made at least 1 Quit Attempt
  - 14.5% Quit
  - 22.1% Reduction in use
  - 51% had a claim for *Tobacco Cessation (pharmacological)*

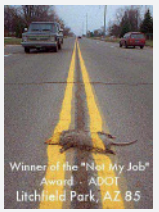
Tobacco: Recovery Across the Continuum (TRAC) Model Principles	
Organization-wide effort	Group and Individual services
Integrated approach	Strong interdisciplinary communication
On-going assessment	Involving natural supports
Stage-based approach	Pharmacological interventions
Motivational interventions	Implementation and Intervention monitoring

Lessons Learned

- People want to quit (and keep trying)
- Need focus on skill-building (in addition to training) especially re: engaging and motivating patients toward behavior change
- TTS less relevant for BH (potential barrier) to implementation
- Steep learning curve to "integrated" approach (easier with single-issue focus)
- MUST have reliable funding streams
- Need to build provider proficiency in documenting *medical necessity*
- Need top-down as well as side-to-side approach
- Stage of Change Readiness relevant:
  - For patients
  - For providers
  - For organizations
  - For systems
- *Just do it* won't cut it
- Training alone is not enough
- Policy alone is not enough
- Early and frequent involvement of stakeholders is necessary
- Expand to include all potential places people receive services (e.g. group home, employment services, peer services)
- Need to eliminate reverse-turf war

Whose job is it? *Everybody's!*

- Mental Health
- Addictions
- Primary Care
- Specialty Care
- Public Health
- Others??



Next Steps

- Continue to elicit buy-in / motivation to address tobacco for people with SPMI
- OhioMHAS and ODH working on a strategic plan to address the issue of high tobacco use rates among Ohioans with BH issues
- Ohio Department of Health (ODH):
  - People with mental illnesses and substance abuse disorders have been identified as an important disparate population with regard to tobacco use in Ohio
  - Will be offering funding for demonstration projects to address tobacco-related disparities
  - Will be directing some funds toward training for BH providers
- Work to define "value" in *Value-Based Payment*

Deb Hrouda, Ph.D.

Debra.hrouda@case.edu
http://www.centerforebp.case.edu

This work is funded, in part, by the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Health, the Smoking Cessation Leadership Center, and Pfizer Medical Education Group grant.

The Center for Evidence-Based Practices at Case Western Reserve University is a partnership between the Jack, Joseph, and Morton Mandel School of Applied Social Sciences (school of social work) at Case and the Department of Psychiatry at the Case School of Medicine. Our Center is a technical assistance organization (consulting, training, evaluation) that promotes recovery among people with mental illness, substance use disorders, and co-occurring disorders through the implementation of evidence-based practices and emerging best practices in behavioral healthcare.

"Physicians and Community Together, to Quit Smoking (PACT to Quit)"

Glendale Adventist Medical Center, Glendale, CA

Smoking Cessation Leadership Center

Glendale Adventist Medical Center

Adventist Health

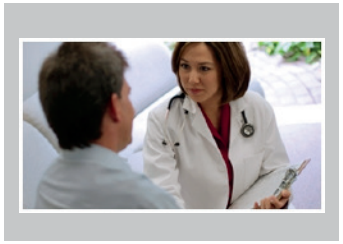
Project Overview

The overall aim of Physicians and Community Together to Quit Smoking, (PACT to Quit), was to increase participation in the American Lung Association's "Freedom from Smoking" (FFS) program, which is offered by Glendale Adventist Medical Center (GAMC) at no cost to participants. In order to accomplish this, the PACT to Quit program sought to increase the training of physicians, nurses, behavioral health practitioners, and Family Practice Residents in Ask, Advise, Assist, and Refer, (AAAR) thereby increasing the number of in-patients and out-patients towards enrollment in GAMC coordinated smoking cessation workshops.
In addition, sustainable relationships were forged between Behavioral Medicine, Care Transitions, Nursing, Family Medicine, and Alcohol and Drug Services to further create an impact on in-patients receiving tobacco cessation counseling.

PACT to Quit Program Staff:
Martha Rivera, *Lead Investigator*
Bruce Nelson, *Co-Lead Investigator*
Michael Olivares, *Program Coordinator*
Pat Etem, MPH, *Program Evaluator*

Who

Glendale Adventist Medical Center (GAMC) residents, nurses, and behavioral health practitioners were trained by GAMC Community Services Cessation Facilitators in delivering effective patient centered smoking cessation programs. Patients targeted included those who had been admitted with tobacco-related conditions (e.g. stroke, asthma, heart disease, mental/behavioral health conditions, and those affected by substance abuse) and those who stated at time of admission, that they used tobacco.



Where and When

Trainings and interventions were conducted at Glendale Adventist Medical Center and involved various departments, including Behavioral Health, Occupational Medicine, Family Medicine, and Urgent Care. One-on-one counseling was also given to patients who required or desired services. PACT to Quit occurred over a two (2) year period from 2013-2014.

Accomplished Outcomes

Currently, and as a direct outcome of PACT to Quit:

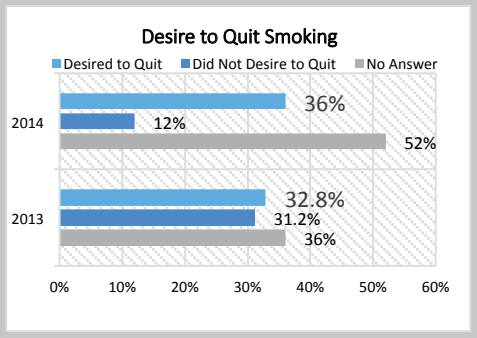
- GAMC Behavioral Health has increased the number of in-patients participating in tobacco cessation sessions to approximately 28 per month from July through December 2014, up from 12-16 participants between January and June 2013. This shows the large impact that Behavioral and Mental Health has on referring in-patients to tobacco cessation sessions.
- Occupational Medicine and Rapid Care Urgent Care Centers have created a process where a pre-formatted cessation referral letter is provided to their patients.
- All Family Medicine Residents have been trained in AAAR, adapting the best practice of providing in-patient brief cessation counseling during rounding. Family Medicine has also increased cessation referrals by two (2) a month.

Impact

As a result of PACT to Quit, GAMC has successfully enhanced and formalized in-patient cessation counseling for patients. The combined efforts made by physicians, nurses, behavioral health practitioners and other clinical care staff created an impact on in-patients receiving cessation counseling, and on increasing use of AAAR by practitioners.

Data -

The data collected represents 319 patients who received smoking cessation in 2014, up from 219 in 2013. Of these patients 72, or 36%, (up from 32.8% in 2013) desired to quit smoking; 12% did not desire to quit smoking (down from 31.2%). 52% did not respond (up from 36% in 2013). Previously, smoking cessation data was minimally tracked.



Innovative Tobacco Control Educational Module for Residents in Surgical Specialties

Margaret Nolan, M.D., David Cook, M.D., David O. Warner, M.D.,
Departments of Anesthesiology and Internal Medicine
Mayo Clinic, Rochester, MN

Background

Surgery represents a teachable moment for tobacco interventions[1], yet few surgical patients actually receive perioperative tobacco use interventions[2]. Surgical subspecialty trainees such as anesthesiologists currently receive little to no training in providing tobacco use interventions.

Study Aims

Our long-term goal is to increase the proportion of surgical patients who receive tobacco use interventions initiated by surgical specialists.

Our aim in this study is to test whether the innovative elements of adaptivity and simulated patient modeling affect the efficacy and efficiency of learning tobacco intervention techniques.

Module Design

Four versions of the module were created, each consisting of two parts (A and B), with two versions of each part as follows.

Part A: Basic information regarding perioperative tobacco control, with the goal of informing and motivating residents
1) Non-adaptive version: Content is provided in a standard fashion that includes some level of interactivity but no opportunities for adaptation.
2) Adaptive version: Content is provided in a fashion that allows the learner to adapt the presentation to his/her needs.

Part B: Teaching of how to apply the Ask-Advise-Refer (AAR) tobacco use intervention to surgical patients.
1) Non-interactive version – an idealized script of how to deliver the AAR is presented without learner interactions.
2) Interactive version – learners have the opportunity to choose from among differing approaches to the patient and model potential patient responses.

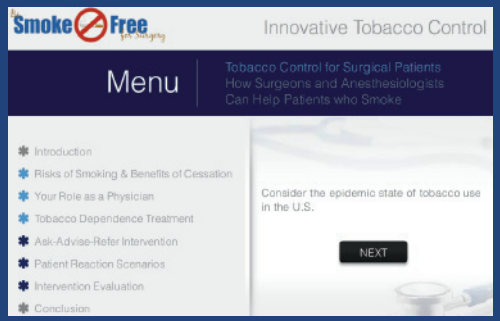
Methods

- Each of the four permutations of Parts A and B will be randomly administered to US anesthesiologists (2x2 design), to evaluate the use of adaptive and simulated patient approaches compared with more standard educational techniques.
- Program directors of the 133 US anesthesiology residency programs will be contacted and asked to distribute invitations to participate to their CA-1 to CA-3 residents.
- Residents who wish to participate will be directed to a learning management system website, and will be randomized to receive one of the four versions of the modules.
- The module will include a pre-test and a post-test.

Measures

- The following overall domains will be assessed:
  - Learning motivation (pre and post-test)
  - Knowledge (post-test)
  - Attitudes, barriers and beliefs (pre-test)
  - Tobacco Control Practices (pre-test)
  - Self-efficacy for tobacco interventions
  - Counseling skills (post-test)
  - Time to complete module and user satisfaction

Module Content



Module Example: Interactive

- Participant can choose response and will receive feedback on choice selected
- "More information" buttons with supplemental information are optional for correct answers, but not optional for incorrect answers

Module Example: Non-adaptive, Non-interactive

- User is required to click " More information" button for additional content even if answer is correct
- An idealized script is presented, without response choices

Analysis

- We will assess changes from pre- to post-test for each item used to measure the domains. The following comparisons will be made using factorial analysis:

1)Standard vs. Adaptive conditions. The ratio of change in each item to the time needed to complete the module, as an index of the efficiency of learning.

2) Simulated patient vs. Script. Self-efficacy for providing tobacco interventions

These results will be used to construct a final module that will then be disseminated to anesthesiology and surgery residency programs, so that every trainee will have access to basic training in tobacco control.

References

1. Shi Y, Warner DO: Surgery as a Teachable Moment for Smoking Cessation. *Anesthesiology* 2009.
2. Warner DO, Sarr MG, Offord K, Dale LC: Anesthesiologists, general surgeons, and tobacco interventions in the perioperative period. *Anesth Analg* 2004; 99: 1776-83.

Poster Contact: warner.david@mayo.edu

Impact of Communication Through Media on Tobacco Cessation Within A Healthcare System

Paul J. Pevoroff, RRT, RN, EMT, CTTS; Stephannie J. Braaf, B.S., CTTS – Memorial Healthcare System
Steven Zucker, D.M.D., M.Ed.; Gustavo Saldias, M.P.H.; Sheri Schour, B.B.A.– Nova Southeastern University College of Osteopathic Medicine

Overview

In 2013, MHS partnered with the Area Health Education Center (AHEC) Program of the Nova Southeastern University College of Osteopathic Medicine to integrate a system-wide inpatient model for delivering cessation counseling and referral services to tobacco dependent patients. The success of this effort has relied on communicating effectively with staff, patients, and the community on the importance of assessing and referring all tobacco dependent patients to appropriate treatment.

Goal: Increase awareness, educate, and promote the treatment of tobacco dependence to ensure that every tobacco dependent patient is assessed for tobacco use, counseled, and referred to cessation services.

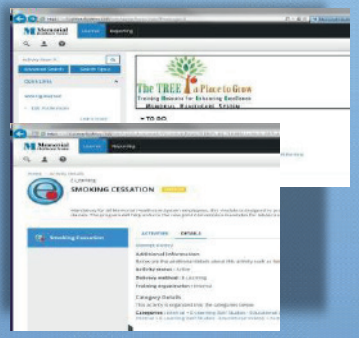
Program Activities

HEALTH COMMUNICATIONS

- Implement process that assesses all patients for tobacco use on every visit
- Generate cessation order upon assessment and route to clinician
- Execute referral process for patients interested in cessation counseling
- Schedule and provide on-site group counseling at MHS hospitals
- Train clinicians to address tobacco dependence with patients
- Provide staff training on tobacco cessation counseling
- Provide staff updates regarding tobacco dependence treatment
- Distribute materials for clinicians and patients on tobacco use and cessation

Methodology

In our ongoing effort to raise awareness and increase client referrals to our cessation programs, a wide range of communication channels are being integrated throughout MHS to convey the importance of addressing tobacco dependence in improving patient outcomes. Among these include online media, TV, publications, and community events. These outlets have been vital to engendering the participation of clinical staff and patients, while also captivating the attention of the current and future generation of tobacco users throughout the community we serve.



Online Training Module:

Mandatory for all MHS employees, an E-Learning online Smoking Cessation module is designed to provide information concerning tobacco use and referrals to tobacco cessation classes. This program supports the *Joint Commission* standards for tobacco cessation services to patients.

M Magazine:

Memorial Community Magazine published in both English and Spanish

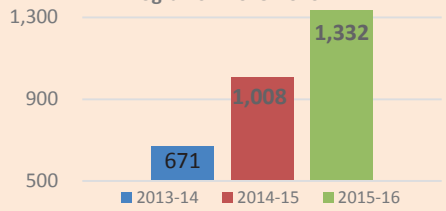
Memorial Community Outreach:

To schools, businesses, and employees

#bandingtogethertoquit

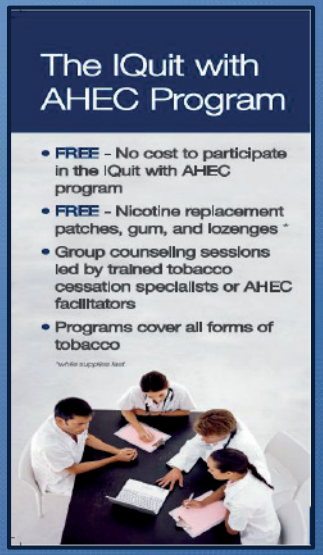
Results

Total Annual Number of Tobacco Dependent Patient Referrals from Five MHS Hospitals to AHEC Cessation Programs - 2013-2016



Television:

Dateline Health. Televised interview with Mr. Pevoroff and Mr. Saldias. Aired May –June, 2015



Program sponsored by the NSU Area Health Education Center (AHEC) Program and the State of Florida Department of Health.

Tobacco Free Florida.com

MultiCare
Center for
Healthy Living & Health Equity
BetterConnected

MultiCare Hospital QuitSmart™ Program

MultiCare Health System - Center for Healthy Living & Health Equity
Tacoma, Washington

Challenge And Project Overview

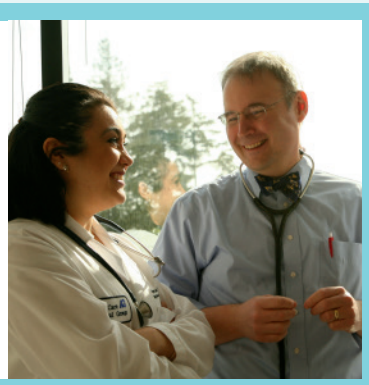
Our overall aim was to foster quality patient care by testing a new implementation process for a sustainable, structured tobacco cessation referral, counseling and intervention program for MultiCare's patients and providers.

The project tested the new intervention model which included online education with weekly group intervention via a call-in phone line, E-visits medication intervention program, and follow up three and six months after initiating in the QuitSmart™ program.

Who

This project was conducted by the MultiCare Health System, under the leadership of the MultiCare Center for Healthy Living (CHL) in collaboration with MultiCare Tacoma General and Good Samaritan Hospitals.

Our target pilot audience included MultiCare patients of Preventive Cardiology, Primary Care and Urgent Care, and employees participating in our employee wellness program, Healthy@Work.



Where and When

MultiCare draws patients from three Puget Sound counties, Pierce, King and Kitsap. Four of MultiCare's five hospitals are centered in Pierce County and three of those are in Tacoma, Washington. Data for Pierce and Kitsap counties show a higher level of tobacco use than the state average of 16% for adults and 14% for teens. Pierce County has a high percentage of adult tobacco users at 20%.

2013 was the year this intervention project took place.

Results | Lessons Learned

Through the QuitSmart online program and MultiCare's Healthy@Work tobacco cessation program, approximately 190 people were either referred or self-referred to MultiCare's tobacco cessation programs.

MultiCare offered scholarship 15-minute, virtual visits during 2013 specifically for tobacco cessation.

Results 1

Using electronic medical records through EPIC via SmartSets, we were able to generate a quick and easy referral system to the QuitSmart™ coordinator, to also include COPD and Pneumonia patient referrals.

Results 2

The QuitSmart™ intervention process was developed for referral, counseling & intervention. The process closed the loop by sending the referring doctor a telephone encounter of the patient's quit status. It is illustrated in the graphic below.

Results 3

Provider incentives and quit-rates were inversely proportional. When doctors advise patients to quit, a more positive reception generally occurs when engaging the patient to join the QuitSmart™ program.

Next Steps

Text Messaging -We would like to add to QuitSmart the component of targeted text messaging. Our goal would be to regularly text out encouraging messages to adults who are trying to quit smoking.

My Chart - Allow for QuitSmart™ to be housed within MyChart or a link within MyChart taking interested patients to the website.

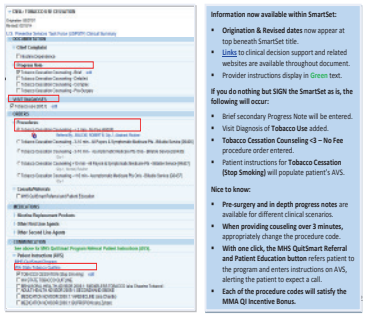
Virtual Visits – Continue to improve virtual visits. Continue with scholarship marketing of E-Visits.

Sustainability – Providers continue to refer to our in-house QuitSmart tobacco cessation program through new, updated referral messaging via EPIC. In house patients receive updated after visit handouts. QuitSmart continues to follow-up with patients to identify the ideal follow-up process.

We are identifying funding to support needed staff for the QuitSmart™ program with virtual telephonic visits offered free through MultiCare's Center for Healthy Living.

Methods

The intervention process included: 1) EPIC-generated referral for providers to order the QuitSmart program for their patients; 2) Counseling and Intervention Process easily accessed by visiting our website: http://www.multicarequitsmart.org. 3) If the tobacco status changed, this information was recorded in the patient's chart as a telephone encounter. The project tested the new intervention model using 145 volunteer patients, and approximately forty-five employee participants completing the intervention in 2013. Volunteers were offered participation in online education and weekly group phone counseling. CHL used a multidisciplinary model from referral to follow-up, involving a health educator, tobacco cessation specialist and primary care medical director.



Information now available within SmartSet:

- **Origination & Revised dates** now appear at top beneath SmartSet title.
- Links to clinical decision support and related websites are available throughout document.
- Provider instructions display in Green text.

If you do nothing but SIGN the SmartSet as is, the following will occur:

- Brief secondary Progress Note will be entered.
- Visit Diagnosis of **Tobacco Use** added.
- **Tobacco Cessation Counseling <3 – No Fee** procedure order entered.
- Patient instructions for **Tobacco Cessation (Stop Smoking)** will populate patient's AVS.

Nice to know:

- **Pre-surgery and in depth progress notes** are available for different clinical scenarios.
- **When providing couseling over 3 minutes,** appropriately change the procedure code.
- **With one click, the MHS QuitSmart Referral and Patient Education button** refers patient to the program and enters instructions on AVS, alerting the patient to expect a call.
- **Each of the procedure codes will satisfy the MMA QI Incentive Bonus.**

QuitSmart Intervention Process

Data Results

Indicator	2013 Apr-Dec
Number of referrals to QuitSmart Program.	142
Percent of patients who initiated QuitSmart Program –received mailer (# of people who initiated/# of referrals).	64.7% 92/142
Percent of QuitSmart patients who quit or cut down (# of people who quit/# of people who initiated).	47.8%
Number of MultiCare employees who participated in QuitSmart program, and responded to Gizmo Survey	38
Percent of MultiCare employees who quit or cut down (# of employees who quit or cut down/# of employees responding to Gizmo Survey	81.5%

Methods

Our plan is to work with MultiCare Connect to utilize our EHR to drive Quitsmart™ process improvement throughout the organization. Virtual visits will be housed within MyChart for expanded accessability. Referral routing utilizing ICD10 coding has been implemented.

MultiCare Connect will be the avenue through building an updated version of referral messaging utilizing ICD10 coding.

Data

Information to be collected will include number of patients served through MyChart, and Virtual visits. Comparisons of year-to-year provider referrals will be collected via QuitSmart™ staff from the on-going referral spreadsheets.

2015 WELLNESS & RECOVERY LEARNING COMMUNITY

Enhancing Tobacco Control Efforts among Addictions Providers through Cross-sector Partnerships in Florida

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.

Behavioral Health & Wellness Program
University of Colorado Anschutz Medical Campus
School of Medicine

Shelina D. Foderingham, MPH, MSW, Stephanie Quillen, BS, Chad D. Morris, PhD
Jim Pavlik, MA, Linda Rosenberg, MSW, Charles Ingoglia, MSW, Mohini Venkatesh, MPH

CHALLENGE & PROJECT OVERVIEW

THE CHALLENGE

- In 2014, nearly 17 of 100 U.S. adults smoked cigarettes.[1]
- Of people receiving care in addiction treatment settings, 77-93% use tobacco.[2]
- In 2011, of 617 the Florida addiction settings, only 41.2% screened for tobacco use, 14.6% prescribed tobacco cessation medications, and 30.8% offered cessation counseling.[3]
- Florida's smoking rates in the general population are lower than the national average,[4] the high rate of tobacco use in people with addictions combined with the low rates of screening and cessation services offered, demonstrates that disparities persist in tobacco cessation prevention and treatment for people with addictions.

OVERVIEW

In April 2015, the Wellness and Recovery Learning Community (WRLC) began. It consisted of an eight-month initiative aimed at:

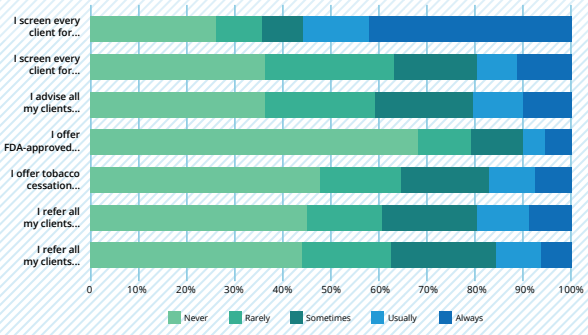
- Improving the overall health of Floridians with addictions by improving tobacco prevention and cessation efforts in seven addiction treatment agencies
- Strengthen cross-systems collaborations

BASELINE DATA COLLECTION EFFORTS

BASELINE ORGANIZATIONAL ASSESSMENT FINDINGS

WRLC participating organizations completed baseline and post-implementation surveys to assess their current clinical structures and their policies and protocols to support tobacco cessation. Below you will find a snapshot of how 422 staff from the WRLC participating organizations assessed their tobacco cessation efforts.

	Never	Rarely	Sometimes	Usually	Always	Total	Weighted Average
I screen every client for tobacco use at intake	26.30% 111	9.48% 40	8.77% 37	13.51% 57	41.94% 177	422	3.35
I screen every client for tobacco use at all subsequent visits	36.28% 152	26.97% 113	17.42% 73	8.35% 35	10.98% 46	419	2.31
I advise all my clients who use tobacco to quit at every visit	36.69% 153	22.78% 95	20.38% 85	10.55% 44	9.59% 40	417	2.34
I offer FDA-approved tobacco cessation medications to all my clients who use tobacco	68.59% 286	11.03% 46	10.55% 44	4.56% 19	5.28% 22	417	1.67
I offer tobacco cessation counseling to all my clients who use tobacco	48.19% 200	16.63% 69	18.31% 76	9.40% 39	7.47% 31	415	2.11
I refer all my clients who use tobacco to the Bureau of Tobacco Free Florida Quitline	45.32% 189	15.35% 64	19.90% 83	11.03% 46	8.39% 35	417	2.22
I refer all my clients who use tobacco to other community tobacco cessation services (i.e. support groups).	44.58% 181	18.23% 74	21.67% 88	9.61% 39	5.91% 24	406	2.14



SEVEN ADDICTION PROVIDER ORGANIZATIONS

disc village
Gateway Steps to Recovery
Henderson Behavioral Health
LifeStream
PAR
South Florida Wellness Network
WestCare

PARTNERS

FADAA Florida Alcohol & Drug Abuse Association
Tobacco Free Florida .com

This opportunity was made possible through a cooperative agreement funded through the Pfizer/SCLC Independent Grants for Learning & Change

METHODS

PLANNING AND DEVELOPMENT

- Recruiting and selecting seven addiction provider organizations through a call for applications
- Collaborating with the Florida Alcohol and Drug Abuse Association (FADAA) and Tobacco Free Florida to develop the program curriculum and support recruiting efforts
- Developing and implementing a robust monitoring and evaluation plan to collect baseline and post-implementation data
- Developing and enhancing cross-systems collaboration between the seven provider organizations, FADAA and Tobacco Free Florida

PROGRAM ACTIVITIES

- In-person kick off meeting
- Webinars to educate and train organizations on tobacco control and prevention
- Peer-to-peer sharing and learning

LESSONS LEARNED & NEXT STEPS

DISSEMINATION OF FINDINGS

The WRLC findings will be disseminated by August 2016 through the following channels:

- National Council Conference workshop, April 2016
- Tobacco Tips for Addiction Providers Infographic and National Webinar, July 2016
- FADAA Annual Conference 2016 workshop, August 2016
- Published findings on www.BHtheChange.org

Preliminary lessons learned and next steps from the participating organizations include:

- Continuing relationship with Tobacco Free Florida and FADAA
- Expanding access to tobacco cessation services for clients through training
- Disseminating tips for addictions provider organizations going tobacco-free

My tip for being tobacco-free is...

- Having a planning committee and making monthly goals to help move the agency toward the end goal
- Love yourself enough to quit
- Keeping busy — the more things patients have to do, the less they seem to want to smoke
- Identifying your end goal and keep your eye on that!

I help the people I serve be tobacco-free by...

- Sharing with patients available resources and support to quit and stay quit
- Offering the smoking cessation classes
- Increasing access to tobacco cessation counseling services and FDA-approved pharmacotherapy
- Emphasizing and encouraging healthy behaviors

1. Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2005–2014. Morbidity and Mortality Weekly Report 2015;64(44):1233–40 [Published Nov 2015]
2. Signal Behavioral Health Network. 2009. Tobacco Treatment for Persons with Substance Use Disorders: A Toolkit for Substance Abuse Treatment Providers. Colorado: Tobacco Use Recovery Now! (TURN).
3. Substance Abuse Mental Health Services Administration. 2011. "State Profile – United States, National Survey of Substance Abuse Treatment Services (N-SSATS)". Accessed October 12, 2014, http://www.dasis.samhsa.gov/webt/state_data/US11.pdf.
4. Signal Behavioral Health Network. 2009. Tobacco Treatment for Persons with Substance Use Disorders: A Toolkit for Substance Abuse Treatment Providers. Colorado: Tobacco Use Recovery Now! (TURN).

www.BHtheChange.org | #BHtheChange

Interactive e-Learning Tobacco Cessation Program for Post-Doctoral Dental Students and Dental Residents

David A. Albert* & Angela M. Ward
Columbia University College of Dental Medicine

INTRODUCTION

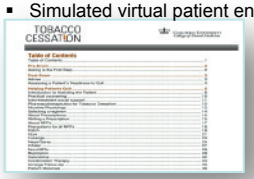
To address barriers associated with implementing tobacco cessation education in the postdoctoral experience, the College of Dental Medicine and Columbia Center for Teaching and Learning (CCTL) developed a web-based, interactive course on tobacco cessation and tested its efficacy with post-doctoral students and dental residents.

Nicotine replacement drag and drop activity

Virtual patient example

Course Content

- Multimedia learning modules on pharmacotherapy regimens
- Demonstrative videos
- Immediate-response quizzes
- Interactive treatment activities
- Self-study exercises
- Simulated virtual patient encounters



General course guide and pharmacotherapy guide included with web material.

METHODS

The Tobacco Cessation course was evaluated with post-doctoral students and dental residents at Columbia University College of Dental Medicine and Jacobi Hospital, both located in New York City. After signing informed consent, participants completed a pre-survey that included demographic questions and assessed tobacco cessation attitudes, knowledge, self-efficacy and perceived barriers. Students then reviewed the course independently and attended a required tobacco cessation seminar. In the seminar they worked in teams to role-play patient encounters and reflect on their experiences. Participants then completed a post-course evaluation and the results were analyzed for pre to post-test changes.

RESULTS

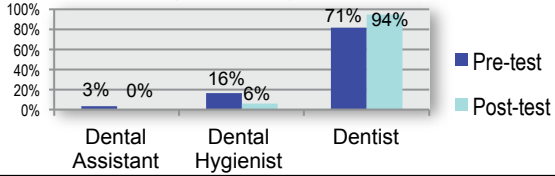
TABLE 1. Post-doctoral student and dental resident descriptive statistics

Variable (N=76)	N	%
School/Hospital		
Columbia University/ NYPH	59	77.6
Jacobi Medical Center	17	22.4
Specialty group		
General Dentistry	36	47.4
Pediatrics or Orthodontics	16	21.1
Oral Surgery or Periodontics	13	17.1
Other	11	14.5
Smoking status		
No	20	84.7
Yes	9	15.3
Gender		
Female	40	53.3
Male	35	46.7
Race and ethnicity		
White	34	44.7
Asian	19	25.0
Hispanic	13	17.1
Black	2	2.6
Other	8	10.5

Professional Responsibilities

At baseline most participants (71%, n=54) believed that tobacco cessation is an important professional responsibility and is primarily the responsibility of the dentist rather than hygienist or assistant.

Table 1. Primary responsibility for tobacco cessation



Tobacco Cessation Knowledge

- The majority of participants rated their knowledge about tobacco cessation as at least "Good" (57.9%, n=44).
- Knowledge of tobacco cessation counseling was limited:
  - At baseline, participants' mean knowledge score was 2.02 out of a possible 5 (SD=1.19).
  - On post-test there was a statistically significant increase in total knowledge score to 2.56 (SD=1.17, p=.007).
  - Analysis of variance tests showed that there were no significant group differences in knowledge at baseline; after the intervention; or in knowledge acquisition by school/hospital, specialty or any demographic factor.

Pharmacotherapy and Counseling Self-Efficacy

- Self-efficacy scores were developed for Assisting behaviors (provision of pharmacotherapeutics and counseling).
  - Pharmacotherapeutic self-efficacy increased (14.58 vs. 21.30, p<0.001).
  - Counseling self-efficacy increased (18.47 vs. 23.4, p<0.001).

Barriers to Implementing Tobacco Cessation in Practice

- Prior to participating in the online course residents identified patient resistance as the most commonly endorsed barrier to providing tobacco cessation.
- On post-test, residents identified lack of time as the most significant barrier.

Table 2. Participant Identified Barriers to Tobacco Cessation

CONCLUSIONS

- Study results indicate that a web-delivered tobacco cessation educational course can be a viable methods for empowering post-doctoral students and dental residents to effectively practice tobacco cessation in their future dental practice.

daa1@cumc.columbia.edu

COLUMBIA UNIVERSITY
College of Dental Medicine

Funding: This work was supported by the Columbia Center for Teaching and Learning's Triangle Initiative and the Pfizer Foundation.

SMOKING CESSATION LEADERSHIP CENTER

IMPLEMENTATION OF ENHANCED TOBACCO USE MEASURES AND INTENSIVE TRAINING IN NEW YORK

Jill M Williams, MD[1], Gregory Miller , MD[2], Maxine Smalling, RN[2] and Scott Stroup, MD, MPH[3]

[1]Rutgers-Robert Wood Johnson Medical School, [2]NY Office of Mental Health, [3]Research Mental Health Foundation/NYSPI

Introduction

• Smokers with mental illness have less access to tobacco dependence treatment across the health care spectrum, and specifically in the behavioral health setting

• Improving documentation of tobacco use and cessation attempts through the electronic health record (EHR) is a powerful strategy that increases smoking cessation interventions provided by health care professionals in primary care settings.

•A similar approach was used successfully in NYS OMH to implement health screenings for cardio-metabolic disease

Study Objective: The focus of this Pfizer Independent Grant for Learning and Change is to develop and implement a new comprehensive measure for tobacco use and cessation attempts within New York State Office of Mental Health (OMH) outpatient facilities.

Methods

NY OMH is a large system that serves over 23,000 outpatients with serious mental illness (SMI) per year.

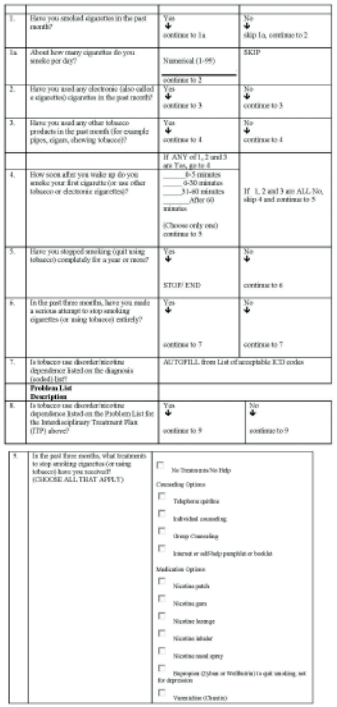
Improving documentation of tobacco use and cessation attempts through the electronic health record (EHR) is a powerful strategy that increases smoking cessation interventions provided by health care professionals in primary care settings.

We will implement a new tobacco use measure in the statewide EHR through training sessions, quality improvement meetings and Learning Collaboratives.

This activity promotes systems change and is synergistic with other planned efforts by NY OMH to provide intensive training for its health care professionals and to develop tobacco free policies for these clinical sites.

Results

Figure 1. Enhanced Tobacco Use Measures in the OMH Cardiometabolic Monitoring System



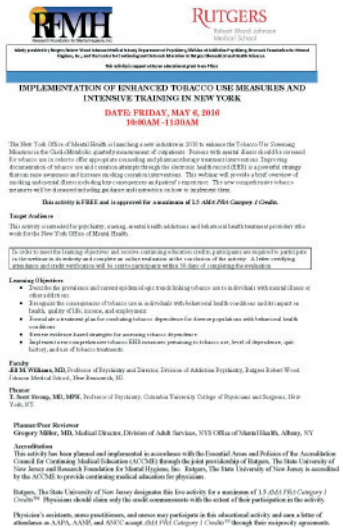
1.	Have you smoked cigarettes in the past month?	Yes ↓ continue to 1a	No ↓ skip 1a, continue to 2
1a.	About how many cigarettes do you smoke per day?	Numerical (1-99) _____ continue to 2	SKIP
2.	Have you used any electronic (also called e cigarettes) cigarettes in the past month?	Yes ↓ continue to 3	No ↓ continue to 3
3.	Have you used any other tobacco products in the past month (for example pipes, cigars, chewing tobacco)?	Yes ↓ continue to 4	No ↓ continue to 4
		If ANY of 1, 2 and 3 are Yes, go to 4	
4.	How soon after you wake up do you smoke your first cigarette (or use other tobacco or electronic cigarettes)?	_____ 0-5 minutes _____ 6-30 minutes _____ 31-60 minutes _____ After 60 minutes (Choose only one) continue to 5	If 1, 2 and 3 are ALL No, skip 4 and continue to 5
5.	Have you stopped smoking (quit using tobacco) completely for a year or more?	Yes ↓ STOP/ END	No ↓ continue to 6
6.	In the past three months, have you made a serious attempt to stop smoking cigarettes (or using tobacco) entirely?	Yes ↓ continue to 7	No ↓ continue to 7
7.	Is tobacco use disorder/nicotine dependence listed on the diagnosis (coded) list?	AUTOFILL from List of acceptable ICD codes	
	Problem List Description		
8.	Is tobacco use disorder/nicotine dependence listed on the Problem List for the Interdisciplinary Treatment Plan (ITP) above?	Yes ↓ continue to 9	No ↓ continue to 9

9.	In the past three months, what treatments to stop smoking cigarettes (or using tobacco) have you received? (CHOOSE ALL THAT APPLY)	☐ No Treatment/ No Help Counseling Options ☐ Telephone quitline ☐ Individual counseling ☐ Group Counseling ☐ Internet or self/help pamphlet or booklet Medication Options ☐ Nicotine patch ☐ Nicotine gum ☐ Nicotine lozenge ☐ Nicotine inhaler ☐ Nicotine nasal spray ☐ Bupropion (Zyban or Wellbutrin) (a quit smoking, not for depression ☐ Varenicline (Chantix)

Enhanced Tobacco Use Measures

"Have you had a puff of a cigarette or more in the past month?" Yes/ No

- ✓Quantify tobacco use
- ✓Include other tobacco and electronic cigarettes
- ✓Assess level of dependence
- ✓Documentation on Problem List and Treatment Plan
- ✓Utilization of tobacco treatments



RFMH RUTGERS Robert Wood Johnson Medical School

IMPLEMENTATION OF ENHANCED TOBACCO USE MEASURES AND INTENSIVE TRAINING IN NEW YORK

DATE: FRIDAY, MAY 6, 2016
10:00AM -11:00AM

This activity is FREE and is approved for a maximum of 1.5 *AMA PRA Category 1 Credits.*

Target Audience

Learning Objectives

Faculty
Jill M. Williams, MD, Professor of Psychiatry and Director, Division of Addiction Psychiatry, Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ.

Planner
T. Scott Stroup, MD, MPH, Professor of Psychiatry, Columbia University College of Physicians and Surgeons, New York, NY.

Planner/Peer Reviewer
Gregory Miller, MD, Medical Director, Division of Adult Services, NYS Office of Mental Health, Albany, NY

Accreditation

Physician's assistants, nurse practitioners, and nurses may participate in this educational activity and earn a letter of attendance as AAPA, AANP, and ANCC accept *AMA PRA Category 1 Credits™* through their reciprocity agreements.

Interim Results

- Developed question set
- Worked with MHARS computer programmers at NYOMH to implement this into EMR.
- Obtained CME approval for webinar training
- Held live CME webinar on May 6, 2016 and archived it for future use.
- Planned date for June 1, 2016 for EMR questions to go live
- Planned quarterly monitoring reports

This activity promotes systems change and is synergistic with other planned efforts by NY OMH to provide intensive training for its health care professionals and to develop tobacco free policies for these clinical sites.

It is hoped that enhanced implementation of tobacco use and cessation attempts through the electronic health record (EHR) will accomplish many things in the OMH system

•Raise the awareness and importance of addressing tobacco, Allow for improved ongoing measurement of tobacco use and quit attempts
•Create an effective longitudinal measure to evaluate the impact of tobacco-related activities on patient outcomes.

RUTGERS Robert Wood Johnson Medical School

RFMH Research Foundation for Mental Hygiene, Inc.

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

CENTER FOR CONTINUING & OUTREACH EDUCATION AT RUTGERS BIOMEDICAL & HEALTH SCIENCES

This work was supported by an unrestricted educational (CME) grant from Pfizer.

"Trash the Ash"

San Jose City College
San Jose, CA

SMOKING CESSATION LEADERSHIP CENTER

san josé·evergreen COMMUNITY COLLEGE DISTRICT

Tobacco Peer Education

- Tobacco Peer Educators (TPE) completed Tobacco Education training or were certified through "COUGH Cessation Student Activist Training" through the California Youth Advocacy Network (CYAN)
- TPE presented "Tobacco Kills" which focused on college age specific information about Tobacco awareness, carcinogens and the benefits of quitting.

Health Care Professional Programs: "Ask Advise and Refer"

- Facilitate the education of healthcare provider students about the dangers of tobacco and the benefits of quitting, as well as a brief tobacco intervention tool to use with their clientele: "Ask, Advise and Refer"
- Educate the public through the health care professional and promote tobacco cessation on an exponential level .
- Each presentation was tailored to the needs of the specific class. For example: The presentation to Dental Assistants includes information about tobacco use with an emphasis on periodontal disease.

San Jose City College and Evergreen Community College 2013-2015

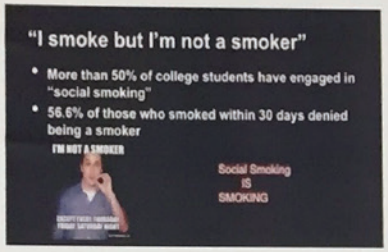
Ask Advise and Refer for Healthcare Providers

- **Ask** Every Patient at every visit
  - About their own tobacco use or that of their family or roommates
  - 5th Vital Sign
  - Incorporate into assessment flow sheet
- **Advise** your advice doubles their chance of making a quit attempt
- **Refer** Free Smoking Cessation Counseling 1-800-No-Butts

Source: UCSF Rx for Change: http://rxforchange.ucsf.edu

"I smoke but I'm not a smoker"

- More than 50% of college students have engaged in "social smoking"
- 56.6% of those who smoked within 30 days denied being a smoker



Healthcare Professional Programs at San Jose Evergreen Community College District

Emergency Medical Technician	Registered Nurse
Dental Assistant	Nursing Assistant
	Medical Assistant

Facilitated Healthcare students' learning about:

1) Tobacco awareness, carcinogens and the health effects of long-term tobacco usage
2) How to encourage smokers to quit smoking or to join a smoking cessation program: 1-800-NO BUTTS
3) Ask, Advise, and Refer Brief tobacco intervention to use in their specific areas of practice

Tobacco Education Events

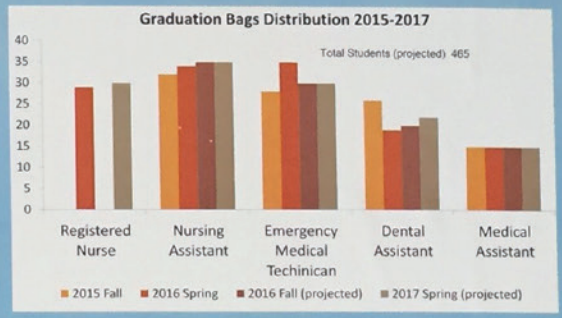
Great American Smoke Out! — **Kick Butts Day Earth Day**

- Tobacco Peer Educators participated in campus events.
- Cigarette butt pick-ups were successful picking up over 5,000 butts in just an hour!
- Tobacco Peer Educators and student activists were featured in the campus newspaper participating in the "I am Not a Replacement" campaign.

Graduation Bags

- Presented to the senior health care provider students.
- Accompanied by a 5 minute video to instruct them in the Ask Advise and Refer model
- The bags are intended to facilitate tobacco intervention in their future fields.

Contents: Help your Patients quit smoking: A guide for Health Care Providers, 1-800 NO-BUTTS referral card, Notebook, Pen, Key Fob, CPR mask.



Student Health 101

- Health and Wellness E-magazine provided for all students on both SJCC and Evergreen Community Colleges (District wide.)
- Each monthly issue features a Tobacco related article on the front page as well as customizable pages that are tailored to include our free Tobacco Cessation services, and tobacco awareness events on campus.
- Promotion of monthly issues include:
  - Email blasts to students: Over 16,000 students per month.
  - Ad's in campus newspapers
  - Banners and subscription links on SJCC and Evergreen Community College websites.

OUR TEAM

Janet Chang RN, MS Janet.Chang@sjcc.edu

Jan Reid, RN
Kathleen Barzegar RN, BSN
Lisa Little
Sonia Torres-Ramos MA
Travis Cheng

COMMUNITY PARTNERS

- Breathe California
- UCSF Rx for Change http://rxforchange.ucsf.edu
- California Youth Advocacy Network (CYAN) http://www.cyanonline.org
- 1-800-NO-BUTTS

DISCLOSURE

I have no **relevant financial or nonfinancial relationships** in the products or services described, reviewed, evaluated or compared in this presentation.

UW Medical Center and Harborview Inpatient Tobacco Cessation Program

Abigail Halperin MD, MPH and Nick Fradkin MPA, MPH
Department of Family Medicine, University of Washington


UW Medical Center (UWMC)


Harborview Medical Center (HMC)

Challenge and Project Overview

The primary aim of this project was to increase the number of tobacco-using patients admitted to two University of Washington (UW) hospitals that receive evidence-based treatment for tobacco use and dependence, as recommended by the Joint Commission (JC) revised tobacco treatment measures (TTMs). This would be accomplished by expanding and enhancing the systems, procedures and protocols of an existing inpatient tobacco cessation program that was implemented in May 2011 but fell short when the JC's expanded tobacco performance measure set was released.

More specifically, the goal of the project was to increase the number of hospitalized patients that are screened for tobacco use, offered and provided with evidence-based cessation counseling and approved medications, and referred for follow-up care following discharge. This would, in turn, increase the number of inpatients who quit smoking during their hospitalization and remain abstinent after discharge, thus leading to reduced prevalence of tobacco use, improved health outcomes, and lower health care costs in our community and state.

Methods

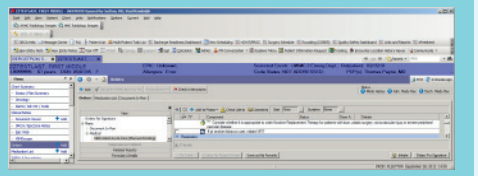
TTM-1: Screen all inpatients for tobacco use and document tobacco use status
Incorporated Meaningful Use smoking questions into electronic medical records (ORCA and EPIC systems) at University of Washington Medical Center (UWMC) and Harborview (HMC) hospitals.

TTM-2: Offer treatment – both medication and counseling – to all patients identified as tobacco users, and document acceptance or decline of offer, as well as receipt of treatment

a) Medication: Implemented computerized physician order entry (CPOE) and dosing protocol for nicotine replacement therapy (NRT) at UWMC and HMC (see screen shot below.
b) Counseling: Identified and addressed an issue related to faulty skip logic in admission intake form whereby patients who declined offer of NRT were not being offered counseling (see screen shot below).

TTM-3: Provide discharge instructions, medications and follow up resources at discharge
Pharmacists at UWMC were charged with providing NRT and counseling at the bedside for patients who accepted the offer, as well as discharge instructions. Pharmacy student interns were also trained to provide tobacco cessation counseling at the bedside and at time of discharge for increased continuity.

TTM-4: Assessing tobacco use status after discharge.
Investigated opportunities and resources for implementing a new mechanism for following up with patients participating in the program, through our state tobacco quitline (WAQL), using a paper or electronic two-way fax, but was not logistically or financially feasible.



Left: Revised tobacco use screening form in ORCA (EMR system)
Above: CPOE form for ordering NRT in ORCA

Results | Lessons Learned

TTM-1: Screen all inpatients for tobacco use

Increased the prioritization of tobacco use screening, by implementing meaningful use questions in the EMR with compliance increasing from an average of 90% of patients screened before the project (2011) to 98% afterwards (2013) at UWMC, and from an average of 69% to 85% at HMC during the same time periods (Figure 1). Smoking rates among admitted patients screened at the two hospitals reveals a large disparity between the populations served; Harborview, our county hospital, serves more indigent patients and has three times the tobacco use rate of patients at UWMC. Eleven percent of UWMC patients reported current smoking, compared with 33% of HMC patients.

TTM-2: Offer treatment (medication and counseling)

a) Medication: This modestly increased the number of patients who were offered, accepted and received NRT during their hospital stay. Unfortunately, we saw declines in uptake of NRT at UWMC (although not at HMC) after a change was made in the EMR intake form in November, near the end of the project..
b) Counseling: Offer and uptake increased (Figure 2), including cases whereby patients who declined offer of NRT but accepted counseling received NRT after counseling by pharmacist. We saw this as a promising development for increasing provision of evidence-based treatment, as counseling and medication together are more effective than either one alone. However, with the EMR changes that took place in November, we also saw declines in provision of counseling at the bedside.

TTM-3: Provide discharge instructions, medications and follow up resources at discharge.

Of the 42% of current smokers who received NRT in the hospital, nearly half (49%) received NRT on discharge from HMC; at UWMC, of the 38% who received NRT in the hospital, over half (58%) received NRT on discharge. All patients discharged from the hospital receive written advice on the discharge summary to quit tobacco if they are smokers or use other tobacco products, along with referral information for follow up with WAQL or the patient's primary care provider.

TTM-4: Assess tobacco use status after discharge.

While we were hopeful to be able to use a paper or electronic fax follow-up (fax-back) referral mechanism, there were barriers from both the UWMC side and the WAQL side. The hospital pharmacy did not have the personnel to send, receive and track paper faxes, and the WAQL did not have electronic fax capability at that time; we investigated a commercially available e-fax vendor , but it was prohibitively expensive.

Figure 1: Post-Implementation Tobacco Use Screening Compliance Rates

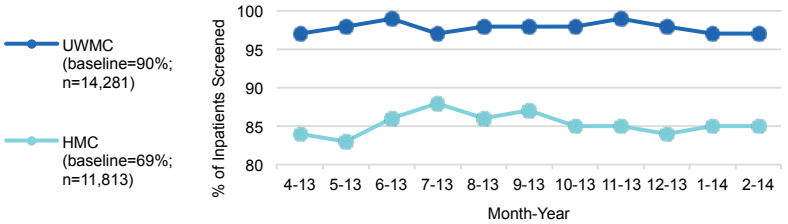
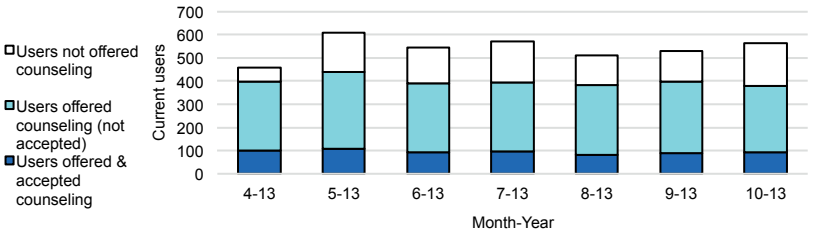


Figure 2: Counseling Offer and Acceptance (UWMC & HMC)



Global Tobacco Dependence Treatment Summit participants, May 2016