Applying the Performance Partnership Model to Smoking Cessation: Lessons Learned by the Smoking Cessation Leadership Center

Connie C. Revell, MA[1]
Margaret B. Meriwether, PhD[1]

A wide array of partners can be convened around a single measurable outcome, such as driving down smoking prevalence, through the use of an innovative approach called the performance partnership model. This approach has certain key characteristics that make it different from ordinary coalition building, such as following four steps leading to a baseline, a target, an action plan, and an impact measurement plan. It also employs great speed and focus to keep partners engaged, and it has led to demonstrable progress on smoking cessation nationwide.

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In September 2003, 14 dental hygienists representing the American Dental Hygienists' Association (ADHA) huddled with a small group of staff from the Smoking Cessation Leadership Center (SCLC) at the University of California, San Francisco and laid out a plan to hasten norm change within their profession with regard to intervening with smoking patients (SCLC, n.d.). The SCLC provided funding to help the ADHA implement the action plan the group developed, creating the Smoking Cessation Initiative. That action plan launched a quiet revolution by directing the hygienists' efforts toward a shortened version of the clinical practice guideline on cessation. That abbreviated version—which the hygienists dubbed "Ask. Advise. Refer."—has spread rapidly around the nation and the world. The story of this process, and how it helped foster the dissemination of a protocol that is agreeable to a wide range of clinicians, is a useful one to relate, with lessons that can be applied to many health promotion activities. The performance partnership model is a systems-based approach that has been used to improve the practice of health professionals on tobacco dependence treatment.

The Smoking Cessation Leadership Center began in 2003 as a national program office of the Robert Wood Johnson Foundation and its mission is straightforward—to decrease smoking prevalence and to increase the number of clinicians and others who intervene with smoking patients. The director, Steven A. Schroeder, MD, was previously president of Robert Wood Johnson Foundation and is well known for his advocacy for tobacco cessation treatment by clinicians, along with other aspects of tobacco control.

Recently, a national survey of seven health professional groups (Tong, Strouse, Hall, Kovac, & Schroeder, 2010) revealed that few actually perform all the steps of the smoking cessation guideline established by the U.S. Public Health Service in the *Treating Tobacco Use and*

[1]*University of California, San Francisco, CA, USA*

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Dependence: 2008 Update Clinical Practice Guideline. The steps to help smokers quit in the guideline are known as the "5 As"—ask, advise, assess, assist, and arrange. Notably, the 2008 *Update* (Fiore et al., 2008) also mentions the Ask. Advise. Refer. shortcut as an acceptable alternative to the 5 As.

The ADHA, an 80-year-old professional association representing more than 150,000 registered dental hygienists and headquartered in Chicago, was the first of a series of associations and localities with which the SCLC used an approach known as the performance partnership model. The idea of the model is simple: to take a group from where it is to where it wants to be on a single, measurable outcome (Dyer, 1996). In this case, the measure involved the percentage of hygienists who intervened with smoking patients.

The performance partnership model involves taking a group through four simple questions:

1. Where are we now? (the baseline)
2. Where do we want to be? (the target)
3. How will we get there? (the action plan with multiple strategies)
4. How will we know we are getting there? (the impact measurement plan)

The essence of the approach lies in its simplicity, but that simplicity is deceiving. What a group does by employing the model is to identify a single, measurable outcome it wishes to focus on, and then brainstorming a sophisticated plan for achieving it. The complexity comes from a central key to the success of performance partnerships: They require complete consensus on *what* a group is trying to achieve, but they encourage wide diversity of strategies and tactics on *how* to achieve it, thereby greatly expanding the inclusiveness of the approach. This "letting go of the *how* in exchange for complete agreement on the *what*" has helped numerous groups transcend intense internal struggles over tactics. It exchanges "program" thinking for that of a broad strategic initiative focused, laser-like, on a single goal around which everyone rallies. It helps people redirect existing projects to coalesce around a common effort, often without creating an additional work burden or cost (Macy, 1996).

The model builds in the fostering of creative solutions to intractable problems. A recent essay in *Newsweek* (Bronson & Merryman, 2010) on creativity wrote, "To be creative requires divergent thinking (generating many unique ideas) and then convergent thinking (combining ideas for the best result)."

The ADHA initiated a campaign to motivate dental hygienists to perform smoking cessation interventions with patients. The campaign, called the Smoking Cessation Initiative, urged all hygienists to ask all patients whether they smoke, advise them to quit, and refer tobacco users to a quitline. Another product of the Smoking Cessation Initiative was the creation of the "Ask. Advise. Refer." website, which promotes tobacco interventions by dental hygienists (Ask. Advise. Refer., n.d.).

During the September summit, the ADHA tobacco task force had established a baseline from rather scanty existing literature regarding hygienist smoking interventions; they agreed that about a quarter of all hygienists at that time intervened in any way with smoking patients. They set a target to increase that proportion to one-half in 3 years (Schroeder, 2006). A postinitiative survey revealed an increase to 56%, exceeding the target.

After ADHA experienced such success with its partnership, SCLC engaged in similar initiatives with a number of other professional organizations and clinician groups; the first was an ambitious undertaking with a number of major pharmacy associations led by the American Society of Health-System Pharmacists (ASHP), an organization with approximately 35,000 members. This pharmacy summit held on October 21, 2004, in suburban Washington, D.C., led a group of 30 pharmacy stakeholders through the same four questions, thus enabling them to focus on cessation intervention, set a realistic target, and make plans to move toward the target. The group established a baseline based on a study showing that only 6% of patients reported having been asked about smoking by a pharmacist. The group set a target of increasing that number to 20% over 3 years (Hudmon & LaCivita, 2006). The SCLC, as a partner in the effort, funded a position to lead the newly formed National Pharmacy Partnership for Tobacco Cessation along with its website (http://www.ashp.org/tobacco) as it strove to implement its action plan and achieve the target (National Pharmacy Partnership for Tobacco Cessation, n.d.).

The SCLC then continued to identify national professional groups interested in partnering to improve their members' performance with regard to tobacco use intervention. In short order, performance partnerships were formed and summits held with respiratory therapists, physician assistants, psychiatric nurses, family physicians, anesthesiologists, and diabetes educators. Each established its own baseline, target, action plan, and impact measurement plan. In each case, the SCLC staff was a major and enduring partner. Following is an example of targets some groups have chosen and progress made:

The Center, in 2006, was invited by the American Legacy Foundation to broaden its focus to a challenging group of hard-core smokers, those with mental health disorders and addictions. Taking up the challenge, the Center staff forged relationships with a wide array of national leadership organizations in the behavioral health

Smoking Cessation Leadership Center Initiatives: Targets and Measures at a Glance

American Dental Hygienists Association (ADHA)	25% of dental hygienists intervene with patients who use tobacco	Double to 50% over 3 years	Establishment of website and state liaisons in each of the 50 states has been key to continued success	As of 2006, 56% of all dental hygienists intervene always or frequently with patients who use tobacco. Tobacco cessation is permanently ensconced with institution of board committee
American Psychiatric Nurses Association (APNA)	2008 survey of APNA membership (approximately 7,000 members) states that 61% of psychiatric nurses do brief interventions; 29% provide intensive interventions	Increase by 5% every year the percentage of psychiatric nurses who do brief interventions (Ask. Advise. Refer.) with their patients who smoke to 75% by 2012 Increase by 5% every year the percentage of psychiatric nurses who do intensive interventions with their patients who smoke to 45% by 2012	APNA Board of Directors approved task force's position statement, "Psych Nurses as Champions for Smoking Cessation" in mid-2009. The association's journal, *JAPNA*, also dedicated an entire issue on tobacco dependence. Chair of the council is on *JAPNA* Board of Editors, with a promise that tobacco be mentioned in future JAPNA issues. More education and training on tobacco dependence interventions remain in high demand among psychiatric nurses	The task force was awarded council status in fall 2009 within APNA, showing support and sustainability of this very successful initiative Efforts to resurvey membership is planned to assess progress
American Society of Anesthesiologists (ASA)	100% of anesthesiologists know their patients' smoking status, but only 5% take further action to intervene. There are approximately 44,000 members of ASA	Increase action to 20% by 3 years Make cessation a part of the fabric of what anesthesiologists do	Launched successful Ask. Advise. Refer. pilot study in September 2007 to determine efficacy of quitline referral in hospital setting for anesthesiologists and their team. ASA quit cards available nationally. ASA has also partnered with the American College of Surgeons	2008 survey show that Ask. Advise. Refer. model is effective and 56% of anesthesiologists intervene with their patients who smoke; results have been published American College of Surgeons also published article on smoking cessation, thanks to ASA connection. ASA also adopted a policy recommending all anesthesiologists do at least Ask, Advise, Refer for all preoperative smokers

arena, beginning with mental health. In March 2007, it convened a performance partnership summit at Lansdowne, Virginia, that led to the creation of the National Mental Health Partnership for Wellness and Smoking Cessation. The resulting action plan is being implemented over time, and far more attention than previously is being given to smoking within behavioral health. For example, the Substance Abuse and Mental Health Services Administration now includes tobacco cessation in its top 10 strategic initiatives, and a plethora of toolkits and other materials have become available to help smokers quit in this arena and to make psychiatric and addictions treatment facilities smoke free (SCLC, n.d.). Further encouraged by the receptivity of groups to the performance partnership model, the Center experimented with an approach that was, in fact, closer to its original form, which it dubbed "place-based performance partnerships." In 2005, it partnered with Los Angeles County's Department of Public Health Tobacco Control and Prevention Program to hold a summit creating a county-wide, broad partnership known as "It's Quitting Time, LA!" (see "It's Quitting Time LA," n.d.). At the summit, some 135 participant organizations pledged to help 200,000 of the county's one million smokers quit over the next 3 years.

This successful place-based initiative spawned others—in Washington state (a business–labor cessation partnership), in Chicago (Chicago Second Wind), numerous California counties, and elsewhere. Indiana held a successful cessation summit in 2010, facilitated by the same consultant who had handled most of the SCLC-sponsored summits. In Oregon, behavioral health agencies led the first state summit to bring mental health, addictions treatment, and public health and tobacco control leaders together with assorted other stakeholders, including consumers. SCLC worked with 20 California counties to hold tobacco cessation summits. Five more summits have taken place in New York, Arizona, Oklahoma, Maryland and North Carolina in late 2010 and 2011 under the aegis of the Substance Abuse and Mental Health Services Administration and SCLC. And another group, the Partnership for Prevention raised private funds to sponsor six state cessation summits in 2010 as part of its tobacco cessation policy state grants (Partnership for Prevention, n.d.).

The model for performance partnerships is not new; its roots lie in the reinventing government initiative led by Vice President Al Gore during the Clinton Administration. That ambitious effort to create a government that works better and costs less led to a wide array of innovations, one of which was the development of the model. When Vice President Gore (1996) reported on the progress of the reinvention, he wrote,

> Based on the success of the Oregon Option, President Clinton has asked Congress to combine 271 separate grants and programs, which now have lots of strings attached, into 27 performance partnerships that are focused on results, just like Oregon's benchmarks. Each of the President's performance partnership grants would consolidate funding streams, eliminate overlapping authorities, create financial incentives to reward results, and reduce micromanagement and wasteful paperwork . . . We are moving control and responsibility back to the people—providing top-down support for bottom-up reform. (pp. 57-58)

Oregon, throughout the late 1980s and 1990s, had been a hotbed of innovation for results. The very first performance partnership was one established in Tillamook County, Oregon, in the late 1980s to help combat high teenage pregnancy rates. One of the Oregon thought leaders, a professor at the University of Oregon named Jeff Luke (1998) described in his book, *Catalytic Leadership*, the success of that partnership, which helped reduce the pregnancy rate by 75% over four years, and delineated four tasks of effective public leadership:

1. Focus attention by elevating the issue to the public and policy agendas.
2. Engage people in the effort by convening the diverse set of people, agencies, and interests needed to address the issue.
3. Stimulate multiple strategies and options for action.
4. Sustain action and maintain momentum by managing the interconnections through appropriate institutionalization and rapid information sharing and feedback. (p. 33)

The model has been used to make progress on outcomes ranging from reducing teen pregnancy and child abuse to improving salmon stocks and watershed health, but here we are interested in its specific applicability to improving smoking cessation interventions. Smoking cessation turns out to be a good fit with the model for a number of reasons.

- It has many committed champions (partly because so many people have been touched by the ravages of smoking, the leading preventable cause of death, and have lost loved ones and friends to it).
- There is a plausible response that is simple, concrete, and feasible for most clinicians, namely ask–advise–refer to a quitline.
- A wide array of evidence-based treatments and interventions now exists.

- Smoking is experiencing rapid denormalization nationwide, and normalizing intervention by clinicians and others is a logical next step.
- You need good data, and smoking cessation has it, readily available from each of the 50 state quitlines and state tobacco control agencies along with the Centers for Disease Control and Prevention.
- Progress translates readily into lives saved, making the work meaningful and rewarding for all who participate, since nearly half of all smokers die prematurely from their smoking.
- There is a widely perceived "enemy" in the form of the tobacco industry, making it easy to capitalize on an "us versus them" psychological approach.

Over more than 7 years, the SCLC staff has worked with such a wide variety of clinicians, including many in behavioral health (mental health and addictions treatment), that many key lessons have emerged for those interested in applying the performance partnership model in the smoking cessation arena. Following is an elaboration on some of these important lessons.

Lesson 1: Groups must agree unanimously on a single, measurable outcome, but they can disagree among themselves about the best strategies to achieve the outcome. The array of strategies can be contained in the action plan they design at their summit.

Lesson 2: Speedy action is a key to the success of the model. The partnership can differentiate itself from other coalitions and task forces through the use of speedy resolution of issues and quick delivery times. For example, the action plan is handed to the participants at the conclusion of the summit—not weeks or months later.

Lesson 3: The most successful partnerships recruit new, unusual, and nontraditional partners to add more perspective and firepower to the initiative, and continue to add new partners along the way.

Lesson 4: The summit will need a catalytic leader, someone to convene the partners and oversee implementation of the action plan. You can identify the leader among the champions who come to the table.

Lesson 5: The effort needs to be data driven and luckily, ample data are available in virtually every state regarding smoking patterns and trends. The frequently reported data serve as both motivator and manager of the initiative.

Lesson 6: Get away from "program" thinking and focus on creating a broad initiative. Program thinking tends to eliminate an array of strategies and zero in on a single one, greatly limiting the inclusiveness and imaginativeness of the partnership. Performance partnerships do not focus on funding, and in fact the later financial aspects are introduced into the effort, the better. Partners instead are encouraged to share resources, shift focus with existing work, and streamline their work to leverage the work of others.

The potential to use the performance partnership model to drive down smoking prevalence more broadly is huge, just as the model can be used for an array of wellness indicators ranging from overweight and inactivity to reducing alcohol consumption. Overall, the model helps leaders mobilize community partners to tackle tough and intractable public health issues. It has already helped many groups nationwide tackle smoking cessation, and more groups are planning to hold summits of their own.

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