Kansas Tobacco Guideline for Behavioral Health Care

AN IMPLEMENTATION TOOLKIT

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Kansas Tobacco Guideline for Behavioral Health Care: An Implementation Toolkit

Smoking rates are disproportionately high among individuals with a history of mental illness or addiction disorders. To help address tobacco use in Kansas among those with mental illness or addiction disorders, the Kansas Behavioral Health Tobacco Project, led by NAMI Kansas, developed the Tobacco Guideline for Behavioral Health. The Tobacco Guideline focuses on four areas: 1) Supporting tobacco prevention efforts; 2) Promoting wellness by integrating evidence-based tobacco treatment into routine clinical practice; 3) Building staff capacity to provide care; and 4) Adopting a tobacco-free environment.

This toolkit provides practical approaches and policy resources that behavioral health organizations can use to implement the Tobacco Guideline for Behavioral Health. The toolkit is focused on supporting culture change within such organizations as member agencies of the Association of Community Mental Health Centers of Kansas, the Kansas Association of Addiction Providers, and primary care clinics under the auspices of the Kansas Association for the Medically Underserved.

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Strategy One: Assess Tobacco Use Regularly and Provide Tobacco Treatment Until Quit Attempts Are Successful.

Assessment is the first step towards tobacco cessation. There are many ways to assess tobacco use, but they all share the same goal — to help clinicians guide patients towards quitting. Assessment identifies tobacco users and increases their access to treatment, including counseling and medication. People with mental illness or substance use disorder may need to be supported through multiple quit attempts before they are successful. Ongoing assessment allows clinicians to provide consistent follow-up and to connect patients to the resources they need, whether it is their first or fifteenth attempt to quit using tobacco.

Assessment ...

- Identifies tobacco users
- Evaluates type and extent of use
- Measures nicotine dependence level
- Connects patients to resources and/or treatment (based on results)
- Considers readiness to quit
- Involves follow-up

The primary goal of assessment and screening is to identify patients who meet a certain set of criteria — in this case, people who use tobacco. Once tobacco users are identified, the goal is to connect them to appropriate treatment resources. Providers should use assessments to create quit plans tailored to the patient's patterns of use and readiness to quit.[1] Further detail on psychosocial and pharmaceutical treatment options can be found in later sections.

The 5 A's: Brief Clinical Interventions for Tobacco Cessation

The process of identifying tobacco users, determining their willingness to quit, providing treatment, and ensuring follow-up involves five basic steps. These are explained in a model known as the **5A's: Ask, Advise, Assess, Assist, and Arrange**.[2]

1. ASK ABOUT TOBACCO USE

All patients should be asked about their tobacco use. Universal screening can easily be integrated into electronic health records, with automatic reminders to ask about tobacco use at each visit, treatment plan review, or new admission.[3] In this way, tobacco use status is documented as a vital sign, similar to blood pressure or pulse rate.[4] In addition to asking whether patients use tobacco, other information can be collected: what type of tobacco they use, the frequency of use, and the length of time they have been using. It may also be useful to ask about exposure to secondhand smoke.[5]

2. ADVISE TO QUIT

When advising patients to quit, providers should communicate clearly and honestly in a personal but non-judgmental way. Some examples include:

Clear	Strong	Personal	Non-judgmental
I want to talk to you about your tobacco use and encourage you to quit smoking.[6]			
*Quitting is the one of the **most important** things you can do for your health. I strongly encourage you to quit.*[7]			
Continuing to smoke will make your asthma worse. Quitting can improve your symptoms.[8] *Quitting will have an impact on your family, too. Your children won't be exposed to the secondhand smoke.*			
When you are ready, I would be more than happy to work with you to make a plan.[9]			

3. ASSESS READINESS TO QUIT

Providers should evaluate every tobacco user's readiness to quit. This can be done with a simple question, "Are you interested in quitting tobacco?"

Quitting is not a single event that happens instantly. Instead, it is an ongoing process. The Stages of Change model suggests that individuals move through five stages as they work to change their behavior. Individuals may cycle or recycle through these stages as they make multiple attempts to quit. Understanding where an individual patient is in this process can help providers decide what action to take next.

Stages of Change for Tobacco Cessation[10]

STAGE	PERSON IS ...	PROVIDER SHOULD ...
Pre-contemplation	**Unaware or unwilling to change:** ▪ Currently using tobacco ▪ Not seriously considering quitting in the next six months	▪ Motivate patient to consider quitting.
Contemplation	**Ambivalent, but considering change:** ▪ Currently using tobacco ▪ Seriously considering quitting in the next six months ▪ Not ready to quit in the next 30 days.	▪ Motivate patient to consider quitting. ▪ Build confidence to make a decision.
Preparation	**Getting ready to take action and make a change:** ▪ Currently using tobacco ▪ Seriously considering quitting in the next six months ▪ Ready to quit in the next 30 days (have set a date). ▪ Have made a quit attempt in the past year.	▪ Help prepare a quit plan. ▪ Provide appropriate cessation treatment.
Action	**Actively working to change their behavior:** ▪ Have quit using tobacco within the past six months ▪ May experience	▪ Provide ongoing support and arrange follow-up. ▪ Help patient recover from relapses.
Maintenance	**Long-term integration of behavior change:** ▪ Have quit using tobacco for more than six months ▪ Continue to be tobacco-free.	▪ Continue to provide support.

4. ASSIST IN QUIT ATTEMPT

At this step, providers should connect patients to treatment based on their patterns of use and readiness to quit. This involves several steps, beginning with setting a quit date and making a plan. Before providing treatment, the patient and provider should discuss key issues. This might include identifying motivating factors, anticipating triggers or challenges, developing coping strategies, and adjusting environments or routines associated with tobacco use.[11]

For more detailed information about cessation treatment — both behavioral interventions and medications — see Strategies Two and Three.

5. ARRANGE FOLLOW-UP

To maintain consistent support for patients, providers should schedule follow ups. A consistent plan should exist at each clinical site so providers know what steps to take and how to document them. Be sure to integrate this follow-up into existing mental health or recovery treatment plans.

Sample Assessment Tools

The following examples of assessment tools have been tested and validated for use with tobacco cessation. This is not an exhaustive list, and does not represent any official endorsement. Tools should be selected based on clinical practices, provider training, and patient needs.

The Fagerstrom Test for Nicotine Dependence[12]

This assessment measures the intensity of a patient's physical addiction to tobacco. The test consists of six questions. The answers are assigned a number, and the total score displays level of dependence on a scale from 1 to 10. This test was originally designed for cigarette use, but newer versions have been adapted for smokeless tobacco [13] (e.g., dip, chew or snuff) and e-cigarettes.[14] A shortened version, called the Heaviness of Smoking Index, uses only questions 1 and 4.[15]

QUESTIONS	SCORE
1. How soon after you wake up do you have your first cigarette?	
A. Within 5 minutes	A. 3
B. 5 to 30 minutes	B. 2
C. 31 to 60 minutes	C. 1
D. After 60 minutes	D. 0
2. Do you find it difficult to refrain from smoking in places where it is forbidden? (in church or school, at a movie theater, on a bus, etc.)	
A. Yes	A. 1
B. No	B. 0
3. Which cigarette would you most hate to give up?	
A. The first one in the morning	A. 1
B. Any other one	B. 0
4. How many cigarettes per day do you smoke?	
A. 10 or fewer	A. 0
B. 11 to 20	B. 1
C. 21 to 30	C. 2
D. 31 or more	D. 3

Sample Assessment Tools

5. Do you smoke more during the first few hours after waking up than during the rest of the day?	
A. Yes	A. 1
B. No	B. 0

6. Do you smoke even if you are so ill that you are in bed most of the day?	
A. Yes	A. 1
B. No	B. 0

Results

1–2 = low dependence
3–4 = low to moderate dependence
5–7 = moderate dependence
8–10 = high dependence

Hooked on Nicotine Checklist[16]

This ten-item questionnaire was designed to assess nicotine dependence in adolescents and young adults. Recently, researchers have found that it is also valid for adults.[17] Each question is designed to measure diminished autonomy — or loss of control — over their use of tobacco. In theory, any 'yes' answer indicates a loss of control, and suggests addiction.

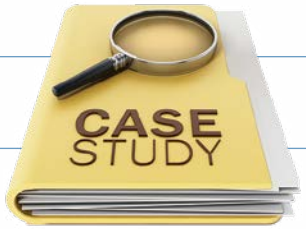
CAGE Questionnaire (Modified for Tobacco Use)[18]

This tool was designed to help screen patients for alcohol addiction, and has been modified for smoking behavior. It contains four questions, corresponding to each letter of the acronym, CAGE. The goal is to learn how patients feel about their smoking behavior, and to prompt them to recognize their addiction. Evidence suggests that these questions yield the best results when they are used as part of a general health history.

1. Have you ever felt a need to **C**ut down on your smoking, but had difficulty doing so?
2. Do you ever get **A**nnoyed or feel angry with people who criticize your smoking or tell you that you should quit?
3. Have you ever felt **G**uilty about your smoking or about something you did while smoking?
4. Do you ever smoke within half an hour of waking up? (**E**ye-opener)

Results: Two or more "yes" responses are considered clinically significant.

Case Study: Prairie View



At Prairie View Mental Health Center in Newton, Kansas, a tobacco screener is built into the electronic medical records (EMR) system. Clinical staff perform the screen and submit it electronically. All patients age 12 and older are required to be screened. If someone is not identified as a tobacco user, a follow-up screen will be required in one year. If someone is identified as a tobacco user, a follow-up screen is required every three months.

The screen asks:

- Have you used tobacco in the past 30 days?
- What type of tobacco is being used?
- How often is tobacco being used?

There is also room to document the patient's choice and/or provider actions:

- Direct counseling
- Refused counseling
- Not provided counseling

An optional narrative section allows clinicians to provide additional information.

For more information, visit https://prairieview.org.

Endnotes

1 *See* Terry A. Rustin, *Assessing Nicotine Dependence*, American Family Physician (Aug. 1, 2000), https://www.aafp.org/afp/2000/0801/p579.html; *see also* U.S. Public Health Service, *Treating Tobacco Use and Dependence: 2008 Update* (last accessed Sept. 15, 2018), https://bphc.hrsa.gov/buckets/treatingtobacco.pdf.

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14 Jonathan Foulds et al., *Development of a Questionnaire for Assessing Dependence on Electronic Cigarettes Among a Large Sample of Ex-Smoking E-Cigarette Users*, 17 Nicotine Tob. Res. 186-92 (2015).

15 *See, e.g.*, Ron Borlund et al., *The Reliability and Predictive Validity of the Heaviness of Smoking Instrument and its Two Components: Findings from the ITC Four Country Study*, 12 Nicotine Tob. Res. S45-S50 (2010). *See also* Todd F. Heatherton et al., *Measuring the Heaviness of Smoking: Using Self-Reported Time to the First Cigarette of the Day and Number of Cigarettes Smoked Per Day*, 84 Br. J Addict. 791-99 (1989).

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17 Robert J. Wellman et al., *Measuring Adults' Loss of Autonomy Over Nicotine Use: The Hooked on Nicotine Checklist*, 7 Nicotine Tob. Res. 157-61 (2005).

18 *See* Rustin, *supra* note 1; *see also* John A. Ewing, *Detecting Alcoholism: The CAGE Questionnaire*, 252 JAMA 1905-7 (1984).

Strategy Two: Provide Psychosocial Treatment within Whole Person Primary Care and Behavioral Health Care Systems.

Many different evidence-based strategies can help individuals quit using tobacco. These strategies address the psychological, social, and environmental factors that influence each person's tobacco use. Behavioral interventions — including group or individual counseling, peer mentoring, and online or telephone support — are a key part of any successful tobacco cessation program. These interventions can be provided within primary care, mental health, and addiction treatment settings.

Treating Tobacco Use

Treating tobacco use helps support mental health recovery and sobriety. Psychosocial treatments address the underlying habits or behaviors associated with tobacco use. For individuals who are ready to quit, the goal of treatment is cessation. For individuals who are not yet ready to quit, the goal of treatment is to increase motivation. Treatment is typically delivered in three ways: group and individual counseling, peer mentorship, and phone counseling (including mobile apps or online programs).

1. GROUP & INDIVIDUAL COUNSELING

Providers can use a variety of evidence-based counseling strategies to treat tobacco dependence, which range in intensity and complexity. Simple, brief advice from a provider during a routine exam or visit (see Section One, Strategy One for the 5As approach) can have a big impact.[1] Group or individual therapy sessions, usually delivered weekly, provide more intense and sustained support as patients make a quit attempt. Therapy approaches include the following:

- **Cognitive Strategies** retrain the way a person thinks about tobacco use and quitting. Individuals build awareness of the negative effects of smoking and consider what becoming tobacco-free would mean to them.[2]
  - **Education:** Provide basic information about nicotine, withdrawal, and the quitting process. Help patients understand the negative health effects of tobacco use.
  - **Mental rehearsal:** Prepare for challenging situations that might arise during the quitting process, and help patients practice how to respond.
  - **Positive self-talk:** Use affirmations to remind individuals that they are capable, successful, and should feel proud each day they continue to be tobacco-free. Encourage patients to brainstorm their own phrases to repeat. For example, "I can do this!" or "I am a nonsmoker, and this craving will pass."

- **Behavioral Strategies** help individuals take action to successfully quit using tobacco. These strategies target the underlying factors behind the addiction.[3]
  - **Recognize trigger situations:** Help patients recognize the factors (including people, places, activities or feelings) that might lead them to use tobacco.
  - **Develop coping skills:** Help patients brainstorm how to avoid triggers and deal with cravings by using distractions or substitutions. This includes lifestyle changes, like reducing stress and abstaining from other substances. It also includes environmental changes, like altering daily routines and avoiding other tobacco users.[4]
  - **Contingency management:** Help tobacco users set up a reward system. Positive reinforcement — such as money, prizes or praise — can help motivate individuals to quit using tobacco.[5] While this strategy often leads to significant reductions in tobacco use, it may be difficult to maintain once incentives go away.[6]

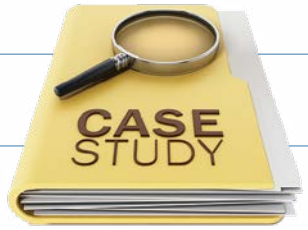
2. PEER SUPPORT AND MENTORSHIP

Peer support is an effective way to promote tobacco cessation in mental health and treatment facilities. It refers to a wide range of interactions between people who have shared experiences of living with mental illness and/or substance use.[7] Peer mentors act as role models, advocates, educators, and sources of motivation to current tobacco users.

Interventions with peer mentors have been used successfully in a variety of mental health and recovery settings, and are often rated very highly by patients.[8] Evaluations of these programs show high rates of participation and positive outcomes related to cessation.[9] In a study of people with serious mental illness who successfully quit smoking, more than half mentioned peer support from other mental health patients as a helpful strategy.[10]

A peer support model can be especially useful where language or cultural barriers exist. Peer counselors are often perceived as being less threatening than non-peer counselors. Because of this perception, they may be able to reach a greater number of tobacco users than other cessation programs.[11]

One example of a peer support model is Nicotine Anonymous, a group support and recovery program for anyone who wants to stop using nicotine. Nicotine Anonymous uses an adapted version of the 12 steps from Alcoholics Anonymous, and is led by peer facilitators with a history of nicotine addiction.[12] There is no cost to join or attend meetings.



Case Study: Kansas Breathe Easy, Live Well Model[13]

In May 2016, the Kansas Health Foundation awarded Episcopal Social Services and Interface Ministries a three-year grant to help persons living with mental illness reduce or eliminate their tobacco use. As a result, Breathe Easy, Live Well — an evidence-based curriculum that addresses overall wellness and tobacco use among mental health consumers — was adapted and administered to over 500 individuals in Wichita. The program, which is now being used by communities throughout Kansas, consists of 15 classroom sessions, regular lesson evaluations, checkups with a carbon monoxide monitor, and quit groups.

The curriculum was originally developed as part of a wellness and tobacco cessation program offered at North Carolina psychosocial clubhouses. "Clubhouses" are communities designed to help people with serious mental illness manage their illness and rejoin the worlds of employment, education, family, and friends. In addition to the Wichita clubhouse and low-income housing organizations and shelters, the Kansas program is also used by other state organizations, including clinical facilities, to help people who live with mental illness have a sustainable and effective way to quit smoking and adopt a healthier lifestyle.

The Breathe Easy, Live Well toolkit contains information applicable to all persons with mental illness and focuses on hope, self-efficacy, and physical wellbeing as consumers progress towards personal recovery. Its train the trainer programs and workshops include ways to personalize the model to accommodate different programs.

For more information, visit https://www.esswichita.org.

3. TELEPHONE AND ONLINE SUPPORT

Online and telephone support for tobacco cessation has grown in recent years. Because most tobacco users (93 percent) report owning a mobile phone, these resources are easy to access.[14] Quit lines, websites, and mobile applications have many advantages for patients and providers: they are free, available 24 hours a day/7 days a week, and are not dependent on insurance coverage. A growing body of research shows the effectiveness of these services for people living with mental illness. Two randomized control trials of online interventions found significant improvement in use of cessation treatment, number of quit attempts, and continued abstinence from tobacco products.[15] Telephone counseling is also associated with positive outcomes. Recent research has confirmed that phone-based support is as effective as in-person support when paired with nicotine replacement therapy.[16]

- Kansas Tobacco Quitline (KSquit.org or 1-800-QUIT-NOW)
  KanQuit provides free tobacco cessation services online and by phone, text message, or mobile application. The quitline provides free, one-on-one coaching services to anyone in Kansas who wants to quit using tobacco. Expanded services may be available for individuals living with mental illness. Through the website or mobile app, individuals can access workbooks, videos, cost savings calculators, and other quitting aids. The quitline is available 24 hours a day, 7 days a week.

- Smokefree.gov
  This website, provided by the National Cancer Institute, provides evidence-based quit support to tobacco users across a variety of platforms, including text message programs and smartphone apps. Programs are targeted at veterans, women, seniors, and teens. Most services are also offered in Spanish. Resources are also available for providers to download and use. Providers/peers can enroll tobacco users online at https://smokefree.gov/tools-tips/text-programs. Also, tobacco users, providers, or peers can enroll directly by texting the following terms to the following numbers:

Smokefree.gov Quit Support

PROGRAM	TARGET AUDIENCE	NUMBER
smokefreeTXT	Adults who want to quit smoking.	Text **START** or **QUIT** to 47848
smokefreeTXT: Daily Challenges	Adults who aren't quite ready to quit smoking.	Text **GO** to 47848
smokefreeTXT: Practice Quit Attempt	Adults who aren't quite ready to quit smoking.	Text **GO** to 47848
smokefreeMOM	Pregnant women who want to quit smoking.	Text **MOM** to 222888
smokefreeTXT for teens	Youth (ages 13–19) who want to quit smoking.	Text **TEEN** to 47848
smokefreeVET	Veterans with VA health care benefits who want to quit using tobacco.	Text **VET** to 47848
dipfreeTXT	Adults who want to quit using dip.	Text **SPIT** to 333888

Motivational Interviewing[17]

Motivational interviewing (MI) is a person-centered counseling intervention aimed at strengthening an individual's motivation to change. It can be especially useful with individuals who are not yet ready to quit using tobacco.

The idea behind MI is that a trained provider, using empathy and consistent methods, can help decrease a patient's resistance to change. In turn, the patient becomes committed to behavior change and takes action.

MI has four main strategies (OARS):

- **O**pen-ended questions
- **A**ffirmations
- **R**eflective listening
- **S**ummarize

"The 5 R's"[18]

Based on the theories of motivational interviewing, the following strategies were developed to enhance motivation to quit tobacco:

1. **Relevance:** Find specific reasons why quitting is personally relevant to the patient.
2. **Risks:** Consider the potential negative consequences of a patient's tobacco use, both acute and long-term.
3. **Rewards:** Identify the potential benefits of quitting tobacco use that are specific to the patient.
4. **Roadblocks:** Think through the barriers the patient might face when quitting, and how they might be addressed.
5. **Repetition:** These strategies should be repeated each time the patient visits the provider. Patients should also be reminded that most people make several quit attempts before they are successful.

Coping Strategies: The Four D's[19]

Delay	Cravings are temporary, and usually last 5–10 minutes. Occupy yourself with other activities during this time and give yourself a quick pep talk ("I can do this.").
Distract	Refocus your thinking when you feel a craving or experience a trigger for tobacco use. Make a conscious decision to do something else. Tobacco products are often relied on for stress relief. Choose healthy substitutes instead. Healthy distractions include: ▪ Taking a walk ▪ Exercising ▪ Listening to music ▪ Reading ▪ Calling a friend or family member ▪ Using non-tobacco oral substitutes: toothpicks, straws, gum, water bottles or sugar-free candy.* ▪ Keeping your hands busy: write in a journal, draw or doodle in a sketchbook, or use a fidget toy.* * **Note:** it is helpful for clinics and treatment facilities to have these items available, too.
Deep breathing	Learn relaxation strategies, such as deep breathing, positive imagery, or meditation. Substitute these strategies for tobacco use as a way to cope with stress.
Discuss	Talk to someone you trust about your challenges and successes. This could be a family member, friend, mentor, or provider. You can also reach out to trained coaches by phone or mobile app. In Kansas, call 1-800-QUIT-NOW or go to KSquit.org.

Endnotes

1 Anne Eden Evins et al. *Treatment of Tobacco Use Disorders in Smokers with Serious Mental Illness: Toward Clinical Best Practice*, 23 Harv. Rev. Psychiatry 90-98 (2015).

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4 *See, e.g.,* University of California, San Francisco, *supra* note 2; *see also* Signal Behavior Health Network, *Tobacco Treatment for Persons with Substance Use Disorders* (last accessed Sept. 15, 2018), https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/COTobaccoToolkit.pdf.

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13 North Carolina Evidence-Based Practices Center, Breathe Easy, Live Well (last accessed Sept. 15, 2018), http://www.ncebpcenter.org/breathe-easy-live-well.

14 *See* Das & Prochaska, *supra* note 5, at 844

15 Joelle C. Ferron et al., *Abstinence and Use of Community-Based Cessation Treatment After a Motivational Intervention Among Smokers with Severe Mental Illness*, 52 Community Ment. Health J 446-56 (2016); Mary F. Brunette et al., *Brief Web-Based Interventions for Young Adult Smokers with Severe Mental Illnesses: A Randomized, Controlled Pilot Study*, Nicotine Tob. Res. 1-9 (2017).

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Strategy Three: Provide Cessation Medications and Ensure Access without Barriers through State Medicaid and Other Third-Party Payers.

Medication is a key component of a successful tobacco cessation program, especially for people with mental illness. People with mental illness generally smoke more cigarettes and have greater nicotine dependence than the general population. They also have lower quit rates and more withdrawal symptoms when they attempt to quit.[1] *Cessation medications, including nicotine replacement therapy (NRT), can help manage withdrawal symptoms and support quit attempts.*[2]

U.S. Preventive Services Task Force Recommendation[3]

The USPSTF is an independent group of experts in primary care and evidence-based medicine. They evaluate preventive care services and make clinical recommendations.

Interventions for Tobacco Smoking Cessation in Non-Pregnant Adults:
Pharmacotherapy interventions, including nicotine replacement therapies, bupropion and varenicline — with or without behavioral counseling interventions — significantly improve the odds of successful cessation.

Grade A Recommendation:
The USPSTF concludes with high certainty that there is a substantial net benefit of pharmacotherapy interventions for tobacco cessation.

FDA-Approved Cessation Medications

The U.S. Food and Drug Administration currently approves seven first-line medications for tobacco cessation: five nicotine replacement therapy (NRT) products and two prescription medications — varenicline and bupropion — that do not contain nicotine.[4] On their own, each of these medications has been evaluated for safety and effectiveness. Studies show that people with mental illness who take these medications have a greater chance of quitting successfully.[5] Evidence suggests that these medications may be even more effective when used in combination or for extended periods of time.[6]

Cessation medications should be coordinated with other treatment plans. Clinicians need to closely monitor the medication levels and side-effects of patients making quit attempts. Tobacco smoke interacts with many medications — including antipsychotics, antidepressants, anxiolytics, blood

thinners and beta blockers — and can alter their absorption or action.[7] Quit attempts that reduce or eliminate cigarette smoking could impact these medication interactions.

Nicotine Replacement Therapy

What is Nicotine Replacement Therapy?[8]
Nicotine replacement therapy (NRT) provides a controlled dose of nicotine, the main addictive substance in tobacco products. Several NRT products are on the market, each with different doses and mechanisms of delivery. They include gum, lozenges, skin patches, nasal sprays, and oral inhalers. These products allow tobacco users to gradually wean themselves off nicotine as they make a quit attempt.

Why use Nicotine Replacement Therapy?
Nicotine replacement therapy (NRT) is used to manage the cravings and withdrawal symptoms associated with quitting tobacco use. Each product has distinct advantages or disadvantages that can be matched to patient preferences and needs. Evidence from clinical trials consistently shows that NRTs improve rates of cessation, both alone and in combination with other treatments.[9]

Cessation Medications Without Nicotine[10]

What is bupropion SR?
Originally approved as an antidepressant, bupropion SR was the first non-nicotine medication approved for cessation. Bupropion SR is a prescription drug.

Why use bupropion SR?
Bupropion has been shown to reduce cravings for cigarettes and to decrease withdrawal symptoms. While the specific way that bupropion works to help cessation is still unknown, several clinical trials have confirmed that it is significantly more effective than a placebo, and may be especially effective when combined with nicotine replacement therapy.

What is varenicline?
Varenicline is a prescription drug approved specifically for cessation. Varenicline works by binding at sites in the brain that are normally affected by nicotine. It is able to block the effects of nicotine and minimize the drop in dopamine that is responsible for withdrawal symptoms.

Why use varenicline?
Varenicline helps with cessation by reducing the rewarding effects of nicotine and by relieving withdrawal symptoms. Evidence from clinical trials shows that varenicline is significantly more effective than a placebo, and may result in higher rates of successful abstinence than NRT or bupropion.

Clinical Guidelines for Tobacco Cessation Medications[11]

SUGGESTED DOSAGE AND DURATION	PRECAUTIONS AND CONTRAINDICATIONS	POSSIBLE SIDE EFFECTS
Nicotine Gum, OTC Rx		
1st cig > 30 min after waking: 2 mg 1st cig ≤ 30 min after waking: 4 mg **Max. 24 pieces/day** Weeks 1–6: one every 1–2 hours Weeks 7–9: one every 2–4 hours Weeks 10–12: one every 4–8 hours **Total: 12 weeks**	**Contraindications** ▪ Recent heart attack ▪ Serious cardiac arrhythmia ▪ Serious angina pectoris **Precautions** ▪ Pregnant or breastfeeding ▪ Less than 18 years old ▪ TMJ disease ▪ Stomach ulcer ▪ Significant dental work	▪ Mouth or jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Dry mouth ▪ Symptoms of too much nicotine: nausea, vomiting, dizziness, fast heartbeat.
Nicotine Lozenge, OTC Rx		
1st cig > 30 min after waking: 2 mg 1st cig ≤ 30 min after waking: 4 mg **Max. 20 pieces/day** Weeks 1–6: one every 1–2 hours Weeks 7–9: one every 2–4 hours Weeks 10–12: one every 4–8 hours **Total: 12 weeks**	**Contraindications** ▪ Recent heart attack ▪ Serious cardiac arrhythmia ▪ Serious angina pectoris **Precautions** ▪ Pregnant or breastfeeding ▪ Less than 18 years old ▪ Stomach ulcer	▪ Mouth/throat soreness ▪ Cough ▪ Hiccups ▪ Dyspepsia ▪ Symptoms of too much nicotine: nausea, vomiting, dizziness, fast heartbeat.
Nicotine Patch, OTC Rx		
>10 cig per day: Weeks 1–6: 21mg Weeks 7–8: 14 mg Weeks 9–10: 7 mg **≤10 cig per day:** Weeks 1–6: 14 mg Weeks 7–8: 7 mg **Total: 8–10 weeks** 1 patch per day	**Contraindications** ▪ Recent heart attack ▪ Serious cardiac arrhythmia ▪ Serious angina pectoris **Precautions** ▪ Pregnant or breastfeeding ▪ Less than 18 yrs. old ▪ Skin disorders ▪ Allergy to adhesive tape ▪ Weight < 100 lbs.	▪ Skin irritation ▪ Headache ▪ Sleep issues (e.g., vivid dreams, insomnia) ▪ Symptoms of too much nicotine: nausea, vomiting, dizziness, fast heartbeat.

Clinical Guidelines for Tobacco Cessation Medications[11]

SUGGESTED DOSAGE AND DURATION	PRECAUTIONS AND CONTRAINDICATIONS	POSSIBLE SIDE EFFECTS
Nicotine Nasal Spray, Rx only		
1 dose = 1 spray in each nostril (each spray = 0.5 mg) 1–2 doses per hour as needed **Maximum 5 doses/hour** **Maximum 40 doses/day** **Total: up to 3 months**	**Contraindications** ▪ Recent heart attack ▪ Serious cardiac arrhythmia ▪ Serious angina pectoris **Precautions** ▪ Pregnant or breastfeeding ▪ Less than 18 years old ▪ Chronic nasal issues (e.g., sinusitis, rhinitis) ▪ Severe reactive airway disease	▪ Nasal/throat irritation ▪ Sneezing, rhinitis ▪ Tearing ▪ Cough ▪ Headache ▪ Changes in smell/taste ▪ Symptoms of too much nicotine: nausea, vomiting, dizziness, fast heartbeat.
Nicotine Inhaler, Rx only		
Individualized dosing: Approx. 1 cartridge every 1–2 hours (1 cartridge = 10 mg) Puff continuously up to 20 minutes **6 to 16 cartridges per day** **Total: 12 weeks**	**Contraindications** ▪ Recent heart attack ▪ Serious cardiac arrhythmia ▪ Serious angina pectoris **Precautions** ▪ Pregnant or breastfeeding ▪ Less than 18 years old ▪ Severe reactive airway disease ▪ Bronchospastic disease (e.g., asthma, COPD)	▪ Mouth/throat irritation ▪ Cough ▪ Headache ▪ Hiccups ▪ Dyspepsia ▪ Bronchospasm ▪ Symptoms of too much nicotine: nausea, vomiting, dizziness, fast heartbeat.

Please consult prescribing information provided by manufacturer for complete usage and safety information.

Clinical Guidelines for Tobacco Cessation Medications[12]

SUGGESTED DOSAGE AND DURATION	PRECAUTIONS AND CONTRAINDICATIONS	POSSIBLE SIDE EFFECTS
Bupropion SR, Rx only		
Begin 1–2 weeks prior to quit date First 3 days: 150 mg once daily After 3 days: 150 mg twice daily (at least 8 hours between doses) **Maximum 300 mg per day** **Total: 7–12 weeks**	**Contraindications** ▪ MAOI use in past 2 weeks ▪ History of seizure disorder ▪ Current or prior diagnosis of bulimia or anorexia nervosa ▪ Undergoing abrupt discontinuation of alcohol or sedatives. **Precautions** ▪ Pregnant or breastfeeding ▪ Less than 18 years old ▪ Hepatic impairment or severe cirrhosis ▪ Uncontrolled hypertension	▪ Mouth or jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Dry mouth ▪ Symptoms of too much nicotine: nausea, vomiting, dizziness, fast heartbeat.
Varenicline, Rx only		
Begin 1 week prior to quit date. First 3 days: 0.5 mg once daily Days 4–7: 0.5 mg twice daily After 7 days: 1 mg twice daily **Total: 12–24 weeks**	**Contraindications** ▪ Known history of serious hypersensitivity to varenicline **Precautions** ▪ Pregnant or breastfeeding ▪ Less than 18 years old ▪ Severe renal impairment	▪ Nausea ▪ Headache ▪ Sleep disturbances (e.g., insomnia, vivid dreams) ▪ Constipation ▪ Flatulence ▪ Vomiting ▪ Neuropsychiatric symptoms (rare)*

Please consult prescribing information provided by manufacturer for complete usage and safety information.

* **Note:** In 2016, the FDA removed the "black box" label from varenicline, which previously warned of serious mental health side effects. This decision was based on a large clinical trial that confirmed the safety of varenicline and bupropion for people with mental illness, and found no significant increase in psychiatric adverse events. The FDA now advises that patients should stop taking varenicline and immediately call their provider if they experience any adverse effects on mood, thinking, or behavior.

Accessing Cessation Medications

Even with strong evidence for the safety and effectiveness of these medications, access remains limited for people with mental illness and/or substance use disorder who are interested in quitting. One study of four community mental health centers in Missouri found that although 44 percent of patients were interested in cessation medication, only 13 percent were receiving it.[13] In a study of people with serious mental illness who successfully quit smoking, only 6 percent had access to cessation medications, although 40 percent expressed a wish for medication treatment.[14]

One way to increase access is to make sure that providers, pharmacists and patients all understand the available treatment options and whether they are covered by insurance. Coverage will vary depending on the patient's insurance — whether it is provided by the government (e.g., Medicaid, Medicare, VA benefits, or TriCare), by an employer, or purchased through the individual marketplace. Additional considerations should be made for uninsured patients.

Medicaid (KanCare) Coverage

Medicaid provides health care coverage to low-income children, parents, seniors, and individuals with disabilities or specific health conditions. Eligibility is based on income, age, and health care needs. Most states offer some form of tobacco cessation benefit; however, patients, providers, and pharmacists may not be aware of this coverage. A recent study found that 60 percent of Medicaid-enrolled smokers and 40 percent of physicians seeing Medicaid patients did not know that their state offered Medicaid coverage for cessation treatment.[15]

In Kansas, adults are eligible for Medicaid if they are parents, pregnant, disabled, or medically needy.[16] Medicaid is jointly administered by the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) through a program called KanCare. The state contracts with managed care organizations to provide services to enrollees. All plans cover the same basic physical, mental, and substance abuse services.[17] If the expansion of Medicaid is adopted in Kansas pursuant to the Affordable Care Act, tobacco cessation services will likely be available to a broader population of currently uninsured individuals.

For tobacco cessation, all managed care organizations offer the same core benefits. Individual MCOs may offer additional services. For example, Sunflower Health offers specific cessation programs to its members.[18]

Individuals with Medicaid (KanCare)[19]

- All FDA-approved cessation medications. Individuals may be prescribed one NRT medication at the same time as bupropion SR or varenicline.
- Medication coverage for up to 4 quit attempts per year.
- Combination pharmacotherapy (e.g., patch plus lozenge) permitted.
- Unlimited individual counseling sessions lasting 3 to 10 minutes.
- Smoking and tobacco use cessation visit; intensive, greater than 10 minutes.
- Smoking cessation classes, non-physician provider, per session.
- No prior authorization or cost sharing required.

Note: although some cessation medications can be purchased over-the-counter, a prescription is required for KanCare coverage.

Nicotine patch

Duration per quit attempt: 12 weeks

Daily limit: 1 patch

Nicotine nasal spray

Duration per quit attempt: 12 weeks

Daily limit: 80 sprays

Nicotine gum

Duration per quit attempt: 12 weeks

Daily limit: 24 pieces

Nicotine oral inhaler

Duration per quit attempt: 12 weeks

Daily limit: 16 cartridges

Nicotine lozenge

Duration per quit attempt: 12 weeks

Daily limit: 20 lozenges

Bupropion SR

Duration per quit attempt: 12 weeks

Daily limit: 2 tablets

Varenicline

Duration per quit attempt: 12 weeks

Daily limit: 2 tablets

Individual Marketplace Coverage

In 2017, approximately 98,780 Kansans enrolled in insurance plans through the individual health insurance marketplace.[20] The marketplace, which is federally facilitated, offers a variety of insurance plans. In the 2017 open enrollment period, for example, 23 policies from three different companies were offered across seven geographic areas.[21] The Affordable Care Act (ACA) requires all health plans purchased through individual marketplaces to cover ten broad categories of care, referred to as the Essential Health Benefits. Additionally, plans must cover all preventive care that the U.S. Preventive Services Task Force has graded A or B. The USPSTF has given tobacco cessation interventions a grade 'A', so individual marketplace plans must provide this coverage.[22]

Individuals Who Purchase Plans through the Marketplace[23]

- Screening for tobacco use.
- Four sessions of individual, group or telephone counseling.
- 90 days of all FDA-approved cessation medications.
- Coverage for two quit attempts per year.
- No prior authorization required.
- No cost-sharing.

Employer-Sponsored Health Insurance

Larger employers who are self-insured (i.e., pay directly for their employee's health care costs) are not required to offer the same Essential Health Benefits as health plans in the individual and small group marketplace. However, the Affordable Care Act does require that private insurance plans provide coverage for all preventive services graded "A" or "B" by the U.S. Preventive Services Task Force. The USPSTF has given tobacco cessation interventions a grade 'A, so employer-sponsored insurance plans must provide this coverage.[24] This is the same requirement that individual marketplace and small group plans have to meet. Note that grandfathered plans — those that existed before the ACA went into effect and have not made significant changes since — are exempt from this requirement.

Individuals with Employer-Sponsored Insurance (Large Group or Self-Insured)[25]

- Screening for tobacco use.
- Four sessions of individual, group, or telephone counseling.
- 90 days of all FDA-approved cessation medications.
- Coverage for two quit attempts per year.
- No prior authorization required.
- No cost-sharing.

No Insurance Coverage / No Prescription Drug Coverage

Individuals without insurance coverage may be able to receive free or discounted cessation medications through a pharmacy assistance program. Pfizer offers over 60 medications for free through their Patient Assistance Program, including Chantix (varenicline), Nicotrol Inhaler and Nicotrol NS (nasal spray) for cessation.[26] Patients qualify if they have a prescription, live in the United States, have no prescription coverage or not enough prescription coverage, and meet income limits.

For more information, call 1-844-989-PATH or visit https://www.pfizerrxpathways.com.

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Strategy Four: Integrate Tobacco Treatment into Assessment, Treatment Planning and Implementation.

People living with mental illness or substance use disorder have much higher rates of tobacco use than the general population. They also face a greater burden of disease and lower life expectancies because of their tobacco use. To address these disparities, mental health care providers must actively provide treatment and promote cessation. To be effective, tobacco treatment should be integrated into all aspects of care, including assessment, planning, treatment, and discharge.

What Is Integrated Treatment?

Integrated treatment involves coordinating the whole health needs of an individual — including primary care, mental health care, and addiction treatment. Integrated care aims to be comprehensive, holistic, and collaborative. It should be tailored to the health needs and goals of each individual, with respect for their dignity and social circumstances.[1]

The U.S. Public Health Service and the Centers for Disease Control and Prevention (CDC) both advocate for integrating tobacco treatment into the clinical workflow.[2] Their recommended approach includes three steps:

1. Screen every patient for tobacco use.
2. Advise every patient who uses tobacco to quit.
3. Connect every patient to appropriate resources, including treatment.

Why Is Integration Important?

People living with mental illness or substance use disorders have higher rates of tobacco use than the general population. In turn, they also have higher rates of tobacco-related illness and death.[3] Despite popular misconceptions, the majority of individuals seen at mental health and treatment facilities are interested in quitting. However, they often have a difficult time accessing the resources they need, such as counseling or medication.[4] The most recent National Mental Health Services Survey found that only 49 percent of mental health facilities screened for tobacco use. An even smaller percentage offered tobacco cessation counseling (38 percent) or nicotine replacement therapy (25 percent).[5] By fully integrating tobacco treatment into mental health care, providers can positively impact the health and wellbeing of their patients.

Elements of Integrated Tobacco Treatment

SCREENING & ASSESSMENT

Tobacco use status should be assessed at each office visit or intake, along with other vital signs like blood pressure or pulse rate. Tobacco dependence should be assessed at the same time as other chemical dependencies.[6] Electronic health records (EHR) are the easiest way for providers to collect information about tobacco use and readiness to quit. Automatic prompts can help providers encourage quitting, provide cessation resources, and ensure follow-up.[7]

See Section One, Strategy One for more detail on specific assessment and screening tools.

TREATMENT PLANNING & IMPLEMENTATION

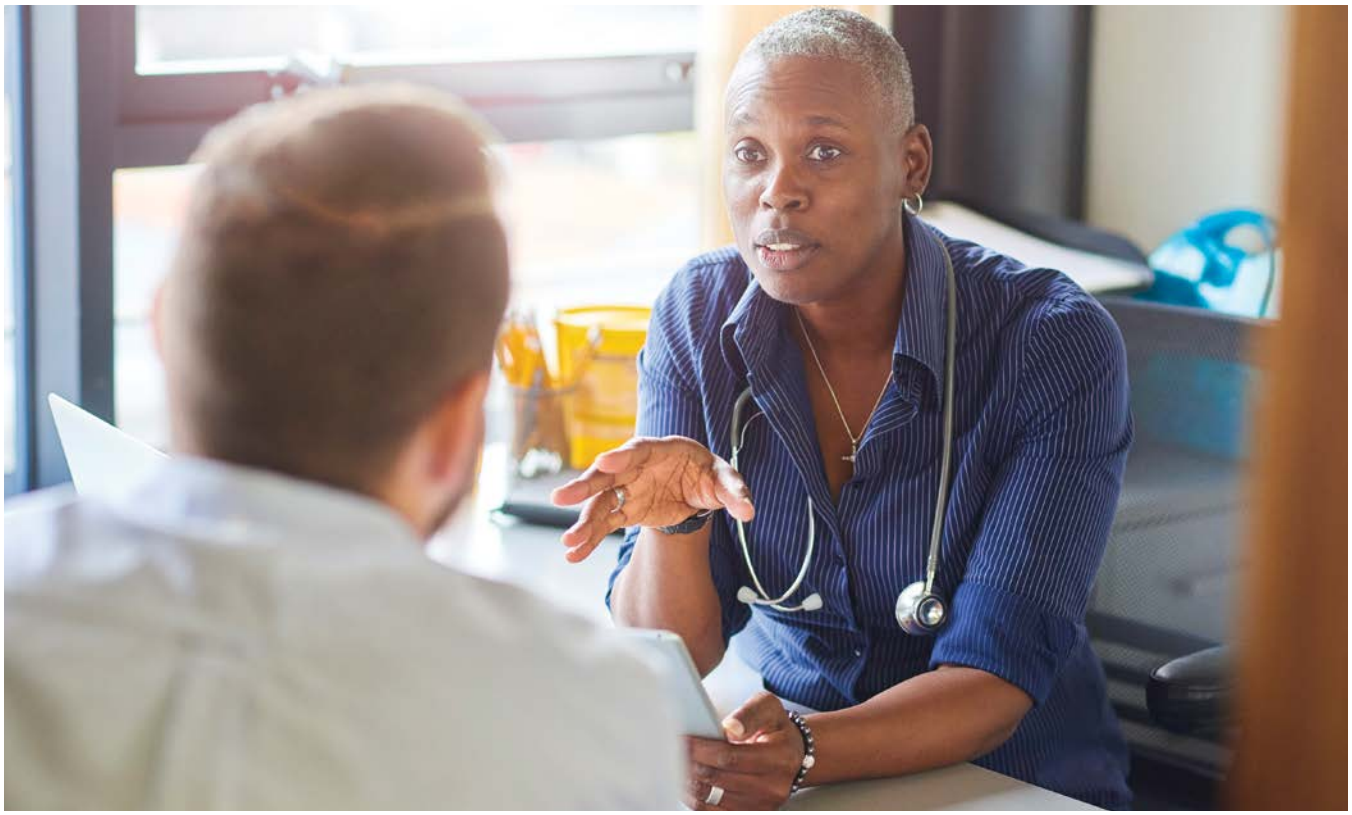
Tobacco use and dependence should be considered a primary medical problem by all providers involved in an individual's treatment.[8] Providers should be trained in how to diagnose and manage tobacco dependence, and be aware of all evidence-based treatment options available to their patients. Each individual's overall treatment plan should include documentation of tobacco use and treatment. These plans should address both behavioral and pharmaceutical treatment options.

Treatment plans should be flexible documents, developed in collaboration with each patient based on their specific needs and preferences. Plans should be reviewed and adjusted regularly according to each individual's progress.

The Tobacco Recovery Resource Exchange[9] (part of the New York Tobacco Control Program) suggests that treatment plans should include the following components:

- **Problem Statements** are specific problems associated with an individual's tobacco use. For example, "The patient smokes cigarettes at home, and the secondhand smoke is negatively affecting his daughter's health."
- **Goal Statements** are broad outcomes made by reframing the problem statements. For example, "The patient will ensure that his daughter is not exposed to secondhand smoke at home by making his house and yard smoke-free."
- **Objectives** are specific and measurable actions that can be taken to reach each goal. For example, "The patient will sign an agreement with his case worker to keep his home smoke-free. The case worker will follow-up about this at each visit."
- **Integrated Program of Therapies and Activities (IPTA)** is a list of actions the provider or agency will take to help the patients complete their objectives and achieve their goals. For example, "The patient will receive individual counseling once per week for 12 weeks" and "The patient is prescribed Bupropion: 150mg once daily for three days, then 150mg twice a day for 12 weeks."

See Section One, Strategy Two and Section One, Strategy Three for details on treatment options.



DOCUMENTATION AND DIAGNOSIS

Tobacco diagnoses should be documented in patient charts according to the correct DSM-5 and ICD-10 criteria. This allows for insurance reimbursement, and helps ensure continuity of care.

See Section Section Two, Strategy Eight for more detail on billing and reimbursement.

DISCHARGE PLANNING

For inpatient settings, tobacco cessation and relapse prevention should be considered when making a discharge plan. Specific goals and objectives will look different depending on the progress the patient made towards cessation. For example, patients who have been using nicotine replacement therapy during their inpatient stay will need a prescription or a referral to an outpatient provider.

Support for integrated care

Many national organizations and professional associations support the use of integrated care for tobacco treatment. The Association for the Treatment of Tobacco Use and Dependence (ATTUD) has compiled a document that includes these statements of support. ATTUD "advocates that all clinicians working with individuals with mental health or substance use disorders provide direct treatment to patients, develop professional capacity to do so, and fully integrate tobacco treatment into behavioral healthcare."[10]

The National Alliance on Mental Illness[11] Has the Following Statement about Tobacco Treatment:

"NAMI is committed to supporting in every way the wellness of people with mental illness and in recovery. NAMI recognizes that cigarette and other tobacco use is a dangerous form of addiction. Such addiction creates more significant health problems for people with mental illness and in recovery. People with mental illness and in recovery have the right to be smoke free and tobacco free. Effective prevention and treatment, including treatment of the effects of withdrawal, are available and should be part of effective mental health care treatment and recovery. People with mental illnesses must be given education and support to make healthy choices in their lives."

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Strategy Five: Incorporate Tobacco Treatment into Other Ongoing Efforts toward Wellness and Recovery.

Tobacco cessation is part of a broader focus on improving the health of people living with mental illness or substance use disorder. In recent years, health systems have shifted towards a recovery model of care, with a focus on building strength and resiliency. This model promotes wellness strategies that help individuals live healthy lives and reach their full potential. Tobacco use is a major cause of poor health, especially for people living with mental illness or substance use disorder. Providers should promote cessation along with other wellness and recovery efforts.

A Wellness and Recovery Model of Care

Recovery-oriented treatment is focused on individual empowerment and self-determination.[1] The focus of this model is on the *whole person*, and on providing treatment and support services that help individuals achieve their own goals and aspirations.[2]

The Substance Abuse and Mental Health Services Administration (SAMHSA)[3] identifies four major dimensions that support the process of recovery:

1. **Health:** Managing diseases or symptoms and making informed, healthy choices.
2. **Home:** Having access to stable, safe housing.
3. **Purpose:** Participating in meaningful activities, including jobs and creative endeavors.
4. **Community:** Accessing support networks and actively engaging in local communities.

A Recovery-oriented Approach to Treatment in Kansas

The Kansas Department for Aging and Disability Services (KDADS) "takes a recovery-oriented approach to substance use disorder treatment for those with drug and alcohol problems, employing a coordinated network of community-based services and person-centered supports, and builds on the strengths and resilience of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life."[4]

The recovery model of care aims to improve quality of life for people living with mental illness or substance use disorder. This model recognizes that *many* factors influence a person's physical and mental health. Patients should be supported in making healthy choices to improve

their well-being and overall quality of life. These choices include healthy eating, physical activity, stress management, and avoiding the use of tobacco or other addictive substances.[5]

The Substance Abuse and Mental Health Services Administration (SAMHSA)[6] suggests eight dimensions of wellness to improve health for people with mental illness or substance use disorder. These dimensions can be used to create wellness plans tailored to an individual's needs and preferences.

1. **Emotional:** Learning effective coping skills, having a positive self-regard and creating satisfying relationships.
2. **Environmental:** Existing in pleasant, stimulating environments that support well-being.
3. **Financial:** Being satisfied with current and future financial situations.
4. **Intellectual:** Recognizing ways to expand knowledge, skills and creative abilities.
5. **Occupational:** Gaining personal satisfaction and enrichment from one's work.
6. **Physical:** Identifying the need for physical activity, healthy foods and sleep.
7. **Social:** Developing connection, belonging, and support systems.
8. **Spiritual:** Attending to a sense of purpose and meaning in life.

Tobacco cessation is an example of a healthy choice that can improve physical and mental well-being. Tobacco use impacts several dimensions of wellness, including emotional, environmental, financial, and physical well-being.

Incorporating Tobacco into Wellness Initiatives

Tobacco use contributes to illness and early death, especially for people living with mental illness and substance use disorder. Tobacco cessation is part of following a healthy lifestyle, and treatment should be integrated into existing wellness initiatives.

One example of a wellness approach that addresses tobacco use is *Learning About Healthy Living*, a group treatment model created by Dr. Jill Williams and her colleagues.[7] This treatment approach addresses tobacco use, unhealthy eating, and physical inactivity. The model is designed for smokers with serious mental illness, whether or not they are currently ready to quit. The curriculum includes twenty weekly sessions, lasting around 50 minutes, that each feature a different topic. The first ten sessions provide more general information about healthy living, tobacco, and mental illness. The final ten sessions are more personalized, and encourage behavior change. The goal is to bring everyone closer to being tobacco free, and to increase their confidence in making a quit attempt.

For more information on staff cessation, see Section Two, Strategy Nine.

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Strategy Six: Conduct Quality Improvement to Define Outcomes, Monitor Progress and Improve Tobacco Treatment Services.

To achieve effective patient outcomes and improve system performance, clinics and other facilities should conduct ongoing evaluations of their tobacco treatment services. This involves collecting information on the structures, processes, and outcomes associated with tobacco cessation. The information should describe how well the current cessation services are working and also identify areas for improvement. As part of this process, clinics and other facilities should set goals, monitor progress, assess outcomes, and use data to improve services.

What Is Quality Improvement?

Quality improvement is an ongoing process of evaluation, comparison, and innovation. It is based on two main questions: "How are we doing?" and "Can we do it better?" Quality improvement is concerned with how effective and efficient a system is at achieving desired outcomes for patients or populations.[1] Comparing the current system's performance with the goals an organization has set might require assessing efficiency, safety, or patient satisfaction.[2] Quality measures may be tied to reimbursement or payments for providers as a way to incentivize performance.[3]

Why Is Quality Improvement Important?

Quality improvement helps organizations set goals and track their progress towards achieving them. Progress is evaluated in a **systematic** and **continuous** way.[4] The information that is collected can be used to evaluate existing programs, make changes, and improve patient care. In turn, this will impact health outcomes. Quality improvement helps health care organizations achieve the triple aim of improving patient care experiences, improving population health, and reducing costs.[5]

Several organizations recommend quality improvement for tobacco treatment services, including the World Health Organization, the American Lung Association, and the Centers for Medicare and Medicaid Services.[6]

Quality Measures in Tobacco Treatment

Evaluations of health care quality are organized into three categories: structural, process, or outcome measures.

STRUCTURAL MEASURES

Also known as inputs, structural measures consider an organization's resources, such as staff, physical infrastructure, equipment, information, and technology.[7] Structural measures can be used to evaluate an organization's **capacity** to provide quality tobacco treatment services.

Resources can be measured with simple surveys or questionnaires. For example, organizations might be asked:

- Does your facility have a tobacco-free grounds policy?
- Does your facility have staff authorized to prescribe medications?
- What percentage of your staff have received training in tobacco cessation?

PROCESS MEASURES

Process measures consider activities, such as treatment interventions, and how they are delivered. Process measures answer the questions "What is done?" and "How is it done?"[8] Organizations need to know what interventions are being done and if they are being implemented correctly.

One major consideration is **reach** — how many tobacco users are reached by each intervention? This might be measured in terms of how many patients are *offered* the treatment, or in terms of how many patients *received* the treatment.[9] Other key process measures include patient satisfaction and perceived barriers to access or implementation.[10]

Simple surveys or questionnaires can be used for process evaluation. Patients or providers can also be interviewed to gather more in-depth information.

Providers or organizations might be asked:

- In the past year, approximately what percentage of patients over the age of 18 did you screen for tobacco use?
- In the past year, approximately what percentage of tobacco users did you advise to quit?
- In the past year, approximately what percentage of tobacco users were prescribed cessation medications?
- What, if any, barriers do you face in providing tobacco cessation treatment to patients?

Patients might be asked:

- During any visit to [facility name] in the last 6 months, did you receive advice to stop smoking?
- During any visit to [facility name] in the last 6 months, did you receive a prescription for medication to help you stop smoking?

- How many group tobacco counseling sessions did you attend in the last six months?
- On a scale of 1-5, with 1 being very dissatisfied and 5 being very satisfied, how satisfied were you with the tobacco cessation counseling you received?

OUTCOME MEASURES

Outcome measures, also known as results, consider the impact of services and interventions on a patient's health. Outcome measures are specific results connected to the broader goals of an organization or program.[11] For example, a clinic may have a **goal** of reducing tobacco use among individuals living with mental illness. They may have **objectives** that specify how the goal will be achieved, such as aiming for at least 50 percent of patients to make a quit attempt within six months. The **outcome measure** would be the *actual* percentage of patients who make a quit attempt — whether this meets the objective or not.

There are three types of outcome measures: short-term, intermediate, and long-term. To measure change over time, these questions should be asked both *before* and *after* an intervention or program takes place.

1. **Short-term outcomes** measure changes in attitude, beliefs, or knowledge.[12] Examples of short-term outcome measures include:
   - What percent of patients are aware of assistance to help them quit smoking, such as telephone Quitlines, cessation medications, or counseling?
   - What percent of patients believe that joining a tobacco cessation group would help them quit?
   - What percent of patients 'strongly agree' or 'agree' that stop-smoking medications would make it easier if they decided they wanted to quit?[13]
2. **Intermediate outcomes** measure changes in behavior.[14] Examples of intermediate outcome measures include:
   - What percent of patients reduced their number of cigarettes per day by at least half in the last six months?
   - What percent of patients made a quit attempt in the last six months?
   - What percent of patients have validated abstinence after six months?
3. **Long-term outcomes** are similar to goals, and measure changes in overall mortality, morbidity, or quality of life.[15] They are often only noticeable after a program or intervention has been in place for a long amount of time. Examples of long-term outcome measures include:
   - What percent of patients successfully quit smoking for more than one year?

- Compared to patients who did *not* quit using tobacco products, do patients who successfully quit experience fewer respiratory diseases?
- Compared to patients who did *not* quit using tobacco products, do patients who successfully quit live longer, on average?

Examples of Tobacco Treatment Quality Measures

The Centers for Medicare and Medicaid Services (CMS) considers tobacco screening and treatment to be an important indicator of provider quality. CMS uses quality measures to decide how providers and clinics are paid, or reimbursed, for their services.

Through the Inpatient Prospective Payment System (IPPS), Medicare will withhold a portion of federal funds for states who do not meet performance goals. The following three standardized performance measures relate to tobacco screening and treatment:[16]

1. Tobacco use screening of patients 18 and over.
2. Tobacco use treatment, including counseling and medication, during hospitalization.
3. Tobacco use treatment management plan at discharge.

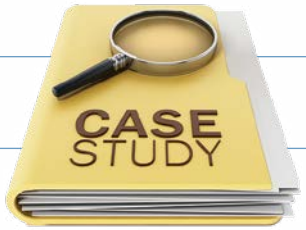
Medicaid also collects information about tobacco screening and treatment. Each year, the federal government publishes a list of core adult health care quality measures. States voluntarily collect and share this data with the Secretary of Health and Human Services.[17] The quality measure related to tobacco has three parts:

1. The percentage of Medicaid beneficiaries age 18 and older who were current smokers or tobacco users and who received advice to quit.
2. The percentage of Medicaid beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications.
3. The percentage of Medicaid beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation medications or strategies.

See Section One, Strategy Four for information on integrating tobacco treatment.

Also, see Appendix A: Kansas Tobacco Guideline for Behavioral Health Care and Appendix B: Implementation Self-Assessment.

Case Study: Quality Improvement in Kansas



At Prairie View Mental Health Center in Newton, Kansas, data for quality improvement is collected in two ways. Each quarter, data from the electronic health records is reviewed. Biannually, staff complete a brief survey about their attitudes towards tobacco treatment. The survey includes the following questions:

- 0–10 Rating of Importance of Tobacco Treatment.
- 0–10 Rating of Confidence of Performing Tobacco Interventions.
- Types of tobacco interventions used (check all that apply):
  - a 2A & R (ask, advise, refer)
  - b Pharmacotherapy
  - c Quitline referral
  - d Motivational Interviewing
  - e Referral to Prairie View's Support Group
  - f Other
- Length of time spent per session on tobacco interventions (in minutes).

Each survey includes additional questions. Examples from past surveys include:

- What resources would you find beneficial for performing tobacco treatment?
- Which treatment modalities do you favor when performing brief tobacco interventions?
- What barriers do you experience with putting a DSM-5 for Tobacco Use Dependence Disorder on a treatment plan?
- What barriers do you experience when talking to a patient about their tobacco use in general?
- Name one way your work could be easier by utilizing tobacco grant resources.
- Name one way patients would emotionally benefit by stopping their tobacco use.
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For more information, visit https://prairieview.org.

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Strategy Seven: Train Staff How To Treat and Prevent Tobacco Dependence.

To be successful, tobacco cessation programs must involve staff in all stages of planning and implementation. This includes preparing staff to provide treatment and prevention services. Staff training should build awareness, address potential barriers, and provide evidence-based information. Many resources for training are available, both nationally and in Kansas. When staff are engaged and informed about best practices for cessation, they are better prepared to support their patients who use tobacco.

Why Training Is Important

Rates of tobacco use are disproportionately high among people living with mental illness and substance use disorder.[1] Although many of these tobacco users would like to quit, they often have a difficult time accessing the support and treatment they need to be successful. Mental health and substance use treatment facilities may not have the resources to offer cessation services. Staff at these facilities may not have adequate training and education in tobacco cessation. Training provides staff with the knowledge, motivation, and confidence to intervene with patients who use tobacco.

Without training, staff may feel uncomfortable or unwilling to intervene.[2] For example, some staff who have not received training may believe that tobacco use is therapeutic for people with mental illness or that quitting will interfere with current treatments.[3] Providers may not see tobacco use as a mental health issue or may consider it a lower priority for their patients.[4] Other providers may believe that patients are uninterested in quitting.[5] Finally, staff may be concerned about implementing new tobacco policies: will there be negative side-effects? Will working conditions become unsafe?[6]

These attitudes and beliefs can be addressed through training and professional development. Research shows that staff who attend trainings feel more confident and willing to intervene.[7] Trainings also increase staff knowledge and help create new norms around tobacco use.[8] When staff are committed to tobacco treatment and believe that it is important, mental health and substance use treatment facilities provide better quality care.[9]

Building Staff Capacity

Trained providers are an essential part of any tobacco cessation policy or program. Their support and buy-in is necessary for those policies and programs to succeed. Many mental health centers, treatment facilities, and hospitals have successfully generated staff support for tobacco cessation. The following actions contribute to their success:

- Provide basic training to all employees *in advance* of starting a new program or policy. Communicate clearly so everyone understands the goals and objectives.[10]
- Connect tobacco cessation to existing workplace priorities and staff roles. For example, use existing addiction treatment frameworks to address tobacco use.[11]
- Integrate new activities into the clinical workflow to limit provider burden. For example, place reminders about brief interventions within the existing electronic medical record system.[12]
- Identify tobacco cessation champions who can serve as an inspiration and a resource for other staff.[13]
- Use quality improvement to track progress. Share success stories with staff, patients, and community members.[14]
- Coordinate with outside organizations and advocacy groups. Supportive policy environments at the city, county, or state level can help increase staff buy-in.[15]

Resources for Staff Training

RESOURCES IN KANSAS

Addressing Tobacco Use in Kansas: The Brief Tobacco Intervention Online Training

This free online course is provided by the Kansas Department of Health and Environment. The course takes about 30 minutes to complete, and continuing education credits are approved for certain health providers. The course is based on current national guidelines for tobacco cessation, and instructs providers on how to complete the Brief Tobacco Intervention with patients. The training also includes demonstrations on the Kansas Tobacco Quitline and motivational interviewing.

More information is available at http://www.kdheks.gov/tobacco/download/BTI_online_course_fact_sheet.pdf and the training can be accessed at www.kstobaccointervention.org.

University of Kansas Medical School: Tobacco Treatment Specialist Training

This intensive four-day training program prepares behavioral health providers to deliver evidence-based tobacco treatment to patients. The in-person training includes six modules, based on a set of core competencies laid out by the Association for the Treatment of Tobacco Use and Dependence (ATTUD). The University of Kansas Medical School is one of several accredited institutions around the country that offers this specialized training.

For more information, visit http://www.kumc.edu/school-of-medicine/preventive-medicine-and-public-health/tts.html.

For information about other accredited TTS trainings programs, visit the Council for Tobacco Treatment Training Programs website: http://ctttp.org/accredited-programs.

OTHER RESOURCES

Tobacco Recovery Resource Exchange[16]

The Tobacco Recovery Exchange was created in 2008, after New York implemented tobacco-free policies at all state-funded substance use treatment programs. The NY State Department of Health worked with Rockefeller College to create training resources for addiction professionals and facilities. These resources are free and available online, including manuals, slides, videos, and toolkits about integrating tobacco treatment into existing programs. The implementation toolkit includes specific resources for engaging staff and gaining buy-in.

Access these resources online at: https://tobaccorecovery.oasas.ny.gov.

Wisconsin Nicotine Treatment Integration Project[17]

This project, funded by the Wisconsin Division of Public Health, Tobacco Prevention and Control, aimed to integrate nicotine treatment into addiction and mental health programs. The website features archived webinars, podcasts, and newsletters, as well as links to other useful training and treatment resources.

For more information, go to: http://www.wisconsinwintip.com.

University of Colorado Behavioral Health & Wellness Program[18]

The Behavioral Health & Wellness Program is part of the University of Colorado School of Medicine, and is dedicated to positive health behavior change. The program specializes in training and technical assistance related to tobacco cessation treatment in behavioral health settings. In addition to providing consultations and evaluations, it offers trainings and other educational resources both online and in person. Fact sheets, reports, clinical guidelines, and other useful publications are available for download.

For more information, go to: https://www.bhwellness.org.

Taking Texas Tobacco Free

The mission of Taking Texas Tobacco Free is to promote wellness among Texans by partnering with healthcare organizations to build capacity for system-wide, sustainable initiatives that will reduce tobacco use and secondhand smoke exposure among employees, consumers, and visitors.

For more information, go to https://www.takingtexastobaccofree.com.

Smokefree.gov[19]

In addition to online and phone-based resources aimed at people trying to quit tobacco, smokefree.gov has a specific page for health professionals. Here, providers can learn about evidence-based treatment and prevention programs, download clinical guidelines, and find links to other resources.

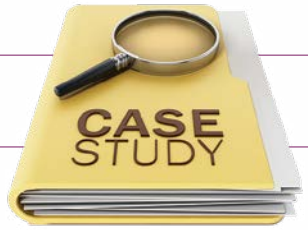
For more information, go to: https://smokefree.gov/help-others-quit/health-professionals/resources-health-professionals.

Centers for Disease Control and Prevention (CDC)[20]

The CDC has many resources related to tobacco prevention and cessation. The agency's Office on Smoking and Health (OSH) provides funding, technical assistance, and other resources to states. The CDC also has extensive resources online about the health effects of tobacco use, new tobacco products, tobacco-related disparities, and tobacco control efforts. In addition, the CDC campaign, *Tips from Former Smokers*, provides useful resources for health care providers.

For more information about the CDC's Office of Smoking and Health, go to: https://www.cdc.gov/tobacco/about/osh/index.htm.

For more information about *Tips from Former Smokers*, go to: https://www.cdc.gov/tobacco/campaign/tips/index.html.



Case Study: Bert Nash Community Mental Health Center

At Bert Nash Community Mental Health Center in Lawrence, Kansas, staff training has had a big impact. In 2017, two therapists attended the Tobacco Treatment Specialist training at the University of Kansas Medical Center. In addition to working one-on-one with patients, the trained therapists were able to work with staff to shift the culture around tobacco use. Staff were encouraged to complete the online Kansas Brief Tobacco Intervention course and trained in how to diagnose and document tobacco use disorder in the electronic medical record. Medical providers received additional training on nicotine replacement therapies and other pharmaceutical treatments.

As a result of these efforts, tobacco use at the Center is being assessed, diagnosed, and treated with greater frequency. A cessation group is available to adult patients who use tobacco, using the Learning about Healthy Living curriculum. Staff attitudes towards tobacco use and cessation have also improved, largely due to the efforts of the trained Tobacco Treatment Specialists who serve as a critical resource within the workplace. The Center has plans to send additional clinical staff to this training.

Increased training also helps staff be more responsive to their patient's needs. For example, one therapist recounted the story of a teen who was experiencing serious behavioral issues during a group session. The therapist was able to recognize the signs of nicotine withdrawal and respond accordingly, instead of removing the teen from the group.

For more information, visit https://bertnash.org.

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Strategy Eight: Bill for Reimbursement and Utilize Other Resources to Pay for Tobacco Treatment.

Tobacco cessation programs need a sustainable source of funding. Insurance plans, government agencies, and other organizations may cover or reimburse for tobacco treatment. Reimbursement makes providers and facilities more likely to provide cessation services. In turn, patients have an easier time accessing the services they need to successfully quit using tobacco. In Kansas, there are several options for patients and providers to get coverage for tobacco treatment.

Why Reimbursement Matters

Billing and reimbursement can be a challenge for mental health and substance use treatment facilities who want to provide tobacco cessation services. For example, directors of addiction treatment programs identify inconsistent insurance coverage and reimbursement as significant barriers to offering tobacco treatment.[1] Even when state programs or insurance companies do offer coverage, providers may be unaware of it. One study found that only 40 percent of physicians who accepted Medicaid were aware that their state offered Medicaid coverage for tobacco treatment.[2]

Although coverage can be challenging for providers to navigate, it can also have a huge impact on the health of patients. Insurance coverage increases access to evidence-based cessation treatment for those who need it most. For example, adults living with mental illness have much higher rates of tobacco use than the general population,[3] but are more than twice as likely to be uninsured.[4] A recent study found that smokers who gained Medicaid coverage were more likely to quit smoking, receive medication, and attend follow-up visits than smokers who remained uninsured.[5]

Reimbursement for Tobacco Treatment

Reimbursement for tobacco treatment counseling depends on many factors: the type of provider, the setting, and what coverage (if any) a patient has. Even if individual or group counseling are not covered, there are still ways for providers to help patients quit using tobacco. Dr. Audrey Darville from the University of Kentucky has outlined the following strategies for providers and other staff to be reimbursed for tobacco treatment.

When new or existing patients are seen about tobacco use, every step should be documented in their health records. Assessments, diagnoses, treatment plans, and time spent counseling should all be recorded. Once a patient's coverage has been confirmed, the appropriate billing code can be assigned for reimbursement.

- **Assess:** Document the type of tobacco, frequency of use, and level of nicotine dependence. See Section One, Strategy One for more information on assessment.
- **Diagnose:** Enter the appropriate ICD-10 code for the patient's diagnosis.[6] The code is used to justify the treatment that is provided, so it should be as specific as possible. It should also be supported by documentation, such as assessments, in the health record.

  Options include:

  - **F17.200** Nicotine dependence, unspecified, uncomplicated
  - **F17.203** Nicotine dependence, unspecified, with withdrawal
  - **F17.210** Nicotine dependence, cigarettes, uncomplicated
  - **F17.213** Nicotine dependence, cigarettes, with withdrawal
  - **F17.220** Nicotine dependence, chewing tobacco, uncomplicated
  - **F17.223** Nicotine dependence, chewing tobacco, with withdrawal
  - **099.330** Smoking (tobacco) complicating pregnancy, unspecified trimester

This list is not complete. Please refer to the most current ICD-10-CM list of codes and guidelines for the full range of options.

- **Treatment Plan:** Based on the patient's diagnosis and insurance coverage, a treatment plan should be created. This could include moderate or intensive individual counseling or group counseling. If counseling is not covered, patients still may be able to get medications. See Section 1, Guideline 2 for more information on medication access. Patients can also be referred to KanQuit, the free tobacco quitline for Kansas, via fax referral, signing up on the KanQuit website or a warm handoff to the quitline in the doctor's office.

- **Confirm Coverage:** Before providing treatment, it is important to confirm what will be covered. This will vary for each patient, depending on whether they are covered by Medicaid, Medicare, private insurance, or none of the above. There may be further requirements for which providers are qualified to perform the services.
  - **Medicare Part B** covers two cessation attempts per year, including up to four individual counseling sessions, for all patients. These must be provided by a Medicare physician or other qualified provider.[7]
  - **KanCare (Medicaid)** covers counseling for all beneficiaries, with no limits on annual quit attempts for individual counseling sessions lasting between 3 and 10 minutes; in addition, Kansas Medicaid covers smoking cessation groups led by non-physician providers.[8]
  - **Private Insurance** through employers or purchased in the individual marketplace vary in their coverage. The Affordable Care Act currently requires insurance plans to cover preventive services graded 'A' or 'B' by the US Preventive Services Task Force. The USPSTF has given tobacco cessation interventions an 'A' grade. Most insurance plans will cover at least four sessions of individual, group, or telephone counseling.[9]
  - If a patient is **uninsured**, it may not be possible to get reimbursed for counseling. Providers should think creatively about how to help these patients access cessation support. Referring patients to the free state tobacco quitline KanQuit, or to free text messaging via smokefree.gov, are excellent options
- **Billing Code:** To be reimbursed for tobacco counseling, a CPT or HCPCS billing code must be used.[10] This code corresponds to the treatment being provided. These codes are how insurance companies, Medicare, and Medicaid determine reimbursement rates. Billing codes related to tobacco treatment include:
  - **99406** for moderate counseling: Smoking & tobacco use cessation counseling visit greater than 3 minutes, but no more than 10 minutes.
  - **99407** for intensive counseling: Smoking & tobacco use cessation counseling visit greater than 10 minutes
  - **S9075** for smoking cessation classes: Per session with a non-physician provider.

Note: Online training is being developed for release in 2019 on Tobacco Dependence Treatment: Coverage, Billing, and Reimbursement. Check with NAMI Kansas for the release date and how to access.

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Strategy Nine: Help Staff Who Use Tobacco to Access Evidence-Based Treatment for Tobacco Dependence.

Staff who use tobacco need help to quit. Offering tobacco treatment services to staff is cost-effective for employers and helps promote cessation among patients. In addition, staff play a big role in supporting tobacco-free policies and encouraging patients to quit.

Why Is Staff Cessation Important?

CESSATION SAVES LIVES

Although this toolkit focuses on people living with mental illness and substance use disorder, treatment and cessation are important for *everyone*. Tobacco use remains the leading cause of preventable death in the United States[1] — people who smoke have a greater risk of dying from cancer, cardiovascular diseases, and respiratory conditions than the general population.[2] Fortunately, most of this risk is reversible. One study found that people who quit before the age of 40 reduced their risk of death from a smoking-related disease by 90 percent.[3] By helping staff access treatment, employers are saving lives.

CESSATION SAVES MONEY

Tobacco use is also costly. The American Lung Association estimates that smoking-related illnesses cost over $300 billion per year in direct medical costs and lost productivity.[4] On average, it costs nearly $6,000 more each year to employ a smoker, compared to a nonsmoker, taking into account higher health care costs, missed days of work, lower productivity, and time lost to smoking breaks.[5] Tobacco use is the number one cause of lost productivity among American workers, above alcohol abuse and family emergencies.[6]

In comparison, treating tobacco use is very cost-effective for employers. Research shows that investments into cessation programs can be fully offset within three years.[7] Staff who receive treatment have fewer health problems, resulting in lower medical costs and insurance premiums.[8] Moreover, staff who do not use tobacco miss fewer workdays and have higher productivity.[9]

The North American Quitline Consortium offers an online tool for employers to calculate the return on investment (ROI) for offering telephone counseling and cessation medications to employees. Generally speaking, an ROI is a measure of cost-effectiveness. This specific online tool considers how much money will be spent on the cessation services and how much money will be saved if current smokers quit. By comparing these two numbers, organizations can see whether a staff cessation program would be a good investment.

For more information, visit: http://www.naquitline.org/resource/resmgr/ppp/pppempworksheetsep3final.docx.

How to Promote Staff Cessation

INSURANCE BENEFITS

One of the most common ways to promote staff cessation is through a comprehensive insurance benefit. Offering these benefits can help reinforce tobacco-free policies, motivate staff to quit, and promote a culture of cessation that will extend to patients.

There are many considerations in designing the right benefits package:

- **Provide incentives to quit.** Balance higher insurance premiums for people who use tobacco with benefits if they quit. A punishment alone may not be enough motivation. If surcharges are too high, individuals may not honestly report their tobacco use status, which limits the ability of providers and employers to help them quit.[10] Current health care laws allow employers to charge tobacco users up to 50 percent more than non-tobacco users if they provide tobacco cessation wellness programs.[11]
- **Offer coverage for a variety of treatments.** Evidence shows that a combination of medication and counseling is the most effective way to quit.[12] Benefits should cover all seven FDA-approved medications and individual or group counseling.

- Medication coverage should include as many brands and generics as possible, including over-the-counter nicotine replacement therapies.[13]
- Coverage of counseling should include a variety of providers, to make access easier. These providers could include physicians and physician assistants, nurses and nurse practitioners, social workers, clinical therapists, and more.[14]

- **Reduce financial barriers.** If possible, eliminate or reduce co-pays or deductibles. These payments may make employees less likely to seek treatment.[15]
- **Avoid other barriers to cessation, such as lifetime or annual limits.**[16] Limit other potential barriers to accessing treatment. The Centers for Disease Control & Prevention and the American Lung Association identify several common barriers to accessing treatments:

  1. **Prior authorization** requires providers to contact a plan directly for permission to prescribe a medication or treatment. This can delay treatment.
  2. **Counseling requirements for medications** prevent patients from getting a prescription unless they attend counseling. Counseling should always be encouraged, but not forced. Patients who are unable or unwilling to attend counseling should be able to access other resources to help them quit.
  3. **Stepped care** requires patients to start with one form of treatment (usually the least expensive), and only allows them to try other options if this is not successful. While this approach may be cost-effective, it limits the ability of providers to tailor treatment plans to each individual.
  4. **Limits on treatment duration** restrict the number of weeks a patient can use a medication, or the number of counseling sessions they can attend. However, patients may need additional time to manage withdrawal symptoms and successfully quit.
  5. **Limits on quit attempts** restrict how many times a patient can access cessation benefits each year, or even in their lifetime. However, most tobacco users make multiple quit attempts before they are successful. Relapse is a normal part of the process in treating addiction. These limits might discourage patients from making new quit attempts. If tobacco users are not successful at quitting the first or second time, they should still be supported in achieving cessation.

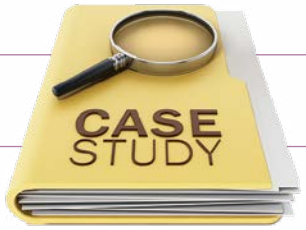
- **Communicate with staff.**[17] Create a communications plan to inform staff about the cessation benefits that are being offered. Use clear and simple language so that everyone understands how to access these services. Share the information in a variety of ways: email, flyers, new employee orientation guides, or other regular channels of communication.

Insurance benefits are not the only way to promote cessation among staff. Employers can offer classes, provide education, encourage the use of free resources like KanQuit, and connect tobacco use to other workplace wellness efforts.

Many people who use tobacco have never had a health care provider advise them to quit.[18] Some may be unfamiliar with the resources available — either through their insurance benefit, their employer, or the community. Educating staff on the hazards of smoking, the benefits of cessation, and the resources available can be very effective. Education helps promote cessation among staff. For example, at a behavioral health clinic in Texas, 46 percent of staff who smoked made a quit attempt after receiving tobacco-related education at work.[19]

Information can also be given to staff through printed materials like pamphlets or posters. It should also be included in employee handbooks or other materials given to new staff. Electronic versions can be made available online or sent through staff email.[20] Communication to staff about cessation or other tobacco-related policies should be clear and easy to read. It should also be empathetic and understanding, pointing out that tobacco use is an addiction, and promoting cessation as a solution.[21]

See Section Two, Strategy Seven for more information on staff training and education.



Case Study: Prairie View Mental Health Center

At Prairie View Mental Health Center in Newton, Kansas, staff are encouraged to remain tobacco-free through a tiered insurance program. Employees who are tobacco users are charged a higher insurance premium than employees who do not use tobacco or who enroll in the wellness program to quit.

For more information, visit https://prairieview.org.

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Strategy Ten: Enact a Comprehensive Tobacco-free Policy that Includes Buildings, Vehicles, Grounds and Expectations for Staff, Visitors, and Patients.

Despite decades of evidence on the adverse health impact of tobacco use and exposure to second-hand smoke, not all mental health and substance use treatment providers have adopted comprehensive tobacco-free policies. However, implementing a tobacco-free policy is one of the most effective measures a behavioral health provider can take to promote and support client and staff tobacco cessation in the health care environment.

This section contains the following resources:

- Tobacco-free Policy Talking Points
- Sample Checklist for Tobacco-free Policy Implementation
- Model Tobacco-free Policy
- Sample Tobacco-free Policy Violations/Enforcement Measures
- Examples of Tobacco-free Policy Signage
- Smoke-free Behavioral Health Facilities in Kansas

Tobacco-free Policy Talking Points

- Tobacco use is the most prevalent substance use disorder in Kansas. In Kansas, smoking causes 4,400 deaths annually, and is responsible for $1.12 billion in health care costs.[1]
- Many, if not most individuals served by behavioral health care providers have co-morbid tobacco dependence.[2]
- Forty percent of cigarettes smoked by adults in the U.S. are smoked by adults diagnosed with mental illness and substance use disorders.[3]
- People diagnosed with severe mental illness die 25 years younger than the general population, largely due to conditions caused/worsened by smoking (heart disease, cancer, and lung disease).[4]
- Studies have shown that smoking prevalence is 25 percent for persons with anxiety disorders, 30 percent for those with depressive disorders, and 50 to 80 percent for those with schizophrenia, and that 14 percent of all U.S. smokers are persons with drug or alcohol abuse problems.[5]

- Tobacco dependence causes approximately 50 percent of the deaths of long-term tobacco users.[6]
- The use of products containing nicotine in any form among youth and young adults, including in e-cigarettes, is unsafe.[7]
- Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.[8]
- Scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke. Short exposures to secondhand smoke can cause blood platelets to become stickier, damage the lining of blood vessels, decrease coronary flow velocity reserves, and reduce heart rate variability, potentially increasing the risk of a heart attack.[9]
- Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.[10]

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Sample Checklist for Tobacco-free Policy Implementation

TASKS	RESPONSIBLE INDIVIDUALS	RESOURCES & SUPPORT		TIMELINE		STATUS
Policy Development		AVAILABLE	NEEDED	BEGINS	ENDS	
Assemble a tobacco-free work group.						
Create survey to gather baseline information about tobacco use among clients and staff and assess attitudes and beliefs about tobacco.						
Review tobacco-free policies at other behavioral health/addiction treatment facilities.						
Establish process for educating clients and staff, as well as visitors, and family members and guardians.						
Determine ways to educate community partners, such as neighboring properties, affected business owners, and other outside groups.						
Draft policy: ▪ Use concise language. ▪ Craft clear definitions. ▪ Identify robust enforcement options (consequences for violations by clients, staff, and visitors). ▪ Set realistic timeline and implementation date.						
Organization Preparation		AVAILABLE	NEEDED	BEGINS	ENDS	
Develop and disseminate information on why policy is being implemented.						
Determine procedures to provide tobacco dependence treatment to clients and staff.						

Sample Checklist for Tobacco-free Policy Implementation

TASKS	RESPONSIBLE INDIVIDUALS	RESOURCES & SUPPORT		TIMELINE		STATUS
Determine strategy for building staff buy-in for tobacco-free policy.						
Educate clients and staff on rationale for tobacco-free policy, tobacco use documentation, and cessation resources and services.						
Solicit questions and concerns of clients and staff and respond in person, meetings, and in follow-up handouts.						
Create signage (e.g., "This is a Tobacco-free Environment").						
Design and order promotional material for education and policy implementation.						
Remove all cigarette receptacles, ash cans, and ashtrays from premises.						
Policy Implementation		AVAILABLE	NEEDED	BEGINS	ENDS	
Post signage throughout facility and grounds.						
Ensure clients and staff comply with tobacco-free policy.						
Celebrate implementation day.						
Monitoring & Assessment		AVAILABLE	NEEDED	BEGINS	ENDS	
Conduct follow-up surveys of staff.						
Work with health insurance provider to compare pre- and post-policy health care costs.						
Use a Health Risk Assessment to determine changes in tobacco usage.						

Model Tobacco-Free Policy for Behavioral Health and Substance Use Treatment Providers

I. PURPOSE

_____ is committed to providing safe and healthy work environments. Tobacco use is a major cause of preventable disease and death. Smoking, tobacco use, and exposure to second-hand smoke have been found to cause heart disease, cancer, asthma, bronchitis, and other respiratory problems. Electronic cigarettes often closely resemble and purposely mimic the act of smoking. They produce a vapor of undetermined and potentially harmful substances and typically contain nicotine derived from tobacco, which is a highly addictive substance. Their use in locations where smoking is prohibited creates concern and confusion and makes policy enforcement more difficult.

_____ believes the use of tobacco products, including electronic cigarettes, on its premises is detrimental to the health and safety of its clients, staff, and visitors. In addition, _____ believes that staff and visitors serve as role models for clients and embraces its obligation to provide clinical and working environments that are safe, healthy, and free from unwanted smoke and tobacco use.

II. DEFINITIONS

a "Any time" means 24 hours a day, seven days a week.

b "Clients" (or "Patients") means persons receiving health care services.

c "Electronic cigarette" means any product that can be used by a person to deliver nicotine, or any other substance through the inhalation of aerosol or vapor from the product. The term includes, but is not limited to, devices manufactured, distributed, marketed, or sold as e-cigarettes, e-cigars, e-pipes, or under any other product name or descriptor.

d "Premises" means all buildings (including those owned, leased, rented or maintained by _____), all grounds, parking lots and ramps (including inside privately-owned vehicles parked on or in _____ property), plazas and contiguous sidewalks within 300 feet of the facility, and all vehicles owned, leased, rented, contracted, used, or controlled by the facility.

e "Smoking" means inhaling or exhaling smoke, aerosol or vapor from any lighted or heated cigar, cigarette, pipe, or any other product, whether natural or synthetic, made of tobacco, nicotine, tobacco, marijuana, or another plant, that is intended for inhalation. "Smoking" includes being in possession of a lighted or heated cigar, cigarette, pipe or any other tobacco product intended for inhalation, or an electronic cigarette that is turned on or otherwise activated.

f "Staff" means any person employed by _____ in a full or part-time capacity, any position contracted for or otherwise employed, with direct or indirect monetary wages or profits paid by _____, or any person working on a volunteer basis. This term includes, but is not limited to personnel, contractors, consultants, and vendors.

g "Tobacco product" means any product containing, made, or commercial tobacco or nicotine, that is intended for human consumption or is likely to be consumed, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to, a cigarette, a cigar, pipe tobacco, chewing tobacco, snuff, or snus. "Tobacco product" also means electronic cigarettes and any component or accessory used in the consumption of such a device, such as filter, rolling papers, pipes, and substances used in electronic cigarettes, whether or not they contain nicotine. The term "tobacco" refers to commercial as opposed to traditional tobacco, which is grown, harvested, and used by American Indians and Alaskan Natives for ceremonial or medicinal purposes.

h "Tobacco-related devices" means ashtrays, cigarette papers, pipes for smoking, or other devices intentionally designed or intended to be used in a manner that enables the chewing, sniffing, smoking, or inhalation of tobacco products.

i "Visitor" means any person subject to this policy that is not a client or staff member.

III. GENERAL STATEMENT OF POLICY

a No client, staff, or visitor shall smoke, possess, use, consume, display, promote, furnish, or sell any tobacco products, tobacco-related devices, or electronic delivery devices at any time on _____ premises. "Promotion" includes product advertising via branded gear, bags, clothing, any personal articles, signs, structures, flyers or any other materials.

b Tobacco use prevention and cessation will be incorporated into _____'s treatment program.

IV. CESSATION ASSISTANCE

a Evidence-based tobacco treatment will be integrated into routine clinical practice.

b Staff will be provided tobacco cessation resources and referrals.

c It is not a violation of this policy to use a product that has been approved by the U.S. Food and Drug Administration for sale as a tobacco cessation product, a tobacco dependence product, or for other medical purposes, and is being marketed and sold solely for such an approved purpose.

V. ENFORCEMENT

a The success of this policy will depend upon the consideration and cooperation of tobacco users and non-users. Enforcement is a shared responsibility of all clients, staff, and visitors.

1 Clients

i Clients who violate the policy will be provided information on cessation.

ii Clients will be asked to adhere to this policy and not use tobacco products or related devices.

2 Staff

i Staff who violate this policy will be offered a referral to cessation services.

ii Staff with repeated violations may be subject to disciplinary action.

3 Visitors

i Visitors who violate this policy will be asked to comply.

ii Individuals who fail to comply upon request may be asked to leave the property.

iii Repeated violations may result in the individual being prohibited from entering the facility for a specified period of time.

b Whenever _____ does not have jurisdiction over adjoining streets, sidewalks, parking lots, or other common areas, staff, clients, and visitors are strongly encouraged to comply with the spirit of the policy. It is the expectation that staff, clients, and visitors will not loiter near neighboring properties or discard litter in a way that reflects negatively on _____.

VI. DISSEMINATION OF POLICY

a Signage indicating _____ is a tobacco-free environment will be posted throughout the premises at building entrances and other appropriate locations.

b Clients and guardians will be notified of this policy at time of admission.

c The tobacco-free policy will be included in organizational guidelines and staff and client handbooks and related materials.

VII. PROGRAM EVALUATION

The tobacco-free policy will be assessed at regular intervals to determine whether policies, policy enforcement, communication, education, staff training, and cessation and treatment programs are effective and will be updated and revised accordingly.

VIII. EFFECTIVE DATE

This policy will take effect on _____.

This sample policy was prepared by the Public Health Law Center at Mitchell Hamline School of Law, St. Paul, Minnesota and made possible with funding from the Kansas Department of Health and Environment, the Kansas Health Foundation, and NAMI Kansas. The Public Health Law Center provides information and legal technical assistance on issues related to public health. The Center does not provide legal representation or advice. This document should not be considered legal advice.

Sample Tobacco-Free Policy: Tobacco Use Violations and Enforcement Measures*

CLIENT	STAFF	VISITOR
1st Violation	1st Violation	1st Violation
▪ Remind client of tobacco-free policy. ▪ Educate client about potential health risks, fire hazards, and second-hand smoke impact. ▪ Offer tobacco cessation classes, treatment options, and health education.	▪ Tobacco-free policy reminder, including consequences of violating policy again. ▪ Educate staff member about potential health risks, fire hazards, and second-hand smoke impact. ▪ Offer referrals to tobacco cessation services and resources.	▪ Remind visitor of tobacco-free policy, including consequences if policy is violated again. ▪ Point out potential health risks, fire hazards, and second-hand smoke impact. ▪ Explain that if visitor continues to violate policy, visiting privileges will be withdrawn.
2nd Violation	2nd Violation	2nd Violation
▪ Repeat 1st violation steps. ▪ Strongly encourage tobacco cessation classes. ▪ Hold team meeting with client to review treatment plan for potential changes. ▪ Peer-counseling with successfully abstinent client.	▪ Repeat 1st violation steps. ▪ Strongly encourage tobacco cessation classes and resources.	▪ Repeat 1st violation steps. ▪ Ask visitor to meet with two treatment members before being able to visit again.
3rd Violation	3rd Violation	3rd Violation
▪ Repeat 1st violation steps. ▪ Team meeting with client to address behavioral triggers for smoking and review treatment plan for potential changes. ▪ 7-day restriction from all unsupervised on-grounds movement	▪ Repeat 1st violation steps. ▪ Strongly encourage tobacco cessation classes. ▪ Explain that continued violations will be subject to disciplinary action, including reprimands and possible discharge.	▪ Tobacco-free policy reminder. ▪ Ask visitor to meet with supervisor. ▪ Discuss holding visitation privileges for __ days.
4th and Beyond Violation	4th and Beyond Violation	4th and Beyond Violation
▪ Repeat 3rd violation steps.	▪ Repeat 3rd violation steps. ▪ Work with HR to take disciplinary action.	▪ Tobacco-free policy reminder. ▪ Ask visitor to meet with supervisor. ▪ Hold visitation privileges for __ days.

* Adapted from State of Ohio Department of Mental Health, Northcoast Behavioral Healthcare System, *Policy and Procedure Manual* (cited in Nat'l Association of State Mental Health Program Directors, *Technical Report on Smoking Policy and Treatment in State-Operated Psychiatric Facilities* (2006)).

Examples of Tobacco-free Policy Signage

Kansas statute dictates who must post signs and where they must be posted. It also requires signs to have two components: the international no smoking symbol and a clear statement that smoking is prohibited by state law.

Kan. Stat. Ann. §21-6111 (2012).

21-6111. Posting smoking prohibited signs. The proprietor or other person in charge of the premises of a public place, or other area where smoking is prohibited, shall post or cause to be posted in a conspicuous place signs displaying the international no smoking symbol and clearly stating that smoking is prohibited by state law.

Tobacco-free Sign Examples

The following graphic, featuring images of cigarettes, chew, and e-cigarettes could be used:

Here are examples of signs featuring this (or a similar) graphic from around the U.S.:

A limited number of tobacco-free signs may be available through the Kansas Department of Health and Environment Community Healthy Prevention Program at https://www.surveymonkey.com/r/tobacco_free_signs.

Smoke-free Behavioral Health Facilities in Kansas

The American Nonsmokers' Rights Foundation compiles periodic lists of smoke-free medical facilities. Check the Foundation's listing, "Individual Hospitals, Clinics & Psychiatric Facilities with 100% Smoke-free Grounds Policies," at http://no-smoke.org/pdf/smokefreehealthcare.pdf.

Strategy Eleven: Provide and support tobacco treatment for youth and young adults, especially high-risk youth.

Most tobacco use begins in youth and young adulthood.[1] Early intervention can reduce the number of adults who use tobacco. Treatment is especially important for more vulnerable populations, including youth experiencing homelessness or living with mental illness. Behavioral interventions — delivered in group settings, by text message, or from peers — show the most promise for treating tobacco use among youth. More research needs to be done to develop effective, evidence-based approaches to youth tobacco treatment.

Tobacco Use Among Youth & Adults

Results from the most recent Kansas Youth Tobacco Survey reveal that 20.8 percent of high school students in Kansas use tobacco in any form. This includes cigarettes, cigars, smokeless tobacco, and e-cigarettes.[2] Among middle school students, 4.3 percent currently use tobacco products.[3]

Across the United States, e-cigarettes are the most commonly used tobacco product. National survey data shows that in 2016, 11.3 percent of high school students and 4.3 percent of middle school students used e-cigarettes.[4] This trend is especially concerning, because people with a history of e-cigarette use are more likely to begin smoking cigarettes.[5]

Tobacco use is higher among certain groups of youth and young adults. Much like adults, youth with mental illness or substance use disorders have higher rates of tobacco use than their peers.[6] Youth experiencing homelessness are more than three times as likely to use tobacco as youth who are not homeless.[7] Lesbian, gay, bisexual, transgender, and queer youth are twice as likely to use tobacco as their non-LGBTQ peers.[8]

Tobacco use among youth and young adults has serious consequences. Nearly every adult who currently uses tobacco started before the age of 24, and most started during high school.[9] Research also suggests that young people are more vulnerable to the addictive properties of nicotine.[10] Tobacco companies have taken advantage of this information for decades, with marketing campaigns and products targeted directly at youth.[11]

Tobacco Treatment for Youth & Young Adults

WHY IS TREATMENT IMPORTANT?

The majority of youth who use tobacco are interested in quitting. However, quit attempts among youth are often unplanned. Without help, youth are more likely to relapse and less likely to successfully quit.[12] One study found that as many as 77 percent of youth ages 12 to 19 had made a quit attempt in the past year, but that only 4 percent were successful.[13] Among youth at

a psychiatric inpatient facility, 52.5 percent of those who smoked expressed an intent to quit. This did not vary by diagnosis, symptom severity, or other substance use.[14]

SAFE & EFFECTIVE TREATMENT OPTIONS

The current research on tobacco cessation interventions for youth and young adults is limited. Most studies are small and only evaluate existing programs. Larger and more rigorous studies are needed to confirm that various treatment options are effective and safe for youth in the long-term. The most promising findings come from targeted behavioral interventions and brief interventions.[15] Several small-scale programs have also shown promising results, and are worth considering.

- **Group Counseling:**
  Evidence from several studies suggests that group and family counseling sessions, based in schools or clinical settings, can have a positive impact on cessation rates for youth.[16] The strongest evidence for success comes from programs that include motivational interviewing or cognitive behavioral therapy.[17] Group cessation counseling is feasible and cost-effective to implement.[18]

- **Brief Intervention:**
  Providers should assess tobacco use in every patient they see. A version of the 5A's (Ask, Advise, Assess, Assist & Arrange Follow-Up) has been adapted for use with youth.[19] Brief interventions that assess tobacco use and connect youth to resources are very cost-effective. Recent research suggests that brief interventions with youth can prevent smoking-related deaths and improve quality of life.[20]

- **Peer Outreach:**
  Interventions from trained peer educators can reach youth and young adults who may not seek treatment in other settings. One example from Sacramento used trained high school and college students to conduct street outreach to youth using tobacco. The brief intervention included motivational interviewing, referrals to other services, and a "Quit Kit." Preliminary results are encouraging: 75% of participants reported a reduction in their use of tobacco products at a 6-months follow-up.[21]

- **Text Messages:**
  Mobile phone technology has become increasingly common for health interventions. The popularity of smart phones among young people makes it easy to reach them using text messages. This is especially true of underserved or vulnerable populations who may not seek treatment in other settings. A recent study showed promising results from a texting-based intervention among urban teens. The messages were informed by motivational interviewing techniques, and aimed to increase readiness to quit among teens using tobacco. Teens who received these text messages smoked fewer cigarettes and expressed more interest in quitting than teens who did not.[22]

- **Cessation Medication:**
  There are very few research studies on the use of cessation medications by youth under the age of 18. Given this lack of evidence, the U.S. Food & Drug Administration does not currently approve any medications for cessation treatment in children or adolescents.[23] The U.S. Preventive Services Task Force recommends pharmacotherapy interventions for non-pregnant adults over the age of 18.[24]

Model Tobacco Treatment Programs

NOT ON TOBACCO (NOT) YOUTH PROGRAM

NOT is a school-based youth tobacco cessation program created by the American Lung Association in 1997. The program consists of ten group sessions, delivered to groups of 10 to 15 teens. The group sessions cover a variety of topics, including motivation, stress management, peer pressure, and media awareness. The NOT program has been evaluated in over 40 schools in West Virginia, Florida, and North Carolina. Compared to youth who only received a brief intervention, youth who completed the NOT program were more likely to quit using tobacco.[25]

Contact the American Lung Association for more information.

ADOLESCENT SMOKING CESSATION ESCAPING NICOTINE AND TOBACCO (ASCENT) PROGRAM

The ASCENT program was created by the Hazelden Betty Ford Foundation, a national provider of addiction treatment services. ASCENT is a group curriculum aimed at youth ages 12 to 17 who use tobacco. The curriculum uses the Stages of Change model to motivate youth to quit. The results of program evaluations are promising: youth in the ASCENT treatment groups felt more confident in their ability to quit, and were less likely to have smoked in the past month.[26]

Contact Hazelden Publishing for more information.

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18 *See, e.g.*, N. Bruce Baskerville et al., *supra* note 8.

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Strategy Twelve: Conduct and support tobacco prevention efforts and policies, such as Tobacco 21, school programs, community-based programs, disseminating messages to promote prevention, and other efforts.

Preventing tobacco use in youth and young adults is a top priority in Kansas and across the United States. Many strategies can be used to achieve this goal, including state and local policies, outreach programs, and school-based initiatives. Clinics, hospitals, and treatment centers should coordinate with these efforts to create healthy communities for patients and their families.

Prevention Goals & Strategies

Preventing initiation among youth is an important goal across the United States. The majority of adults who currently use tobacco started as teenagers.[1] In Kansas, 78 percent of adult smokers started smoking by age 18.[2] The need for prevention is clear. Tobacco use remains the leading underlying cause of death in Kansas: an estimated 3,900 people die each year as a result of tobacco-related diseases.[3] Tobacco use prevention is included in several state and national plans for health improvement.

HEALTHY PEOPLE 2020

Healthy People 2020 is a set of goals for promoting health and preventing disease. Healthy People creates a new plan every ten years, with specific, evidence-based objectives for improving the health of all Americans. The Healthy People 2020 plan identifies 21 different objectives related to tobacco use, including prevention.[4]

HEALTHY KANSANS 2020

Within Kansas, certain parts of the Healthy People 2020 plan are identified as priority strategies. These strategies were used to create the Healthy Kansans 2020 Framework and the State Health Improvement Plan.[5] The State Plan identifies the following priority strategy and objective about prevention:

Priority Strategy Two: Promote Prevention and Control of Tobacco Use[6]

Goal: Implement a comprehensive state tobacco control program with extensive evidence-based programming at the local and regional levels.

Objective 1: Prevent initiation of tobacco use among young people.

- *By 2020, increase the percentage of schools that prohibit tobacco use at all times in all locations to 75% (baseline = 48%).*
- *By 2020, decrease the percentage of high school students that smoked a whole cigarette for the first time before age 13 to 7% (baseline = 9.7%).*
- *By 2020, decrease the percentage of high school students that have ever tried smoking a cigarette to 20% (baseline = 41.3%).*

KANSAS TOBACCO CONTROL STRATEGIC PLAN

The 2016–2020 Tobacco Control Strategic Plan is a framework for preventing and eliminating tobacco use across Kansas. The plan has four goals, each with specific objectives, strategies, and activities. The plan identifies the following objectives for prevention:

Goal 1: Prevent initiation among youth and young adults[7]

Objective 1: Reduce the percentage of high school students who use cigarettes, e-cigarettes, and any tobacco products by 5 percentage points.

Objective 2: Reduce the percentage of 18 to 24 year olds who use cigarettes, e-cigarettes, and any tobacco products by 5 percentage points.

Best Practices for Prevention

There are many ways to prevent tobacco use among youth and young adults. Interventions in clinics or schools promote prevention among individuals; counter marketing campaigns promote prevention across communities; and local and state policies promote an environment of prevention.

CLINICAL INTERVENTIONS

The U.S. Preventive Services Task Force recommends behavioral interventions to prevent initiation of tobacco use in children and adolescents.[8] Interventions may include interactions with a primary care provider, printed educational materials, and computer or mobile applications.[9] Youth should be told about the harmful effects of tobacco use and be reminded that all tobacco products can cause addiction.[10] Counseling youth can reduce tobacco-related deaths and improve quality of life.[11] Parents who use tobacco should also be advised to quit. Children whose parents smoke are more likely to begin smoking themselves.[12]

Providers can also direct children and teens to these online resources: www.teen.smokefree.gov and at www.cdc.gov/tips.

SCHOOL-BASED PROGRAMS

Approximately one in every five high school students in Kansas has used tobacco in the last month.[13] School-based programs help current tobacco users quit and prevent new tobacco users from starting.[14] Specific programs have been designed for use in schools:

- **ASPIRE** is an online, bilingual multimedia program that is free for educators and students. By means of videos, animations, games, testimonials, and other resources, ASPIRE

motivates teens to be tobacco-free. ASPIRE was created by researchers at the University of Texas MD Anderson Cancer Center.

For more information, visit https://www.mdanderson.org/about-md-anderson/community-services/aspire.html.

- **Project Towards No Drug Abuse** is a prevention program for high school students designed by researchers at the University of Southern California's Keck School of Medicine. This classroom-based program builds motivation, skills, and decision-making ability in youth ages 14 to 19. The program includes 12 classroom sessions, taught by a trained teacher or health educator.[15]

  For more information, or to purchase supplies, visit http://tnd.usc.edu/index.php.

COMMUNITY PROGRAMS

- **Resist** is a statewide youth-led movement supported by the Kansas Department of Health & Environment, Tobacco Free Kansas Coalition, and the Kansas Health Foundation. The goal of Resist is to fight against the influence of the tobacco industry. Youth who participate in Resist help design and implement tobacco control activities at the state and local levels. Resist is led by a council of youth representatives from across the state. Youth interested in being involved can join or start a chapter at their school.

  For more information, visit http://www.resisttobacco.org.

COUNTER MARKETING CAMPAIGNS

The tobacco industry spends over $76 million each year to market its products in Kansas.[16] Youth and young adults are especially vulnerable to this marketing and those exposed to tobacco advertising and promotions are more likely to use tobacco.[17] Mass-media campaigns to counter these advertisements are a key element of comprehensive tobacco control programs.[18]

- **End the Trend** is an anti-vaping social media campaign created by Johnson County Mental Health. The campaign includes videos, images, and other shareables to educate teens about the potential dangers of using e-cigarettes.

  For more information, visit: https://endthetrend.me.

- **Truth Campaign** produces TV and web content targeted at youth ages 15 to 21. Their most recent "Finish It" campaign encourages youth today to be the generation that ends smoking. Truth campaigns emphasize the exploitative practices of the tobacco industry, and encourage young people to resist these tactics. They also provide easy-to-understand information about addiction and tobacco products.

  For more information, visit: https://www.thetruth.com/.

STATE & LOCAL POLICIES

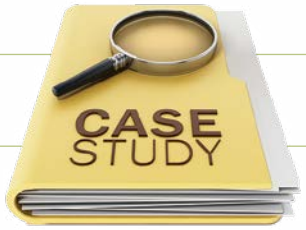
Policies at the state and local level can shape the environment and change social norms around tobacco use.[19]

- **Tobacco 21** is a movement to raise the minimum legal sales age for tobacco to 21. Many states and cities across the United States have passed these laws, including several localities in Kansas.[20] Researchers from the Institute of Medicine found significant public health benefits associated with raising the minimum sales age. Increasing the sales age would reduce the number of youth who initiate tobacco use. In the long term, this decrease in tobacco use would mean fewer tobacco-related deaths and better quality of life.[21]

- **Tobacco-Free School Policies** are being adopted across Kansas to help reduce the use of tobacco products among children and teens. The Kansas Indoor Clean Air Act prohibits smoking and tobacco use in schools, and within 10 feet of school windows or doorways.[22] Individual schools and districts should adopt policies that prohibit the use of all tobacco products on school property, including indoor and outdoor areas and school vehicles. The tobacco-free policy should apply to all students and staff, as well as visitors.[23]

  A model tobacco-free policy for Kansas schools can be found on the website of the Public Health Law Center: http://www.publichealthlawcenter.org/sites/default/files/resources/Kansas-tobacco-free-schools-model-policies-2017.pdf.

Case Study: CKF Addiction Services



CKF Addiction Services provides staff support for the Saline County Tobacco Use Prevention Coalition. The coalition began in the early 1990's and has two subcommittees: School Committee and Cessation Committee. The School Committee meets every other month at a local Saline County school. The School Committee has representation from multiple schools in Saline County as well as youth-serving organizations, and works to support local youth prevention groups and the District Health Councils.

Through the years, the School Committee has assisted local schools with developing tobacco free policies and completed retailer initiatives including Operation Storefront. The School Committee holds youth-focused movie ad contests, with the winning ad being played in the Salina Theatre. The committee has also worked to educate youth on the effects of tobacco through programs like the Campaign for Tobacco Free Kids: Taking Down Tobacco.

For more information, visit https://ckfaddictiontreatment.org.

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Kansas Tobacco Guideline for Behavioral Health Care

Section One: Promoting wellness by integrating evidence-based tobacco treatment into routine clinical practice.

1. Assess tobacco use regularly and provide tobacco treatment until quit attempts are successful.
2. Provide psychosocial treatment within whole person primary care & behavioral health systems.
3. Provide cessation medications and ensure access without barriers through state Medicaid and other third-party payers.
4. Integrate tobacco treatment into assessment, treatment planning, and implementation.
5. Incorporate tobacco treatment into other ongoing efforts toward wellness and recovery.
6. Conduct quality improvement to define outcomes, monitor progress, and improve tobacco treatment services.

Section Two: Building staff capacity to provide care.

7. Train staff how to treat and/or prevent tobacco dependence.
8. Bill for reimbursement and utilize other resources to pay for tobacco treatment.
9. Help staff who use tobacco to access evidence-based treatment for tobacco dependence.

Section Three: Adopting a Tobacco Free Environment

10. Enact a comprehensive tobacco-free policy that includes buildings, vehicles, grounds and expectations for staff, visitors, and clients.

Section Four: Engaging in Tobacco Cessation and Prevention Efforts Among Youth

11. Provide and/or support tobacco treatment for youth and young adults, especially high-risk youth and/or those in treatment for other conditions.
12. Conduct and/or support tobacco prevention efforts and policies such as "Tobacco 21," school programs, community-based programs, disseminating messages to promote prevention, and other efforts.

Implementation Self-Assessment

The self-assessment identifies which Tobacco Guideline steps your program is, or is not, implementing. Completing this assessment will help identify strengths and targets for quality improvement in your program. For the most recent version of the Self-Assessment Checklist, visit the NAMI Kansas website at https://namikansas.org/resources/smoking-cessation-information.

Please complete the following 12 items, which correspond to the 12 items in the *Kansas Tobacco Guideline For Behavioral Health Care*. Please circle one response for each item.

For assistance completing this assessment or implementing the *Tobacco Guideline*, please contact: kdads.prevention@ks.gov.

Promoting wellness by integrating evidence-based tobacco treatment into routine clinical practice

1. Our program has assessed tobacco use status among the following percentage of our current consumers/clients: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence for level of implementation. Please describe how this was measured or evaluated. This may include actual data from medical records or staff estimates of the degree of implementation:

2. Our program has provided individual counseling, group counseling, or other behavioral support for tobacco treatment among the following percentage of our current consumers/ clients **who use tobacco**: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence for level of implementation. Please provide details on how this was measured. This may include actual data/descriptions of, what kinds of in-house, external support services clients are referred to:

3. Our program has facilitated access to tobacco treatment medication among the following percentage of our current consumers/clients **who use tobacco**: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence for level of implementation. Please provide details on how this was measured. This may include actual data/descriptions of how medications were facilitated (i.e., medications could be provided on site, they could be prescribed on site, clients could be referred to an on-site prescriber or referred to off-site prescriber):

4. Our program has integrated goals for tobacco into the treatment plans of the following percentage of our current consumers/clients **who use tobacco**: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence for level of implementation. Please provide details on how this was measured. This may include chart review, surveys of staff, or informal estimate of level of service:

5. Our program has integrated tobacco into broader wellness/recovery initiatives: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence for level of implementation. Please provide details on how you have integrated tobacco into wellness and recovery policies/programs/practices:

6. Our program makes efforts to evaluate and improve the quality and extent of tobacco treatment: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence for level of implementation. Please provide details on how you have integrated tobacco into wellness and recovery policies/programs/practices:

Building staff capacity to provide care

7. What percentage of your current staff has received training specifically in how to treat tobacco dependence? *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence of staff training in how to treat tobacco dependence (numbers attending, types of trainings). These could include Brief Tobacco Intervention training (kstobaccointervention.org), Tobacco Treatment Specialist (TTS) training (http://ctttp.org/wp-content/uploads/2015/06/What-is-a-TTS-2011_12_1.pdf), or others:

8. Our program has billed for, or obtains **other** resources, to pay for tobacco treatment among the following percentage of our current consumers/clients **who use tobacco**: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence of reimbursement or other resources leveraged/obtained for tobacco treatment:

9. Current program staff who use tobacco have easy access to free/low cost tobacco cessation medications and behavioral support: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	FEW (10% OR LESS)	SOME (~25%)	ABOUT HALF (~50%)	MANY (~75%)	NEARLY ALL (90%-100%)

Evidence for staff resources for quitting. This could include a copy of staff benefits for tobacco cessation or internal memos:

Adopting a tobacco-free environment

10a. What best describes where **client** tobacco use is permitted at your facility? *(Circle one)*

0	1	2	3	4	5
DON'T KNOW/NOT SURE	TOBACCO USE IS PERMITTED IN ALL INDOOR/ OUTDOOR AREAS	TOBACCO USE IS PERMITTED OUTDOORS AND IN RESTRICTED INDOOR AREAS	TOBACCO USE IS PERMITTED OUTDOORS BUT PROHIBITED IN ALL INDOOR AREAS	TOBACCO USE IS PERMITTED IN RESTRICTED OUTDOOR AREAS BUT PROHIBITED IN ALL INDOOR AREAS	TOBACCO USE IS PROHIBITED ON ALL GROUNDS AND IN ALL INDOOR AREAS

Please provide details. A copy of the policy is welcome. For example, does your facility have a written policy, or does it simply follow the Kansas Indoor Clean Air Act? Describe any specifics of your policy that differ from the above options. Describe evidence for policy adoption, implementation, and enforcement:

10b. What best describes where **staff** tobacco use is permitted at your facility? *(Circle one)*

0	1	2	3	4	5
WE HAVE NO POLICY	TOBACCO USE IS PERMITTED IN ALL INDOOR/ OUTDOOR AREAS	TOBACCO USE IS PERMITTED OUTDOORS AND IN RESTRICTED INDOOR AREAS	TOBACCO USE IS PERMITTED OUTDOORS BUT PROHIBITED IN ALL INDOOR AREAS	TOBACCO USE IS PERMITTED IN RESTRICTED OUTDOOR AREAS BUT PROHIBITED IN ALL INDOOR AREAS	TOBACCO USE IS PROHIBITED ON ALL GROUNDS AND IN ALL INDOOR AREAS

Please provide details. A copy of the policy is welcome. For example, does your facility have a written policy, or does it simply follow the Kansas Indoor Clean Air Act? Describe any specifics of your policy that differ from the above options. Describe evidence for policy adoption, implementation, and enforcement:

Engaging in tobacco cessation and prevention efforts among youth

11. Our program provides and or supports tobacco treatment to **help youth and young adults quit** while they're still young: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE

Evidence for level of implementation: Any examples or data depicting efforts to support youth tobacco cessation are welcome.

12. Our program conducts or supports **youth tobacco use prevention efforts**: *(Circle one)*

0	1	2	3	4	5
NOT YET IMPLEMENTED	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE

Evidence for level of implementation:

Scoring Instructions

- Add the numbers circled for all items.
  - Lowest score is zero (0).
  - Highest score is sixty-five (65).
- A program that scores 0 has implemented **no steps** in the *Kansas Tobacco Guideline*.
- A program that scores 65 has implemented **all steps** of the *Kansas Tobacco Guideline*, to a high degree of quality and with nearly all of their clients.
- A program that has implemented some steps, but not others, will score somewhere in between 0–65.
- Your program may choose to strengthen implementation of some steps, or begin implementing other steps, to increase its score.