Center of Excellence for CHSI Health Systems Improvement

CASE STUDY:

Successful Implementation of Tobacco Dependence Treatment Policy in a Behavioral Health Setting Using the

Addressing Tobacco Use Through Organizational Change (ATTOC) Framework

A Best Practice Story from Ellis Mental Health

A Project of CAI

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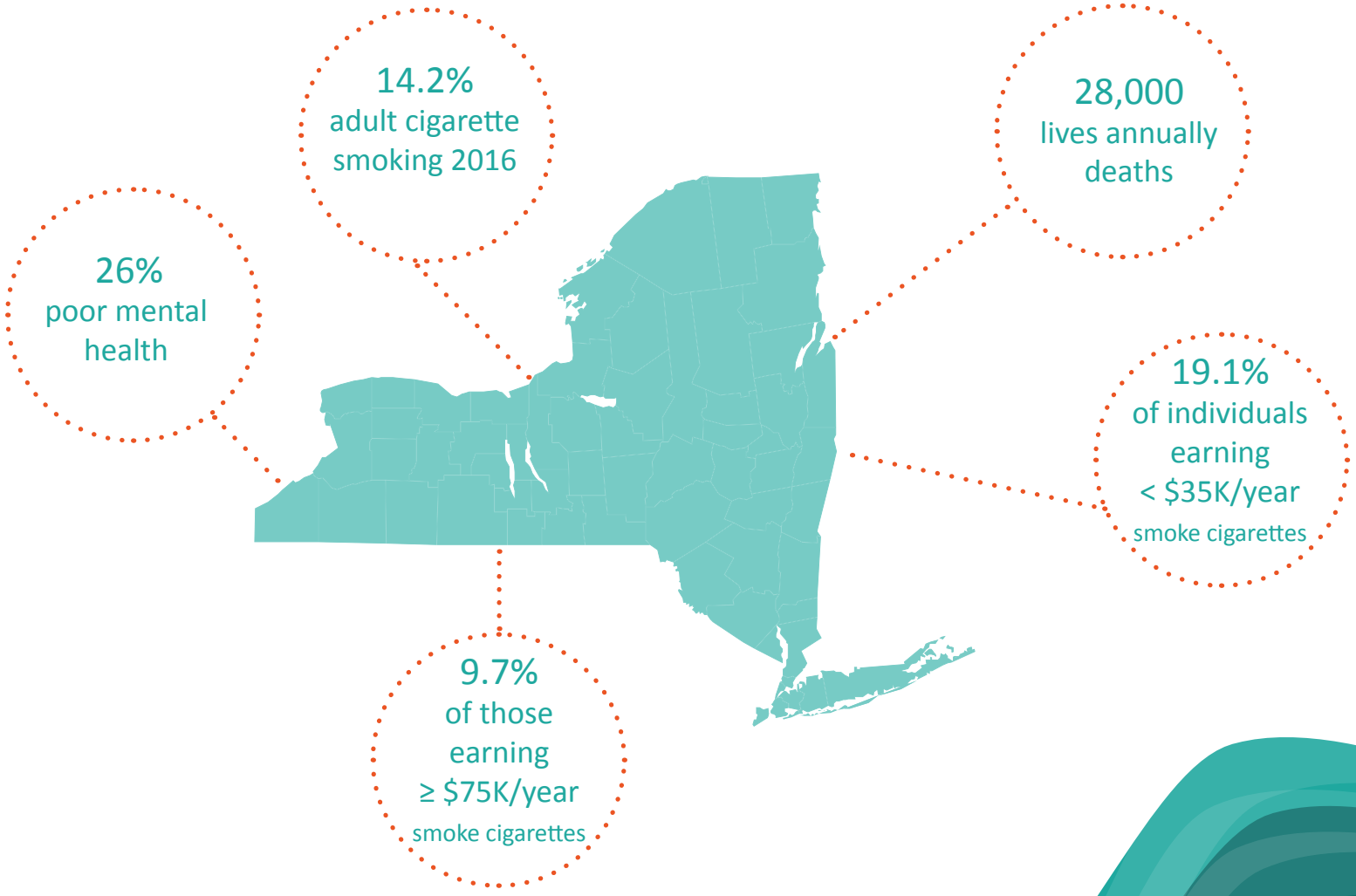
Introduction

TOBACCO USE PREVALENCE IN NEW YORK STATE

Tobacco use is the leading cause of preventable disease, disability, and death in the United States[1]. In New York State (NYS), tobacco use claims approximately 28,000 lives annually, and results in more deaths than alcohol consumption, motor vehicle crashes, firearms, toxic agents, and unsafe sexual behaviors combined.[2] The adult cigarette smoking prevalence rate in NYS as of 2016 was 14.2%, and rates among adults self-reporting poor mental health (>14 days/year) were much higher than the overall prevalence rate (26%).[3]

Tobacco-use rates have remained persistently higher among vulnerable populations, including those earning lower household incomes, those with less than a high school education, and individuals who report behavioral health issues. To further illustrate this phenomenon, in NYS, 19.1% of individuals earning < $35K/year smoke cigarettes, while only 9.7% of those earning ≥ $75K/year are smokers.[3]



Why Addressing Tobacco Use is Important

The Institute for Healthcare Improvement describes the need to improve health system performance in order to meet the "Triple Aim"

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations and
- Reducing the per capita cost of health care delivery[4]

Changing health systems to ensure that every client is screened and treated for tobacco use improves overall health by helping people quit, leads to lower costs per capita, and improves quality of care and client satisfaction.

Goal of the Case Study

IDENTIFY AND DESCRIBE A FRAMEWORK AND STRATEGY FOR IMPLEMENTING TOBACCO DEPENDENCE TREATMENT POLICY

The goal of this case study is to describe an example of successful implementation of Tobacco Dependence Treatment (TDT) Policy utilizing an evidence-based implementation framework that was designed specifically for TDT. The Center of Excellence for Health Systems Improvement for a Tobacco-Free New York (COE for HSI) works with a network of 10 statewide (regional) Health Systems Improvement (HSI) Grantees funded by the NYS DOH Bureau of Tobacco Control.

These Grantees support health systems improvement efforts to implement systems to reliably and consistently screen and identify clients in need of TDT, and ensure that they receive timely counseling and treatment services when they are ready to quit. The HSI Grantees work with healthcare organizations within their respective regions to increase access to and utilization of evidence-based TDT, especially for those who are disproportionately impacted by tobacco use. This is accomplished by providing technical assistance to facilitate:

- ✓ Adoption or enhancement of TDT policies
- ✓ Integrating of the "5A's" (Ask, Advise, Assess, Assist, Arrange) into clinical workflow
- ✓ Establishing TDT as a priority with their clients

Given the need to identify evidence-based strategies to support implementation, COE for HSI recognized the importance of understanding varying perspectives by role, and compiled the information contained within this study to assist those working to implement health systems improvement in the area of TDT.

An Evidence-based Framework for Implementing TDT Policy

ADDRESSING TOBACCO USE THROUGH ORGANIZATIONAL CHANGE (ATTOC)

It is an evidence-based implementation framework designed specifically to facilitate the initiation or improvement in systems to treat tobacco addiction, reduce tobacco addiction amongst employees, restrict or eliminate tobacco use on campuses, and change the work environment to promote overall health and wellness.[5]

Recognizing that strengthening systems to address tobacco use requires organizational readiness as well as clinical, programmatic, and systems-level changes, the ATTOC Model utilizes a ten-step process conducted in three phases of change to assist organizations in moving through the entire change process. The framework can be adapted to the unique context, level of readiness, and population served by an individual agency. The ATTOC framework is flexible and allows an organization to tailor their improvement process to meet their own unique needs.[5,6] The three phases and accompanying steps of the ATTOC process are as follows:

Table 1: ATTOC Phases of Implementation

ATTOC PHASE	ATTOC STEP
Phase 1: Planning for Change	Step 1 Establish a Sense of Urgency and Preliminary Organizational Goals
	Step 2 Establish a Leadership Group and Prepare for Change
	Step 3 Assess Organizational Readiness and Do an Environmental Scan
	Step 4 Develop Written Change Plan and Realistic Timeline
	Step 5 Develop Written Communication Plan and Materials to Disseminate
Phase 2: Implementing Change	Step 6 Implement Client Goals: Assessment, Treatment, and Empowerment
	Step 7 Implement Staff Goals: Training and Staff Recovery
	Step 8 Implement Environmental Goals: End or Restrict Tobacco Use
Phase 3: Sustaining Change	Step 9 Document Changes in Policies and Procedures
	Step 10 Support, Encourage, and Sustain Organizational Changes

In the following pages, we describe how one organization successfully used the ATTOC implementation framework to strengthen systems to screen for and treat tobacco use by establishing a change in culture prior to the implementation of policies.

Description of Case Study Site and Population

This case study focuses on Ellis Medicine's Outpatient Mental Health Clinic and Personalized Recovery Oriented Services (PROS) Programs, and their experience implementing TDT and tobacco-free grounds utilizing an evidence-based implementation framework that was designed specifically for tobacco dependence (ATTOC). This study aims to provide a best practice example for other healthcare organizations attempting to implement tobacco dependence screening and treatment policies and tobacco-free grounds in a structured, organized way.

Ellis Medicine is a healthcare system serving NYS' Capital Region (Albany, Rensselaer, and Schenectady) with approximately 2,900 employees, comprising two inpatient hospitals and several additional outpatient service locations throughout Schenectady County. The healthcare system includes both a **Mental Health Clinic and a PROS Behavioral Health Program – both of which are the focus of this case study.**

Ellis Mental Health Clinic (EMHC) is located in Schenectady, NY and provides safe and compassionate coordinated behavioral health care to over 1,300 clients. Their 2017 annual non-salary operating budget is approximately $845,000. EMHC is currently adding clinical and support staff to accommodate the planned expansion of their census to 1,600-1,700 clients with the opening of their new state of the art facility in Schenectady. The clinic also provides care for clients with co-occurring behavioral health and substance use issues. **EMHC's Personalized Recovery Oriented Services (PROS) Program** offers an array of educational and social skill acquisition groups geared to help clients achieve their chosen recovery goals in the areas of work, education, relationships and living environment. PROS also provides individual therapy and medication management. The PROS average census is 125, but has planned to increase to 180 with the opening of their new facility, which will combine both clinical and PROS services in one-building. The EMHC PROS 2017 annual non-salary operating budget is approximately $324,200.

The new facility opened while this study was in progress. It plans to accommodate more clinical services – including primary care services, which are planned to begin at their new location the near future. This will allow EMHC clients to have increased access to necessary medical care, and the ability to receive both behavioral health and primary care services within the same building.

Ellis Mental Health Clinic/PROS newly opened facility in Schenectady (June 2017)

SMOKING PREVALENCE RATES IN NYS' CAPITAL REGION AND SCHENECTADY COUNTY

Smoking rate data regarding individuals who report mental illness (>14 days per year) specific to Schenectady County could not be found at the time of this study. However, the Statewide rate of smoking by persons reporting poor mental health is almost twice that of the general population statewide. As of 2016, Schenectady's adult smoking rate of 20.3% was higher than the adult smoking rate for "Rest of State" (ROS), which was 14.2% in 2016 (most recent prevalence data available. Schenectady's adult smoking rate actually increased from its rate in 2008-2009 (17.0%) to 20.3% in 2016. Additionally, the county's smoking rate is higher than that of the capital region of NYS (15%), within which it is located.6 Hospitalization rates for asthma, congestive heart failure, and heart attack are higher in Schenectady County than they are in the Capital Region overall.[7]

According to Capital Region Public Health Prioritization Task Force data, Schenectady has a slightly lower percentage of adults who report poor mental health when compared to ROS, however, these percentages have increased between 2008 and 2014. An estimated 19% of the county's adult population have a diagnosed mental illness, and 4% have serious mental illness.[7] Schenectady also had higher behavioral health related emergency room visits and inpatient hospitalization rates when compared to ROS.[7]

Case Study Methodology

During the summer of 2017, COE for HSI conducted a series of interviews with key individuals from EMHC, as well as NYS Advancing Tobacco Free Communities (ATFC) and HSI Grantees. Table 2 outlines the amount of time spent with each interviewee and provides a detailed description of their background and involvement with the process.

Table 2: Overview and Background of Interviewees

Title	Interviewee Background
Clinical Manager, Clinic and PROS Programs, Ellis Mental Health	Licensed Clinical Social Worker that has been a Clinical Manager for both the clinic and PROS Programs at Ellis for one year, and prior to that was a care provider and Clinical Supervisor for Ellis for 10 years.
Health Programs Manager, St. Peter's Health Partners, and NYS Health Systems Improvement Advisor for a Tobacco-Free NY	Health Systems Improvement expert advisor for four years and an expert at medical and behavioral health systems change. Assists hospitals, clinics, and behavioral health centers with workflow and systems changes aimed at ensuring that every tobacco user is screened, and receives timely tobacco dependence counseling and treatment when desired.
Community Engagement Coordinator for Tobacco-Free Communities, and NYS ATFC Coordinator, NYS Capital Region	NYS ATFC Coordinator for 10 years for Albany, Schenectady and Rensselaer counties. Expert at methods of reducing exposure to second-hand smoke (SHS), preventing youth initiation of tobacco use, limiting tobacco tobacco-free facilities policy implementation.
Supervisor, Peer Advocacy, Ellis Mental Health Clinic	Licensed Clinical Social Worker that has been working at EMHC for twenty years. She is supervisor of Peer Advocacy, and assists clients with making healthy lifestyle choices to improve overall well-being by connecting clients in recovery to clients who have already achieved successes in certain areas of treatment for peer support and encouragement.
Dual Recovery Coordinator, Ellis Mental Health Clinic	Licensed Clinical Social Worker that has been a Dual Recovery Coordinator at EMHC for two years, providing clinical care to clients with dual chemical dependency and behavioral health issues.
Former Dual Recovery Coordinator for Ellis PROS	Licensed Mental Health Counselor and Certified Addiction Specialist that worked at Ellis PROS Program as a Dual Recovery Coordinator providing clinical care to clients with dual chemical dependency and behavioral health issues. Recently moved on from Ellis PROS to another position, but was willing to assist us with this study.

During each of the six 45-60 minute interviews, COE for HSI asked interviewees questions regarding a series of topics to better understand timelines and key drivers influencing EMHC's success in following the three phases of the ATTOC framework. These interview topics included:

- ATTOC methodology and approach
- Organizational readiness
- Staff and client attitudes and motivation
- Systems-level characteristics
- Facility characteristics/environment of care
- Screening clients for tobacco use and client treatment planning
- Staff training
- Policies regarding TDT and tobacco free grounds

Prior to the interviews, COE for HSI developed an interview guide to gather information on the application and experience of using the ATTOC framework to pursue system strengthening and improvement activities. Questions were tailored by role/position of interviewee.

Interview were audio-recorded, and professionally transcribed. Interview transcripts were then analyzed for key themes and commonalities to determine the factors impacting EMHC's success. No client-identifying information was shared during the course of these interviews.

Results

One of the themes that emerged most during the interview process is that those involved in implementing the ATTOC methodology at EMHC felt very positive about ATTOC allowing customization and flexibility by encouraging organizations to begin from their own starting point, and focus on areas in which they need improvement. The following paragraphs describe EMHC's journey through the ATTOC implementation framework.

ATTOC PHASE 1: PLANNING FOR CHANGE

Phase 1 of the ATTOC model (Steps 1-5) involves preparing, planning and organizing for change. During this phase, an organization establishes a foundation for addressing tobacco use by identifying the leadership team and workgroup members that will guide the change process. Also during Phase One, an organization develops goals and identifies strategies for communicating plans for change to clients and staff.

Step 1: Establish a Sense of Urgency and Preliminary Organizational Goals

In March 2014, Douglas Ziedonis, MD, MPH, ATTOC Founder and co-author of the ATTOC Model, provided a day-long capacity-building session to Behavioral Health Organizations and HSI/ATFC Grantees in the capital region. The session was designed to give participants the ability to apply the ATTOC methodology within their own organizations. Dr. Ziedonis is also Professor and Chair of the Department of Psychiatry at the University of Massachusetts Medical School and University of Massachusetts Memorial Medical Center, and is an internationally recognized leader in co-occurring mental illness and addiction; especially tobacco dependence.

We learned from interviewees that this capacity-building session came about through the efforts of multiple stakeholders coming together to maximize limited resources to assist Behavioral Health organizations within three counties at one time. Every 3 years, each county Department of Health (DOH) within NYS is required to submit a Community Health Improvement Plan (CHIP). The CHIP is meant to summarize how each county will approach emerging and persistent public health issues and improve overall health over the coming three-year period. When the process of creating the CHIPs in 2013 began, interviewees (2) stated that it was a more collaborative process when compared to previous years, and included all organizations having a part in public health and well-being at the table during planning and execution, including the County Mental Health Departments in the capital region. The issue of disproportionate use of tobacco among people with living with mental illness continued to emerge during this process.

At this time, the capital region ATFC and HSI Grantees worked together to rally the support of leadership from NYS OMH and County Mental Health Departments in the region to help bring to the table all of the private, non-profit behavioral health service agencies within the three counties to provide

input to the CHIP. This collaborative process was called the **Tri-County Behavioral Health for Tobacco-Free Living** initiative, and EMHC was part of it from its inception. As an incentive for private, non-profit Behavioral Health service providers to take advantage of this opportunity and commit to addressing tobacco use, the three counties funded the ATTOC training, and the organizations in attendance were not charged a fee to attend. The idea behind this was to get these Behavioral Health sites to sign on to taking on the issue of tobacco use; specifically, improving their individual responses to clients and creating environments supportive of tobacco free choices.

To begin the process of **establishing a sense of urgency and setting organizations goals**, each organization in attendance was asked to identify a team of individuals within their organization, including a Tobacco Free Champion and a Clinical Lead, and begin the process of goal-setting regarding TDT and smoke-free grounds. Organizations were asked to consider what they were already doing well and not doing well in terms of addressing tobacco use, and prioritize the areas that they needed to begin working on immediately. Each organization that sent an attendee signed a letter of commitment to dedicate staff and time to tobacco use reduction efforts going forward. Following this capacity building session with ATTOC, HSI and ATFC experts carried the torch and continued to work with Behavioral Health agencies in the Capital Region (including EMHC) to assist them in continuing through the phases of the ATTOC model.

Step 2: Establish a Leadership Group and Prepare for Change

A *Tobacco Recovery Task Force* was officially formed at EMHC. The task force was comprised of EMHC leadership and providers, including those that had a background in addiction treatment and had worked on TDT at previous places of employment, as well as HSI and ATFC Grantees. Building upon the work that was initiated at the ATTOC capacity-building session, the Task Force collaborated to implement each step of the ATTOC model, and discussed progress on a regular basis. The Clinic Director of EMHC at that time led the task force and served as the dedicated Tobacco Free Champion. At initial Tobacco Recovery Task Force meetings, the team began to think about ways in which to assess organizational readiness as well as staff and client attitudes toward tobacco use.

Step 3: Assess Organizational Readiness and Do an Environmental Scan

Assessing Organizational Readiness

In addition to being a part of the task force, HSI and ATFC experts checked-in with ECMH regularly to assist with implementation of the ATTOC framework. With the guidance of ATFC and HSI, EMHC developed a survey of staff attitudes toward tobacco use and tobacco in the workplace. The survey was a well thought-out tool that would be used to determine staff attitudes toward changing organizational culture around tobacco use and treatment. The Stages of Change model, also known as the Trans-Theoretical Model, was considered in the development of the survey tool.

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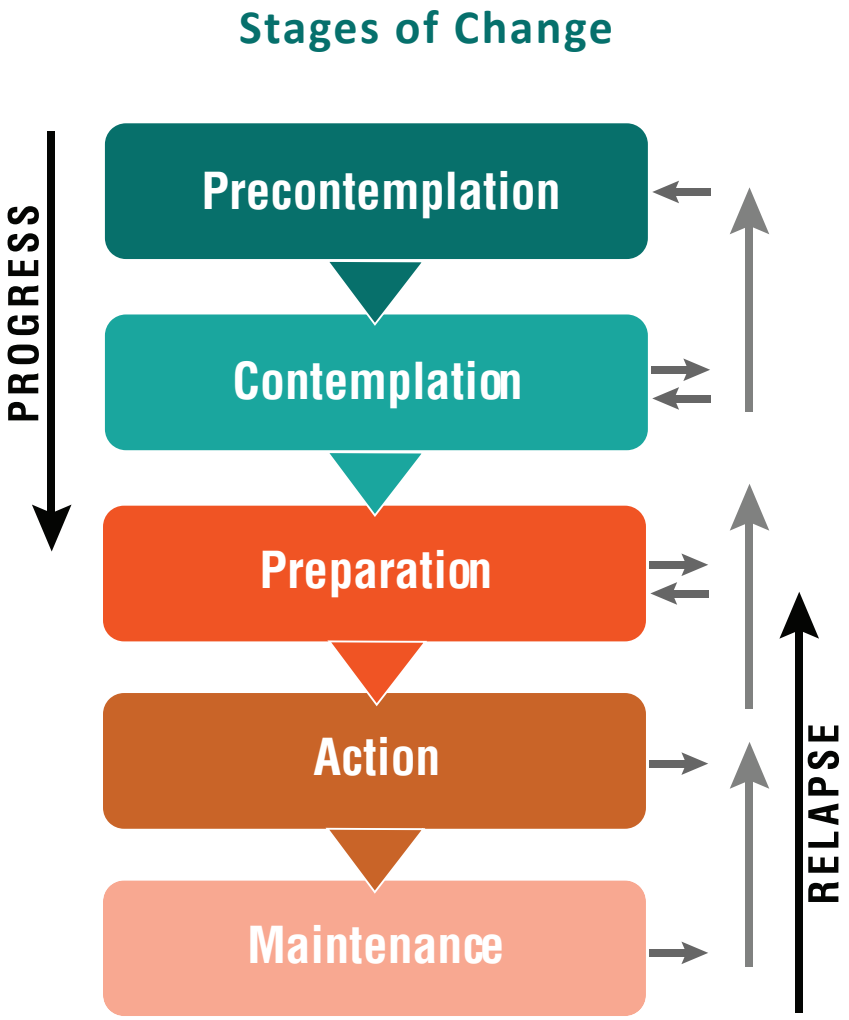
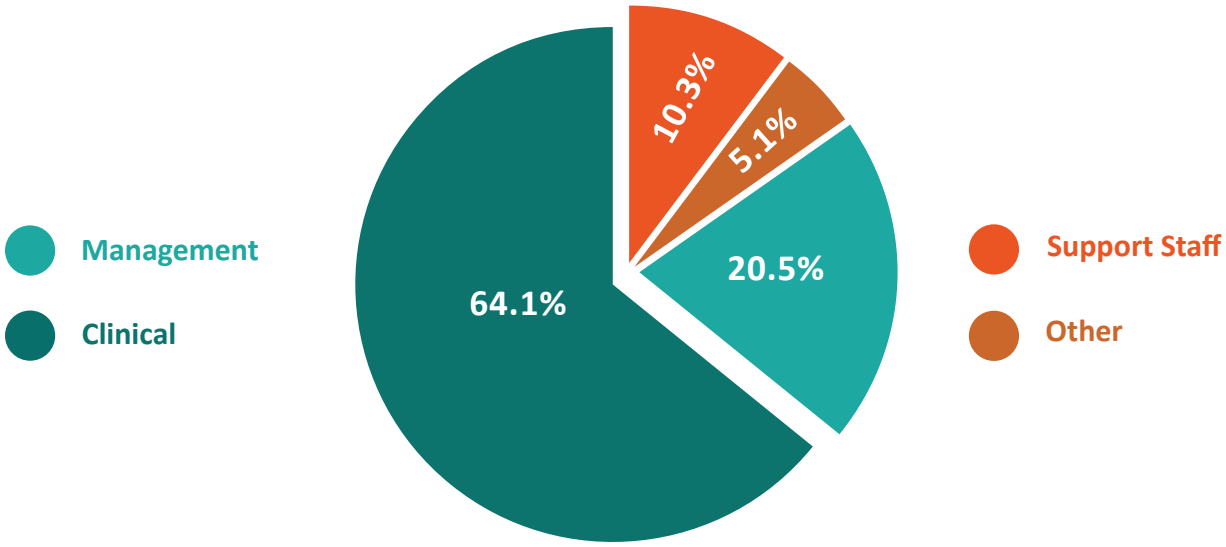


This means that staff were being assessed on whether they were not considering making organizational changes, were thinking about how to apply changes, were taking steps to prepare for changes, or had already taken steps to make organizational changes toward TDT and smoke-free grounds. This same model is utilized to determine client readiness to address their tobacco use.

October 2015 Survey Results of EMHC Staff Attitudes Toward Tobacco Use and tobacco in the workplace (n=41)

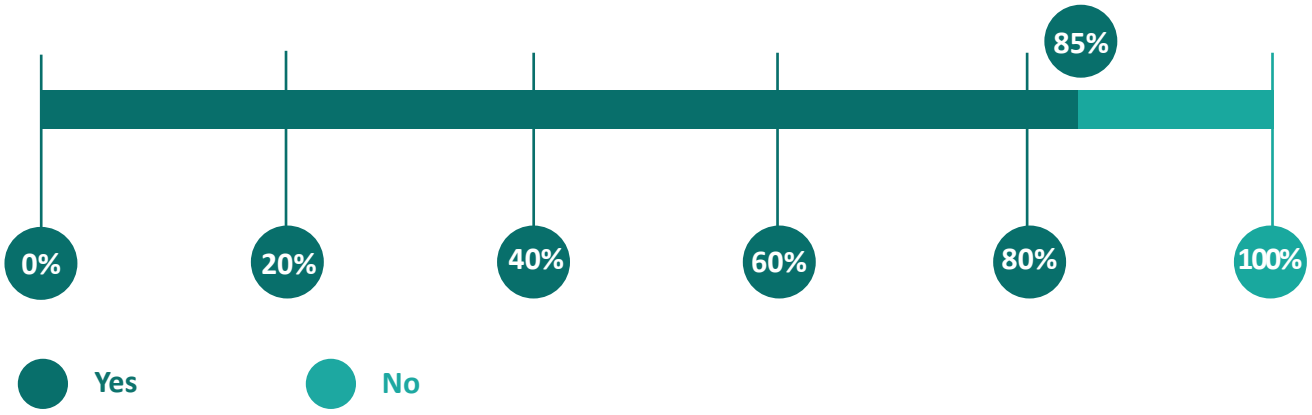
Current Position at Ellis



"How important is it for you to work in a Tobacco-Free Workplace?" - scale of 1 (not important) to 10 (very important)

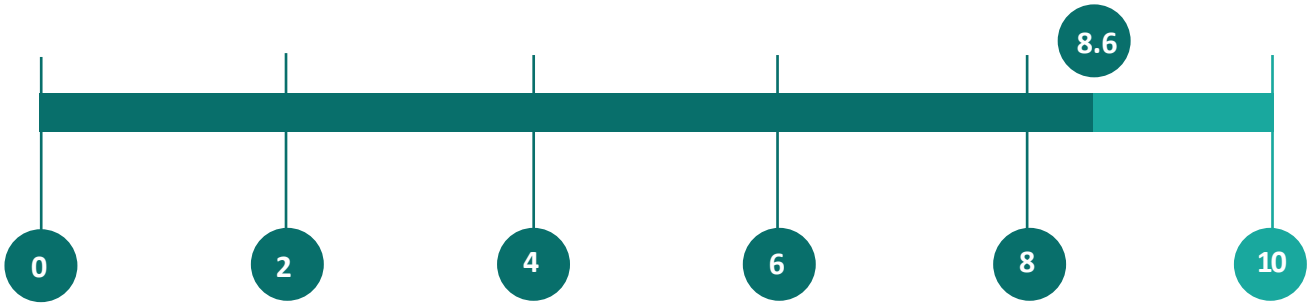
Result= weighted average of 7.9/10

Awareness of Existing Tobacco Free Policy in Place for Ellis Medicine

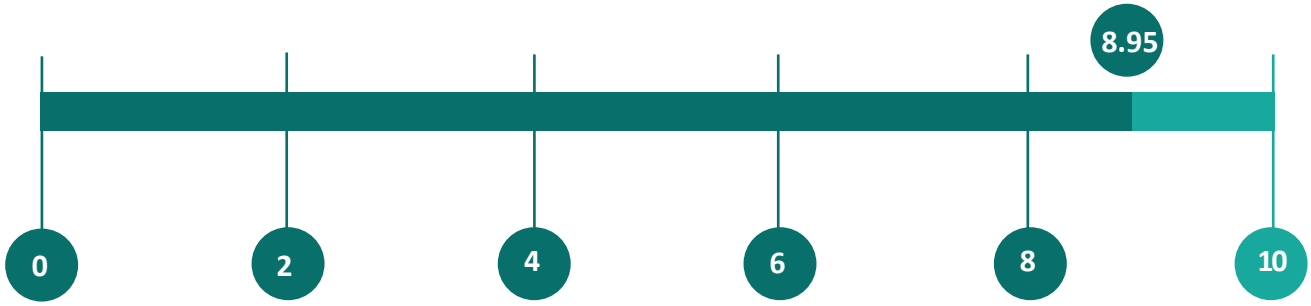


"How important do you think being tobacco-free is to the clients we serve?" - scale of 1 (not important) to 10 (very important). Result= weighted average of 8.6

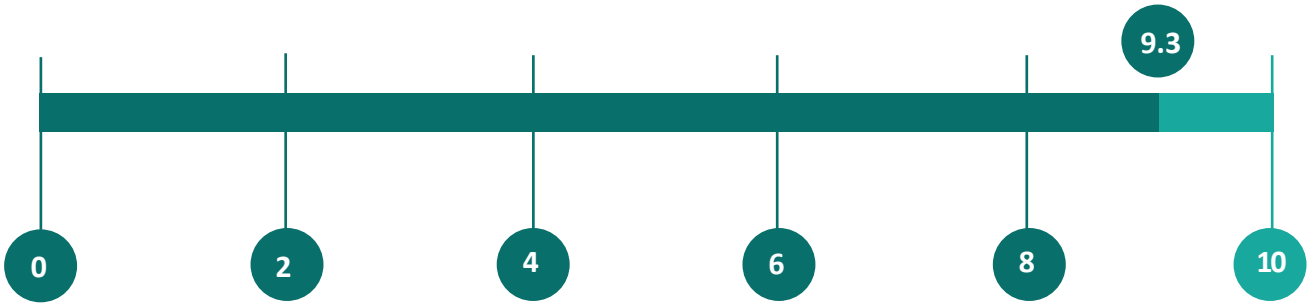
How important do you think being tobacco-free is to the clients we serve?



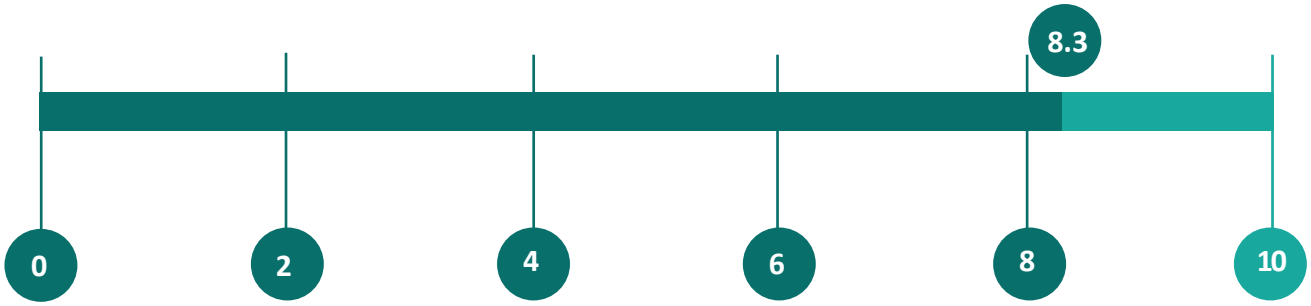
"How confident do you feel about treating co-occurring Behavioral Health, Substance Use, and Tobacco Dependence?" - scale of 1 (not at all confident) to 10 (very confident). Result= weighted average of 8.95/10



"How would you rate the effects that tobacco has on a user's health?" scale of 1 (healthy) to 10 (deadly)
Result= weighted average of 9.3/10



"How would you rate the effects that second-hand smoke has on a person's health?" - scale of 1 (healthy) to 10 (deadly) Result= weighted average of 8.3/10



> it was a relief to learn from the survey that in terms of Stages of Change, the staff were already at the contemplation stage rather than the pre-contemplation stage.

Survey participants were also asked to write a free-text description of how they would define a tobacco-free policy, and what elements they would include. They were given a large enough character allowance to write thoughtful policy detail, as many staff did. Survey results revealed that not much work needed to be done in terms of convincing EMHC staff that this was a critical issue that needed to be dealt with. Even the three staff that self-identified as tobacco-users indicated that they felt that tobacco use needed to be addressed at EMHC.

Environmental Scan

Until 2015, EMHC had a "smoking gazebo" on campus where clients would go to smoke and socialize. Over time, the gazebo had become a symbol of acceptance of tobacco use amongst clients. As this was known by all staff to be the case, the full environmental scan suggested by the ATTOC model wasn't necessary. EMHC staff already knew the areas where clients were using tobacco, and began thinking about ways to implement smoke-free grounds.

Step 4: Develop Written Change Plan and Realistic Timeline

During their initial meetings, HSI and ATFC experts assisted the EMHC Tobacco Recovery Task Force in developing written plans and timelines for readiness assessments, staff training, and policy implementation. Although timelines changed along the way due to multiple other organizational

priorities (including planning for their new site), interviewees from EMHC felt it was helpful to have the assistance of HSI and ATFC Grantees in establishing a structured timeline for change.

Step 5: Develop Written Communication Plan and Materials to Disseminate

As EMHC does not have a very large workforce in comparison to other organizations that have implemented ATTOC, plans regarding addressing tobacco use were communicated at the start of the process in staff meetings, Tobacco Recovery Task Force meetings, and through the administration of the staff survey. EMHC began to promote and communicate a tobacco-free environment to their clients through a non-punitive, overall healthy living approach. The task force established a "Healthy Living" group for clients, and disseminated materials for this group to clients that were adapted from Dr. Jill Williams' (Robert Wood Johnson University Hospital) "Learning about Healthy Living: Tobacco and You." Further details about this approach will be discussed in further detail in "Step 9".

ATTOC PHASE 2: IMPLEMENTING CHANGE

Phase 2 of the ATTOC model (Steps 6-8) involves implementing change, integrating best practices, and adapting an organization to these changes. During this phase, the organization puts previously planned changes into effect to achieve client, staff, and environmental goals.

Step 6: Implement Client Goals: Assessment, Treatment, and Empowerment

To engage clients in taking a part in promoting a tobacco-free environment, EMHC staff and management encouraged clients who formerly used tobacco near the two entrances of the building to plant flower gardens in these two areas where they used to throw their cigarette butts. This gave these patients a sense of empowerment, ownership and pride in the facility where they receive their mental health treatment.

EMHC also created a **"Tobacco-Free Agreement"** to be signed by existing and incoming clients. This agreement states that clients will not use or display any tobacco products on the grounds of EMHC facilities, and becomes part of their medical record. The agreement includes a statement about prohibiting clients from wearing clothing or hats that have tobacco product logos on them, and not to have cigarettes behind their ears or in any other visible place while they are on the premises.

Clients at EMHC who used tobacco and agreed to make an attempt to quit were further engaged in their own treatment by using Carbon Monoxide (CO2) monitors on-site, and self-monitoring the decrease of carbon monoxide in their exhalations as they progressed through their quit attempt. Interviewees reported that this was very inspiring for clients in the process of quitting, and that clients often looked-forward to doing the CO2 tests during their visits

Step 7: Implement Staff Goals: Training and Staff Recovery

During their initial meetings at individual Behavioral Health sites throughout the Capital Regions, HSI and ATFC Grantees then began assisting each Behavioral Health program in implementing their own Tobacco-Free Committees and initiatives, setting realistic timeframes, and moving them through the ATTOC phases. They held monthly calls with each site's Tobacco-Free Champion to assess progress and provide guidance. ATFC and HSI Grantees also worked together to conduct TDT Trainings for staff at the sites to build their capacity to assess every client for tobacco-use status, and provide counseling and treatment to clients who did report tobacco use. Trainings on the topic of TDT at EMHC were facilitated by the HSI and ATFC Grantees in 2016 utilizing the Supporting Evidence-Based Tobacco Dependence Screening and Treatment Training Toolkit, developed by the Center of Excellence for Health Systems Improvement with input from HSI Grantees. This toolkit provides a full set of training resources (including PowerPoint slides and Handouts) for sites to deliver TDT trainings within their facilities to providers and staff. These training resources focus on the burden of tobacco use, screening and assessment, effective treatment planning, counseling, and prescribing. Quality Improvement tools and resources are also included within the toolkit. Since that time, a similar Training Toolkit specific to Behavioral Health facilities has been created by COE for HIS and was released in November 2017.

Only 3 staff at EMHC identified as tobacco users. To address staff tobacco-use, staff were offered free tobacco cessation services through the EMHC. Staff who were tobacco users at the time agreed to refrain from smoking on the grounds, and from showing up at work smelling like tobacco products.

Step 8: Implement Environmental Goals: End or Restrict Tobacco Use

To address Environmental Goals, EMHC took an approach that proved to be very empowering to their clients. As previously stated, ECMH had a "smoking gazebo" on their grounds. It was removed in 2015 around the time that EMHC began to promote a smoke-free environment and overall healthy living to their clients. Some clients continued to smoke near either of the two entrances of the facility. In response to this, EMHC began to increase their signage on campus notifying clients that tobacco use was prohibited on EMHC grounds. Some interviewees noted that this wasn't consistently enforced at first, likely due to hesitancy of staff to cause clients to feel suddenly uncomfortable coming for mental health treatment, and therefore possibly not receive their necessary care. During Tobacco Recovery Task Force meetings, it was realized by staff that the responsibility of addressing client tobacco use on EMHC grounds should not fall on only the EMHC Security staff

It was decided that all staff should take part in reminding clients that using tobacco on EMHC grounds was prohibited in a non-punitive way in order to send a clear and consistent message. All staff agreed to do so consistently, and clients began being redirected to the public sidewalk areas (away from entrances to the building) to smoke.

PHASE 3: SUSTAINING CHANGE

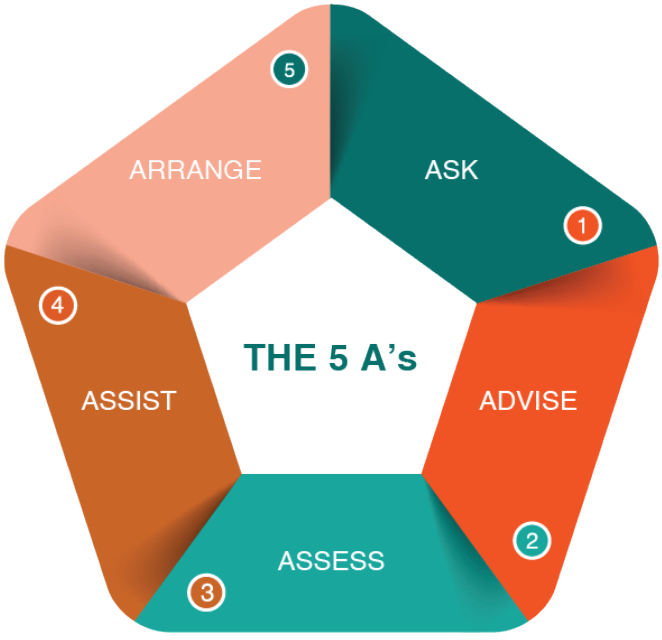
Phase Three of the ATTOC model (Steps 9 & 10) involves sustaining change by ensuring that the proper infrastructure exists to maintain the organization's progress. During this phase, policies are developed to support long-term change.

Step 9: Document Changes in Policies and Procedures

EMHC ultimately finalized their tobacco treatment policies in 2016. There were initially separate written policies for the Clinic and PROS programs (which were in two different locations until the opening of EMHC's new facility). The PROS policy and procedure became effective January 2017, and the Clinic policy and procedure in March 2017. Both were signed off by senior program leadership.

The policy incorporates specific language regarding the use of the **5A's** Tobacco Dependence Intervention that was developed by the U.S. Public Health Service as a best-practice guideline, and requires that clients are assessed for tobacco use upon initial intake, and during quarterly and annual Treatment/Service Plan Reviews.

The 5A's Tobacco Dependence Intervention Model



The policy specifies that providers are required to ask, advise, and assess patient readiness to quit on a regular basis if the client reports tobacco use but is not ready to quit upon the first assessment. It also requires providers to document this in Quarterly Treatment/Service Plan Reviews. Providers are also required to utilize a brief intervention technique that can promote motivation to quit called the "5R's" (see diagram below). If the client does not indicate readiness to quit after the 5R's have been discussed with them, it still lays a groundwork for the patient to begin thinking about the negative effects of tobacco use and the positive effects that quitting would have on their lives.

The 5R's Model to Increase Motivation to Quit

The policy requires clinical providers at EMHC to add a goal and objective related to tobacco cessation to the Treatment/Service Plan of any individual that indicates that they use tobacco, regardless of whether they indicate readiness to quit. This is meant to provide a reminder to clinicians to reassess the client's readiness upon every Treatment/Service Plan review. Additionally, clients that do not indicate readiness to quit are offered an opportunity to attend Ellis' "Learning About Healthy Living" group.

The curriculum and materials for this group were adapted from Dr. Jill Williams' (Robert Wood Johnson University Hospital) *"Learning about Healthy Living: Tobacco and You."* This is part of EMHC's overall approach to tobacco use with their clients; which promotes overall healthy living rather than just tobacco cessation. According to interviewees, changing from a client "Tobacco Cessation"

group to a "Healthy Living" group encouraged more tobacco-using clients to attend, as they felt less pressured to agree to quit tobacco use immediately. This encouraging, positive, and non-punitive approach proved to be very successful for EMHC's overall tobacco reduction efforts, and gave staff an opportunity to have empowerment over their own health and lifestyle.

If a client is assessed as a current tobacco-user, clinicians are required to assess the extent of their nicotine addiction by utilizing the **Fagerström Test for Nicotine Dependence**, a widely-used, evidence-based scale for assessing physical addiction and reliance on nicotine. The tool can also be useful to organizations in providing documentation for the indications for prescribing medication for nicotine withdrawal (Nicotine Replacement Therapy) and for billing for tobacco cessation counseling.[9] Additionally, EMHC clinicians are required to take a full history of tobacco-use (frequency, length of time of use, pattern of daily use, etc.) for any client that reports a history of tobacco use.

View/Print Figure

Modified Fagerström Test for Nicotine Dependence

1. How soon after you wake up do you smoke your first cigarette?
   - Within 5 minutes (3 points)
   - 5 to 30 minutes (2 points)
   - 31 to 60 minutes (1 point)
   - After 60 minutes (0 points)
2. Do you find it difficult not to smoke in places where you shouldn't, such as in church or school, in a movie, at the library, on a bus, in court or in a hospital?
   - Yes (1 point)
   - No (0 points)
3. Which cigarette would you most hate to give up; which cigarette do you treasure the most?
   - The first one in the morning (1 point)
   - Any other one (0 points)
4. How many cigarettes do you smoke each day?
   - 10 or fewer (0 points)
   - 11 to 20 (1 point)
   - 21 to 30 (2 points)
   - 31 or more (3 points)
5. Do you smoke more during the first few hours after waking up than during the rest of the day?
   - Yes (1 point)
   - No (0 points)
6. Do you still smoke if you are so sick that you are in bed most of the day, or if you have a cold or the flu and have trouble breathing?
   - Yes (1 point)
   - No (0 points)

Scoring: 7 to 10 points = highly dependent; 4 to 6 points = moderately dependent; less than 4 points = minimally dependent.

FIGURE 1.

Modified Fagerström test for evaluating intensity of physical dependence on nicotine.

Adapted with permission from Heatherton TF, Kozlowski LT, Frecker RC, Fagerström KO. The Fagerström test for nicotine dependence: a revision of the Fagerström Tolerance Questionnaire. Br J Addict 1991;86:1119–27.

Step 10: Support, Encourage, and Sustain Organizational Changes

After settling in at their new facility, EMHC management plans to sustain these impressive organizational changes by beginning to implement quality measures around TDT. While EMHC leadership is sure that they are screening clients at a rate of 100% at least quarterly (because it is a mandated part of the Intake Assessment and Quarterly Treatment Plan review for each patient), they would like to begin tracking and reporting measures such as:

- Percentage of all clients identified as tobacco users
- Percentage of those identified as tobacco users who committed to a quit-plan
- Percentage of those identified as tobacco users who were prescribed Nicotine Replacement Therapy
- Percentage of those identified as tobacco users who successfully quit tobacco use

Ideally, once these measures are formalized and tracking has begun, performance would be discussed at quality improvement committee meetings, and projects would be undertaken to improve performance if and when necessary.

Discussion

WRITTEN POLICY SHOULD FOLLOW A SHIFT IN CULTURE AND STAFF TRAINING

> …you have all these things going on concurrently to try to build a sense within the organization that not only is this an important problem, but we really do have the capacity to behave differently with our clients to make a difference. And that only comes from experience- not from a policy…

A consistently apparent theme throughout the interviews was the need to address organizational culture and readiness and provider education before the creation and implementation of a written policy. This builds buy-in for policies, which is necessary for successful implementation. In fact, EMHC's policy was written, approved, and implemented 3 years after the initial capacity building session from ATTOC. Interviews revealed that the majority of EMHC's efforts were focused on engaging staff and clients in establishing a mission and vision for implementing TDT and tobacco-free grounds that was meaningful for their patient population and that would help their clients without intimidating them or deterring them from necessary treatment. When clients, care providers, and support staff believe in – and feel like they have a part in – implementing tobacco related initiatives, they are more likely to engage in it in a meaningful way

THE INTRODUCTION OF TDT SHOULD BE NON-THREATENING TO CLIENTS AND PART OF AN OVERALL HOLISTIC HEALTH APPROACH

> ATTOC focused on helping employers establish tobacco free grounds not just for the sake of it- but because we know that a tobacco free environment can support tobacco free choices.

Another reoccurring theme that emerged was the importance of the use of a holistic and non-judgmental approach to addressing tobacco-use and tobacco free grounds for clients and staff. Clients were never made to feel uncomfortable about choosing to continue tobacco use for the time being, therefore, it never interfered with their necessary clinical treatment. Eliminating client tobacco use on EMHC's grounds was not abrupt and punitive, but rather the result of client choice over a period of time during which the organization's culture was slowly, but effectively changed. Clients were even involved and empowered when

asked to be part of the beautification process of EMHC's grounds by helping to plan and create flower gardens in areas where they previously threw their cigarette butts.

FRAMEWORKS FOR IMPLEMENTATION OF TDT SHOULD BE FLEXIBLE AND CUSTOMIZABLE

> …it inches them along and creates and environment to support change and not dictate it. It's not focused on policy or language- it's focused on the end goal. It supports long-term change.

Interviewees felt overall that the ATTOC implementation framework served as a flexible roadmap for guiding their health systems strengthening activities. It enabled the organization to start at a place that they were most-ready to address and build upon successes over time.

Interviewees were in agreement that any organization can write a policy, and even provide training about it, but if people don't value and believe in that policy, implementation will have limited success. Though one might intuitively believe that three years is a long time for an organization to implement this kind of organizational change, none of the interviewees indicated that they thought so. Having gone through the ATTOC phases, they understood why culture change takes time, and why it's necessary to have prior to policy implementation.

Conclusion

Implementation of TDT and smoke-free grounds policies within an organization is a long and multi-step process that is unique to the culture of the organization and their level of readiness. Use of an evidence-based implementation framework to guide the change process can be of benefit in pursuing health systems improvement activities to improve access to TDT. Assessing organizational culture and staff and client attitudes toward tobacco cessation efforts must occur as part of the activities to develop and implement a written policy.

Engaging both clients and staff in the change process and addressing their concerns about change should occur continuously throughout the entire process. Presenting best practice examples, and encouraging staff and providers to think about creating a similar success stories tailored toward their specific facility was helpful to EMHC and gave them a sense of pride and understanding in why they were undergoing this change for the sake of their clients.

Resources

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