TAKING TEXAS TOBACCO FREE

Implementing a Sustainable Education/Training Program Designed for Personnel Addressing Tobacco Control within Behavioral Health Settings

A Step-By-Step Guide

TAKING TEXAS TOBACCO FREE

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www.takingtexastobaccofree.com

ACKNOWLEDGEMENTS

HEALTH
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Integral Care

CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS

This step-by-step *Implementation Guide* reflects experience gained through previous evidence-based cancer prevention projects funded by the Cancer Prevention & Research Institute of Texas [CPRIT; PP130032 (PI: Drs. Lorraine R. Reitzel & Cho Y. Lam), PP160081 (PI: Dr. Lorraine R. Reitzel), and PP170070 (PI: Dr. Lorraine R. Reitzel)]. The development of this *Implementation Guide* was funded by CPRIT grant #PP200051 (PI: Dr. Lorraine R. Reitzel) that focuses on the dissemination and implementation of the Taking Texas Tobacco Free Education/Training Program for Personnel Addressing Tobacco Control within organizations treating individuals with behavioral health needs (i.e., mental and substance use disorders).

This work would not be possible without the co-leadership of our community partners, Integral Care of Austin, Texas, our academic partners from the University of Houston, and many, many strong advocates and stakeholders at the behavioral health and substance use disorder treatment centers with whom we worked. In particular, we are grateful for the collaboration of the 3 local mental health authorities with whom we piloted this program, West Texas Center for MHMR, Border Region Behavioral Health Center, and Heart of Texas Region MHMR Centers for partnering with us in developing and improving this training program. The contents of this *Implementation Guide* are solely the responsibility of the University of Houston and Integral Care authors and do not necessarily represent the official views of the project supporters. More information on the program described herein can be found on the TTTF website: www.TakingTexasTobaccoFree.com.

Thank you

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INTRODUCTION TO THE
TAKING TEXAS TOBACCO FREE PROGRAM (TTTF)

WHAT IS TTTF?

Taking Texas Tobacco Free (TTTF) is an evidence-based organizational-level intervention funded by the Cancer Prevention & Research Institute of Texas that provides practical advice, technical assistance, consultation, education, training, and treatment resources to mental/behavioral health and substance use disorder treatment centers throughout the state of Texas. https://www.takingtexastobaccofree.com

The mission of TTTF is promoting wellness among Texans by partnering with healthcare organizations to build capacity for system-wide, sustainable initiatives that will reduce tobacco use and environmental tobacco smoke exposure among employees, service consumers, and visitors.

TTTF works with organizations that serve consumers with mental health and/or substance use disorders. This includes marginalized subgroups with high rates of smoking and other tobacco use, including those experiencing homelessness, identifying as members of a sexual minority, who are disadvantaged single mothers, criminal justice-involved, and who are of lower socio-economic status. TTTF assists centers to implement a multi-component tobacco free workplace program that includes: 1) tobacco free workplace policies banning all tobacco products, including chewing or smokeless tobacco and e-cigarettes or electronic nicotine delivery systems (ENDS); 2) education to all employees; 3) the integration of tobacco use assessments (e.g., tobacco use screenings) into routine practice; 4) training of clinicians (i.e., direct service clinicians) on evidence-based tobacco use cessation services and their provision to employees and consumers; and 5) a community engagement and outreach component. On our website https://www.takingtexastobaccofree.com, we provide detailed information on implementing each of the 5 TTTF program components within our *Implementation Guides*. Both *Implementation Guides* can be found under TOOLS: *Implementation Resources*, *Taking Texas Tobacco Free Implementation Guide for Behavioral Health Settings* and *Taking Texas Tobacco Free Implementation Guide for Substance Use Treatment Centers*.

WHY FOCUS ON BEHAVIORAL HEALTH CENTERS?

The focus on organizations treating individuals with mental and behavioral health needs is critically important to cancer prevention because these individuals: 1) comprise 21% of the population but represent approximately 44.3% of the tobacco market[1]; 2) account for as many as 50% of annual smoking-related premature deaths[2]; 3) experience cancer incidence that is 70% higher than the general population predominately due to tobacco use[3–6]; and 4) despite the existence of effective treatments and overall decline in tobacco use among the general population, have smoking rates that have remained relatively static over time, suggesting that they benefit less from existing tobacco control interventions than other tobacco users.[7–9] Organizational-level interventions are necessary to affect tobacco use rates among subgroups experiencing tobacco-related disparities because they yield greater reach with enhanced cost-effectiveness relative to individual-level treatments.[10,11] Therefore, evidence-based tobacco free workplace programs like TTTF have the potential to make a significant impact on the prevention of tobacco-related cancers among individuals with mental or behavioral health needs and those who serve them.

Individuals with Mental & Behavioral Health Needs

REPRESENT ABOUT	ACCOUNT FOR	EXPERIENCE CANCER RISK	SMOKING RATE WITH
44.3%	**~50%**	**70%**	**Low**
OF THE TOBACCO MARKET	OF ANNUAL SMOKING-RELATED PREMATURE DEATHS	HIGHER THAN THE GENERAL POPULATION	DECLINE OVER TIME DESPITE DECLINE IN GENERAL POPULATION

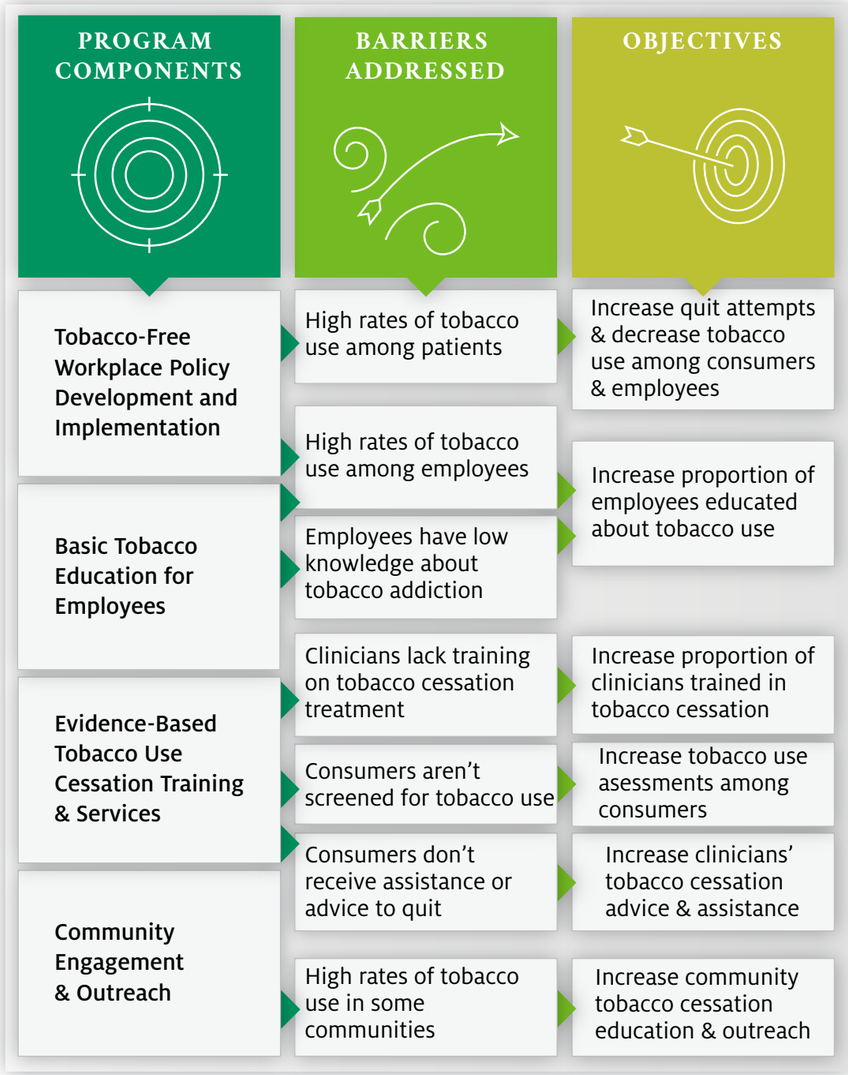
ARE TOBACCO FREE POLICIES EFFECTIVE?

Comprehensive tobacco free workplace programs are multi-component programs that include a tobacco free workplace policy as well as attention to the identification and treatment of tobacco users through clinician training/education and the implementation of regular screening and treatment/referral policies/procedures. Tobacco free workplace policies that completely prohibit the use of tobacco and other nicotine delivery products on worksite property alone are an effective means in reducing tobacco use and dependence.[12] For example, smokers employed in workplaces with complete smoking bans are more likely to consider quitting and quit at higher rates than those employed at workplaces with partial or no bans.[13] The implementation of tobacco free workplaces, particularly when coupled with the provision of tobacco use cessation resources, may also reduce smoking rates among those who continue to smoke.[13] Additional benefits include reduced absenteeism, reduction in smoking-related fires, increases in employee productivity, averted medical costs,[14] sustenance of cessation through the elimination of tobacco cues, and a reduction in exposure to environmental tobacco smoke among non-smokers.[12,13]

HOW DOES TTTF WORK?

TTTF was adapted from a comprehensive tobacco free workplace program previously implemented within Integral Care, one of the 39 Local Mental Health Authorities serving individuals with behavioral health needs in Texas, and was guided by recommendations for comprehensive tobacco control programming.[15,16] TTTF was specifically designed to increase the capacity for and the provision of evidence-based interventions for tobacco use in behavioral health settings because the delivery of evidence-based interventions is known to increase quit attempts and cessation.[16] TTTF program components were designed to address consumer-level, center-level, and community-level barriers and thereby meet the need for evidence-based service provision within the targeted settings. Primary program components entailed tobacco free workplace policy implementation and enforcement (center-level); employee education about tobacco use hazards (employee-level); clinician training to regularly screen for and address tobacco dependence via intervention (clinician-level); and community outreach to address and prevent tobacco use more broadly (community-level); each of these components impact consumer-level tobacco cessation services (consumer-level). These are further explicated in Figure 1. To maximize buy-in at the targeted settings, we used a toolkit-based approach to facilitate center, employee and clinician, and community-level changes in how tobacco use was being addressed, which allowed stakeholders in these settings to identify their needs at each level and select evidence-based strategies for best addressing them within their context.

Figure 1.
Major Components of TTTF and How They Address Barriers at Behavioral Health Centers



DOES TTTF WORK?

As of 2022, TTTF has been implemented within 22 local mental health authorities across Texas, 15 substance use treatment centers, and 9 community agencies, representing almost 302 individual treatment "centers" covering over half the state of Texas. We have trained over 14,000 professionals in over 276 training sessions and reached over 710,370 individuals with our program materials. Our professional publications and more information about TTTF's successes can be obtained online https://www.takingtexastobaccofree.com articles or by contacting the team directly via the website.

BUILDING & EMBEDDING CENTER-BASED EXPERTISE TO SUSTAIN TOBACCO CONTROL EFFORTS

A cornerstone of TTTF implementation has been the provision of education to all employees and clinicians at participating agencies on evidence-based practices for treating tobacco dependence within behavioral health settings, because education is the foundation for changing how employees and clinicians address tobacco use among the consumers in their care.

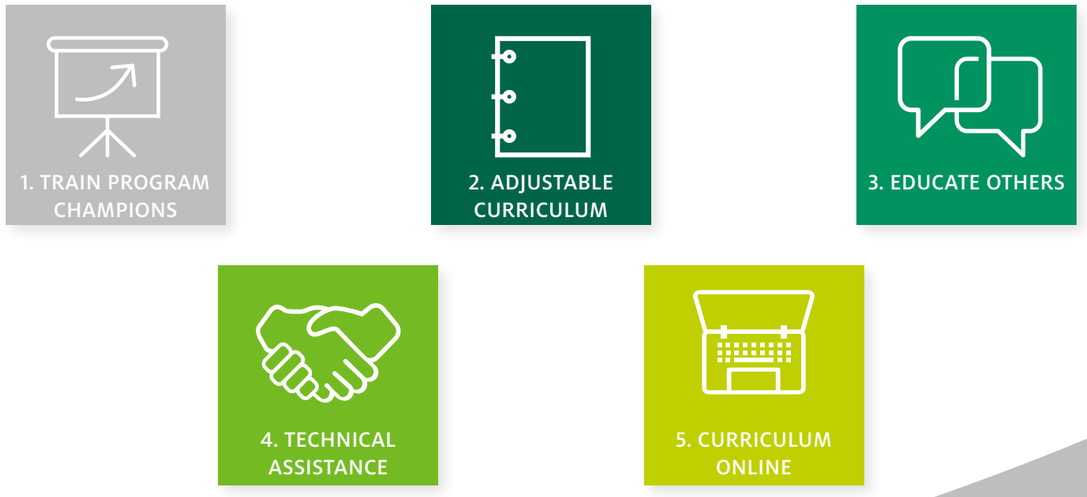
While TTTF team members delivered a tobacco education/training curriculum to clinicians and employees at participating behavioral health centers in our prior grants PP130032, PP160081, and PP170070, our program partners reported they lacked the necessary training and materials to sustain ongoing in-house educational/training efforts. Research shows that lack of education or training on how to treat tobacco dependence is the biggest barrier to providing tobacco treatment.[17–20] Given the high employee turnover in behavioral health centers, it is essential to ensure continuous, in-house expertise in effective tobacco treatment through establishing an ongoing tobacco education training program. As provision of education on each core program component is essential to successful program implementation and sustainment, we responded to this gap in the TTTF program by developing an evidence-based tobacco control training curriculum and program.

The TTTF Sustainable Education/Training Program is a "Train the Trainer" program. Our goal is to increase the reach, adoption, and effectiveness of evidence-based tobacco cessation interventions within behavioral health treatment settings through the development, dissemination, and implementation of a curriculum and training program. This program is intended for use by "program champions" within these settings. The program champion is a center employee, usually a clinician or manager, who is trained in treating tobacco dependence and is responsible for training others in their center in tobacco education and treatment. The aim of this "Train the Trainer" program is to facilitate long-term, competent, center-led delivery of employee and clinician education about evidence-based practices for tobacco control through New Employee, Annual, and In-service Trainings. Developing local center program champions as tobacco education trainers will ensure that embedded expertise on evidence-based practices for tobacco control is not jeopardized over time through employee turnover.

PILOTING THE PROGRAM

Three local mental health authorities, who had previously successfully adopted the TTTF program into their centers, partnered with us on piloting this Train the Trainer program. Through their collaboration and guidance, we developed curricula, program materials, and this *Implementation Guide*. Through their partnership, this training program has successfully: 1) developed and trained program champions who can confidently deliver evidence-based tobacco training to their center employees and clinicians; 2) provided participants with a curriculum adjustable to their center's needs; 3) trained center stakeholders on how to educate others through delivering center-led trainings; 4) provided technical assistance to ensure the establishment of a long-term training initiative for new employees/clinicians or continuing education for existing employees/ clinicians; and 5) developed and made the training curriculum available online for other centers interested in implementing this training program. The piloting of this training program has been successful: participating local mental health authorities have increased their capacity to facilitate sustainable, competent, center-led education in behavioral health settings to address the problem of tobacco use and dependence among individuals with behavioral health needs, and are now regularly providing on-site trainings.

Program Successes Through Collaboration & Guidance



IMPLEMENTATION COMPONENTS OF THE TTTF SUSTAINABLE EDUCATION/ TRAINING PROGRAM

Implementation of the training program occurs in phases that include formative evaluation – exploring the needs and characteristics of a center to develop and fit the training program accordingly, center preparation, active program implementation, and sustainment. Stakeholder feedback collected during each phase should guide implementation efforts.

Our training program includes the following main components: 1) selection and comprehensive training of center program champions, who will become trainers and deliver tobacco education/trainings to center employees; 2) development of an evidence-based tobacco education curriculum, tailored to needs and length (generally ~60-90 minutes) of individual centers; 3) training of program champion(s) on delivery of tobacco education curriculum via mock practice training sessions with other champions/peers, including constructive feedback/evaluation forms developed by TTTF; 4) delivery of the tobacco education curriculum by program champion(s) to actual center employees, assessed by at least 2 peer observers; and the 5) integration of regular tobacco education into New Employee Trainings, Annual Employee Trainings and In-service Trainings.

Each of the aforementioned main components represent different phases of training, each of which involves observation and assessment of trainers by peers using assessment tools developed by the TTTF team. Train the Trainer materials and tools are located within this *Implementation Guide* and available online on our program website for free: https://www.takingtexastobaccofree.com/trainthetrainer. Additional tobacco education and dissemination materials (e.g., posters, rack cards and quit cards) are available for free download on our home page in various languages including English, Spanish, Chinese, Vietnamese, Farsi and Japanese, at: https://www.takingtexastobaccofree.com.

THE PURPOSE OF THE *IMPLEMENTATION GUIDE*

The purpose of this *Implementation Guide* is to share the TTTF Training Program with non-participating behavioral health centers and the broader public, and to offer step-by-step guidance for its implementation in other settings. On the following pages, the reader will find our recommendations, field-tested training curriculum and evaluation materials, and several appendices developed through our work in disseminating and implementing the TTTF Training Program across Texas. **Should you need further guidance on implementing the TTTF Train the Trainer program, please contact our program manager, Bryce Kyburz, at** Bryce.Kyburz@integralcare.org.

While the implementation of the TTTF Train the Trainer program is not dependent upon the adoption of a comprehensive tobacco free workplace program, we strongly encourage behavioral health centers that are interested in effectively treating tobacco dependence to consider adopting such a comprehensive approach to tobacco control. For more information on developing and implementing a comprehensive tobacco free program within behavioral health or substance use treatment centers, please see our other step-by-step *Implementation Guides*, available on our webpage: https://www.takingtexastobaccofree.com.

We have organized this *Implementation Guide* roughly by each component of the training program, as each component is implemented in a sequential manner. All components are important and attending to each will increase the impact that your center can have on addressing tobacco use and preventing cancer among your consumers. We are exceedingly pleased to share our experiences with you and are available to your center should questions arise during your tobacco free journey.

Sincerely,

The TTTF team

THE TTTF SUSTAINABLE EDUCATION/TRAINING PROGRAM

TIPS ON DELIVERING THE TTTF TRAINING PROGRAM ONLINE

The entire TTTF Education and Training Program has been designed to be delivered online, in-person, or a hybrid of the two, depending on center employees' preferences and accommodations regarding safety concerns during the COVID-19 pandemic. For your convenience, we have included a "TTTF General Video Conferencing Platform Training Instructions" (Appendix A), that provides detailed technical instructions on using Zoom and Microsoft Teams. Here, we describe best practices for presenting with Zoom to assist trainers in delivering a smooth and effective training experience for all.

PREPARE YOURSELF

The first thing you must do as a good presenter, whether online or in a live classroom, is prepare yourself.

- Reduce distractions in your physical space by removing anyone or anything that may distract you. Consider moving your cell phone to another room and unplugging the land line (if you still have one). If there are other people or pets in your home, have a plan in place for mitigating interruptions.
- Remove visual clutter from your background. A messy closet or unfolded laundry behind you may distract your attendees. Even a neat shelf with mementos or books can be distracting.
- Make sure your materials are readily available. Consider creating one folder on your desktop for all your presentation-related materials so you are not fumbling around during the session.
- Practice your presentation ahead of time, preferably numerous times. Seamless transfers between a PowerPoint slide, other documents, and your own image can help the attendees focus on your message, rather than on your technical skills.

PREPARE YOUR VIRTUAL SPACE

Presenting in a virtual environment requires a bit of juggling and a good amount of technical fluency. However, you do not have to be a technical wizard to present online. There are many things you can do to prepare your virtual space so that you present your best self to an audience.

- Have a Zoom buddy who can take care of the technical details that arise before and during your presentation. Online, the potential problems that audience members might have—difficulty logging in, problems with the audio, inability to see a shared screen (we could go on and on)—are numerous, and the presenter cannot solve them all. A Zoom buddy can work through these issues while you continue your presentation.

- Check your Zoom settings. Make sure that you have enabled any features that you will need during the course of your presentation such as file sharing, nonverbal feedback, sound notifications, waiting rooms, and allowing participants to join before the host.
- Adjust your webcam so that you appear present and engaged. Remember that if you are looking at your webcam, the audience will perceive that you are looking at them. Face your camera at all times. If you find your eye wandering to your own video, try pinning the video of a specific attendee top and center and looking at that attendee's video; each individual will perceive that you are looking at them.
- Make sure you close other applications that may make distracting noises during your training (e.g., a verbal cue that you received an email).
- If your internet connectivity is not fantastic, sometimes turning off the camera for a bit will prevent some lagging.

PREPARE YOUR ATTENDEES

Getting your space ready and getting yourself ready for an online presentation are not your only preparatory tasks. You also need to get your audience ready by setting expectations for how they will communicate with the hosts or panelists. The more your audience knows what to expect, the more successful your presentation will be.

- Have a strategy for managing audience questions. Live questions from an online audience can easily get out of hand; however, you can let your audience know that questions should be entered in the Q&A format (Zoom webinars), through a raised hand, or in the chat box. You may want to assign a Zoom buddy to monitor the chat while you are presenting. This can be a colleague, or you might ask for a volunteer from the audience.
- The chat feature is wonderful in Zoom, but it can also lead to side conversations and well-intentioned but distracting comments. With Zoom you can allow attendees to chat privately with one another, publicly with the entire room, or just with the host. Consider blocking the ability of attendees to send messages to the whole room. These often add very little to the presentation and can be intrusive. As mentioned above, consider using the Q&A format if you have access to Zoom webinars.
- Remind attendees about their sound controls (i.e., Mute/Unmute). Online discussions in which more than a few people are participating at once are very difficult to control and should be avoided if possible.
- Set expectations for camera use. Cameras can be valuable tools for small seminars or classroom presentations, but they can also be distracting in a large meeting or session. Additionally, webcams take up bandwidth and slow the speed of the meeting.
- Finally, consider requiring registration so that attendees can receive relevant materials ahead of the class or meeting. Providing materials ahead of time not only will help attendees be prepared but also is a convenience for those who may want to print the documents and for those who may use assistive technologies to read the materials. This could include providing advance instruction for using the technology platform (e.g., Zoom).

COMPONENT 1:
COMPREHENSIVE TRAINING OF CENTER PROGRAM CHAMPIONS

The first step in implementing the TTTF Train the Trainer program is selection and comprehensive training of a center program champion(s). As stated previously, a program champion is a center employee, usually a clinician or manager, who is trained as a tobacco treatment specialist, and will lead the center's efforts in training employees on tobacco education. We recommend training 2–4 program champions per center, with a minimum of 2 per center. Training various employees to become program champions in your center will ensure that the necessary expertise to train employees on tobacco control is continuously embedded within your organization, given the high turnover of employees within behavioral health settings. Departing program champions can use this training program to ensure that they replace themselves within the organization. Program champions can be individuals who have or have not previously received training and certification as tobacco treatment specialists.

We have included a "Project Instrument Administration Timeline" for your convenience, to facilitate planning of the various steps involved in implementing this training program.

The first step in this program consists of a 5-hour comprehensive training of program champions in tobacco education, entitled "Master Tobacco Education Refresher" Training Slide Deck (Appendix B) (hereafter referred to as the "Master Training"), which, depending upon whether one has been previously trained or not, serves as either a refresher or a foundational course in tobacco education. As with our past work with behavioral health centers throughout Texas, the content for this presentation is informed by recommendations for best practices in tobacco control,[15,16] the expertise of team members, and prior tobacco free workplace implementation work within substance use treatment centers and mental health settings,[21–23] and is a condensed version of the Certified Tobacco Treatment Specialist Training (CTTS). It consists of an intensive, 5-hour PowerPoint presentation that provides an overview of specialized knowledge pertaining to tobacco use and tobacco treatment strategies, focusing on:

- Tobacco Use among Vulnerable Groups (e.g. those who are: diagnosed with mental and/or substance use disorders, intellectual and developmental disabilities, vulnerably housed, members of a sexual minority and of lower socioeconomic status)
- Why People Use Tobacco: Marketing
- Why People Use Tobacco: Nicotine Addiction
- Benefits of Quitting
- Empirically Supported Treatments for Tobacco Dependence
- Tobacco Free Policies
- Behavioral Counseling and Interventions
- Over-the-Counter Nicotine Replacement Therapy (NRT) and Prescription Medications
- Myths and Facts About Smoking among Those with Behavioral Health Conditions
- Motivational Interviewing Basics
- E-Cigarettes and ENDS
- Resources

Project Instrument Administration Timeline

1	2	3	4	5	6	7	8	9	10	11	12
Administer "Program Champion Self-Assessment – Baseline Survey" for snapshot of champion self-efficacy before training begins	Utilize "Observer Ratings of Practice Instruction Feedback Form" to evaluate program champion's performance during practice sessions where they deliver mock trainings to trainers	Administer "Employee Attendees' Tobacco Education Training Pre-Test" before the champion delivers the training to employees at their center	Administer "Program Champion Self-Assessment Pre-Actual Training Survey" for snapshot of champion's self-efficacy at this point of program	Utilize "Observer Ratings of Actual Instruction Feedback Form" to evaluate program champion's performance during training delivered to employees	Administer "Employee Attendees' Post-Test & Ratings of Instruction Survey" after champion's employee training concludes	Send "Sample Certificate for Employee Attendees" to program champion to distribute to those who attended their training	Fill out "Program Champion Summary Sheet" with analyzed data from employee attendees' pre + post test & evaluations, and send to champion	Administer "Program Champion Self-Assessment Post Training & Ratings of Curriculum & Training Survey" for snapshot of champion's self-efficacy at this point of program & evaluation of the training they received	Fill out the "Sample Certificate for Program Champion" and send to champion to signify their successful completion of the training program	Hold focus group or 1-on-1 interviews with champions, utilizing the "Program Champion Post-Implementation Interview Guide"	Follow up with champions periodically using the "Post-Implementation Program Champion Survey" to collect data on number of trainings delivered & trainees to evaluate training program outcomes/ reach
	Trainings delivered to program champions		Program champion "passes" the practice session and proceeds to organize the first training to be delivered to their fellow employees		Program champion delivers training to employees at their center						

COMPONENT 2:
DEVELOPMENT OF TAILORED EVIDENCE-BASED TOBACCO EDUCATION CURRICULUM

As with all the materials in this *Implementation Guide*, the "Master Training" can be delivered live, in-person, or live via a web-based platform such as Zoom. Additional material specific to a treatment site (e.g., how to record information in consumer records or an electronic health system) and/or consumer population (e.g., pregnant smokers, youth who vape, opioid users), can be added to this presentation as needed. Please check our website, https://www.takingtexastobaccofree.com for presentations addressing smoking in special populations, i.e., among sexual minorities, people with opioid disorders, people experiencing homelessness, and those living in subsidized housing.

Upon completion of the "Master Training," program champions will have been trained on how tobacco use and environmental tobacco smoke affects the body; specifics about tobacco use among individuals with behavioral health conditions (i.e., mental health and substance use disorders); the most effective ways of treating tobacco use and dependence, including adoption of a tobacco free workplace policy; and how to assist others with maintaining compliance with the policy; and how to address barriers to treating tobacco use among those with behavioral health conditions. The "Master Training" contains 94 slides and serves as the basis from which shorter, 45, 60, or 90 minutes training presentations to be delivered to employees, can be developed.

This initial phase of training the program champions includes an optional, brief, 3-minute baseline assessment, the "Program Champion Self-Assessment-Baseline Survey" (Appendix C). This survey assesses the program champion's self-efficacy and experience with training and delivering educational curriculum to others. Program champions rate themselves on a 5-point scale ranging from "strongly disagree" to "strongly agree," on different characteristics, e.g. "I am a good public speaker," and "I currently have the capacity to deliver trainings in tobacco control." This same self-rating assessment is repeated both before and after the delivery of actual trainings to center employees. The purpose of this assessment throughout the training phase is to provide feedback to program champions on their training process and to build their confidence as trainers. It can also reveal opportunities for professional development that can be pursued/recommended.

Assessments/Tools:

1. TTTF General Video Conferencing Platform Training Instructions (Appendix A)
2. Master Tobacco Education Refresher Training Slide Deck (Appendix B)
3. Program Champion Self-Assessment-Baseline Survey (Appendix C)

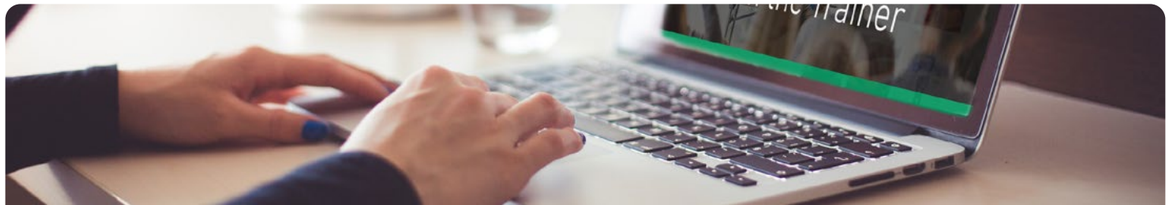
The second step, after being educated on the harms of tobacco use and how to effectively treat dependence, is to develop a tobacco education curriculum tailored to the needs and time preferences of the individual center. The "Master Training" slides serve as the basis for the development of the 3 different types of center-led trainings, New Employee, Annual, and In-service Training events. As every center is unique, the length of each of these training events is decided by the individual center. We have developed the "90-minute Employee Training Slides"(Appendix D) consisting of 30 slides, condensed from the "Master Training," that each of the 3 local mental health authorities that piloted this training program adopted in their centers for their Annual Employee Training. These training slides include presenter notes to facilitate learning. However, we encourage trainers to put the slide notes into terms they are comfortable with, delivering the presentation in their own words, rather than struggling to use terms that may be unfamiliar to them. Additionally, many of our trainers have used personal stories to explain some of the training material with great success. Sharing your own experience about a topic being covered in a slide with attendees is the best way to make it real and engage their interest.

We recommend that the "90-minute Employee Training Slides" also be used for New Employee Training, whereas shorter presentation can be developed for the In-service Trainings. Through our YouTube channel on our Train the Trainer webpage, we also provide a video that models what a 90-minute tobacco dependence and education training video may look like. In this training video, viewers will identify the impact smoking and tobacco use has on people living with a mental illness and/or a substance use disorder. The goal of this phase of the training is to teach program champions presentation skills and teaching strategies in delivering the content of the deck as effectively as possible.

Certain slides in the "Master Training" are marked in the upper right-hand corner by a red star ★ and/or a capital green T. The star indicates that the slide is considered essential information that needs to be included in the basic employee training. While we recommend that trainers use the "90-minute Employee Training Slides," we are aware that your center may edit the presentation to accommodate shorter time frames. The red star ★ is meant to assist you in determining which slides are most essential. The green, upper-case T, identifies the slide as answering a test-question on the TTTF-developed pre- and post-training knowledge test. If your center intends to utilize the pre- and post-training tests (described below), all the slides marked with an upper-case, green T will need to be included in your employee training presentation, or you will need to modify the pre- and post-training tests.

Assessments/Tools:

1. 90-minute Employee Training Slide Deck (Appendix D)



COMPONENT 3:

PRACTICE TRAINING SESSIONS: TRAINING AND ASSESSMENT OF PROGRAM CHAMPION(S) ON DELIVERY OF TOBACCO EDUCATION CURRICULUM

Once your center program champion(s) has downloaded, and made any necessary adjustments, to the 90-minute employee presentation, they will start the process of training to deliver the tobacco training to center employees. This process consists of 4 steps:

1. Program champion(s) study the Employee Training Presentation that they intend to present, to thoroughly familiarize themselves with the information.
2. To help prepare for delivering the training, we have written up suggested "Presentation/Teaching Tips" (Appendix E), to assist program champions.
3. Program champion(s) schedule at least 2 practice sessions in which they deliver a "mock training" of the Employee Training Presentation to at least 2 center "training observers/assessors." Training observers/assessors are other center employees, e.g., peers or other program champions who will assess the program champion on their delivery and mastery of training material.
4. Training observers will provide program champions with verbal and written feedback, using an assessment tool developed by TTTF, the "Observer Rating of Practice Instruction Feedback Form" (Appendix F). At the end of each practice session:
   a. feedback is summarized and delivered verbally to the program champion
   b. the written observer feedback forms are given to the program champion for a more detailed evaluation and recommendations for improvement
5. Program champions are scheduled for additional practice sessions if one or both of the following conditions are met:
   a. One or both observers give program champion(s) a rating of 3 or less in the Overall ratings section of the "Observer Rating of Practice Instruction Feedback Form," which measures the following 2 items on a scale of 1-5, where 1 = Poor and 5 = Excellent:
      1. The delivery of the training curriculum by the trainer to setting stakeholders
      2. The effectiveness of the trainer as a teacher
   b. The program champion requests additional practice sessions

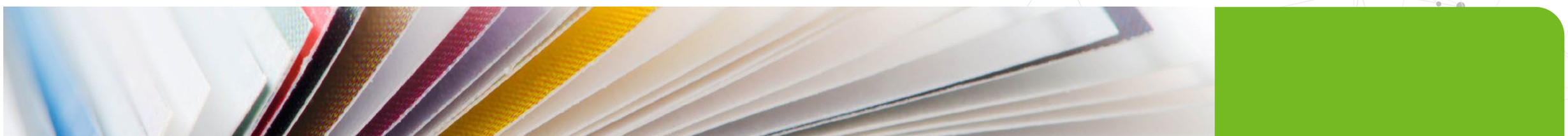
*NOTE: If neither of the conditions are met and both observers agree that the program champion earned a true 4-5 on the overall ratings section of the feedback form, then program champion can proceed to Step 6 below. Otherwise, program champions will continue to schedule additional practice sessions until they receive a 4-5 overall ratings on the observer feedback form.

6. The training observers determine that the program champions have developed enough skill and confidence in delivering the training material effectively to move on to the next step and communicate to the program champions that they are ready to progress to the next step—delivering actual trainings to center employees.

If your center is training more than one program champion, we recommend having other program champions attend these practice sessions of their colleagues, optimally as assessors, as observing other program champions during training is a good way to gain valuable training experience and expertise for other champions-in-training, and to support them in their efforts. Our pilot program partners reported that training as a group, where program champions attended each other's trainings, was extremely helpful for them, providing an invaluable learning experience.

Assessments/Tools:

1. Presentation/Teaching Tips (Appendix E)
2. Observer Rating of Practice Instruction Feedback Form (Appendix F)



COMPONENT 4:

DELIVERY AND ASSESSMENT OF ACTUAL INSTRUCTION TO CENTER EMPLOYEES

Program champions are now ready to deliver tobacco education trainings to center employees. Program Champions begin scheduling procedures to deliver the curriculum to employees at their respective center. Each champion is scheduled to deliver the curriculum to 10-15 employees for ideally 2 trainings—the champion may need to coordinate with administrative/managerial leaders to send out the appropriate information and invitations to employees at their center.

The delivery and assessment of actual instruction to center employees consists of the following steps, whether the training is being conducted in-person or virtually. The only difference between the in-person and virtual trainings is that for the in-person trainings, the program champions and observers/assessors have the option of printing out and using hard copies of the different assessment instruments.

Prior to conducting the actual trainings:

1. Starting a week before the scheduled tobacco education training, registered attendees will be asked by the program champion(s) or their designee to complete an anonymous "Employee Attendees' Tobacco Education Training Pre-Test" (Appendix G) before the training begins. This provides a knowledge measure pre-training that can be compared with a post-training knowledge assessment. The program champion should ensure all employees are signed in, so they have a record of attendance, and their correct name for filling out the "Sample Certificate for Employee Attendees" (Appendix H) at the conclusion of the training.
2. A week prior to the actual training, registered attendees are emailed a "Training Package," that includes a copy of the PowerPoint slides, so that they can take notes, should they so desire, as well as the 2 handouts, one on "Drug Interactions with Tobacco Smoke," (Appendix I) and a "Pharmacologic Product Guide," (Appendix J), that details FDA-approved medications to treat tobacco use and dependence. Program champions may also wish to send out instructions for accessing the presentation platform (e.g., Zoom) as well to maximize their preparation.
3. During the week before the program champion is scheduled to deliver their first actual employee training, they will be administered the "Program Champion Self-Assessment Pre-Actual Training Delivery Survey" (Appendix K) online to assess their self-efficacy related to training others on the educational curriculum, specifically in relation to where they stood when surveyed in the beginning of the program.
4. The program champion will enlist the assistance of 2 observers/assessors to observe them delivering the employee training. The 2 observers will be assessing their performance and efficacy in the delivery of the curriculum using the "Observer Rating of Actual Instruction Feedback Form" (Appendix L). Ideally, both observers would rate the program champion a 4-5 (Very Good or Excellent) on the Overall Ratings section of the form, which is the same measurement as the "Observer Rating of Practice Instruction Feedback Form" (Appendix F).
5. At the end of the employee training, feedback should be summarized and delivered verbally to the program champion, and the observer feedback forms should be given as a follow up for a more detailed evaluation.

At the conclusion of the delivery of the actual trainings:

6. The program champion will send out a link to the "Employee Attendees' Post Test" (Appendix M) and "Employee Attendee Ratings of Training Instruction," (Appendix N), using SurveyMonkey or another free survey software platform.

   Alternatively, for in person trainings, these materials can be printed out and physically distributed.

*****NOTE: Steps 1-6 above should be repeated for every employee training the program champion delivers as part of the training program (ideally twice).**

7. Program champions will fill out and email (or print and distribute) individual "Sample Certificate for Employee Attendees" (Appendix H) for the employee's participation in their training.
8. Once the program champions have successfully delivered 2 or more actual trainings to employees and have received a rating of 4-5 (Very Good or Excellent) from their observers/assessors, they will complete the "Program Champion Self-Assessment Post-Training Delivery & Trainer Ratings of TTTF-Provided Curriculum and Training" (Appendix O).
9. Center employees can analyze the data on knowledge gain as well as employee attendee ratings of their training and their performance using the "Employee Attendees' Tobacco Education Training Pre-Test" (Appendix G) (administered in Step 1 above), and the "Employee Attendees' Post Test & Ratings of Instruction Survey" (Appendix M) (administered in Step 6 above).
10. The data from "Employee Attendees' Tobacco Education Training Pre-Test" (Appendix G) and the "Employee Attendees' Post Test" (Appendix M) & "Employee Ratings of Training Instruction" (Appendix N) should be compiled and entered into the "Program Champion Summary Sheet" (Appendix P), and be delivered to the presenting program champions upon completion. Appropriate attention should be given to ensure comments provided to the champions on this document are not unnecessarily derogatory or potentially identifiable in the case of very small employee trainings. It is best to identify major themes from employee comments and select 1-2 representative ones for inclusion on the summary sheet. The person compiling this information for the program champions might also make corresponding recommendations for how to address any critical feedback in future trainings on this summary sheet. It is important to be encouraging and helpful to the program champions in this regard.
11. A "Sample Certificate for Program Champion" (Appendix Q) should also be tailored for the program champion(s) and sent to them for their participation and successful completion of the training program.
12. Additionally, an optional "Program Champion Post-Implementation Interview Guide" (Appendix R) is included for a more in-depth evaluation of the training program.

Assessments/Tools:

1. Employee Attendees' Tobacco Education Training Pre-Test (Appendix G)
2. Sample Certificate for Employee Attendees (Appendix H)
3. Drug Interactions with Tobacco Smoke (Appendix I) Pharmacologic Guide (Appendix J)
4. Program Champion Self-Assessment Pre-Actual Training Delivery Survey (Appendix K)
5. Observer Rating of Actual Instruction Feedback Form (Appendix L)
6. Employee Attendees' Post Test (Appendix M) and Employee Ratings of Training Instruction (Appendix N)
7. Program Champion Self-Assessment Post-Training Delivery & Trainer Ratings of TTTF-Provided Curriculum and Training (Appendix O)
8. Program Champion Summary Sheet (Appendix P)
9. Sample Certificate for Program Champion (Appendix Q)
10. Program Champion Post-Implementation Interview Guide (Appendix R) (Optional)

COMPONENT 5:

INTEGRATION OF REGULAR TOBACCO EDUCATION INTO NEW EMPLOYEE TRAININGS, ANNUAL EMPLOYEE TRAININGS, AND IN-SERVICE TRAININGS

Once the program champions have successfully completed their training in becoming tobacco educators, they will work with their departmental and center partners to integrate regular tobacco education into New Employee Trainings, Annual Employee Trainings, and In-service Trainings. Interdepartmental cooperation and planning are necessary to develop a sustained training program. Program managers are ultimately responsible for the education of their employees and cooperating with program champions to ensure that employees' work schedules can accommodate periodic tobacco training events. It is essential that in-house expertise regarding tobacco treatment is consistently maintained within the center to effectively address tobacco dependence.

ONGOING TRAINING

Behavioral health centers historically have a high employee turnover rate; keeping knowledge current and appreciation for the purpose behind the tobacco free workplace is essential to its sustainability. Therefore, it is important to focus on adequately training all new employees and this can be accomplished by embedding this training within New Employee Orientation, Annual Employee Training, and In-service Trainings. New employees should also receive training on addressing people who choose to break the tobacco free workplace policy. Policy violation/treatment resource cards to hand out, role playing how to approach violators in the workplace, and different examples of scripts for education about the tobacco free workplace policy (available under Implementation Resources, Tobacco free campus policies, on our website) should be provided to new employees during this training. These resources are available on our website, https://www.takingtexastobaccofree.com. New employees can also shadow current employees to become familiar with the processes and procedures.

ONGOING TRAINING: MAINTAINING TOBACCO TREATMENT COMPETENCY

It is essential that as many clinicians as possible are provided a high level of tobacco treatment training and that the training is ongoing and sustainable. A significant barrier preventing clinicians from addressing tobacco use is a lack of training, knowledge, and skills to adequately assist a person with a quit attempt.[18-20] A robust training program will provide the foundation for competent and highly skilled clinicians and ensure that all employees have a consistent level of knowledge. The more employees who have a higher level of tobacco treatment training, the more likely consumers are going to be screened, referred for treatment, provided resources for quitting, and followed up.

Program champions should incorporate ongoing tobacco treatment training as refresher courses and webinars for current clinicians, provide periodic advanced level training (e.g., Treating Tobacco Dependence in Mental Health Settings —Dr. Jill Williams) for nurses and clinicians, and commit to either training other employees in treating tobacco dependence using the "Master Training," or alternately, sending employees to become Certified Tobacco Treatment Specialists (CTTS). Ideally, before providing tobacco treatment services to a consumer, a training program should be developed for credentialing clinicians. Additionally, if program champions are moving on to other organizations, they can plan to replace themselves by training other employees, using this training program, to become program champions. Without a consistent training program, untrained employees are less likely to talk with consumers about their tobacco use or may provide incorrect and/or potentially harmful information to a consumer.

Centers should encourage clinicians to take advantage of high-quality free online resources and webinars. Some examples include:

- **Smoking Cessation Leadership Center**: (http://smokingcessationleadership.ucsf.edu/webinars)
- **National Behavioral Health Network For Tobacco & Cancer Control**: (https://www.bhthechange.org)

Additionally, there are many CTTS programs available across the country. For a full list of CTTS program, visit https://www.attud.org/. Below is a list of some programs we are familiar with:

- **MD Anderson Certified Tobacco Treatment Training Program:** https://www.mdanderson.org/education-training/professional-education/cme-conference-management/conferences/certified-tobacco-treatment-training-program-.html
- **Mayo Clinic Nicotine Dependence Education Program:** http://www.mayo.edu/research/centers- programs/nicotine-dependence-center/education-program/overview
- **University of Massachusetts Medical School:** http://www.umassmed.edu/tobacco
- **Rutgers University Tobacco Dependence Program:** http://www.tobaccoprogram.org
- **Florida State University College of Medicine:** http://med.fsu.edu/index.cfm?page=ahec.tobaccoTreatment
- **University of Mississippi Medical Center:** Act Center for Tobacco Treatment, Education and Research: http://www.act2quit.org/education
- **University of Colorado School of Medicine:** RMTTS-C Program: https://www.bhwellness.org/programs/rmtts

TOBACCO TREATMENT MEDICATION AVAILABILITY

Breaking the dependence on tobacco is very difficult; only 3–5% of people are able to quit without any assistance.[24] It is important that processes and procedures be developed to provide convenient and inexpensive access to tobacco treatment medications. The availability of the medications will likely reduce anxiety and fear among consumers (and employees), provide a valuable incentive to make a quit attempt, and show that the organization wants to support tobacco users to quit rather than punish them for using tobacco.

Many behavioral health centers are concerned about how to pay for tobacco treatment medications for consumers. Many consumers receiving services do not have private insurance, and if they do, nicotine replacement therapy (NRT) and other medications may not be covered.

One way to offset the cost of providing medications is to utilize the Patient Assistant Program (PAP). PAP provides free or very low-cost medications to people who meet financial need requirements. Varenicline (Chantix) and buproprion (Wellbutrin/Zyban) are typically available through PAP formulary.

Centers can also bill for reimbursement for tobacco treatment services. Revenue generated from the billing will likely not cover the costs for the service, but it could be used to defer some of the cost to purchase NRT or other medications.

To further reduce the cost burden of purchasing NRT, non-profit organizations may be able to access NicoDerm CQ™ patches and Nicorette™ gum and mini lozenges manufactured by GlaxoSmithKline Client Healthcare through their NRT - Direct Purchase Program (DPP). DPP provides NRT to organizations at a significantly discounted rate. For more information on the NRT DPP Program, please contact:

Jim Karl
U.S. Expert Sales: Regional Account Manager, Healthcare Solutions
GlaxoSmithKline Client Healthcare
184 Liberty Corner Road, Warren, New Jersey, 07059, United States
Email: james.f.karl@gsk.com
Cell: 618-558-7459

Some other options to cover the cost for tobacco treatment medications include collaborating with the center's development/fund raising specialists to solicit funds. Members of a work group can also explore local or regional community foundations, hospital foundations, community donations, or local, regional, or state grants. CVS Pharmacy has community grants available to organizations who provide tobacco treatment services. Visit their Community Grants website to learn more: https://cvshealth.com/social-responsibility/our-giving/corporate-giving/community-grants

Tobacco treatment medications should also be made available to all employees. Your center will want to review their insurance coverage and determine:

- **What tobacco treatment medications are covered?**
- **How long can an employee access the medication?**
- **Any applicable co-pays and/or pre-authorization requirements, and**
- **Whether cessation groups and/or individual counseling charges are covered.**

Coverage benefits should be communicated to all employees in advance of the tobacco free workplace policy implementation and employees should be reminded of the benefits on a regular basis before and after the tobacco free workplace policy becomes effective. Implementing organizational screensavers with this information and/or including it on within-organization media may be helpful to enhance communication.

The Affordable Care Act has mandated that compliant insurance carriers include tobacco cessation services among their coverage. If your organization's insurance plan has limited or no coverage for tobacco treatment services, the Human Resources department should inquire about implementing this required benefit. If medications are not covered under the insurance plan, it becomes critical for the organization to provide tobacco treatment medications to interested employees. For instance, the organization should consider adding tobacco treatment medication expenses as a line item in the general budget. For example, an organization serving approximately 20,000 consumers that employs approximately 1,000 employees should expect to budget between $50,000 and $80,000 annually for NRT. Please contact our GlaxoKlineSmith representative, Jim Karl, email: james.f.karl@gsk.com (additional information included previously), about receiving a discount on NRT products and calculating the estimated cost for your center's needs.

FREQUENTLY ASKED QUESTIONS

The following are some of the more commonly asked questions or concerns of behavioral health centers implementing the TTTF program:

Can this training program be implemented during COVID-19?

Yes. The entire TTTF Education/Training Program has been designed to be implemented and delivered either online using a video-conferencing platform such as Zoom, or in-person. Components 1–5 can be delivered online along with the different assessment and other helpful tools.

Is it better to train in-person or live online?

Optimally, we would recommend training in-person, whenever feasible, as participants are generally more comfortable, attentive, and easily engaged during a live, in-person training rather than online. However, we recognize that in-person training may not always be feasible or safe and have made this training program available for live, online delivery. Alternatively, a hybrid approach using in-person and live, online training may appeal to your center employees.

Can this training be delivered using a previously recorded training presentation?

While live delivery of this training is recommended, whether in-person or live online, that may not always be feasible. We have recorded a 90-minute Employee Education and Training Video, both as a model for trainers on how to deliver the training as well as an alternative when a live training is not feasible, that can be accessed via our webpage at www.takingtexastobaccofree.com, under our Train the Trainer program or directly on YouTube.

What technology is required for training remotely/ online?

General technology prerequisites/requirements include:

- Computer with inbuilt or external microphone & webcam
- Zoom software (online download)
- Microsoft Teams (integrated into Microsoft 365 platform)

In Appendix A—"TTTF General Video Conferencing Platform Training Instructions," we provide detailed instructions on how to conduct trainings using Zoom and Microsoft Teams. We recommend that you practice delivering the online training various times, particularly if you are not very familiar with the technology that you are using. Practicing using the technology will ensure that your presentation is technologically trouble-free so you can focus of on delivering the content to your colleagues.

What if I encounter technological problems?

We recommend that you consult your center's IT specialists prior to commencing any online trainings to ensure that your equipment (computer, microphone, and webcam) and software programs are functioning correctly prior to conducting any portion of the training online. It is important that the technological aspects of the training function well so as not to distract from, but instead support a smooth delivery of the training.

Employees at my center are very busy, scheduling a 90-minute tobacco training will be challenging. How long should the training presentations be?

We understand that behavioral health centers are busy places and employees have tight schedules. The "90-minute Employee Training Slides" Appendix D developed for this training serve as the basis from which trainers can draw to tailor a presentation according to the needs of their specific center. While our training partners have generally preferred a 90-minute presentation for the basic employee training, a 60- or 45-minute presentation could also be effective. Alternately, trainers may choose to break the basic, general tobacco education training into shorter segments delivered consecutively. Or, trainers may choose to periodically deliver a shorter presentation, focused on a particular aspect of tobacco control, e.g., FDA-approved medications such as nicotine replacement therapy and prescription medications, or behavioral interventions for treating tobacco dependence, as booster educational
sessions. These shorter segments might be particularly suited to periodic, In-service Trainings.

How you choose to schedule the delivery of tobacco education depends upon your center's particular needs and characteristics. However, adequately training clinicians on how to treat tobacco addiction is the cornerstone to effective tobacco control. As such, we encourage your center to find a way of delivering adequate tobacco education to your employees to reduce tobacco consumption and contribute to improving the health of your employees, consumers, and center visitors. Should you need additional assistance with implementing this training program, please contact us at: https://www.takingtexastobaccofree.com.

Do I have to deliver the tobacco training word-for-word, exactly as it is written in the slides?

No. We encourage presenters to "translate" or adapt the slide notes into their own language. The notes are provided to facilitate learning and highlight important information on the slides. Adapting and delivering the presentation in your own words will increase your comfort level with the material and attendee engagement. We also encourage you to make the presentation your own through including real-life experiences and stories on the material that is being presented. Sharing your own experience on a certain topic is a wonderful way of enlivening the presentation and engaging your audience with the material. Obviously, confidential, or identifiable information about current or former consumers should not be shared; many of our program champions find examples from their own personal lives to present.

Where can I get additional program materials, such as educational brochures on tobacco control?

On our website we provide various educational and dissemination materials for free. Please visit https://www.takingtexastobaccofree.com, under Tools, please select Download Center, where you will find various informational, or rack, cards, posters, quit cards and our One-Page Taking Texas Tobacco Free brochure available for download for free in English, Spanish, Vietnamese, Chinese, Japanese, and Farsi.

What happens if our tobacco education program champions leave our organization?

Behavioral health centers often experience high employee turnover. This is one of the primary reasons that we encourage training 2-4 employees as tobacco education program champions. If program champions are moving on to other organizations, they can plan to replace themselves by training other employees, using this training program, to become program champions. Without a consistent training program, untrained employees are less likely to talk with consumers about their tobacco use or may provide incorrect and/or potentially harmful information to a consumer.

How can I stay informed about current research and policy recommendations on e-cigarettes, vaping, JUUL, etc.?

The tobacco industry is constantly developing new electronic nicotine delivery systems (ENDS), many targeting youth and teens, that have been shown to be particularly harmful to developing youth. To stay abreast of the current research on the harms of these products and recommendations or guidelines regarding their use, please check out the following websites:

- American Cancer Society Position Statement on Electronic Cigarettes. November 2019 https://www.cancer.org/healthy/stay-away-from-tobacco/e-cigarette-position-statement.html
- Center for Disease Control (CDC) Smoking and Tobacco Use: Electronic Cigarettes: https://www.cdc.gov/tobacco/basic_information/e-cigarettes/index.htm
- Our website, Taking Texas Tobacco Free: https://www.takingtexastobaccofree.com
- Visit http://txsaywhat.com or the Campaign for Tobacco free Kids: https://www.tobaccofreekids.org and the Truth Initiative https://www.thetruth.com to get involved in campaigns to raise awareness of the dangers of nicotine addiction and e-cigarettes to youth.

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APPENDICES

APPENDIX A

TTTF GENERAL VIDEO CONFERENCING PLATFORM TRAINING INSTRUCTIONS

TTTF GENERAL VIDEO CONFERENCING PLATFORM TRAINING INSTRUCTIONS

TTTF has used Zoom and Microsoft Teams video conferencing platforms for the virtual tobacco dependence treatment and education trainings. Below are information and instructions for the use of each video conferencing platform, followed by some helpful tips.

GENERAL PREREQUISITES/REQUIREMENTS:

- Computer with inbuilt or external microphone & webcam
- Zoom software (online download—instructions below)
- Microsoft Teams (integrated into Microsoft 365 platform)

ZOOM DOWNLOAD INSTRUCTIONS FOR TRAINING ATTENDEES

1. Enter the URL for the meeting into any browser (Google Chrome, Internet Explorer, etc.) DO NOT SHARE THE URL LINK WITH ANYONE ELSE.
2. If a dialog box opens, click “ok” to open the meeting in Zoom. Otherwise, you can download Zoom, by clicking the download & run zoom button/text on the webpage for the URL.
3. Once the installer downloads, click on it to complete the download for Zoom. This is possible on Windows, iOS, and Android operating systems.
    a. If you are downloading and using Zoom for the first time, you will have to enter the URL for the meeting once again to access the meeting.
4. Once Zoom opens, you may or may not be asked for a password. If you are asked for a password, you can find the password in the meeting invite or email and upon entering the password, you will also be prompted to type in your name. Type in your name as you want to be known to others.
5. Next, you will be asked to join the conference. Depending on your device, click either “join by computer” or “join by telephone.”
6. You will be automatically muted; however, if you are not, please do so by clicking on the button resembling a microphone.

MICROSOFT TEAMS INSTRUCTIONS FOR TRAINING ATTENDEES

1. Ensure that Microsoft Teams is included in your Microsoft suite. You may need to contact your IT/MIS department to determine whether your Microsoft suite includes Teams.
2. Enter the URL for the meeting into any browser (Google Chrome, Internet Explorer, etc.) or click on the link included in a meeting invite. DO NOT SHARE THE URL LINK WITH ANYONE ELSE.
3. You should not need to download any programs and the video conference should be begin after clicking on the provided link. You may need to “ask” to join the meeting, depending on when you join, and the settings established by the trainer.

APPENDIX A
(CONTINUED)

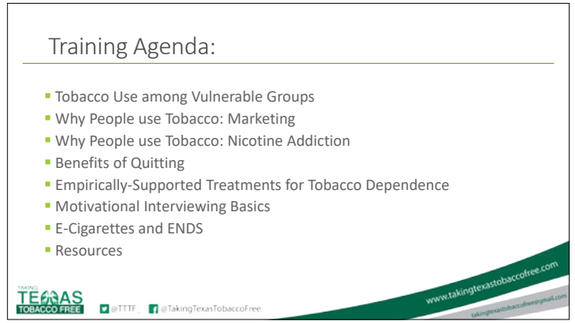
ADDITIONAL TECHNOLOGY TIPS:

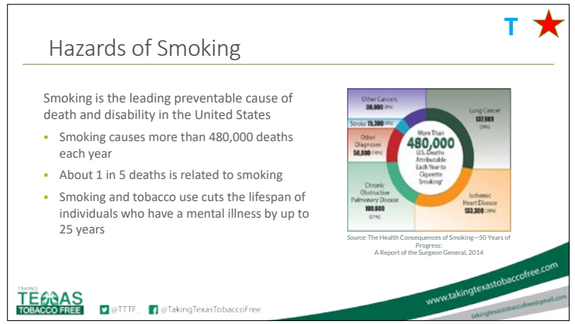
- For both Zoom and Teams, attendees can use the CHAT function to make general comments or ask questions about technical issues. The CHAT feature is located in different areas for each platform (Zoom located on bottom task bar; Teams locate in upper right corner)
- Zoom helpful hint: If you are currently viewing a presentation in full screen mode but need to view the presenter's screen for a live demonstration (e.g., to see what a nicotine patch looks like), press "Esc" to exit full screen mode.
- Your video may be off automatically; however, if you are participating in group activities or you desire to have your video on (or if it is requested/required by the presenter), you will be able to turn on your video by clicking on the video camera icon on the bottom ribbon on your screen.
- Try not to have additional applications running at the same time as a video conferencing call. Also, ensure optimal internet connection for undisturbed audio and video.
- To ensure that all attendees can hear the presentation, please mute your microphone when you join and after you make a comment or ask a question.
- Zoom helpful hint #2: Attendees may wish to have a phone handy, in case their audio is not working, so they can call in. In this case, the attendee should mute themselves on 1 device.

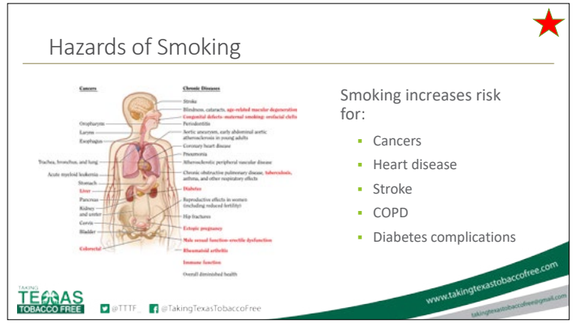
TIPS FOR PRESENTERS:

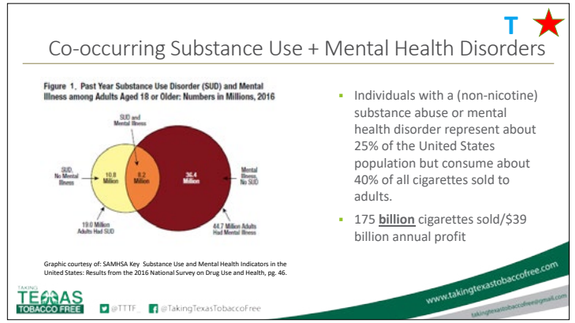
- Practice using the video conference platform with colleagues several times before your presentation. Do not assume you will be able to "figure it out" on the day of the training.
- Log on 15–30 minutes early to ensure that everything is working and to allow you time to troubleshoot any problems you may experience. You may also need to "accept" people into your presentation depending on the security settings. You want to be there first so people are not waiting to join.
- Ensure that you have access to the training materials/PowerPoint and your notes on your computer or network drive. Have the training backed up on a flash drive in the event that you cannot access a network drive, or you experience problems with your computer and need to use a back-up computer. Print your notes in the event that you cannot pull the notes up with your training. With Teams, you can also use presenter mode in PowerPoint to be able to view the slide notes while delivering the presentation.
- For Zoom while presenting in a Webinar mode, for attendees to ask a question to the presenters, use the **Q/A function** on the bottom ribbon of the screen.
- Zoom helpful hint #3: For Zoom, if you wish to play a video, be sure to click on "**Enable Sound**" on the Share screen. If you do not do this, your video will play but the attendees will not be able to hear it.

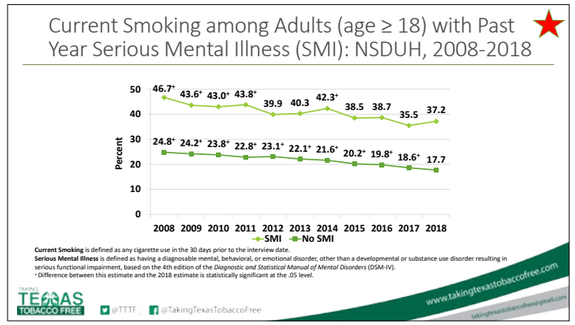
APPENDIX B
MASTER TOBACCO EDUCATION REFRESHER

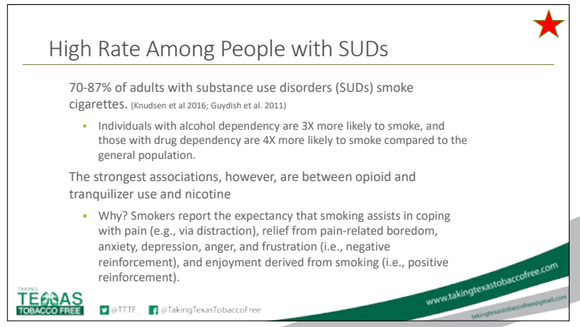








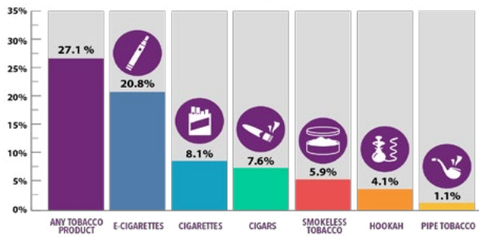




APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

Tobacco Products Use Among High School Students



Tobacco Product Use Among High School Students – 2018

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Individuals with Intellectual & Developmental Disabilities (IDD)

Limited Data on tobacco use and individuals with IDD

- Men are more likely than women to use tobacco
- Individuals with intellectual and developmental disabilities and comorbid substance use disorders have lifetime tobacco use estimates of 83%
- Individuals with mild to moderate intellectual disabilities have higher smoking rates than those with more severe intellectual disabilities
- Even though individuals with IDD are more likely to see a doctor- they are not likely to receiving tobacco screening or intervention
- An individuals living in group home settings and living independently generally smoke more (20%) than people living with family members/significant others/friends (3 – 5%)

High Rate of Smoking/Tobacco Use Among the Homeless

- Prevalence of smoking among homeless populations is between 60% and 80%
- Homeless adults spend a third of their monthly income on tobacco
- Homeless adults are targeted by the tobacco industry – nearby tobacco shops, discounted prices and low end tobacco products, free giveaways and samples at festival and events
- Homeless adults experience substance abuse and/or mental health concerns that can be exacerbated by heavy cigarette use
- Study done among clients from six homeless-serving agencies/shelters in Oklahoma City (N=396) indicated that rate of concurrent use of multiple tobacco products was high, at 67.2%.

Neisler et al., 2018

High Rate of Smoking/Tobacco Use Among Sexual Minorities

- Disproportionate Impact Among LGBT
  - 20.5% of LGB adults smoke cigarettes compared to 15.4% of heterosexual adults
  - 2013 National Health Interview Survey: Modified from: Ward, Dahlhamer, Galinsky, & Joestl

(%) Current Cigarette Smokers	Both Sexes	Men	Women
Gay or Lesbian	25.8	25.8	25.7
Straight	17.6	20.3	15
Bisexual	28.6	28.8	28.5

*Unsheet data for transwender adults

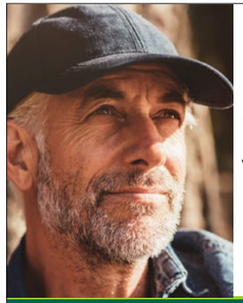
- Data from states is limited – only 6 states have published reports on tobacco use by sexual orientation
  - Arizona, California, Massachusetts, New Mexico, and Oregon/Washington (joint)

Source: CDC. Lesbian, Gay, Bisexual, and Transgender Persons Tobacco Use, 2018

Why Such High Smoking Rates?

- Due to lower income:
  - Lack access to health insurance, health care, and help to quit
  - Often directly targeted for tobacco marketing*
- Chronic stress and ineffective coping skills*
- Environmental exposure and peer groups
- Lack social support systems
- Widespread misconceptions and myths about dual tobacco and substance use
- Are at higher risk because of perceived benefits of tobacco use on stress and anxiety reduction (CDC. Vital Signs, Feb. 2013)

*Will discuss in more detail later



Why People Use Tobacco: Marketing

Tobacco Marketing in African American Communities

- Tobacco industry spent $8 BILLION on point-of-sale marketing in 2014.
- Menthol cigarettes specifically marketed to the African American community
  - The tobacco industry has targeted African American communities by using urban culture and language to promote menthol cigarettes, sponsoring hip-hop bar nights, and targeting direct-mail promotions.
  - A study of neighborhoods with high schools in California found that as the proportion of African American high school students rose, the proportion of menthol advertising increased, the odds of a Newport promotion were higher, and the cost of Newport cigarettes was lower.
  - A 2011 study of cigarette prices in retail stores across the U.S. found that Newport cigarettes, the top selling menthol cigarette brand in the U.S. and the most commonly used among African American youth, are significantly less expensive in neighborhoods with higher proportions of African Americans.

https://truthinitiative.org/sites/default/files/media/files/2019/03/Achieving%20Health%20Equity%20In%20Tobacco%20Control%20-%20Version%201.pdf

APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

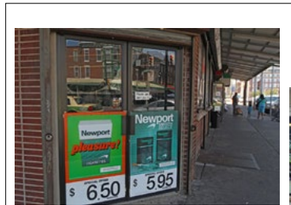
Tobacco Marketing in Various Populations

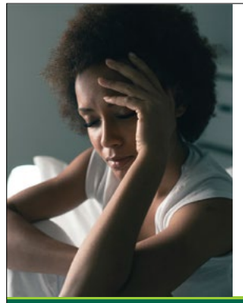
- In 1994, the Phillip Morris (under the brand name Merit) donated 7,000 blankets to homeless shelters in Brooklyn, in order to "generate media coverage."
- RJR directly targeted the homeless as part of an urban marketing plan in the 1990s, focused on the advertising of "value" brands to "street people."
- In 1995, one tobacco company developed a marketing plan aimed at homeless people and gays. They called it project SCUM: Sub Culture Urban Marketing
- Hispanic and Latino neighborhoods tend to have a high concentration of retail tobacco outlets and these neighborhoods have significantly more businesses selling tobacco products to underage consumers.

Tobacco Marketing in Sexual Minorities

The Tobacco Industry consistently and aggressively targets sexual minorities

- Normalizing Smoking
  - 30% of non-tobacco ads in LGBT publications feature tobacco use (American Lung Association)
  - Many LGBT leaders do not see tobacco as a priority health issue
- Bar and Club Culture
  - Historically, bars were safe places for the LGBT community
  - Some LGBT leaders believe that drinking and smoking are central to the coming out process
- Marketing: price discounts paid to retailers to reduce cigarette costs to LGBTQ and additional customers (FTC, 2016)
- Tobacco continues to be heavily advertised at Pride festivals and other LGBT community events





Why People Use Tobacco: Nicotine Addiction

We don't smoke that s_ _ _. We just sell it. We reserve the right to smoke for the young, the poor, the black and stupid."

R.J. Reynolds executive's reply when asked why he didn't smoke according to Dave Goerlitz, lead Winston model for seven years for R.J. Reynolds.] Giovanni, J, "Come to Cancer Country; USA; Focus," The Times of London, August 2, 1992.

Nicotine Addiction: The Cigarette: A Case Study

Components that make cigarettes so addictive:

- Increase in nicotine level
- Presence of ammonia or ammonia compounds => increase the speed in which nicotine is delivered to the brain

https://www.tobaccofreekids.org/assets/content/what_we_do/industry_watch/product_manipulation/2014_06_19_DesignedForAddiction_web.pdf

Understanding Nicotine Addiction

- Taking Texas Tobacco Free website: https://www.takingtexastobaccofree.com/addiction-videos
- Quitting, Brain chemistry-Mayo Clinic: https://www.youtube.com/watch?v=5ewwzazHfq4
- Mayo Clinic: https://www.youtube.com/watch?v=IpWMgPHn0Lo

APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

Benefits of Quitting

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Tobacco Use & Recovery

Quitting smoking does not jeopardize sobriety or treatment outcomes

- Smoking cessation interventions were associated with 25% increased likelihood of long-term alcohol and drug abstinence (Prochaska, 2004)
- In a recent review of quitting smoking programs on substance use, the majority of studies found:
  - For alcohol and other substances – decreased consumption, decreased relapse, and increased past year abstinence (McKelvey et al, 2017)
- Continued tobacco use can harm recovery and trigger other substance use (Williams, 2005; Kohut, 2017)

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Not Treating Tobacco Dependence has Negative Treatment Outcomes

Treatment Outcomes for Smokers
- Increased opioid withdrawal
- Increased cravings
- Lower detox completion/ Methadone taper

Clinicians mistakenly believe smoking has positive psychological functions
- Use smoking as an indirect coping strategy
- Reinforces coping through addiction
- Perceived stress reduction is often relief of withdrawal symptoms

Smoking cessation (i.e., being abstinent from cigarette use after a period of withdrawal) is positively related to opiate and cocaine abstinence (Shoptaw et al, 2002)

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Mental Health Improvements Associated with Quitting

- Quitting smoking is associated with significant decreases in anxiety, depression, and stress
- Increase in psychological quality of life and positive affect
- Associated improvements are greater than or equal to effect of antidepressants in depressive and anxiety disorders (Taylor et al., 2014)

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Long-term and short-term benefits to quitting smoking

After quitting for:

- **20 minutes** An individual's heart and blood pressure decrease.
- **12 hours** The body's carbon monoxide levels return to healthy levels.
- **2-3 weeks** Circulation and lung functionality improve.
- **1-9 months** Lungs continue to improve and heal, reducing coughing and shortness of breath.
- **1 year** The risk of coronary heart disease and heart attack is reduced.
- **5 years** The risk of mouth, throat, esophagus and bladder cancer are decreased by half. The risk of cervical cancer and stroke decline to that of a nonsmoker.
- **10 years** The risk of mortality from lung cancer is 50% less likely compared with a current smoker's risk. Pancreas and larynx cancer risks are also decreased.
- **15 years** The risk of coronary disease equates to that of a nonsmoker's.

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Empirically Supported Treatments for Tobacco Dependence

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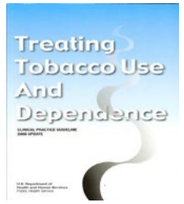
What Works to Helps People Quit?



- Tobacco-free Policies Workplaces/Campuses, paired with:
  - Behavioral Counseling
  - Medications

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CDC

Press Release

Embargoed Until 1:00 PM ET
Thursday, May 10, 2018

Contact: CDC Media Relations
(404) 639-3286

Half of mental health facilities and a third of substance abuse treatment facilities have smoke-free campuses

Opportunity to enhance tobacco cessation treatment in these settings

About half of mental health (49%) and a third of substance abuse treatment facilities (35%) reported having smoke-free campuses in the 50 states, Washington, D.C., and Puerto Rico, according to a new report from the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

People with mental and/or substance use disorders are more than twice as likely to smoke cigarettes as people without such conditions, and are more likely to die from a smoking-related illness than from a behavioral health condition. Yet, many individuals are not screened for tobacco use in behavioral health facilities. The study also found that in 2016, nearly 1 in 2 (49 percent) mental health treatment facilities and 2 in 3 (64 percent) substance abuse treatment facilities reported screening patients for tobacco use.

"Too many smokers lack access to proven interventions that could ultimately help them quit smoking," said Corinne Graffunder, Dr.P.H., director of CDC's Office on Smoking and Health. "Many people with mental health and substance abuse disorders want to stop smoking and are able to quit, and can do it with help."

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APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

***MMWR* Highlights**

Tobacco-related policies and practices in mental health treatment facilities, 2016

- 48.9% reported screening patients for tobacco use.
- 37.6% offered tobacco cessation counseling.
- 25.2% offered nicotine replacement therapy.
- 21.5% offered non-nicotine cessation medications.
- 48.6% had a smoke-free campus policy.

Tobacco-related policies and practices in substance abuse treatment facilities, 2016

- 64.0% reported screening patients for tobacco use.
- 47.4% offered tobacco cessation counseling.
- 26.2% offered nicotine replacement therapy.
- 20.3% offered non-nicotine cessation medications.
- 34.5% had a smoke-free campus policy.

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Barriers to Intervention

- Lack necessary knowledge and training about cessation treatments
- Reduced confidence in their abilities to deliver cessation treatments
- Persistent misconceptions and myths about the joint use of tobacco and other substances/mental illness and hinder recovery
- Fear that people will leave treatment
- Long standing permissive "culture of smoking"
- Clients report that "smoking helps with symptoms"
- Clients are under a lot of stress
- We don't want to "police" tobacco use

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Myths & Facts About Smoking Among People with SUD/Behavioral Health Conditions (BHC)

MYTHS:

- People with SUD/BHC:
  - do not want to quit smoking
  - are unable to quit smoking
  - will jeopardize their recovery by quitting smoking

FACTS:

- People with SUD/BHC:
  - are as motivated to quit as smokers without SUD/BHC
  - are able to quit, especially when offered proven treatments
  - who quit smoking have a lower risk of substance use relapse and decreased negative mental health symptoms

Source: CDC. Vital Signs, Feb. 2013; Prochaska et al, 2004; Taylor, 2014

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Benefits of a Tobacco Free Policy

- Significantly reduces exposure to secondhand smoke
- Behavioral health providers have high smoking rates (between 30% to 50%)
- Does not impact client's willingness to seek treatment
- Benefits clients, staff, stakeholders, and community
  - Increases quit attempts and decreases number of cigarettes smoked per day
  - Increases effectiveness of medications
  - Promotes abstinence from other substances, lowers relapse rates
  - Lowers health costs
  - Reduces sick days of former smokers and their families

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Engaging Tobacco Users on Tobacco-free Campus

- **Polite and Respectful**: Be empathetic & understanding
- **Listen to them:** Hear what they have to say
- **Educate:** Share information about the policy and why it is in place, inform them about cessation services, answer their questions
- **Be non-judgmental:** Don't make assumptions or criticize/blame people, be comfortable with yourself

https://www.takingtexastobaccofree.com/copy-of-videos

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Behavioral Counseling

* More about this in a minute

Brief Treatments
- Primary care model*

Intensive Treatments
- Sessions > 10 minutes
- More than 4 sessions
- Can be individual or group
- Led by tobacco treatment specialists, behavioral health and/or addictions specialists
- Focus: Problem solving, skills-training, stress management, relapse prevention, social skills training (change cognitions about smoking, reinforce non-smoking, avoid high-risk situations)

Quitline Referral
- Good for settings where counselor availability is limited; client should want to quit
- May offer 2 weeks of NRT

2008 PHS Guideline Update

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Common Areas of Concern during a Quit Attempt

Stress relief/stress management:
- People revert to old coping skills, especially in times of uncertainty, frustration, anger
- Continue to recognize challenges and develop new methods to handle situations
- Internalize smoking doesn't help situation – relate to alcohol/drug use
- Deep breathing and remove from situation – STOP. BREATHE. THINK.

Social status:
- Quitting smoking threatens social status/relationships
- Requires examining existing relationships and developing new relationships
- Development of assertiveness skills and refusal skills
- Change playmates, play places and playthings – which is very hard!

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Common Areas of Concern during a Quit Attempt

Weight gain/loss:
- People typically gain weight when they quit smoking (avg. 5 – 10 lbs.)
  - Nicotine suppresses appetite; quitting increase appetite a little bit
  - Smoking reduces sense of smell and taste; return when quit smoking, food tastes and smells better
  - Quitting increases desire for sugary/sweet foods; high calories in candy and junk foods
- Identify positive ways to manage calorie intake and deal with stress
  - Eating low calorie snacks fruit (apple, orange, banana) and vegetables (carrots, celery, broccoli) – pack into Ziplock bags – **great treat: low butter & salt popcorn**
  - Suck on low calorie, sugar-free candies – TicTacs, Jolly Ranchers, gum, suckers, etc.
  - MOVE – go for a short walk, move around house/apartment, burn calories and developing healthy coping skill
  - Portion control and seek alternatives – instead of eating 4 donuts, eat 1 donut and some fruit/vegetables
  - Brainstorm with client or within the group to identify what they think may work and what they are willing/able to do

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APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

Common Areas of Concern during a Quit Attempt

Support system:
- Utilize existing support systems to assist with quitting smoking
- AA and/or NA groups – may require finding a non-smoking sponsor if current sponsor smokes
- Heath department/community health services – seek assistance from doctors, nurses
- Mental health services – seek assistance from social worker, counselor or case manager
- Dentist – connecting with dental provider to help
- Veteran's administration – services to help quit
- Calling the Texas QuitLine

Others continue to smoke:
- Express goal to quit smoking and share how you hope to achieve it
- Negotiate parameters regarding smoking – no smoking in house or cars, no offering cigs, don't sabotage
  - Secondhand smoke is harmful and a strong trigger for relapse
- Don't expect others to quit because you are.

What Clients with SUD/BHC May Need

More introductory sessions
- 3 sessions prior to quit date

More total sessions
- Relapse prevention

Suggest moving this slide up after slide #10 – doesn't fit or flow well in 90 minute training

Treatment Modifications for Individuals with IDD

Intra-treatment support
- Enlist significant others (and treatment team if applicable) to express concerns about smoking and to listen to fears about quitting
- Identify roles for significant others to assist in efforts to quit if smoker were to make quit attempt

Practical counseling
- Be certain that any educational materials are understandable to client; use repetition to reinforce skills
- Clearly define terms such as *urge* or *craving* to smoke
- Be aware of length of counseling time smoker can tolerate
- Additional counseling sessions may be necessary
- Extra counseling sessions around "quit date"
- Allow time at end of counseling session to reinforce key concepts

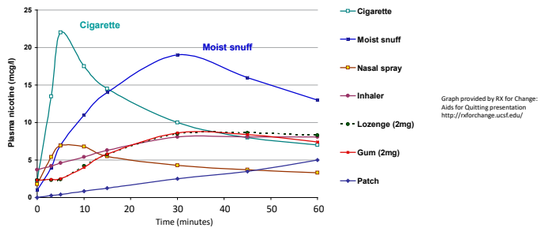
The 5 A's

ASK	about tobacco USE
ASSESS	READINESS to quit
ADVISE	consumer to QUIT
ASSIST	with QUIT ATTEMPT
ARRANGE	FOLLOW-UP care

Why Use Nicotine Replacement Therapy?

NRT
- Helps relieve physical withdrawal symptoms
- Addresses a person's physiological need
- Delivers lower levels of clean nicotine

Nicotine Concentrations for Nicotine Containing Products



Graph provided by RX for Change: Aids for Quitting presentation http://rxforchange.ucsf.edu/

How NRT Works

REPLACES harmful cigarettes

REDUCES dependence on nicotine

RETRAINS the smoker not to crave nicotine

Nicotine from NRT = Nicotine from Tobacco

The amount of nicotine a person receives from their NRT should equal or be a little more than the nicotine they were receiving from their tobacco.
- People inhale approximately 1 mg of nicotine with every cigarette (regardless of brand; cigarettes are pretty standardized)
- There are 20 cigarettes in a pack of cigarettes
  - Little cigars or cigarillos are similar to cigarettes but have different packaging standards – may be sold individually, in packages or 2, 3, or 5 little cigars) – they are likely flavored as well.
- Spit tobacco (chew, snus, snuff) have differing nicotine concentrations and people use the products in many different ways.

APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

Tobacco Treatment Medications

	Patches	Gum	Lozenge	Chantix (most effective)	Zyban/ Wellbutrin
Strength	21, 14, 7 mg	2, 4 mg		.5, 1 mg	150 mg
Dosing	1 patch/ 24 hrs	1 piece every 1-2 hours		• **Days 1-3:** .5 mg every morning • **Days 4 - 7:** .5 mg twice daily • **Day 8 - end:** 1 mg twice daily	**Days 1-3:** 150 mg once in AM **Day 4 – end:** 150 mg twice daily
Advantages	Private Once a day	Offset cravings Reduces dependence		High success rates	Also treats depression
Adverse Reactions	Skin reaction Sleep Disturbance	Jaw tired/sore Hiccups	Indigestion Hiccups Insomnia	Nausea Abnormal, strange or vivid dreams Depressed mood, agitation, changes in behavior, suicidal ideation	Dry mouth Insomnia Do not use w/ seizure disorder or eating disorder

Tobacco Treatment Medications- Prescription NRT

Nicotine Inhaler
- 10 mg cartridge – delivers 4 mg of nicotine per puff/inhale
- 6 – 10 cartridges per day – effectively delivering 24 – 40 mg of nicotine per day
- Easy to use and delivers good dose of nicotine
- Expensive and need a prescription

Tobacco Treatment Medications- Prescription NRT

Nicotine Nasal Spray
- 1 dose (a dose equal two sprays – one in each nostril) every 1 – 2 hours
- Each spray delivers approximately .5 mg of nicotine to nostril
- Initially use at least 8 doses/day (not to exceed 40 doses)
- Do not inhale, sniff or swallow spray through nose
- Expensive and need a prescription

Nicotine Replacement- Gum/Lozenges
- Gum - Chew and Park, repeat until can't feel tingle in gum (Chew & Park method)
  - Step 1: one piece of gum or lozenge every 1 - 2 hours for Week 1 - 4
  - Step 2: one piece of gum or lozenge every 2 – 4 hours for Week 4 - 8
  - Step 3: one piece of gum or lozenge every 4 – 8 hours for Week 8 - 12
- Chew gum (alternating different sides of mouth) for approximately 25 minutes.
- Mini lozenges will dissolve in mouth within approximately 10 – 12 minutes.
- Can use gum or lozenge based on craving need. Do not need to stick to a certain time schedule.
- Nicotine gum and lozenges work great in combination with the nicotine patches for high craving times.

Two Week Cost Comparison

Nicotine Replacement Therapy

Nicotine patches
- Nicoderm CQ = $41.99 ($82.00 per month)
- Generic brand = $27.49 ($54.98 per month)

Nicotine gum
- Nicorette – 100 pcs = $41.99 ($82.00 per month)
- Generic – 100 pcs = $25.99 ($51.98 per month)

Nicotine lozenges
- Nicorette – 81 pcs = $41.99 ($82.00 per month)
- Generic – 81 pcs = $23.99 ($48.00 per month)

Cigarettes (one pack per day)
- Marlboro (@ $5.76) x 14 days = $80.64
- Camel (@ $5.74) x 14 days = $80.36
- Newport (@ $6.99) x 14 days = $97.86
- Kool (@ $5.34) x 14 days = $74.46
- Pall Mall (@ $4.50) x 14 days = $63.00
- Virginia Slims (@ $6.58) x 14 days = $92.12
- American Spirit (@ $6.63) x 14 days = $92.82

NRT is available in smaller quantities
- 72 count 4 mg lozenges = $25.49
- 20 piece 2 mg gum (generic) = $6.99
- 20 piece 4 mg gum (Nicorette) = $9.99
- 10 piece 4 mg gum/lozenge (generic) = $5.49

Great alternative to purchasing a pack of cigarettes

Stepping Down with Nicotine Patches

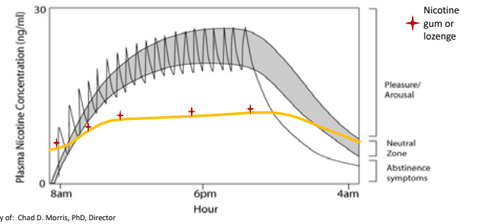
Step down instructions can be found on NRT box

If smoking more than 15 - 20 cigarettes per day…
- Step 1: one 21 mg patch per day for weeks 1 - 4
- Step 2: one 14 mg patch per day for weeks 4 - 8
- Step 3: one 7 mg patch per day for weeks 9-12

If smoking 10 or less cigarettes per day…
- Step 1: one 14 mg patch per day for weeks 1-4
- Step 2: one 7 mg patch per day for weeks 4-8

If a person is using multiple patches per day (example: smoke 30 cigarettes per day, they would use a 21 mg and a 14 mg patch (or a 21 mg patch plus nicotine gum or lozenges) each day. They would step down one patch at a time until they are only using one patch, then follow the above guidelines.

Pack a Day Smoker- 20 Cigarettes



Graphic courtesy of: Chad D. Morris, PhD, Director
Behavioral Health & Wellness Program University of Colorado Anschutz Medical Campus • School of Medicine

Medications for Tobacco Users - Summary

Medication Type	Availability
Nicotine Patch	Over the counter
Nicotine Gum	Over the counter
Nicotine Lozenge	Over the counter
Nicotine Inhaler	Prescription only
Nicotine Nasal Spray	Prescription only
Chantix / Varenicline	Prescription only
Zyban / Wellbutrin	Prescription only

APPENDIX B

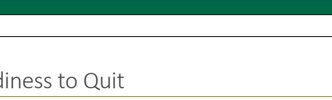
MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

Example of Procedures at a LMHA: Gulf Coast

1. **Each time** an individual is seen by a provider the individual will be assessed for current tobacco use, frequency of tobacco usage, and desire to quit.
2. Nursing staff or other designated staff will complete initial tobacco use screening and cessation intervention utilizing the Flow Sheet and record in SmartCare/EHR.
3. Designated staff will provide individuals with continual ongoing assessment for desire to quit as needed, both in and outside of the clinic setting.
4. If individual indicates they are currently using tobacco then Tobacco Use Intervention must be completed and documented in SmartCare/EHR.
5. Designated staff will provide clients with a quit card and, if appropriate, information on the text message program (https://smokefree.gov)

Example of Procedures at a LMHA: Gulf Coast

3. Designated staff will provide individuals with information on Nicotine Replacement Therapy (NRT) products available including, gum, patches or lozenges. If patches are chosen designated staff will use established Nicotine Replacement Therapy Protocols to determine dosage.
4. For individuals who express an interest in quitting and utilizing NRT, designated staff will complete a *GCC Client NRT Order Form*, indicating NRT choice and dosage. Client will take completed signed form to the medication room of their choice and present an ID to receive their NRT free of charge.



Example of Procedures at a LMHA: Gulf Coast

1. In order to receive the over the counter NRT, the client must meet with the designated staff and complete the tobacco assessment in SmartCare/EHR.
2. Individual will present NRT ORDER FORM at Medication Room which will indicate NRT formulation, strength and amount to be released to individual. Possession of NRT ORDER FORM confirms that individual has a completed tobacco assessment.
3. An initial two-week supply of NRT will be provided. If individual chooses to continue NRT, individual can present at the clinic medication room to obtain additional supplies as authorized utilizing established protocols.
4. The need for additional NRT supplies will be assessed by designated staff during scheduled appointments.
5. Individual can receive up to 12 weeks of NRT per calendar year as supplies permit.

Challenges of Psychotropic Medications & Tobacco Use

MEDICATIONS	TOBACCO
Lethargic	Boost energy
Weight gain	Appetite suppressant
Insomnia, lack of concentration	Help focus, improves concentration
Nervous/anxiety	Provides sense of relaxation/well-being

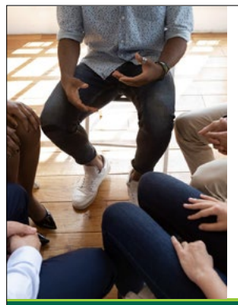
- Nicotine does provide some benefits to clients that may offset side effects from psychotropic medications.
- Nicotine replacement therapy can reduce anxiety attributed to nicotine withdrawal.
- Clients may use tobacco for the immediate relief of stress, but in the long-run, tobacco increases stress.
- This does not justify not helping clients quit tobacco.

The 5 R's

For tobacco users not ready to quit, clinicians should consider the 5 R's…

- **Relevance**
  Identify why it is personally relevant to get patient to quit.
- **Risks**
  Ask the patient to identify negative consequences of smoking.
- **Rewards**
  Ask the patient to identify the benefits of stopping.
- **Roadblocks**
  Identify the patient's barriers to success and how to approach them.
- **Repetition**
  Repeat motivational interventions.

…as well as Motivational Interviewing techniques to explore and resolve ambivalence to quit.



Motivational Interviewing Basics

Motivational Interviewing (MI)

Underlying Perspective of MI

- Partnership
  - Dancing, not wrestling
- Acceptance
  - Absolute worth, accurate empathy, affirmation, autonomy support
- Evocation
  - Assumes clients already have motivation and resources within
- Compassion
  - Pursuit of best interest for the client

Readiness to Quit

For most people attempting to quit tobacco, the process is cyclical

- May take years to move through process, retreating and moving forward
- Clinical staff play vital role in moving consumers along continuum by strongly advising to quit
- Relapse is common and should be viewed as learning experiences rather than failures

TOBACCO USERS DON'T PLAN TO FAIL. MOST FAIL TO PLAN.

APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

Developing Discrepancy

Recognize difference between present behavior and important personal goals or values. For example:

- Living completely drug-free lifestyle
- Save money for housing, new car, supplies for school, clothes for children
- Being positive role model for children

Client, not counselor, should present arguments for change

Sustain Talk vs. Change Talk

- Sustain talk decreases commitment and maintains status quo.
- Change talk increases commitment and moves client forward.

- Eliciting change talk
  - Use open-ended questions
  - Explore client goals, values and wants
  - Question extremes
  - Look forward not backward

Explore:
- **D**esire
- **A**bility
- **R**easons
- **N**eed

Recognize and Reinforce "Change Talk" and Readiness

When you hear clients say things that indicate they are ready to commit, activated toward change, or taking steps, become all **E.A.R.S.**

- Ask for Elaboration – Tell me more about that…
- Affirm (especially effort) – Quitting heroin was a big step and you are proud of that accomplishment.
- Reflect – Information on NRT is the next step for quitting smoking and you are ready for that.
- Summarize – Bill Miller (MI developer) says that summaries are like a change talk bouquet. You pick the flowers of change talk that you have heard the client say and present those back to the client in a bouquet that you have arranged for them that moves them in the direction of change.

Tools to get Change Talk

Decisional Balance & Importance-Confidence-Readiness (ICR) Rulers

Decisional Balance

- Enhances credibility and rapport
- Always start with the "not-so-good things"
- Explore with open-ended questions
- Offer summary statements of both sides
- End summary as a motivational tool

Decisional Balance Exercise

"Not so good things" about smoking	"Good Things" about smoking	Alternative way to get the "Good Things"

Importance Ruler

How ***important*** is it for you right now to quit smoking?

On a scale of 0 – 10, what number would you give yourself?

0 10
Not at all important — Extremely Important

Readiness Ruler

How ***ready*** are you to quit smoking right now?

On a scale of 0 – 10, what number would you give yourself?

0 10
Not at all ready — Extremely ready

Confidence Ruler

If you decide to quit smoking, how ***confident*** are you that you could quit smoking?

On a scale of 0 – 10, what number would you give yourself?

0 10
Not at all confident — Extremely confident

APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)

When using ICR Rulers

- Low number = sustain talk
- High number = change talk
- Solicit discussion by "moving people up" the ruler, rather than question why not a lower score.
  - Decreased discussion of the problem
  - Helps client envision/verbalize possible change
  - Encourages experimenting or hypothetical thinking
  - May solicit "change talk" and true desire for change

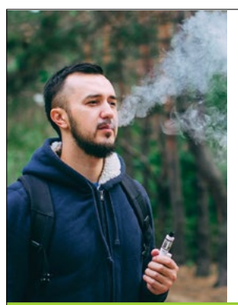
What's Next- Make a Plan

- "So, what's next?"; "Where do we go from here?"
- Offer menu of options, if client is unable to make a plan
  - Eliminates guessing and trying things
  - Allows client autonomy/choice
  - Start simple and not providing too many options
  - "Which option seems most possible?"
  - "Where's the best place to start?"
  - Recognize and acknowledge ambivalence and uncertainty

Recognize "Commitment Language" as a Sign to Move from MI to Cognitive-Behavioral Strategies

Commitment Language

- Friday is my quit day. I am never going to smoke again.
- I am looking for information on nicotine replacement therapy.
- I heard using a vape pen can help me quit. I am thinking about buying one.
- I need to quit smoking and intend to some day.
- My grandfather just had a heart attack and I think I should stop smoking.
- I just quit heroin and I think quitting smoking is too much for me to handle.



E-cigarettes and Electronic Nicotine Delivery Systems

Electronic Nicotine Delivery Systems (ENDS): To Vape or Not to Vape?

Evidence suggests ENDS are less harmful than traditional, combustible cigarettes, but not harmless

Research states:

- Presence of toxic substances (i.e., fine/ultrafine particles, cytotoxicity, various metals, TSNAs, and carbonyls), but lower levels than cigarettes
- Dual use of ENDS & combustible cigs common & is problematic
- Not effective method to quit smoking
- Long term health consequence of e-cigarette use unknown

Use of ENDS should be discouraged and not be used as a first line cessation method

*Shown to demonstrate approximate scale

1. Generic Combustible Tobacco Cigarette
2. First Generation E-Cigarette
3. Second Generation E-Cigarette
4. Third Generation E-Cigarette

National Academies of Sciences, Engineering and Medicine. 2018. *Public health consequences of e-cigarettes.* Washington, DC: The National Academies Press

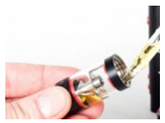
CA Cancer J Clin 2017;67:449-471. Key Issues Surrounding the Health Impacts of Electronic Nicotine Delivery Systems (ENDS) and Other Sources of Nicotine

Electronic Nicotine Delivery Systems (ENDS): To Vape or Not to Vape?

- As of November 20, 2019, 2,290 cases of e-cigarette, or vaping, product use associated lung injury (EVALI) have been reported to CDC from 49 states (all except Alaska), the District of Columbia, and 2 U.S. territories (Puerto Rico and U.S. Virgin Islands).
- Forty-seven deaths have been confirmed in 25 states and the District of Columbia.
- CDC recommends that people should not:
  - Use e-cigarette, or vaping, products that contain THC.
  - Buy any type of e-cigarette, or vaping, products, particularly those containing THC, from informal sources such as friends, family, or in-person or online dealers.
  - Modify or add any substances to e-cigarette, or vaping, products that are not intended by the manufacturer, these include but are not limited to vitamin E acetate and other cutting agents and additives products purchased through retail establishments.

1st Generation - Cigalike

2nd Generation- Tank System



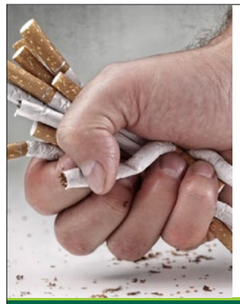
3rd Generation- Tank Systems (MODS)

New Generation- myBlue, Vuse, Alto, JUUL, Riptide

E-cigarettes and Treatment

- E-cigarettes are not an FDA approved method for smoking cessation – for this reason, they should not be recommended to help quit smoking.
- E-cigarettes contain much more nicotine than regular cigarettes – thus, they can make addiction worse.
- Treatments to smoking can also address e-cigarette addiction

Additional Resources



Resources

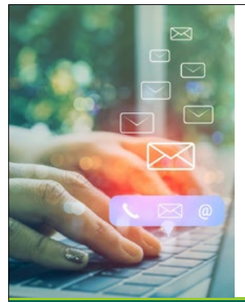
Clients:

- Quit Line 1-877-YES-QUIT
  - https://www.quitnow.net/mve/quitnow?anclient=texas (click on the **Refer A Patient** in the upper right-hand corner).
  - Download the Texas QuitLine app (refer clients to the QuitLine from phone):
  - https://www.uttobacco.org/our-programs/for-health-care-providers-and-emr-vendors
  - https://smokefree.gov/ (Text message quit programs for veterans, pregnant women, teenagers, Spanish-speaking people and older adults
- Nicotine Anonymous (support groups, online, phone)
- Non-smoking AA & NA meetings (majority are smoke-free)
- On site NRT

Resources

Employees:

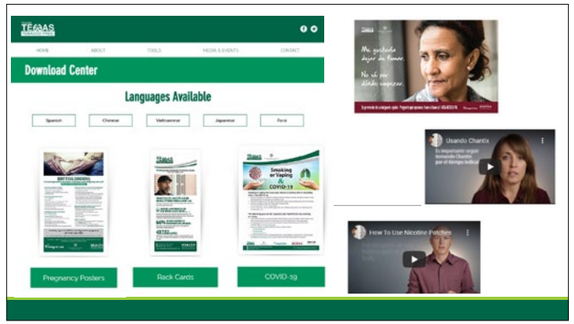
- EAP
- PCP co-pay and prescription reimbursement (spouses and eligible dependents included)
- Nicotine Anonymous, as well as non-smoking NA and AA groups
- On site NRT
- Quit Line 1-877-YES QUIT

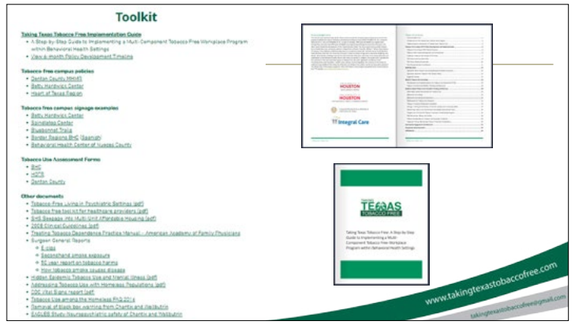


TTTF Website

APPENDIX B

MASTER TOBACCO EDUCATION REFRESHER (CONTINUED)





APPENDIX C

PROGRAM CHAMPION SELF-ASSESSMENT—BASELINE SURVEY

Program Champion Self-Assessment BASELINE

What is your name? _____

What center do you work for? _____

For how long have you been training/educating others (in years/months)?

Total = _____ years and _____months.

For how long have you been training/educating others in tobacco control specifically (in years/months)?

Total = _____ years and _____months.

Please rate your level of agreement with the following items:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I am a good public speaker.	1	2	3	4	5	N/A
I currently have the capacity to deliver trainings in tobacco control.	1	2	3	4	5	N/A
I have observed others conducting tobacco control trainings before.	1	2	3	4	5	N/A
I feel comfortable speaking in public and training others.	1	2	3	4	5	N/A
I feel anxious just considering idea of training others.	1	2	3	4	5	N/A
When conducting a training, I am afraid attendees will notice that I am nervous.	1	2	3	4	5	N/A
I have previously received feedback about my ability to conduct trainings.	1	2	3	4	5	N/A
I have received support and encouragement to engage in activities as a trainer/ health educator.	1	2	3	4	5	N/A
I feel confident about answering my colleagues' questions about tobacco control in the context of this training.	1	2	3	4	5	N/A

Items were developed by the TTTF research team for the purpose of this project.

	Poor	Fair	Good	Very Good	Excellent
Overall, how would you rate your capacity to conduct a training on tobacco control to members of your organization?	1	2	3	4	5

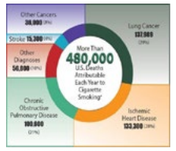
APPENDIX D

90-MINUTE EMPLOYEE TRAINING SLIDE DECK

Hazards of Smoking

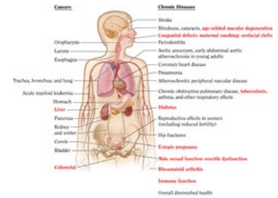
Smoking is the leading preventable cause of death and disability in the United States

- Smoking causes more than 480,000 deaths each year
- About 1 in 5 deaths is related to smoking
- Smoking and tobacco use cuts the lifespan of individuals who have a mental illness by up to 25 years



Source: The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014

Hazards of Smoking

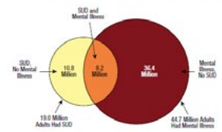


Smoking increases risk for:

- Cancers
- Heart disease
- Stroke
- COPD
- Diabetes complications

Co-occurring Substance Use + Mental Health Disorders

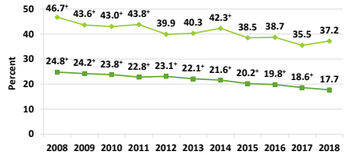
Figure 1. Past Year Substance Use Disorder (SUD) and Mental Illness among Adults Aged 18 or Older: Numbers in Millions, 2016



Graphic courtesy of: SAMHSA Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health, pg. 46.

- Individuals with a (non-nicotine) substance abuse or mental health disorder represent about 25% of the United States population but consume about 40% of all cigarettes sold to adults.
- 175 **billion** cigarettes sold/$39 billion annual profit

Current Smoking among Adults (age ≥ 18) with Past Year Serious Mental Illness (SMI): NSDUH, 2008-2018



Current Smoking is defined as any cigarette use in the 30 days prior to the interview date.
Serious Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder resulting in serious functional impairment, based on the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).
* Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

High Rate Among People with SUDs

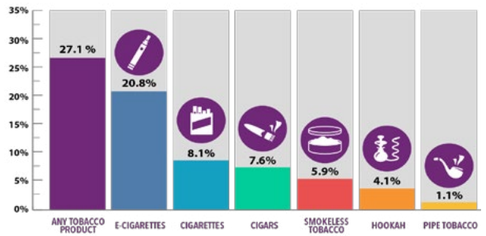
70-87% of adults with substance use disorders (SUDs) smoke cigarettes. (Knudsen et al 2016; Guydish et al. 2011)

- Individuals with alcohol dependency are 3X more likely to smoke, and those with drug dependency are 4X more likely to smoke compared to the general population.

The strongest associations, however, are between opioid and tranquilizer use and nicotine

- Why? Smokers report the expectancy that smoking assists in coping with pain (e.g., via distraction), relief from pain-related boredom, anxiety, depression, anger, and frustration (i.e., negative reinforcement), and enjoyment derived from smoking (i.e., positive reinforcement).

Tobacco Products Use Among High School Students



Tobacco Product Use Among High School Students – 2018

Individuals with Intellectual & Developmental Disabilities (IDD)

Limited Data on tobacco use and individuals with IDD

- Men are more likely than women to use tobacco
- Individuals with intellectual and developmental disabilities and comorbid substance use disorders have lifetime tobacco use estimates of 83%
- Individuals with mild to moderate intellectual disabilities have higher smoking rates than those with more severe intellectual disabilities
- Even though individuals with IDD are more likely to see a doctor- they are not likely to receiving tobacco screening or intervention
- An individuals living in group home settings and living independently generally smoke more (20%) than people living with family members/significant others/friends (3 – 5%)

Treatment Modifications for Individuals with IDD

Intra-treatment support

- Enlist significant others (and treatment team if applicable) to express concerns about smoking and to listen to fears about quitting
- Identify roles for significant others to assist in efforts to quit if smoker were to make quit attempt

Practical counseling

- Be certain that any educational materials are understandable to client; use repetition to reinforce skills
- Clearly define terms such as *urge* or *craving* to smoke
- Be aware of length of counseling time smoker can tolerate
- Additional counseling sessions may be necessary
- Extra counseling sessions around "quit date"
- Allow time at end of counseling session to reinforce key concepts

APPENDIX D

90-MINUTE EMPLOYEE TRAINING SLIDE DECK (CONTINUED)

High Rate of Smoking/Tobacco Use Among the Homeless

- Prevalence of smoking among homeless populations is between 60% and 80%
- Homeless adults spend a third of their monthly income on tobacco
- Homeless adults are targeted by the tobacco industry – nearby tobacco shops, discounted prices and low end tobacco products, free giveaways and samples at festival and events
- Homeless adults experience substance abuse and/or mental health concerns that can be exacerbated by heavy cigarette use
- Study done among clients from six homeless-serving agencies/shelters in Oklahoma City (N=396) indicated that rate of concurrent use of multiple tobacco products was high, at 67.2%.

Neisler et al., 2018

High Rate of Smoking/Tobacco Use Among Sexual Minorities

- Disproportionate Impact Among LGBT
  - 20.5% of LGB adults smoke cigarettes compared to 15.4% of heterosexual adults
  - 2013 National Health Interview Survey: Modified from: Ward, Dahlhamer, Galinsky, & Joestl

(%) Current Cigarette Smokers	Both Sexes	Men	Women
Gay or Lesbian	25.8	25.8	25.7
Straight	17.6	20.3	15
Bisexual	28.6	28.8	28.5

*Unreliable estimate data for transgender adults

  - Data from states is limited – only 6 states have published reports on tobacco use by sexual orientation
    - Arizona, California, Massachusetts, New Mexico, and Oregon/Washington (joint)

Source: CDC. Lesbian, Gay, Bisexual, and Transgender Persons Tobacco Use, 2018

Why Such High Smoking Rates?

- Due to lower income:
  - Lack access to health insurance, health care, and help to quit
  - Often directly targeted for tobacco marketing*
- Chronic stress and ineffective coping skills*
- Environmental exposure and peer groups
- Lack social support systems
- Widespread misconceptions and myths about dual tobacco and substance use
- Are at higher risk because of perceived benefits of tobacco use on stress and anxiety reduction (CDC. Vital Signs, Feb. 2013)

*Will discuss in more detail later

Myths & Facts About Smoking Among People with SUD/Behavioral Health Conditions (BHC)

MYTHS:

- People with SUD/BHC:
  - do not want to quit smoking
  - are unable to quit smoking
  - will jeopardize their recovery by quitting smoking

FACTS:

- People with SUD/BHC:
  - are as motivated to quit as smokers without SUD/BHC
  - are able to quit, especially when offered proven treatments
  - who quit smoking have a lower risk of substance use relapse and decreased negative mental health symptoms

Source: CDC. Vital Signs, Feb. 2013; Prochaska et al, 2004; Taylor, 2014

Benefits of Quitting

Tobacco Use & Recovery

Quitting smoking does not jeopardize sobriety or treatment outcomes

- Smoking cessation interventions were associated with 25% increased likelihood of long-term alcohol and drug abstinence (Prochaska, 2004)
- In a recent review of quitting smoking programs on substance use, the majority of studies found:
  - For alcohol and other substances – decreased consumption, decreased relapse, and increased past year abstinence (McKelvey et al, 2017)
  - Continued tobacco use can harm recovery and trigger other substance use (Williams, 2005; Kohut, 2017)

Not Treating Tobacco Dependence has Negative Treatment Outcomes

Treatment Outcomes for Smokers

- Increased opioid withdrawal
- Increased cravings
- Lower detox completion/ Methadone taper

Clinicians mistakenly believe smoking has positive psychological functions

- Use smoking as an indirect coping strategy
- Reinforces coping through addiction
- Perceived stress reduction is often relief of withdrawal symptoms

Smoking cessation (i.e., being abstinent from cigarette use after a period of withdrawal) is positively related to opiate and cocaine abstinence (Shoptaw et al, 2002)

Mental Health Improvements Associated with Quitting

- Quitting smoking is associated with significant decreases in anxiety, depression, and stress
- Increase in psychological quality of life and positive affect
- Associated improvements are greater than or equal to effect of antidepressants in depressive and anxiety disorders (Taylor et al., 2014)

APPENDIX D

90-MINUTE EMPLOYEE TRAINING SLIDE DECK (CONTINUED)

Barriers to Intervention

- Lack necessary knowledge and training about cessation treatments
- Reduced confidence in their abilities to deliver cessation treatments
- Persistent misconceptions and myths about the joint use of tobacco and other substances/mental illness and hinder recovery
- Fear that people will leave treatment
- Long standing permissive "culture of smoking"
- Clients report that "smoking helps with symptoms"
- Clients are under a lot of stress
- We don't want to "police" tobacco use

The 5 A's

ASK	⇨	about tobacco USE
ASSESS	⇨	READINESS to quit
ADVISE	⇨	consumer to QUIT
ASSIST	⇨	with QUIT ATTEMPT
ARRANGE	⇨	FOLLOW-UP care

Why Use Nicotine Replacement Therapy?

NRT

- Helps relieve physical withdrawal symptoms
- Addresses a person's physiological need
- Delivers lower levels of clean nicotine

Nicotine from NRT = Nicotine from Tobacco

The amount of nicotine a person receives from their NRT should equal or be a little more than the nicotine they were receiving from their tobacco.

- People inhale approximately 1 mg of nicotine with every cigarette (regardless of brand; cigarettes are pretty standardized)
- There are 20 cigarettes in a pack of cigarettes
  - Little cigars or cigarillos are similar to cigarettes but have different packaging standards – may be sold individually, in packages or 2, 3, or 5 little cigars) – they are likely flavored as well.
- Spit tobacco (chew, snus, snuff) have differing nicotine concentrations and people use the products in many different ways.

Tobacco Treatment Medications

	Patches	Gum	Lozenge	Chantix (most effective)	Zyban/ Wellbutrin
Strength	21, 14, 7 mg	2, 4 mg		.5, 1 mg	150 mg
Dosing	1 patch/ 24 hrs	1 piece every 1-2 hours		• **Days 1-3:** .5 mg every morning • **Days 4 - 7:** .5 mg twice daily • **Day 8 - end:** 1 mg twice daily	**Days 1-3:** 150 mg once in AM **Day 4 – end:** 150 mg twice daily
Advantages	Private Once a day	Offset cravings Reduces dependence		High success rates	Also treats depression
Adverse Reactions	Skin reaction Sleep Disturbance	Jaw tired/sore Hiccups	Indigestion Hiccups Insomnia	Nausea Abnormal, strange or vivid dreams Depressed mood, agitation, changes in behavior, suicidal ideation	Dry mouth Insomnia Do not use w/ seizure disorder or eating disorder

Two Week Cost Comparison

Nicotine Replacement Therapy

Nicotine patches
- Nicoderm CQ = $41.99 ($82.00 per month)
- Generic brand = $27.49 ($54.98 per month)

Nicotine gum
- Nicorette – 100 pcs = $41.99 ($82.00 per month)
- Generic – 100 pcs = $25.99 ($51.98 per month)

Nicotine lozenges
- Nicorette – 81 pcs = $41.99 ($82.00 per month)
- Generic – 81 pcs = $23.99 ($48.00 per month)

NRT is available in smaller quantities
- 72 count 4 mg lozenges = $25.49
- 20 piece 2 mg gum (generic) = $6.99
- 20 piece 4 mg gum (Nicorette) = $9.99
- 10 piece 4 mg gum/lozenge (generic) = $5.49

Cigarettes (one pack per day)
- Marlboro (@ $5.76) x 14 days = $80.64
- Camel (@ $5.74) x 14 days = $80.36
- Newport (@ $6.99) x 14 days = $97.86
- Kool (@ $5.34) x 14 days = $74.46
- Pall Mall (@ $4.50) x 14 days = $63.00
- Virginia Slims (@ $6.58) x 14 days = $92.12
- American Spirit (@ $6.63) x 14 days = $92.82

Great alternative to purchasing a pack of cigarettes

Medications for Tobacco Users - Summary

Medication Type	Availability
Nicotine Patch	Over the counter
Nicotine Gum	Over the counter
Nicotine Lozenge	Over the counter
Nicotine Inhaler	Prescription only
Nicotine Nasal Spray	Prescription only
Chantix / Varenicline	Prescription only
Zyban / Wellbutrin	Prescription only

Challenges of Psychotropic Medications & Tobacco Use

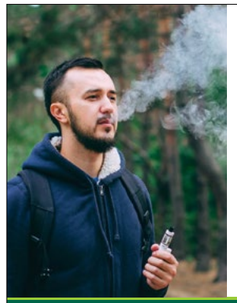
MEDICATIONS
- Lethargic
- Weight gain
- Insomnia, lack of concentration
- Nervous/anxiety

TOBACCO
- Boost energy
- Appetite suppressant
- Help focus, improves concentration
- Provides sense of relaxation/well-being

- Nicotine does provide some benefits to clients that may offset side effects from psychotropic medications.
- Nicotine replacement therapy can reduce anxiety attributed to nicotine withdrawal.
- Clients may use tobacco for the immediate relief of stress, but in the long-run, tobacco increases stress.
- This does not justify not helping clients quit tobacco.

APPENDIX D

90-MINUTE EMPLOYEE TRAINING SLIDE DECK (CONTINUED)



E-cigarettes and Electronic Nicotine Delivery Systems

Electronic Nicotine Delivery Systems (ENDS): To Vape or Not to Vape?

Evidence suggests ENDS are less harmful than traditional, combustible cigarettes, but not harmless

Research states:
- Presence of toxic substances (ie, fine/ultrafine particles, cytotoxicity, various metals, TSNAs, and carbonyls), but lower levels than cigarettes
- Dual use of ENDS & combustible cigs common & is problematic
- Not effective method to quit smoking
- Long term health consequence of e-cigarette use unknown

Use of ENDS should be discouraged and not be used as a first line cessation method

*Shown to demonstrate approximate scale

a. Generic Combustible Tobacco Cigarette
b. First Generation E-Cigarette
c. Second Generation E-Cigarette
d. Third Generation E-Cigarette

National Academies of Sciences, Engineering and Medicine. 2018. *Public health consequences of e-cigarettes.* Washington, DC: The National Academies Press.

CA Cancer J Clin 2017;67:449-471. Key Issues Surrounding the Health Impacts of Electronic Nicotine Delivery Systems (ENDS) and Other Sources of Nicotine

Benefits of a Tobacco Free Policy

- Significantly reduces exposure to secondhand smoke
- Behavioral health providers have high smoking rates (between 30% to 50%)
- Does not impact client's willingness to seek treatment
- Benefits clients, staff, stakeholders, and community
  - Increases quit attempts and decreases number of cigarettes smoked per day
  - Increases effectiveness of medications
  - Promotes abstinence from other substances, lowers relapse rates
  - Lowers health costs
  - Reduces sick days of former smokers and their families

Engaging Tobacco Users on Tobacco-free Campus

- **Polite and Respectful**: Be empathetic & understanding
- **Listen to them:** Hear what they have to say
- **Educate:** Share information about the policy and why it is in place, inform them about cessation services, answer their questions
- **Be non-judgmental:** Don't make assumptions or criticize/blame people, be comfortable with yourself

https://www.takingtexastobaccofree.com/copy-of-videos

Resources

Clients:
- Quit Line 1-877-YES-QUIT
  - https://www.quitnow.net/mve/quitnow?qnclient=texas (click on the **Refer A Patient** in the upper right-hand corner).
  - Download the Texas QuitLine app (refer clients to the QuitLine from phone):
  - https://www.uttobacco.org/our-programs/for-health-care-providers-and-emr-vendors
  - https://smokefree.gov/ (Text message quit programs for veterans, pregnant women, teenagers, Spanish-speaking people and older adults
- Nicotine Anonymous (support groups, online, phone)
- Non-smoking AA & NA meetings (majority are smoke-free)
- On site NRT

Resources

Employees:
- EAP
- PCP co-pay and prescription reimbursement (spouses and eligible dependents included)
- Nicotine Anonymous, as well as non-smoking NA and AA groups
- On site NRT
- Quit Line 1-877-YES QUIT

APPENDIX E

PRESENTATION/TEACHING TIPS

What does your audience need to know and want to know?

Have clear objectives and let those guide the direction of the presentation. People want to know why this information is important and what they will be learning.

Be conversational in your approach

Think of your presentation as a discussion with your coworkers. Make eye contact with people as you make your points throughout your talk. You will feel less like you are on stage and it will help you to be conversational in your approach.

Passion for the subject draws the listeners in

You are the champion of the ideas you are presenting. Your enthusiasm for the topic and your energy around the event may be contagious in the best way.

Tell Stories

If you have stories to highlight some of the information you are giving, a story associates that information to the story which raises its importance and makes it easier to remember. Overall, your presentation should be one big story on the topic you are presenting.

Ask Questions

Get the audience involved by asking open-ended questions. Ask what they may already know about a topic you are about to talk about. Ask how this could apply in their specific work setting.

Use Experiential Learning

Small group discussion or role-playing a new skill is a great way to get people involved. Breakouts for experiential learning are a great way to keep learners engaged throughout a presentation.

Use Visual Aids

Visual aids help people retain information and can anchor a point you want to make. Be selective and make sure it is relevant.

Stop for Q & A

Make sure that you take time throughout any training or presentation to stop periodically to check for understanding and discussion of concepts. Some may not feel comfortable asking questions in an interactive way, so it is good to stop and check for comprehension and engagement.

Avoid too much text if using slides

I know, we have so much to say and they have so much to learn! Keep it simple. Slides that are jammed with too many words are less likely to be read. Likewise, if we use font that is too small, we are likely to put too many words on the slide. A picture every now and then breaks up too many words. Remember, you are the expert. Everything you know doesn't have to be on the slide.

Relax and don't forget to smile!

You would be surprised how many people forget to look happy to be presenting. Of course, presenting or teaching can induce nerves. Don't forget that you know more about your presentation than they do.

For more information, see:

https://www.skillsyouneed.com/present/presentation-tips.html

https://www.participoll.com/powerpoint-presentation-tips

APPENDIX F

OBSERVER RATING OF PRACTICE INSTRUCTION FEEDBACK FORM

TTTF Observer/Coach: Complete for Actual Training Observation with Agency Attendees

Program Champion Name:

Date:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
The trainer was knowledgeable about the subject matter.	1	2	3	4	5	N/A
The trainer appeared confident and comfortable with the material.	1	2	3	4	5	N/A
The trainer's ability to explain was excellent.	1	2	3	4	5	N/A
The trainer seemed well prepared for the training.	1	2	3	4	5	N/A
Concrete examples and illustrations were used to clarify the material.	1	2	3	4	5	N/A
The trainer promoted an atmosphere conducive to work and learning.	1	2	3	4	5	N/A
The rate of delivery of material was appropriate.	1	2	3	4	5	N/A
The training was engaging.	1	2	3	4	5	N/A
The trainer listened thoughtfully to attendees' comments and demonstrated empathy and respect.	1	2	3	4	5	N/A
The trainer's eye contact was appropriate.	1	2	3	4	5	N/A
Technology was used without difficulty.	1	2	3	4	5	N/A
Visual training content could be easily read.	1	2	3	4	5	N/A
The trainer's articulation and voice level was clear.	1	2	3	4	5	N/A
The trainer handled attendee questions well.	1	2	3	4	5	N/A
Overall, there was an absence of verbalized pauses (such as er, ah, um).	1	2	3	4	5	N/A

Most items are selected and adapted from C. Roland Christensen, the Center for Teaching and Learning, Harvard Business School (2005, from a peer observation scale used at the University of Minnesota and from items used at the University of Albany

	Poor	Fair	Good	Very Good	Excellent
Overall, how would you rate the delivery of the training curriculum by the trainer to setting stakeholders?	1	2	3	4	5
Overall, how would you rate the effectiveness of the trainer as a teacher?	1	2	3	4	5

Please provide any comments that would help to clarify your above ratings.

Cancer Prevention & Research
Integral Care
University of Houston
Health Research Institute

APPENDIX G

EMPLOYEE ATTENDEES' TOBACCO EDUCATION TRAINING PRE-TEST

TAKING TEXAS TOBACCO FREE
@TTTF_ @TakingTexasTobaccoFree
www.takingtexastobaccofree.com

THE CANCER PREVENTION & RESEARCH INSTITUTE
OF TEXAS IN COLLABORATION WITH THE
UNIVERSITY OF HOUSTON AND INTEGRAL CARE

CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS

Tobacco Dependence Treatment & Education Training Pre/Post Test

PRE TEST

1. Smoking causes approximately _____ deaths a year in the United States.
   A. 240,000 B. 480,000 C. 640,000 D. 840,000

2. Which of these tobacco treatment medications requires a prescription?
   A. Nicotine patch
   B. Nicotine inhaler
   C. Nicotine lozenge
   D. Nicotine gum
   E. All the above

3. Individuals with a (non-nicotine) substance abuse or mental health disorder represent about 25% of the United States population but consume about 40% of all cigarettes sold to adults.
   A. True B. False

4. Smoking cessation interventions were associated with ____ increased likelihood of long-term alcohol and drug abstinence following substance abuse treatment.
   A. 15% B. 20% C. 25% D. 30%

5. Which of the following is NOT one of the "Five A's" of tobacco cessation brief intervention.
   A. Ask B. Arrange C. Assess D. Allow

6. What strength of nicotine patch should be used for a person who is smoking a pack of cigarettes per day?
   A. 28 mg B. 21 mg C. 14 mg D. 7 mg

7. Behavioral health treatment center employees have a _____ smoking rate than the national average.
   A. lower B. higher C. same as

8. Which of the following tobacco treatment medications is the most effective in helping a person quit smoking?
   A. Chantix B. Wellbutrin C. Nicotine gum D. Nicotine nasal spray

9. Behavioral health treatment professionals are reluctant to address tobacco use due to:
   A. lack of training on how to address tobacco use
   B. believing it will negatively impact a person's recovery
   C. believing quitting smoking is impossible for people getting clean and sober
   D. believing people will withdraw from treatment
   E. all of the above

10. Tobacco-free campus/workplace policies will lead to premature withdrawal from behavioral health treatment programs at significant levels.
    A. True B. False

11. Please check your position:
    A. Provider (provide direct counseling services to clients) B. General Staff

APPENDIX H

SAMPLE CERTIFICATE FOR EMPLOYEE ATTENDEES

APPENDIX I

DRUG INTERACTIONS WITH TOBACCO SMOKE

DRUG INTERACTIONS WITH TOBACCO SMOKE

Many interactions between tobacco smoke and medications have been identified. Note that in most cases it is the tobacco smoke—not the nicotine—that causes these drug interactions. Tobacco smoke interacts with medications through pharmacokinetic (PK) and pharmacodynamic (PD) mechanisms. PK interactions affect the absorption, distribution, metabolism, or elimination of other drugs, potentially causing an altered pharmacologic response. The majority of PK interactions with smoking are the result of induction of hepatic cytochrome P450 enzymes (primarily CYP1A2). PD interactions alter the expected response or actions of other drugs. The amount of tobacco smoking needed to have an effect has not been established, and the assumption is that any smoker is susceptible to the same degree of interaction. The most clinically significant interactions are depicted in the shaded rows.

DRUG/CLASS	MECHANISM OF INTERACTION AND EFFECTS
Pharmacokinetic Interactions	
Alprazolam (Xanax)	▪ Conflicting data on significance, but possible ↓ plasma concentrations (up to 50%); ↓ half life (35%).
Bendamustine (Treanda)	▪ Metabolized by CYP1A2. Manufacturer recommends using with caution in smokers due to likely ↓ bendamustine concentrations, with ↑ concentrations of its two active metabolites.
Caffeine	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (56%). Caffeine levels likely ↑ after cessation.
Chlorpromazine (Thorazine)	▪ ↓ Area under the curve (AUC) (36%) and serum concentrations (24%). ▪ ↓ Sedation and hypotension possible in smokers; smokers may require ↑ dosages.
Clopidogrel (Plavix)	▪ ↑ Metabolism (induction of CYP1A2) of clopidogrel to its active metabolite. ▪ Clopidogrel's effects are enhanced in smokers (≥10 cigarettes/day): significant ↑ platelet inhibition, ↓ platelet aggregation; while improved clinical outcomes have been shown, may also ↑ risk of bleeding
Clozapine (Clozaril)	▪ ↑ Metabolism (induction of CYP1A2); ↓ plasma concentrations (18%). ▪ ↑ Levels upon cessation may occur; closely monitor drug levels and reduce dose as required to avoid toxicity
Erlotinib (Tarceva)	▪ ↑ Clearance (24%); ↓ trough serum concentrations (2-fold)
Flecainide (Tambocor)	▪ ↑ Clearance (61%); ↓ trough serum concentrations (25%). Smokers may need ↑ dosages.
Fluvoxamine (Luvox)	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (24%); ↓ AUC (31%); ↓ plasma concentrations (32%). ▪ Dosage modifications not routinely recommended but smokers may need ↑ dosages.
Haloperidol (Haldol)	▪ ↑ Clearance (44%); ↓ serum concentrations (70%).
Heparin	▪ Mechanism unknown but ↑ clearance and ↓ half-life are observed. Smoking has prothrombotic effects. ▪ Smokers may need ↑ dosages due to PK and PD interactions.
Insulin, subcutaneous	▪ Possible ↓ insulin absorption secondary to peripheral vasoconstriction; smoking may cause release of endogenous substances that cause insulin resistance. ▪ PK & PD interactions likely not clinically significant, smokers may need ↑ dosages.
Irinotecan (Camptosar)	▪ ↑ Clearance (18%), ↓ serum concentrations of active metabolite, SN-38 (~40%, via induction of glucuronidation); ↓ systemic exposure resulting in lower hematologic toxicity and may reduce efficacy. ▪ Smokers may need ↑ dosages
Mexiletine (Mexitil)	▪ ↑ Clearance (25%; via oxidation and glucuronidation); ↓ half-life (36%).
Olanzapine (Zyprexa)	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (98%); ↓ serum concentrations (12%). ▪ Dosage modifications not routinely recommended but smokers may need ↑ dosages.
Propranolol (Inderal)	▪ ↑ Clearance (77%; via side-chain oxidation and glucuronidation).
Ropinirole (Requip)	▪ ↓ Cmax (30%) and AUC (38%) in study with patients with restless legs syndrome. ▪ Smokers may need ↑ dosages.
Tacrine (Cognex)	▪ ↑ Metabolism (induction of CYP1A2), ↓ half-life (50%), serum concentrations 3-fold lower. ▪ Smokers may need ↑ dosages.
Theophylline (Theo Dur, etc.)	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (58–100%); ↓ half life (63%). ▪ Levels should be monitored if smoking is initiated, discontinued, or changed. Maintenance doses are considerably higher in smokers. ▪ ↑ Clearance with second-hand smoke exposure.
Tricyclic antidepressants (e.g., imipramine, nortriptyline)	▪ Possible interaction with tricyclic antidepressants in the direction of ↓ blood levels, but the clinical significance is not established.
Tizanidine (Zanaflex)	▪ ↓ AUC (30-40%) and ↓ half-life (10%) observed in male smokers.
Warfarin	▪ ↑ Metabolism (induction of CYP1A2) of R enantiomer; however, S enantiomer is more potent and effect on INR is inconclusive. Consider monitoring INR upon smoking cessation.
Pharmacodynamic Interactions	
Benzodiazepines (diazepam, chlordiazepoxide)	▪ ↓ Sedation and drowsiness, possibly caused by nicotine stimulation of central nervous system
Beta blockers	▪ Less effective antihypertensive and heart rate control effects; possibly caused by nicotine-mediated sympathetic activation. ▪ Smokers may need ↑ dosages.
Corticosteroids, inhaled	▪ Smokers with asthma may have less of a response to inhaled corticosteroids.
Hormonal contraceptives	▪ ↑ Risk of cardiovascular adverse effects (e.g., stroke, myocardial infarction, thromboembolism) in women who smoke and use oral contraceptives. Ortho Evra patch users shown to have 2-fold ↑risk of venous thromboembolism compared to oral contraceptive users, likely due to ↑ estrogen exposure (60% higher levels). ▪ ↑ Risk with age and with heavy smoking (≥15 cigarettes per day) and is quite marked in women ≥35 years old.
Opioids (propoxyphene, pentazocine)	▪ ↓ Analgesic effect; smoking may ↑ the metabolism of propoxyphene (15–20%) and pentazocine (40%). Mechanism unknown. ▪ Smokers may need ↑ opioid dosages for pain relief.

Adapted and updated, from Zevin S, Benowitz NL. Drug interactions with tobacco smoking. *Clin Pharmacokinet* 1999;36:425–438.

APPENDIX J

PHARMACOLOGIC PRODUCT GUIDE

PHARMACOLOGIC PRODUCT GUIDE: FDA-APPROVED MEDICATIONS FOR SMOKING CESSATION

	NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS					BUPROPION SR	VARENICLINE
	GUM	LOZENGE	TRANSDERMAL PATCH	NASAL SPRAY	ORAL INHALER		
PRODUCT	**Nicorette[1], ZONNIC[2], Generic** OTC 2 mg, 4 mg original, cinnamon, fruit, mint	**Nicorette Lozenge,[1] Nicorette Mini Lozenge,[1] Generic** OTC 2 mg, 4 mg; cherry, mint	**NicoDerm CQ[1], Generic** OTC (NicoDerm CQ, generic) Rx (generic) 7 mg, 14 mg, 21 mg (24-hr release)	**Nicotrol NS[3]** Rx Metered spray 10 mg/mL aqueous solution	**Nicotrol Inhaler[3]** Rx 10 mg cartridge delivers 4 mg inhaled vapor	**Zyban[1], Generic** Rx 150 mg sustained-release tablet	**Chantix[3]** Rx 0.5 mg, 1 mg tablet
PRECAUTIONS	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Temporomandibular joint disease ▪ Pregnancy[4] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[4] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[4] (Rx formulations, category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ▪ Severe reactive airway disease ▪ Pregnancy[4] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Bronchospastic disease ▪ Pregnancy[4] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Concomitant therapy with medications/conditions known to lower the seizure threshold ▪ Hepatic impairment ▪ Pregnancy[4] (category C) and breastfeeding ▪ Adolescents (<18 years) ▪ Treatment-emergent neuropsychiatric symptoms[5]: BOXED WARNING REMOVED 12/2016 **Contraindications:** ▪ Seizure disorder ▪ Concomitant bupropion (e.g., Wellbutrin) therapy ▪ Current or prior diagnosis of bulimia or anorexia nervosa ▪ Simultaneous abrupt discontinuation of alcohol or sedatives/benzodiazepines ▪ MAO inhibitors in preceding 14 days; concurrent use of reversible MAO inhibitors	▪ Severe renal impairment (dosage adjustment is necessary) ▪ Pregnancy[4] (category C) and breastfeeding ▪ Adolescents (<18 years) ▪ Treatment-emergent neuropsychiatric symptoms[5]: BOXED WARNING REMOVED 12/2016
DOSING	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 piece q 1–2 hours Weeks 7–9: 1 piece q 2–4 hours Weeks 10–12: 1 piece q 4–8 hours ▪ Maximum, 24 pieces/day ▪ Chew each piece slowly ▪ Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) ▪ Resume chewing when tingle fades ▪ Repeat chew/park steps until most of the nicotine is gone (tingle does not return; generally 30 min) ▪ Park in different areas of mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 lozenge q 1–2 hours Weeks 7–9: 1 lozenge q 2–4 hours Weeks 10–12: 1 lozenge q 4–8 hours ▪ Maximum, 20 lozenges/day ▪ Allow to dissolve slowly (20–30 minutes for standard; 10 minutes for mini) ▪ Nicotine release may cause a warm, tingling sensation ▪ Do not chew or swallow ▪ Occasionally rotate to different areas of the mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	*>10 cigarettes/day:* 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks *≤10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ▪ Rotate patch application site daily; do not apply a new patch to the same skin site for at least one week ▪ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ▪ Duration: 8–10 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in **each** nostril), each spray delivers 0.5 mg of nicotine to the nasal mucosa ▪ Maximum – 5 doses/hour or – 40 doses/day ▪ For best results, initially use at least 8 doses/day ▪ Do not sniff, swallow, or inhale through the nose as the spray is being administered ▪ Duration: 3–6 months	6–16 cartridges/day Individualize dosing; initially use 1 cartridge q 1–2 hours ▪ Best effects with continuous puffing for 20 minutes ▪ Initially use at least 6 cartridges/day ▪ Nicotine in cartridge is depleted after 20 minutes of active puffing ▪ Inhale into back of throat or puff in short breaths ▪ Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe ▪ Open cartridge retains potency for 24 hours ▪ No food or beverages 15 minutes before or during use ▪ Duration: 3–6 months	150 mg po q AM x 3 days, then 150 mg po bid ▪ Do not exceed 300 mg/day ▪ Begin therapy 1–2 weeks **prior** to quit date ▪ Allow at least 8 hours between doses ▪ Avoid bedtime dosing to minimize insomnia ▪ Dose tapering is not necessary ▪ Duration: 7–12 weeks, with maintenance up to 6 months in selected patients	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid ▪ Begin therapy 1 week **prior** to quit date ▪ Take dose after eating and with a full glass of water ▪ Dose tapering is not necessary ▪ Dosing adjustment is necessary for patients with severe renal impairment ▪ Duration: 12 weeks; an additional 12-week course may be used in selected patients ▪ May initiate up to 35 days before target quit date OR may reduce smoking over a 12-week period of treatment prior to quitting and continue treatment for an additional 12 weeks

APPENDIX J

PHARMACOLOGIC PRODUCT GUIDE (CONTINUED)

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Adverse Effects	▪ Mouth/jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Effects associated with incorrect chewing technique: – Lightheadedness – Nausea/vomiting – Throat and mouth irritation	▪ Mouth irritation ▪ Nausea ▪ Hiccups ▪ Heartburn ▪ Headache ▪ Sore throat ▪ Dizziness	▪ Local skin reactions (erythema, pruritus, burning) ▪ Headache ▪ Sleep disturbances (insomnia, abnormal/vivid dreams); associated with nocturnal nicotine absorption	▪ Nasal and/or throat irritation (hot, peppery, or burning sensation) ▪ Rhinitis ▪ Tearing ▪ Sneezing ▪ Cough ▪ Headache	▪ Mouth and/or throat irritation ▪ Cough ▪ Headache ▪ Rhinitis ▪ Dyspepsia ▪ Hiccups	▪ Insomnia ▪ Dry mouth ▪ Nervousness/difficulty concentrating ▪ Nausea ▪ Dizziness ▪ Constipation ▪ Rash ▪ Seizures (risk is 0.1%) ▪ Neuropsychiatric symptoms (rare; see Precautions)	▪ Nausea ▪ Sleep disturbances (insomnia, abnormal/vivid dreams) ▪ Constipation ▪ Flatulence ▪ Vomiting ▪ Neuropsychiatric symptoms (rare; see Precautions)
Advantages	▪ Might serve as an oral substitute for tobacco ▪ Might delay weight gain ▪ Can be titrated to manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Might serve as an oral substitute for tobacco ▪ Might delay weight gain ▪ Can be titrated to manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Once-daily dosing associated with fewer adherence problems ▪ Of all NRT products, its use is least obvious to others ▪ Can be used in combination with other agents; delivers consistent nicotine levels over 24 hours	▪ Can be titrated to rapidly manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Might serve as an oral substitute for tobacco ▪ Can be titrated to manage withdrawal symptoms ▪ Mimics hand-to-mouth ritual of smoking ▪ Can be used in combination with other agents to manage situational urges	▪ Twice-daily oral dosing is simple and associated with fewer adherence problems ▪ Might delay weight gain ▪ Might be beneficial in patients with depression ▪ Can be used in combination with NRT agents	▪ Twice-daily oral dosing is simple and associated with fewer adherence problems ▪ Offers a different mechanism of action for patients who have failed other agents
Disadvantages	▪ Need for frequent dosing can compromise adherence ▪ Might be problematic for patients with significant dental work ▪ Proper chewing technique is necessary for effectiveness and to minimize adverse effects ▪ Gum chewing might not be acceptable or desirable for some patients	▪ Need for frequent dosing can compromise adherence ▪ Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	▪ When used as monotherapy, cannot be titrated to acutely manage withdrawal symptoms ▪ Not recommended for use by patients with dermatologic conditions (e.g., psoriasis, eczema, atopic dermatitis)	▪ Need for frequent dosing can compromise adherence ▪ Nasal administration might not be acceptable or desirable for some patients; nasal irritation often problematic ▪ Not recommended for use by patients with chronic nasal disorders or severe reactive airway disease	▪ Need for frequent dosing can compromise adherence ▪ Cost of treatment ▪ Cartridges might be less effective in cold environments (≤60°F)	▪ Seizure risk is increased ▪ Several contraindications and precautions preclude use in some patients (see Precautions) ▪ Patients should be monitored for potential neuropsychiatric symptoms[5] (see Precautions)	▪ Cost of treatment ▪ Patients should be monitored for potential neuropsychiatric symptoms[5] (see Precautions)
Cost/Day[6]	2 mg or 4 mg: $1.90–$3.60 (9 pieces)	2 mg or 4 mg: $3.33–$3.60 (9 pieces)	$1.52–$2.90 (1 patch)	$7.30 (8 doses)	$12.42 (6 cartridges)	$2.58–$8.25 (2 tablets)	$11.88 (2 tablets)

[1] Marketed by GlaxoSmithKline.
[2] Marketed by Niconovum USA (a subsidiary of Reynolds American, Inc.)
[3] Marketed by Pfizer.
[4] The U.S. Clinical Practice Guideline states that pregnant smokers should be encouraged to quit without medication based on insufficient evidence of effectiveness and theoretical concerns with safety. Pregnant smokers should be offered behavioral counseling interventions that exceed minimal advice to quit.
[5] In July 2009, the FDA mandated that the prescribing information for all bupropion- and varenicline-containing products include a black-boxed warning highlighting the risk of serious neuropsychiatric symptoms, including changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide. Clinicians should advise patients to stop taking varenicline or bupropion SR and contact a health care provider immediately if they experience agitation, depressed mood, or any changes in behavior that are not typical of nicotine withdrawal, or if they experience suicidal thoughts or behavior. If treatment is stopped due to neuropsychiatric symptoms, patients should be monitored until the symptoms resolve. Based on results of a mandated clinical trial, the FDA removed this boxed warning in December 2016.
[6] Approximate cost based on the recommended initial dosing for each agent and the wholesale acquisition cost from Red Book Online. Thomson Reuters, June 2017.

Abbreviations: MAO, monoamine oxidase; NRT, nicotine replacement therapy; OTC, over-the-counter (nonprescription product); Rx, prescription product.

For complete prescribing information and a comprehensive listing of warnings and precautions, please refer to the manufacturers' package inserts.

APPENDIX K

PROGRAM CHAMPION SELF-ASSESSMENT PRE-ACTUAL TRAINING SURVEY

Program Champion Self-Assessment PRE-ACTUAL TRAINING DELIVERY

What is your name? _____

What LMHA do you work for? _____

Please rate your level of agreement with the following items:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I am a good public speaker.	1	2	3	4	5	N/A
I currently have the capacity to deliver trainings in tobacco control.	1	2	3	4	5	N/A
I have observed others conducting tobacco control trainings before.	1	2	3	4	5	N/A
I feel comfortable speaking in public and training others.	1	2	3	4	5	N/A
I feel anxious just considering the idea of training others.	1	2	3	4	5	N/A
When conducting a training, I am afraid attendees will notice that I am nervous.	1	2	3	4	5	N/A
I have previously received feedback about my ability to conduct trainings.	1	2	3	4	5	N/A
I have received support and encouragement to engage in activities as a trainer/ health educator.	1	2	3	4	5	N/A
I feel confident about answering my colleagues' questions about tobacco control in the context of this training.	1	2	3	4	5	N/A

Items were developed by the TTTF research team for the purpose of this project.

	Poor	Fair	Good	Very Good	Excellent
Overall, how would you rate your capacity to conduct a training on tobacco control to members of your organization?	1	2	3	4	5

	Not at all	Just once	Twice	Three times	Several times
Besides the observed practice with the TTTF team, how many times did you practice/rehearse the presentation that you will deliver to members of your organization?	0	1	2	3	4

APPENDIX L

OBSERVER RATING OF ACTUAL INSTRUCTION FEEDBACK

TTTF Observer/Coach: Complete for Actual Training Observation with Agency Attendees

Program Champion Name:

Date:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
The trainer was knowledgeable about the subject matter.	1	2	3	4	5	N/A
The trainer appeared confident and comfortable with the material.	1	2	3	4	5	N/A
The trainer's ability to explain was excellent.	1	2	3	4	5	N/A
The trainer seemed well prepared for the training.	1	2	3	4	5	N/A
Concrete examples and illustrations were used to clarify the material.	1	2	3	4	5	N/A
The trainer promoted an atmosphere conducive to work and learning.	1	2	3	4	5	N/A
The rate of delivery of material was appropriate.	1	2	3	4	5	N/A
The training was engaging.	1	2	3	4	5	N/A
The trainer listened thoughtfully to attendees' comments and demonstrated empathy and respect.	1	2	3	4	5	N/A
The trainer's eye contact was appropriate.	1	2	3	4	5	N/A
Technology was used without difficulty.	1	2	3	4	5	N/A
Visual training content could be easily read.	1	2	3	4	5	N/A
The trainer's articulation and voice level was clear.	1	2	3	4	5	N/A
The trainer handled attendee questions well.	1	2	3	4	5	N/A
Overall, there was an absence of verbalized pauses (such as er, ah, um).	1	2	3	4	5	N/A

Most items are selected and adapted from C. Roland Christensen, the Center for Teaching and Learning, Harvard Business School (2005, from a peer observation scale used at the University of Minnesota and from items used at the University of Albany

	Poor	Fair	Good	Very Good	Excellent
Overall, how would you rate the delivery of the training curriculum by the trainer to setting stakeholders?	1	2	3	4	5
Overall, how would you rate the effectiveness of the trainer as a teacher?	1	2	3	4	5

Please provide any comments that would help to clarify your above ratings.

APPENDIX M

EMPLOYEE ATTENDEES' POST TEST & RATINGS OF INSTRUCTION SURVEY

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THE CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS IN COLLABORATION WITH THE UNIVERSITY OF HOUSTON AND INTEGRAL CARE

CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS

Tobacco Dependence Treatment & Education Training Pre/Post Test

POST TEST

1. Smoking causes approximately _____ deaths a year in the United States.
   A. 240,000 B. 480,000 C. 640,000 D. 840,000

2. Which of these tobacco treatment medications requires a prescription?
   A. Nicotine patch
   B. Nicotine inhaler
   C. Nicotine lozenge
   D. Nicotine gum
   E. All the above

3. Individuals with a (non-nicotine) substance abuse or mental health disorder represent about 25% of the United States population but consume about 40% of all cigarettes sold to adults.
   A. True B. False

4. Smoking cessation interventions were associated with ____ increased likelihood of long-term alcohol and drug abstinence following substance abuse treatment.
   A. 15% B. 20% C. 25% D. 30%

5. Which of the following is NOT one of the "Five A's" of tobacco cessation brief intervention.
   A. Ask B. Arrange C. Assess D. Allow

6. What strength of nicotine patch should be used for a person who is smoking a pack of cigarettes per day?
   A. 28 mg B. 21 mg C. 14 mg D. 7 mg

7. Behavioral health treatment center employees have a _____ smoking rate than the national average.
   A. lower B. higher C. same as

8. Which of the following tobacco treatment medications is the most effective in helping a person quit smoking?
   A. Chantix B. Wellbutrin C. Nicotine gum D. Nicotine nasal spray

9. Behavioral health treatment professionals are reluctant to address tobacco use due to:
   A. lack of training on how to address tobacco use
   B. believing it will negatively impact a person's recovery
   C. believing quitting smoking is impossible for people getting clean and sober
   D. believing people will withdraw from treatment
   E. all of the above

10. Tobacco-free campus/workplace policies will lead to premature withdrawal from behavioral health treatment programs at significant levels.
    A. True B. False

11. Please check your position:
    A. Provider (provide direct counseling services to clients) B. General Staff

APPENDIX N

PROGRAM CHAMPION SELF-ASSESSMENT POST TRAINING & RATINGS OF TTTF-CURRICULUM AND TRAINING SURVEY

TAKING TEXAS TOBACCO FREE
@TTTF_
@TakingTexasTobaccoFree
takingtexastobaccofree@gmail.com
www.takingtexastobaccofree.com

Employee Attendees' Rating of Instruction Survey

Please rate the trainer on the following items:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
The trainer was knowledgeable about the subject matter.	1	2	3	4	5	N/A
The trainer appeared confident and comfortable with the material.	1	2	3	4	5	N/A
The trainer's ability to explain was excellent.	1	2	3	4	5	N/A
The trainer seemed well prepared for the training.	1	2	3	4	5	N/A
Concrete examples and illustrations were used to clarify the material.	1	2	3	4	5	N/A
The trainer promoted an atmosphere conducive to work and learning.	1	2	3	4	5	N/A
The rate of delivery of material was appropriate.	1	2	3	4	5	N/A
The training was engaging.	1	2	3	4	5	N/A
The trainer listened thoughtfully to attendees' comments and demonstrated empathy and respect.	1	2	3	4	5	N/A
The trainer's eye contact was appropriate.	1	2	3	4	5	N/A
Technology was used without difficulty.	1	2	3	4	5	N/A
Visual training content could be easily read.	1	2	3	4	5	N/A
The trainer's articulation and voice level was clear.	1	2	3	4	5	N/A
The trainer handled attendee questions well.	1	2	3	4	5	N/A

Most items are selected and adapted from C. Roland Christensen, the Center for Teaching and Learning, Harvard Business School (2005, from a peer observation scale used at the University of Minnesota and from items used at the University of Albany.

	Poor	Fair	Good	Very Good	Excellent
Overall, how would you rate the effectiveness of the trainer as a teacher?	1	2	3	4	5

	Extremely Dissatisfied	Dissatisfied	Neutral	Satisfied	Extremely Satisfied
Overall, please rate how satisfied you were with this training.	1	2	3	4	5

This is a two sided document – please turn the page over and complete the other side.

APPENDIX N

PROGRAM CHAMPION SELF-ASSESSMENT POST TRAINING & RATINGS OF TTTF-CURRICULUM AND TRAINING SURVEY (CONTINUED)

TAKING TEXAS TOBACCO FREE
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Please provide any comments that would help to clarify your ratings.

Please discuss the strengths of the training and trainer.

Please provide suggestions for changes or improvement for the training or trainer.

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A project of Integral Care and the University of Houston, supported by the Cancer Prevention & Research Institute of Texas.

APPENDIX O

PROGRAM CHAMPION SELF-ASSESSMENT POST-TRAINING DELIVERY & TRAINER RATINGS OF TTTF-PROVIDED CURRICULUM AND TRAINING

@TTTF_
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takingtexastobaccofree@gmail.com
www.takingtexastobaccofree.com

Program Champion Self-Assessment POST TRAINING DELIVERY

What is your name? _____
What center do you work for? _____

Please rate your level of agreement with the following items:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I am a good public speaker.	1	2	3	4	5	N/A
I currently have the capacity to deliver trainings in tobacco control.	1	2	3	4	5	N/A
I have observed others conducting tobacco control trainings before.	1	2	3	4	5	N/A
I feel comfortable speaking in public and training others.	1	2	3	4	5	N/A
I feel anxious just considering the idea of training others.	1	2	3	4	5	N/A
When conducting a training, I am afraid attendees will notice that I am nervous.	1	2	3	4	5	N/A
I have previously received feedback about my ability to conduct trainings.	1	2	3	4	5	N/A
I have received support and encouragement to engage in activities as a trainer/ health educator.	1	2	3	4	5	N/A
I feel confident about answering my colleagues' questions about tobacco control in the context of this training.	1	2	3	4	5	N/A

Items were developed by the TTTF research team for the purpose of this project.

	Poor	Fair	Good	Very Good	Excellent
Overall, how would you rate your capacity to conduct a training on tobacco control to members of your organization?	1	2	3	4	5

Trainer Ratings of TTTF-Provided Curriculum and Training

	Extremely Dissatisfied	Dissatisfied	Neutral	Satisfied	Extremely Satisfied
Overall, please rate your satisfaction with curriculum provided to you by the TTTF team.	1	2	3	4	5

APPENDIX O

PROGRAM CHAMPION SELF-ASSESSMENT POST-TRAINING DELIVERY & TRAINER RATINGS OF TTTF-PROVIDED CURRICULUM AND TRAINING (CONTINUED)

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Overall, please rate your satisfaction with training you received to implement the curriculum provided to you by the TTTF team.	1	2	3	4	5

Please, below indicate any strengths of the training you received.

Please, below indicate any ways in which the training you received could be improved.

Please, below let us know if you have additional training needs that the TTTF team can help with.

Please, provide us with any feedback you would like for us to know.

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APPENDIX P

PROGRAM CHAMPION SUMMARY SHEET

Taking Texas Tobacco Free and Click here to enter text.

The Taking Texas Tobacco Free (TTTF) program helps behavioral health agencies across the state of Texas to implement a comprehensive program to address tobacco use through education, screening, and treatment, and outreach services at their workplaces.

You recently participated in TTTF's newest initiative targeting tobacco cessation treatment education and its sustainability within the behavioral health agencies we partner with. Ongoing efforts to educate employees on tobacco use outcomes and tobacco cessation treatment is essential in ultimately helping clients and employees become successful in their quit attempts.

As part of this training initiative, Click here to enter text. employees from Click here to enter text. participated in two 1-hour trainings that you delivered on Click here to enter a date. and Click here to enter a date. to learn more about the hazards of tobacco use and how to guide tobacco users in their quit attempts. Training activities included an evaluation of participating employees' knowledge before and after the training, as well as an evaluation of you as a trainer and the training you provided.

Employees trained by Click here to enter text.: Knowledge Gained

Congratulations! Pre- and post-training evaluations revealed Choose an item. in all areas assessed, with about a Click here to enter text. in overall tobacco and tobacco-cessation knowledge.

	Employee Training 1	Employee Training 2	Total Across Trainings
Pre-Training, % Correct			
Post-Training, % Correct			
% Change, Pre- to Post-Training			

The Impact of your Tobacco Use Treatment Training Efforts at Click here to enter text.

Results suggest that employees at your trainings have increased their awareness of the risks associated with tobacco use and the benefits of becoming tobacco-free. They are in an excellent position to help their clients and colleagues quit tobacco and improve their health and quality of life!

The employees that attended each of your trainings were asked to evaluate the training session as well as your performance as their trainer. On a scale where 1=Poor and 5= Excellent, the employees that attended your first training altogether rated your effectiveness as a teacher as Click here to enter text. and Click here to enter text. of employees were satisfied or extremely satisfied with the training. For your second training session, employees that attended overall rated your effectiveness as a teacher as Click here to enter text. and Click here to enter text. of employees were satisfied or extremely satisfied with the training.

The following are some of the comments that employees provided on your evaluations:

- Click here to enter text.
- Click here to enter text.
- Click here to enter text.

APPENDIX P

PROGRAM CHAMPION SUMMARY SHEET (CONTINUED)

- Click here to enter text.
- Click here to enter text.

Every employee has a role to play in making Click here to enter text. a tobacco-free environment and supporting tobacco-using clients, and we deeply appreciate all the training and work that you have done to support this effort.

Please continue to educate your employees in order to support your tobacco-using clients in their quit attempts and continued recovery from tobacco use. We are continually adding training materials and resources on our website under the "Train the Trainer" section that will assist you in ongoing tobacco control education efforts at your center, so make sure to check back in often!

APPENDIX Q

SAMPLE CERTIFICATE FOR PROGRAM CHAMPION

APPENDIX R

PROGRAM CHAMPION RATINGS OF TTTF-CURRICULUM INTERVIEW GUIDE

CPRIT TOBACCO EDUCATION GRANT
BY THE UNIVERSITY OF HOUSTON AND INTEGRAL CARE

Program Champion Post-Implementation Interview Guide

1. Tell us about what was good about the training you received.
2. Tell us about what could be improved about the training you received.
3. Tell us about what was good about the education/curriculum materials you received for your training.
4. Tell us about what could be improved about the education/curriculum materials you received for your training.
5. What additional training needs do you have that the TTTF team can help with?
6. Our aim is to provide you with effective and comprehensive training to ensure that you can confidently train others in your organization regarding tobacco use and treatment. Can you tell me how confident you feel in delivering tobacco trainings to others in your organization?
7. What else do you need to deliver these trainings effectively within your organization? (i.e. resources, interdepartmental/organizational cooperation and planning)
8. We are going to make the curriculum and materials online for other centers to use. What do you think we might need to change or otherwise provide to make these materials as helpful as possible to those who did not receive the hands-on training you received?
9. What else would you like for the TTTF team to know?

Closing: Thank you so much for your time and for sharing your thoughts today.

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HEALTH Research Institute

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UNIVERSITY of HOUSTON

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