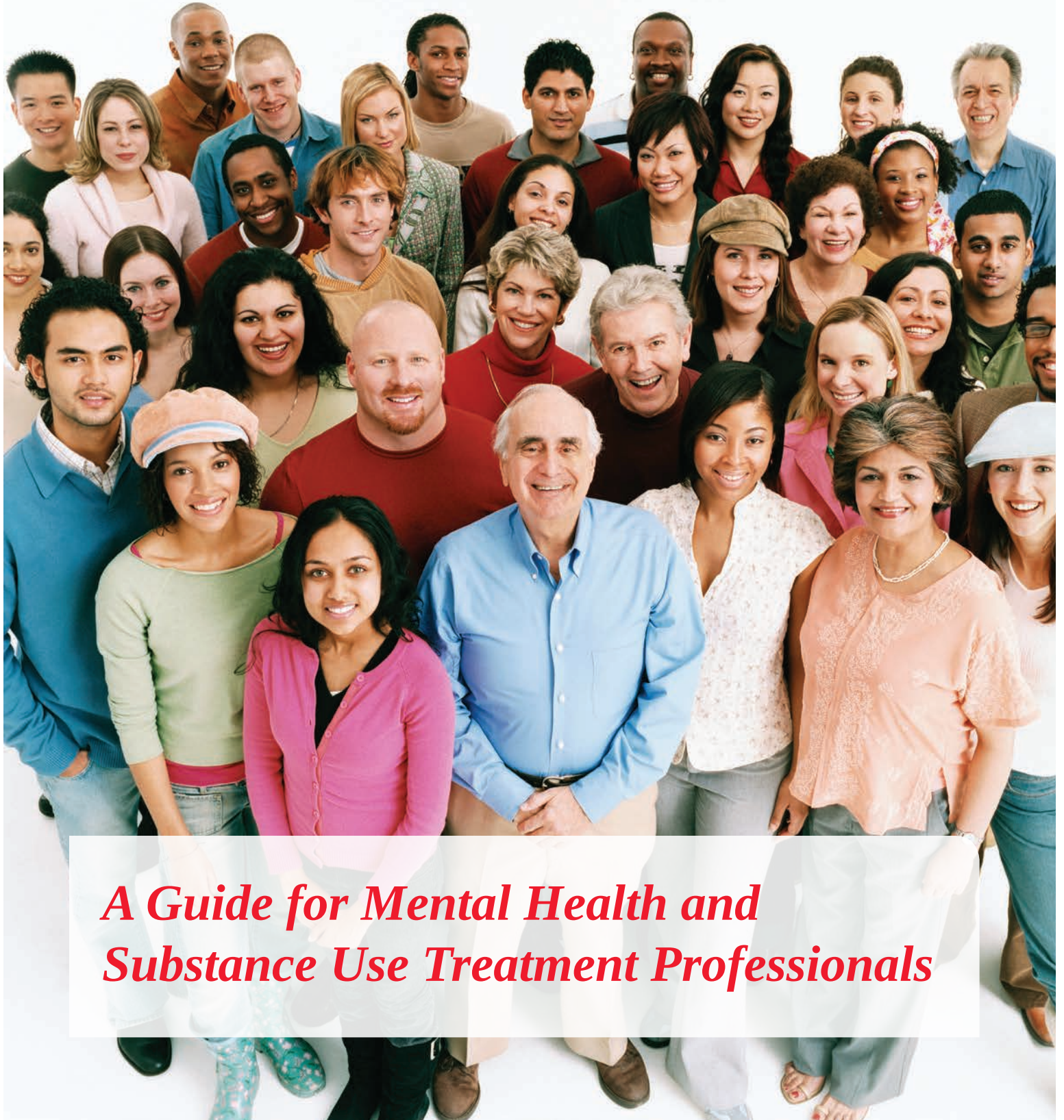# A TOOLKIT TO ADDRESS TOBACCO USE IN BEHAVIORAL HEALTH SETTINGS

A Guide for Mental Health and Substance Use Treatment Professionals

TABLE OF CONTENTS

The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through education, advocacy and research. For more than 100 years, we have led the fight for healthy lungs and healthy air, whether it's searching for cures to lung diseases, keeping kids off tobacco, or fighting for laws that protect the air we all breathe.

OUR MISSION: To save lives by improving lung health and preventing lung disease.

OUR VISION: A world free of lung disease.

ABOUT THIS TOOLKIT

Who is this toolkit for?

This toolkit was developed for a broad continuum of mental health and substance use treatment professionals. Materials are intended for direct providers, as well as administrators and behavioral health organizations. Many of the materials are also appropriate for primary care and other health care providers focused on substance use disorders.

How do I use this toolkit?

The toolkit contains a variety of information and step-by-step instruction about:
- Low burden means of assessing readiness to quit
- Tobacco treatment
- Strategies for implementing policy
- Strategies to increase cessation opportunities and success
- Referral to community resources

Funding Tobacco Cessation Services

There are many ways to fund tobacco cessation services for both employees and clients. The Affordable Care Act requires that insurance companies provide some level of tobacco cessation support. However, not all private insurers offer the full range of available services. Insured people interested in accessing tobacco cessation treatment should be encouraged to verify their coverage. If your organization provides an employer-sponsored insurance plan, confirming what the coverage is, how services can be obtained and at what cost to employees is an important and much appreciated part of your staff communication plan.

As of August 2010, the Centers for Medicare and Medicaid Services (CMS) began covering tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries. Although coverage differs depending upon whether a tobacco-related diagnosis has been made, services are covered regardless of the patient signs and symptoms of tobacco-related disease.[1] If the Medicare recipient has not been diagnosed with a disease caused or exacerbated by tobacco, Medicare treats tobacco cessation counseling as a preventative treatment. **In Minnesota, co-pays have been removed on cessation medications, and free coverage is available for individual and group counseling. Medicaid can cover all FDA-approved cessation medications, but benefits are state specific.**

Tobacco, in this document, refers specifically to the use of manufactured, commercial tobacco products and not the sacred, medicinal, and traditional use of tobacco by American Indians and other groups.

> "Simply put, offering tobacco treatment therapy and resources to our clients is not only best practice, but also our duty and privilege as mental health professionals."
>
> ~ Jamie Andycha, Health and Wellness Project Manager at People Incorporated

ONLY 1 IN 4 MENTAL TREATMENT FACILITIES OFFER TOBACCO CESSATION SERVICES.

THE IMPORTANCE OF ADDRESSING TOBACCO USE

They NEED to quit.

IT'S THE **#1** CAUSE OF DEATH IN PEOPLE WITH **MENTAL ILLNESS**

They WANT to quit.

75% WANT TO QUIT COMPARED TO **60%** OF THE GENERAL POPULATION.

They CAN quit.

SMOKING CESSATION + ADDICTION TREATMENT = 25% INCREASED LIKELIHOOD OF **LONG-TERM ABSTINENCE** FROM ALCOHOL & ILLICIT DRUGS

BEHAVIORAL HEALTH can take the lead.

» THERE IS A **HIGH PREVALENCE OF TOBACCO USE** & PATIENT NEED

» PROVIDERS ARE **TRAINED IN TREATING ADDICTIONS**

» TOBACCO INTERACTS **NEGATIVELY WITH SOME PSYCHIATRIC MEDS**

» **TOBACCO USE DISORDER** IS A BEHAVIORAL HEALTH CONDITION IN THE **DSM-5**

= **25%** HIGHER SUCCESS RATE

TREATMENT WORKS.

THE TOBACCO IMPACT

44% OF THE US TOBACCO MARKET IS **CONSUMED BY PEOPLE WITH MENTAL ILLNESS** AND SUBSTANCE USE DISORDERS

44%
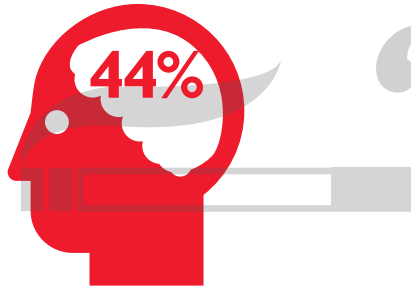
" **Tobacco treatment isn't only about treating tobacco, it is a core service that significantly impacts the overall health and quality of life of the individuals we serve."**

~ Katie O'Brien, Vice President of Operations at People Incorporated

" **We see, first-hand, the health disparities experienced by our clients. Tobacco treatment plays a significant role in treating the whole person—a key part of our mission and promise to our clients, staff, and communities."**

~ Jill West, CEO at People Incorporated

1 IN 3 PEOPLE WHO SMOKE IN THE U.S. HAVE BEEN DIAGNOSED WITH **MENTAL ILLNESS**

U.S. SMOKING PREVALENCE

- NO MENTAL DISORDER — 21.3%
- ANXIETY DISORDER — 37.8%
- AFFECTIVE DISORDER — 45.1%
- SUBSTANCE USE DISORDER — 63.6%
- ANY MENTAL ILLNESS — 40.1%
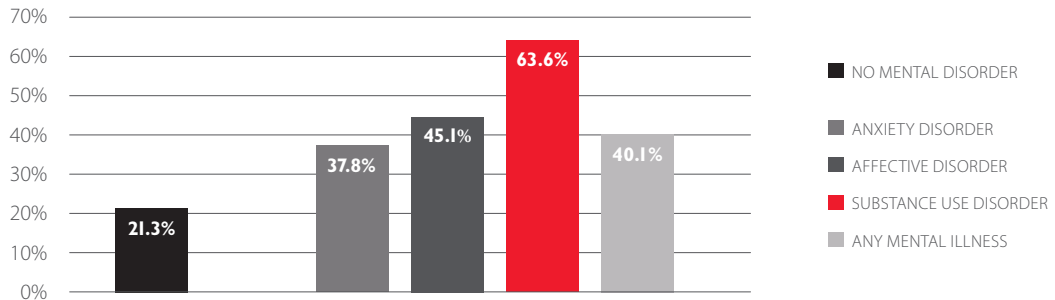
32 years ADULTS WITH SERIOUS MENTAL ILLNESS & A TOBACCO-RELATED DIAGNOSIS HAD A MEDIAN AGE AT **DEATH 32 YEARS EARLIER** THAN ADULTS WITHOUT SMI AND WITHOUT A TOBACCO- RELATED DIAGNOSIS.

75% OF PEOPLE WHO SMOKE **HAVE A PAST OR PRESENT PROBLEM** WITH MENTAL ILLNESS OR ADDICTION

NICOTINE ADDICTION:
What It Looks Like in the Brain

Tobacco Use and Mental Illness
Smoking and Mental Illnesses: Nicotine Effects and Other Considerations

Why do our clients smoke more?
Researchers believe that a combination of biological, psychological and social factors contribute to increased tobacco use among persons with mental illnesses.

People with mental illnesses:
• Access general medical services and other community resources relatively infrequently
• Struggle with stigma on several levels
• Generally experience a greater burden of morbidity and mortality than the overall population

Biological predisposition to biological considerations
• Persons with mental illnesses have unique neurobiological features that may increase their tendency to use nicotine, make it more difficult to quit and complicate withdrawal symptoms.
• Nicotine affects the actions of neurotransmitters (e.g. dopamine). For example, people with schizophrenia who use tobacco may experience less negative symptoms (lack of motivation, drive and energy).
• Nicotine enhances concentration, information processing and learning. (This is especially important for persons with psychotic disorders for whom cognitive dysfunction may be a part of their illness or a side effect of antipsychotic medications.)

• Other biological factors include nicotine's positive effects on mood, feelings of pleasure and enjoyment. Some evidence also suggests that smoking is associated with a reduced risk of antipsychotic-induced Parkinsonism.

Psychological considerations
• Tobacco use is perceived to relieve feelings of tension and anxiety and is often used to cope with stress.
• People develop a daily routine of smoking.

Social considerations
- People may smoke to feel "part of a group." This can be especially true in residential and treatment settings.
- Smoking is often associated with social activities.
- The site of a social activity may support tobacco use.

Stigma
- Providers often think that people with mental illnesses are unable to quit smoking.
- Symptom management often takes precedence over preventive health measures.

Specific psychiatric and co-occurring disorders
What are some considerations for smoking cessation in regard to specific mental disorders?

Depression
- Among patients seeking smoking cessation treatment, 25-40% have a history of major depression and many have minor dysthymic symptoms.
- Depression has been shown to predict poorer smoking cessation rates. Consider starting or restarting psychotherapy or pharmacotherapy for depression in patients who state that depression intensified with cessation or that cessation caused depression.
- Cognitive behavioral therapy for depression and antidepressants has been found to improve smoking cessation rates in those with a history of depression or symptoms of depression.

Schizophrenia
- Persons with schizophrenia who smoke may be less interested in tobacco cessation, making strategies to enhance motivation to quit especially important.
- When patients with schizophrenia do try to stop, many are unsuccessful; thus, intensive treatments are appropriate even with early attempts.

Tobacco Use and Chemical Dependency

The Substance Use Connection
Tobacco use is strongly correlated with development of other substance use disorders and with more severe substance use disorders such as the following:
- Early onset of smoking and heavy smoking are highly correlated with the subsequent development of other substance use and psychiatric disorders.[1]
- Heavy smokers have more severe substance use disorders than do non-smokers and more moderate smokers.[2]
- Tobacco use impedes recovery of brain function among clients whose brains have been damaged by chronic alcohol use.[3,4]

The Chemical Connection
Nicotine affects the actions of neurotransmitters such as dopamine. Psychological effects and considerations include the following:
- Nicotine positively affects mood, feelings of pleasure and enjoyment.

- Tobacco use may temporarily relieve feelings of tension and anxiety, and is often used to cope with stress.
- Nicotine appears to affect the same neural pathway—the mesolimbic dopamine system—as alcohol, opioids, cocaine and marijuana.[5]
- Smoking hinders the metabolism of some medications, such as highly active antiretroviral therapy for persons with HIV/AIDS, interfering with their effectiveness.[6]

The Social Connection

Smoking is often associated with social activities or with "smoke breaks" while at work or in treatment. Examples include the following:

- People may smoke to feel "part of a group" and may be afraid that quitting tobacco will damage their social relationships.
- In substance use treatment settings, "giving" smoke breaks to clients rather than healthy alternatives, such as walks or quiet times, can reinforce the social connection to tobacco.
- Persons who do not participate in many activities may become bored and smoke more to keep themselves busy.
- Workplace smoking restrictions lead to less smoking among employees.[7]
- Smoke-free and tobacco-free workplace policies lead to reductions in daily consumption of cigarettes and increases in tobacco use cessation among workers.[8]

The Treatment Connection

Between 70-80% of clients receiving treatment for alcohol and other drug problems want to stop using tobacco.[9] Integrating tobacco treatment into the treatment of alcohol and other drug problems helps clients and improves treatment outcomes, such as the following:

- Clients who receive treatment for tobacco use are more likely to reduce their use of alcohol and other drugs and have better treatment outcomes overall.[10]
- People with alcohol use problems are as successful at quitting tobacco as people without alcohol problems.[11] Illicit drug-user rates are lower, but still promising.[12]
- A meta-analysis of 18 studies found that treating the tobacco use of clients improved their alcohol and other drug outcomes by an average of 25%.[13]

Between 70-80% of clients receiving treatment for alcohol and other drug problems want to stop using tobacco.[9]

MYTHS

Q: **How can we expect people to quit smoking, while they're quitting everything else? We are here to deal with "real drugs," not cigarettes. Besides, clients don't want to quit. Even those who want to quit, won't be able to.**

A: Cigarettes are real drugs. They contribute to more illness and early death than any other drug, legal or illegal. And they are highly addictive— on par with heroin. As we create a healthier environment, we will train staff and clients about smoking, the quitting process, and how smoking impacts other addictions. Evidence suggests that smoking actually harms recovery from the addiction to other drugs because it can trigger the use of those substances. Also, as part of this initiative, we want to work with other community treatment facilities to similarly protect clients and staff from smoke and help them quit or maintain their abstinence from smoking.

Q: **Clients will just start smoking again once they are discharged. Why bother quitting?**

A: Many of our clients will smoke again. We don't refuse treatment for other addictions, even when we believe the client is not motivated to remain abstinent. We give everyone the opportunity to detoxify while in treatment with the hope that they will choose a substance-free life. Quitting is hard, especially in environments where tobacco use is acceptable. By incorporating tobacco cessation in our recovery philosophy, we can help clients learn refusal skills, identify triggers, and regain control if they relapse. We also hope to be leaders, inspiring other mental health facilities in our community to similarly ban tobacco use to open new doors to wellness and recovery.

Q: **Smoking calms down clients. When they can't smoke, won't we experience complete mayhem?**

A: Banning smoking in psychiatric hospitals actually reduces mayhem. Facilities that do not allow smoking report fewer incidents of seclusion and restraint and a reduction in coercion and threats among patients and staff. We will reduce uncomfortable nicotine withdrawal symptoms by appropriately using nicotine replacement therapy and other medications.

Q: **What about electronic cigarettes?**

A: The FDA's Center for Drug Evaluation and Research has not approved any e-cigarette as a safe and effective method to help smokers quit. The American Lung Association is troubled about unproven claims that e-cigarettes can be used to help smokers quit. Also unknown is what the potential harm may be to people exposed to secondhand emissions from e-cigarettes.

Q: **Clients won't have support to continue quitting smoking once they move back home.**

A: More and more multi-unit housing developments are becoming smoke free. As of February 3, 2017, U.S. Housing and Urban Development has issued a smoke-free rule ban for all Public Housing Authorities (PHA). Each PHA must implement a "smoke-free" policy banning the use of prohibited tobacco products in all public housing living units, indoor common areas in public housing and in PHA administrative office buildings. The smoke-free policy must also extend to all outdoor areas up to 25 feet from the public housing and administrative office buildings. This rule improves indoor air quality in the housing; benefits the health of public housing residents, visitors and PHA staff; reduces the risk of catastrophic fires; and lowers overall maintenance costs. Supporting them in their efforts to quit smoking will help them transition into a smoke-free lifestyle in their permanent residence.[14]

TOBACCO PRODUCTS 101
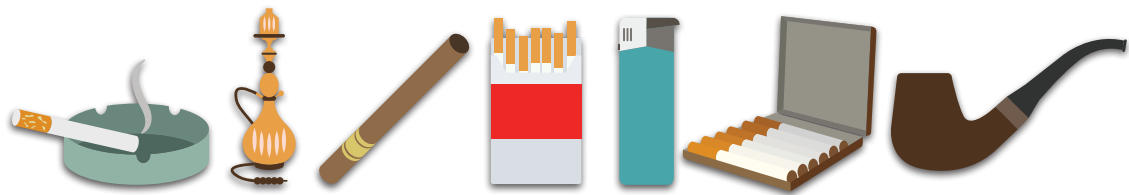
Cigarettes: Tobacco rolled into a paper wrapping. The smoke produced by cigarettes contains 7,000 chemicals. Seventy of these chemicals have been proven to cause cancer.

Light Cigarettes: These may be labeled "low-tar," "mild," "light" or "ultra-light." In 2010, the use of this terminology in labeling was banned. These are not a safer alternative to regular cigarettes.

Menthol Cigarettes: These are cigarettes that contain a minty flavoring. These are also not a safe alternative to regular cigarettes.

Cigars, Cigarillos and Little Cigars: These are bundles of dried and cured tobacco that are rolled in a paper wrapping. These could be flavored, making them appealing to youth and young adults. These are not a safe alternative to cigarettes.

Hookah: These products allow for the inhalation of smoke from flavored tobacco products. Also referred to as water pipes, hookahs are not a safe alternative to other forms of tobacco.

Snuff: A dry form of tobacco that can be inhaled through the nose. This is not a safe alternative to smoking.

Electronic Cigarettes (e-cigs): These products produce an aerosol of nicotine and other chemicals that are inhaled. They can look like traditional cigarettes, cigars or even pens. The

FDA's Center for Drug Evaluation and Research has not approved any e-cigarette as a safe and effective method to help smokers quit. These are not safe alternatives to cigarettes and are not approved for tobacco-use cessation.

Chewing Tobacco: A smokeless tobacco that users typically place between their cheek and gums. Tobacco juices are usually spit out, but some users may swallow these juices. This is not a safe alternative to smoking.

Snus: Moist snuff that is placed in a small pouch and placed between the cheek and gums. This product does not require the user to spit. This is not a safe alternative to smoking.

Khat: Khat is typically chewed like tobacco—retained in the cheek and chewed intermittently to release the active drug—and can also be smoked. Using khat can cause mild to moderate psychological dependence. Compulsive use of khat may result in manic behavior with grandiose delusions or in a paranoid type of illness, sometimes accompanied by hallucinations. Khat use may also lead to tooth decay and gum disease, gastrointestinal disorders such as constipation and ulcers, irregular heartbeat and heart attack.[15]

Betel Nut: Betel nut use has been linked to illicit drug use later in adults. Similar to cigarette smoking and alcohol use, the age of onset of betel nut use was 18 among illicit drug users, which was younger than nonillicit drug users at age 20.[16]

Source: http://betobaccofree.hhs.gov/about-tobacco/index.html
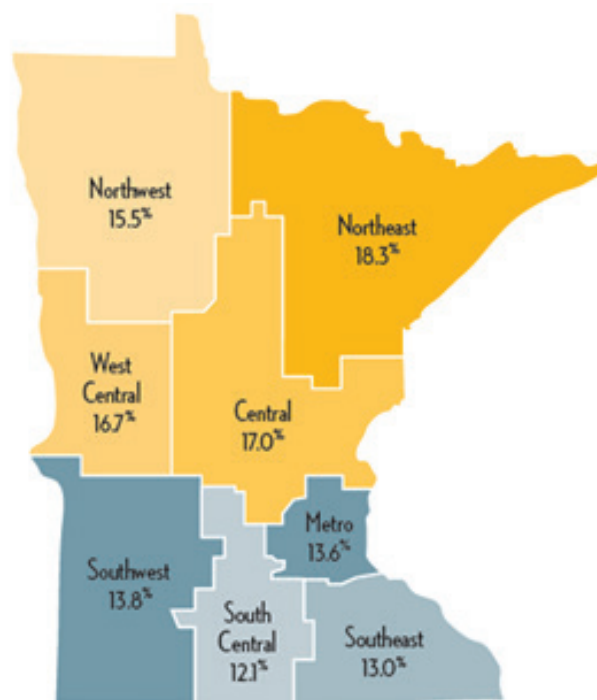
CURRENT TOBACCO USE IN MINNESOTA

In 2014, 14.4% of Minnesotans reported being current smokers compared to 17.3% nationally.[13] The smokers in Minnesota are more likely to be male, have lower incomes, and completed less schooling than their nonsmoking counterparts.[13] Adults 25-44 years old had the highest rate of smoking in 2014, compared to young adults 18-24 years old.[13]

In addition to cigarettes, the use of other tobacco products such as snus, cigars, smokeless tobacco, and electronic cigarettes (e-cigarettes) is rising. The number of adults in Minnesota using e-cigarettes in the past 30 days increased from .7% in 2010 to 5.9% in 2014.[13] Currently in Minnesota, 25.1% of smokers smoke menthol cigarettes.[13]

Smoking also continues to be a problem in youth. Although cigarette smoking among Minnesota high school students has decreased sharply from 10.6% in 2014 to 4.9% in 2016, e-cigarette use has increased. In fact 17.1% of students reported using e-cigarettes in the past 30 days.[17]

Tobacco use continues to be a leading cause of preventable death and disease in Minnesota. Each year 5,900 Minnesotans die from tobacco-related diseases and costs Minnesotans $2.51 billion annually.[18]

MINNESOTA TOBACCO USE

- Northwest 15.5%
- Northeast 18.3%
- West Central 16.7%
- Central 17.0%
- Metro 13.6%
- Southwest 13.8%
- South Central 12.1%
- Southeast 13.0%

Since 1964, more than 20 million Americans have died because of smoking. Of the 20 million who died, 2.5 million were nonsmokers who died because of secondhand smoke.

—2015, 50th Anniversary U.S. Surgeon General's Report

Tobacco use effects almost every part of the body

TOBACCO USERS ARE AT AN INCREASED RISK FOR A LONG LIST OF HEALTH CONDITIONS.
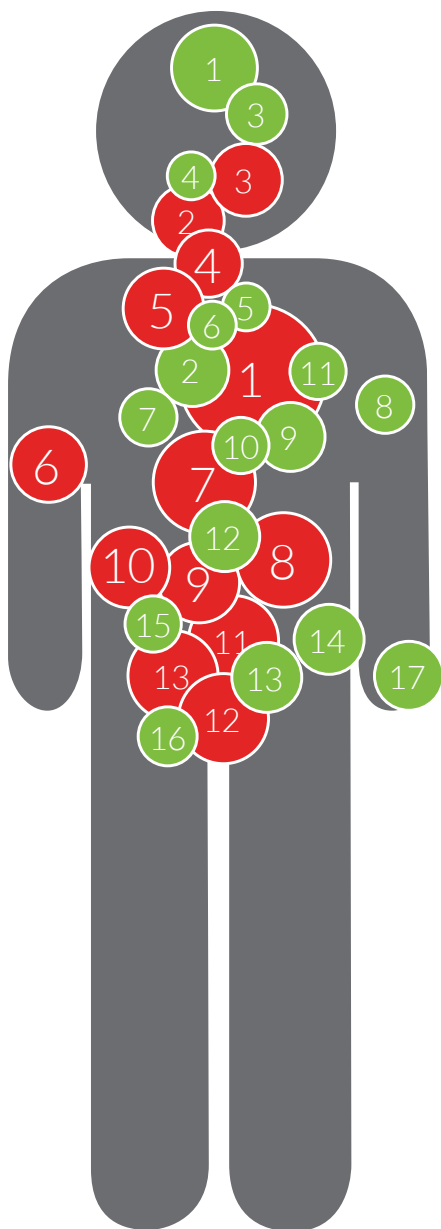
Tobacco use has been proven to cause the following cancers:[19]

1. Lung, Trachea, and Bronchus Cancer
2. Oropharynx Cancer 3. Cancers of the Lip and Oral Cavity 4. Laryngeal Cancer
5. Esophageal Cancer 6. Acute Myeloid Leukemia 7. Stomach Cancer 8. Liver Cancer 9. Pancreatic Cancer 10. Kidney Cancer 11. Cervical Cancer 12. Bladder Cancer 13. Colorectal Cancer

Beyond cancer, tobacco-use has also been proven to cause:[7]

1. Strokes 2. Coronary heart disease
3. Vision loss due to cataracts and macular degeneration 4. Periodontitis (serious gum infection that can end in tooth loss) 5. Aortic aneurysm 6. Early abdominal atherosclerosis
7. Pneumonia 8. Atherosclerotic peripheral vascular disease 9. Chronic obstructive pulmonary disease (COPD) 10. Tuberculosis
11. Asthma 12. Diabetes 13. Reproductive health issues 14. Hip fractures 15. Ectopic pregnancy 16. Erectile dysfunction
17. Rheumatoid arthritis 18. Immune dysfunction 19. Heart Disease
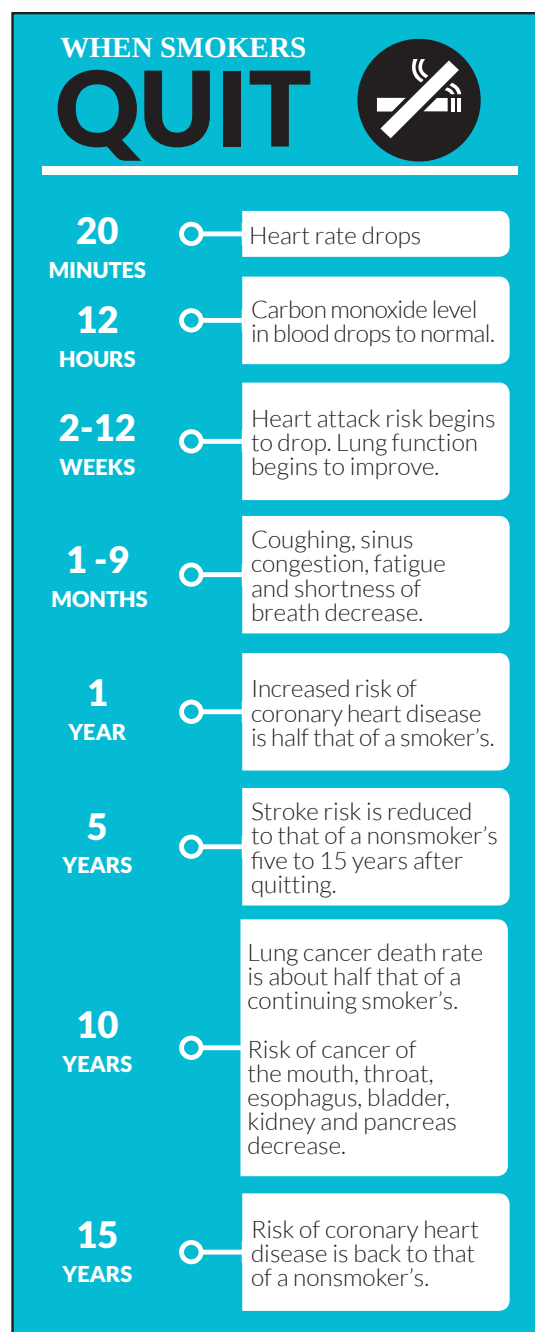
Consequences of Tobacco Use

In 1964, the Surgeon General of the United States released a report stating that smoking cigarettes is a cause of both lung cancer and chronic bronchitis.[20] Today, more men and women die of lung cancer than any other cancer.[21] In Minnesota, an estimated 2,430 people will die from cancers of the lung and bronchus in 2016.[22] Smoking increases a man's risk of dying from lung cancer by 80% and a woman's risk by 90%.[23] The effects of tobacco use do not end at lung cancer. Tobacco users can have negative health effects in almost every organ of their body.[23]

The Effects of Secondhand and Thirdhand Smoke

Non-smokers that are exposed to cigarette smoke can also suffer negative health effects. Secondhand smoke has been proven to cause strokes, lung cancer, and coronary heart disease in adult non-smokers.[19] Pregnant women exposed to secondhand smoke have an increased risk of delivering a low birth weight infant.[19] It is estimated that 42,000 Americans die each year from secondhand smoke exposure, with the majority of these being from lung cancer and heart disease.[19,24]

Secondhand smoke also causes numerous health issues for infants and children. Infants that are exposed to secondhand smoke have an increased risk of sudden infant death syndrome (SIDS).[19] Children exposed to secondhand smoke are also more likely to suffer from ear infections, coughing, sneezing, bronchitis, pneumonia, and shortness of breath.[25-26] Children with asthma that are exposed to secondhand smoke are more likely to suffer from severe asthma attacks.[25-26]

Individuals are exposed to thirdhand smoke when they are forced to inhale the chemicals from tobacco products that remain on a smoker's clothing, hair, or skin.[24] The chemicals from tobacco products that cause thirdhand smoke can also linger on carpets, furniture, window treatments, within vehicles, and on various other surfaces.[24] Workers that take smoke breaks and then return to the office can expose their coworkers to this deadly mix of chemicals.

WHEN SMOKERS QUIT

Time	Effect
20 MINUTES	Heart rate drops
12 HOURS	Carbon monoxide level in blood drops to normal.
2-12 WEEKS	Heart attack risk begins to drop. Lung function begins to improve.
1-9 MONTHS	Coughing, sinus congestion, fatigue and shortness of breath decrease.
1 YEAR	Increased risk of coronary heart disease is half that of a smoker's.
5 YEARS	Stroke risk is reduced to that of a nonsmoker's five to 15 years after quitting.
10 YEARS	Lung cancer death rate is about half that of a continuing smoker's. Risk of cancer of the mouth, throat, esophagus, bladder, kidney and pancreas decrease.
15 YEARS	Risk of coronary heart disease is back to that of a nonsmoker's.

Tobacco-free Policies Help People Quit

According to the Community Preventive Services Task Force, smoke-free worksite policies "…reduce consumption by continuing smokers, increase smoking cessation attempts, increase the number of smokers who successfully quit, and reduce the prevalence of tobacco use among workers."[27]

This is especially important because smokers that quit before age 30 can almost entirely eliminate their risk of dying prematurely of a smoking-related cause and smokers that quit before age 40 reduce their risk of early death by 90%.[19,28] Beyond this, smokers who quit at any age will see health benefits and quality of life improvements.[28]

Many recent studies have been able to show that implementing tobacco-free or smokefree policies at worksites help people quit!

In 2007, the University of North Carolina Health Care System implemented a tobacco-free worksite policy. Nearly 66% of tobacco users reported making a quit attempt in the preparation for and aftermath of this policy change. This was much higher than the state average for quit attempts of 56.8%. Sixty of those clients that reported quit attempts or cessation success following the policy change indicated that the policy helped them make this life change.[29]

A New York hospital implemented a smoke-free campus policy in July of 2006. Prior to the policy implementation in 2005, 14.3% of hospital employees reported smoking. In 2007, following the implementation of the policy, only 9% of employees reported themselves as smokers.[30]

A study of a worksite with over 3,000 adults in South Korea found that smoking decreased by 6.4 clientage points after implementing a smoke-free policy. For smokers that did not quit, they averaged 3.7 fewer cigarettes each per day.[31]

WHAT TOBACCO USERS COST EMPLOYERS

2.6 DAYS Increased Absenteeism

It is estimated that smokers miss approximately 2.6 more days of work than their nonsmoking peers each year.[32]

1% LESS Reduced productivity as a result of nicotine addiction

A smoker can start to feel withdrawal symptoms within 30 minutes of their last cigarette/tobacco use.[19] These withdrawal symptoms, as a result of nicotine addiction, can interfere with an employee's ability to effectively perform his or her job. It is estimated that smokers are 1% less productive than nonsmokers.[32] In a worksite with many smokers, these productivity losses can add up!

5.5 DAYS Missed work time due to smoke breaks

While every person is different, a recent study estimated that the average smoker takes two 15 minute smoke breaks per day in excess of regularly scheduled and allowed breaks.[32] This results in 5½ days per year of paid time that an employee is not working.

8% HIGHER Increased healthcare expenses

A recent study estimated that the healthcare expenses of a smoker are approximately 8% higher than the expenses for a nonsmoker.[32] For employers that self-insure their employees, this can drastically increase the total amount spent on healthcare costs. Even employers who purchase private insurance are likely to see an increase in healthcare expenses due to their smoking employees.[32] Smokers are likely to have more insurance claims, and this could require employers to pay higher premiums.[32]

WHY ADDRESS THIS ISSUE

A recent study found that for every smoker that quits, an employer can save between $2,885 and $10,125 annually.[32] The breakdown of these potential savings can be seen in the table below. It is clearly evident that implementing a tobacco-free worksite policy can reduce costs for your business.

By implementing a tobacco-free worksite policy, you could help your employees quit. This life change will not only improve their health and quality of life, it will also save you money!
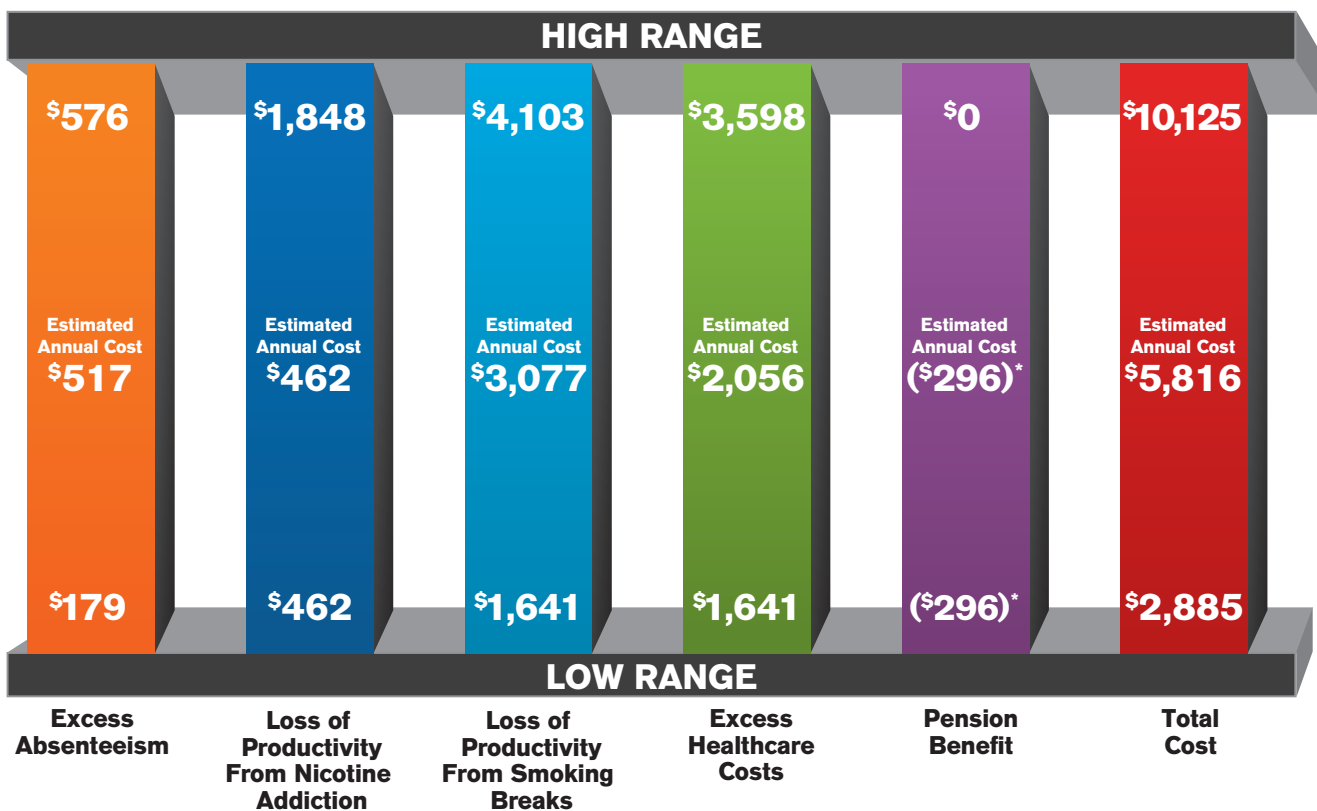
You can easily estimate the number of smokers at your worksite, the productivity losses of your business due to tobacco use, your excess healthcare costs due to smoking, and the total amount of money your company could save by helping all tobacco using employees quit.

A cost calculator tool is on page 49 of the Appendix.

Improve the Health of all Employees and Visitors

More people in the United States die prematurely due to tobacco use than any other cause.[19] Approximately 480,000 Americans and 5,900 Minnesotans die each year as a result of smoking and exposure to secondhand smoke.[18,19] Implementing a tobacco-free policy at your worksite can help tobacco users quit and extend their lives.

Total Annual Excess Cost of a Smoking Employee to a Private Employer

HIGH RANGE

	Excess Absenteeism	Loss of Productivity From Nicotine Addiction	Loss of Productivity From Smoking Breaks	Excess Healthcare Costs	Pension Benefit	Total Cost
High	$576	$1,848	$4,103	$3,598	$0	$10,125
Estimated Annual Cost	$517	$462	$3,077	$2,056	($296)*	$5,816
Low	$179	$462	$1,641	$1,641	($296)*	$2,885

LOW RANGE

POLICY MENU

When thinking about how your organization can reduce tobacco's harm, it can be thought of as a menu of policy options to choose from.

Type of Policy	Who is Affected	Brief Outline of Policy
Tobacco-free Grounds	• Employees • Patients • Clients • Visitors	• The use of tobacco products prohibited on the grounds, and business-owned vehicles
Treatment Plan	• Patients	• Intake/Triage questions upon check-in • Referral: Refer client to resources available either within organization, those that are free to Minnesotans or both. (Referral options can be found in the Appendix.) • Integrated Treatment Plan: Other providers that connect with client are aware of cessation efforts
Patient/Client Interactions	• Employees • Patients	• Providers are prohibited to use or provide tobacco products with patients/clients.

A sample workplan is on page 33 of the Appendix.

STEPS TOWARD POLICY CHANGE

Many decisions need to be made prior to drafting the policy. Your leadership and wellness committee members should make these decisions prior to announcing the plan. As you receive input from employees, clients and other interested parties, you will want to adjust and amend your policy, as needed. But keep in mind that making accommodations based on feedback from all dissenting voices can weaken the policy. Be sure that the policy matches your overall intentions and goals. You will want to regularly revisit your policy, even after implementation, to respond to changes within the organization or in tobacco use and cessation treatment overall.

After deciding the type of policy that is right for your business, your employees and your clients, it is time to begin the policy implementation. This may seem overwhelming at first, but the following pages of this toolkit will guide you through the process.

Steps Toward Policy Change

1. Assemble a tobacco-free committee or workgroup.

2. Assess tobacco attitudes, belief and use.

3. Develop a comprehensive policy.

1. Assemble a Tobacco-free Committee or Workgroup

Depending on the size of your organization, a tobacco-free committee or workgroup may be a crucial part of your implementation process. This committee can take responsibility for many of the activities. Committee members can also provide ongoing support after the implementation has occurred.

Some large organizations may choose to break their committee into sub-committees based on the skills and expertise of the people involved. For example, a worksite could assemble an education subcommittee, a marketing subcommittee and a facilities subcommittee. These could all be overseen by a steering or advisory committee. If this structure is used, it is highly recommended that current and former tobacco users be included within each subcommittee. In a smaller business, the committee may be made up of only a few members. These individuals could include a human resources representative, the committee may be made up of only a few members. These individuals could include a human resources representative, a manager and a business owner.

Additional Steps for Tobacco-free Grounds Policy

4. Select a timeline and implementation date.

5. Determine compliance and enforcement strategies.

6. Install adequate signage and remove any barriers in the implementation of this policy.

7. Implementation date celebration.

8. Evaluative effectiveness of policy.

Ongoing

• **Develop messaging on why you are implementing this policy**
• **Develop and disseminate educational materials**

Please remember that each organization is unique and has different needs while going through this process. Some suggestions within this toolkit may not be applicable or feasible for your situation. Focus on what is best for your worksite and employees. If you need additional assistance in determining the best steps and timeline for your worksite, there are free resources available to you. To connect with local resources, please contact the American Lung Association at **Info@LungMN.org.**

2. Assess Tobacco Attitudes, Belief and Use

During the early stages of this implementation process, it may be beneficial for committee members to conduct a broad assessment of the proposed policy to be implemented. Gathering additional information now will allow you to get a better picture of the current state of tobacco use with your employees and prepare you for future evaluation of the policy (if you choose to do so).

Please know that while these suggestions can improve the policy implementation process, they are not required. Conduct the strategies that are applicable to your worksite and possible with\ your resources. American Lung Association staff members are happy to connect you with local resources to assist you in this process and help determine what is best for your worksite.

Here are some ideas of information to gather at this point in the process:

1. Research what your current policies are in relation to smoking and tobacco use. If changes have occurred to these policies in recent years, see if any information exists related to the policy change process. This may better inform you on the steps you should take and any issues that you may encounter.[33]

2. Research what tobacco cessation options are currently available to your employees. This includes an analysis of current insurance benefits for coverage of cessation counseling and/or medications.[33]

3. If applicable, meet with any union representatives to determine if there are any contract issues that may impact the policy implementation process.[33]

A sample staff survey can be found in the Appendix.

Example of Responsibilities by Committees and Subcommittees*

Steering/Advisory Committee
• Set policy implementation date
• Create overall timeline
• Determine Subcommittees needed
• Select Subcommittee chairs and help recruit participants
• Approval and oversight of committee activities
• Update affiliate office managers on progress of policy implementation
• Education Subcommittee
• Create education Subcommittee timeline
• Develop the tobacco-free policy
• Develop educational materials about the policy
• Identify community resources and decide how best to utilize them
• Provide resources for those who want to quit tobacco
• Work with public relations/marketing Subcommittee to address communication to visitors

Public Relations/Marketing Subcommittee
• Create public relations/marketing Subcommittee timeline
• Create theme/campaign/logo
• Create messaging
• Create internal/external signage
• Media relations/press releases
• Business-to-business communication

Facilities Subcommittee
• Create facilities' Subcommittee timeline
• Remove any smoking huts, ashtrays and receptacles
• Install signage on property

*Please disregard if you have decided a committee is not appropriate for your worksite.

3. Develop a Comprehensive Policy

See Appendix for a sample Tobacco-free Grounds Policy.

A comprehensive tobacco-free policy includes all tobacco and "look-a-like" products and encompasses the entire property.

Tobacco and tobacco-like products that should be listed as prohibited substances include, but are not limited, to:

   • Cigarettes
   • Electronic cigarettes
   • Cigars
   • Chewing tobacco
   • Snuff
   • Pipes
   • Dissolvable tobacco products
   • Snus

For a policy that includes tobacco-free grounds, it should apply to the following places:

   • all buildings (including those owned, leased, rented or maintained by your organization)
   • all property grounds
   • parking lots and ramps (including while inside privately-owned vehicles)
   • plazas and contiguous sidewalks within 300 feet of the property
   • company-owned vehicles

People that would be covered under a comprehensive tobacco-free policy include all those that step onto the property. These include, but are not limited, to:

- Employees
- Visitors
- Patients (for healthcare facilities)
- Vendors
- Clients
- Contract workers
- Volunteers

Other important things to include in a comprehensive tobacco-free policy include:

- The sale or distribution of any tobacco products on the property is prohibited
- The procedures for the implementation of the policy
- The effective date for this policy
- Any new rules or regulations related to hiring new employees
- Plans for enforcement of the policy and consequences for violations
- Prohibiting activities such as providers smoking with clients
- Any new cessation benefits or options that will be made available to employees

ADDITIONAL STEPS FOR TOBACCO-FREE GROUNDS POLICY

4. Select a Timeline and Implementation Date

Many businesses choose to make this policy change over a six month or one-year timeframe. However, some may require more or less time. The timeline for implementing a tobacco-free worksite, the number of individuals involved in making decisions related to the policy, the number of employees and locations that will be affected, the anticipated public impact and various other factors.

This six-month timeline has been provided as a guide. However, a blank work plan has also been provided in the Appendix of this toolkit.

Determine Enforcement Strategies

The first step in enforcing a policy is to ensure that all staff, clients visitors and other impacted are aware of the policy and the reason for its implementation. Taking the time to thoroughly educate employees, vendors, clients, neighbors, and the community of the new policy's content and the reason for the change will make it less likely that individuals will violate the policy.

This education should be provided on a continual basis, with reminders being part of ongoing communications at your organization. Installing tobacco-free signage throughout the worksite will also provide notification of the policy to all who enter. In many cases, simply ensuring that everyone is aware of this policy will be sufficient to achieve compliance.[37]

While it is hopeful that all will respect the policy of your organization, it may be difficult to achieve 100% compliance of any policy. Asking employees to sign a document that states that they have read and understand the new policy and the disciplinary actions that will take place if they are in violation can be helpful toward compliance as well.[34]

Worksites and organizations may also find it helpful to provide information to employees on how to handle situations in which they encounter other employees or visitors violating this policy.

For example, staff may be asked to politely inform violators that this worksite is tobacco-free and instruct them on where they can find additional information about the policy. Employees may also be instructed on who to notify if individuals refuse to comply. This could be a security officer for visitors or a human resources representative for other employees. Some organizations may also find it beneficial to provide a means for staff to anonymously submit complaints. A confidential "Complaint Form" could be made available online or in written form, and this may reduce anxiety associated with reporting a coworker. Each worksite must decide what enforcement strategies will work best for them and their employees.[34]

Implementation Day Celebration

Worksites may find it rewarding to have implementation day celebrations. To kick off the new policy, employers may choose to invite staff and community members to an on-site event. This could also be an opportunity to invite members of the media to share your company's commitment to health and wellness.

An implementation day celebration could also be as simple as bringing in baked goods or allowing employees to have a potluck lunch.

While certainly not required, a celebration such as this can raise awareness about the new policy and cessation options and serve as encouragement for employees to quit.

Evaluate Effectiveness of Policy

One additional step that you can take after you implement a policy is to evaluate the effectiveness of this policy change. You may wish to know if your policy has helped employees quit using tobacco products, reduced the amount of tobacco they use throughout the day, or saved your company money.[35] Much of your ability to evaluate these changes will be dependent on the information gathered prior to the change (see Assess Tobacco-Use at Worksite).[35] Planning ahead and considering your evaluation needs prior to implementing the policy can help you get. You can analyze the effect this policy has had on your worksite. Here are a few ways to evaluate your policy:

1. **Conduct follow-up surveys of employees.**[35]
   If you conducted an employee assessment prior to implementing your policy, you may be able to conduct a follow-up survey to analyze changes. This could help you determine the level of employee awareness regarding the new policy and new cessation options. This could also be an opportunity for employers to ask for any concerns or suggestions. We recommend conducting this follow-up survey six months after the policy is implemented.[35]

2. **Conduct follow-up assessments of the organization.**[35]
   If you performed an assessment prior to policy implementation, you can observe and record changes in the number of people and note changes based on policy.

3. **Work with your health insurance provider to compare healthcare costs prior to and following the implementation of the policy.**[35]
   Depending on how health insurance is provided to your employees and what type of policy has been implemented (tobacco-free grounds, for example), you may be able to quantify the cost savings of the policy. If you wish to conduct an evaluation in this manner, begin with partnering with your insurance provider prior to the policy implementation.

4. **Utilize a Health Risk Assessment to determine changes in tobacco usage.**[33]
   If your worksite participates in annual Health Risk Assessment activities, you may be able to use this as a method of determining how many of your employees used tobacco products prior to the policy and any changes to this number in the years following the policy implementation.[35-36]

ONGOING TASKS

Develop Messaging on Why You Are Implementing This Policy

It is important to develop messaging on why these changes will be taking place very early in the policy implementation process. By doing this, you can ensure that a positive and consistent message is sent to all impacted by these changes. Notifying employees, clients, vendors, neighbors and other community members early in the process allows them to express their opinions, get involved in the process and prepare for the changes. The purpose of this messaging is to state the employer's intention to develop and implement a tobacco-free worksite policy. This message should either come from company leadership or be accompanied by a letter of support from this leadership.

Develop and Disseminate Educational Materials

While implementing a tobacco-free worksite policy, it is important to develop and disseminate educational materials for a variety of impacted groups.

Strategies should be developed for reaching out to:
• Employees
• Visitors
• Patients/clients
• Job applications and new employees
• Vendors and partners
• Surrounding worksites/neighbors
• General public/community, if applicable
• Board of Directors
• Students, if applicable

Strategies for reaching these audiences include:
• Tobacco-free signage
• Company website
• Company intranet
• Email
• Newsletters
• Letter from company leadership
• Pamphlets for visitors
• Appointment card announcements
• Insert with pay slip
• Newspaper articles
• Social media
• Job applications
• Admittance forms or other check-in paperwork (for patients at healthcare facilities)
• Posters/displays/bulletin boards throughout worksite
• Employee handbooks
• Window clings on company vehicles
• Discussion at staff meetings/trainings
• Guest speakers
• New employee orientation
• Mass media (press releases, articles, features, news conferences, conducting interviews, hold special event)

TOBACCO TREATMENT INTO EXISTING PROGRAMS

Individual and group counseling: When treating tobacco use disorder, medications are often necessary but alone are not sufficient. People do best with properly dosed pharmacotherapy and intensive tobacco dependence counseling. Tobacco dependence treatment combining intensive cognitive behavioral therapy and multiple pharmacotherapies has shown the greatest efficacy for individuals with co-occurring substance use disorder and mental illness.

Peer Recovery Programs

Peer specialists have experience within a specific community, such as behavioral health, and are trained to work with their peers to support them along their journey. Depending upon your setting, peers can be employees or clients who are former tobacco users. Peers uphold the values of recovery and resiliency, serving as role models for wellness, responsibility, and empowerment.

In their interactions, peers have the opportunity to communicate warmth, empathy, and a nonjudgmental stance while honoring the unique needs of specific at-risk populations.

Source: njchoices.org/pages/quit_tips

Medications can help

- Most experts recommend that EVERYONE trying to quit smoking should use medications to help them.
- There are five types of nicotine medications and two non-nicotine medications called bupropion (Zyban) and varenicline (Chantix).
- Nicotine patch, nicotine gum and nicotine lozenge are available in stores without a doctor's prescription.
- Nicotine inhaler, nicotine nasal spray, bupropion (Zyban) and varenicline (Chantix) are available with a doctor's prescription only and are covered by Medicaid in Minnesota.
- For Medicaid patients, both Nicotine Replacement Therapy and prescription medications are free.

People who use medications to quit smoking:

- Are twice as likely to be successful in quitting smoking than people who do not use medication.
- Gain less weight when they quit smoking than people who do not use medication.
- Have less unpleasant nicotine withdrawal symptoms and less craving for nicotine.

Setting a Quit Date

- Although most smokers think about quitting someday, it can be helpful to set an exact day to try to stop smoking. This is called the "Quit Date."
- The Quit Date can be any day of the month but sometimes people like to choose a special day (birthday, anniversary) that has meaning for them.
- It can be helpful to choose a Quit Date a few weeks from now, to give yourself some time to prepare.
- Making preparations to quit smoking can help you to be more successful.

Here are some ways you can prepare for your Quit Date:

- Do not buy large amounts of cigarettes or other tobacco products, like cartons of cigarettes, for example.
- Buy cigarettes one pack at a time so you can run out of cigarettes on your Quit Date.
- Throw away ashtrays, lighters and other things that remind you of smoking.
- Remove ashes from your home or car. Smelling cigarettes or ashes can make you want to smoke.
- Tell someone you are thinking about stopping smoking. This can be a roommate, friend or significant other. Let them know when your Quit Date will be so they can help you.
- Call someone to get help. Ask your psychiatrist, nurse or mental health counselor if they can assist you.

While precise job descriptions vary widely across agencies, peers focus heavily on the identification of strengths, skill building, effective symptom management, and goal setting. They can also provide outreach, advocacy, social and logistical support and education. Peers need specialized training to incorporate tobacco cessation interventions into their roles and responsibilities.

Stages of Change

- **Precontemplation:** No change is intended in the foreseeable future. The individual is not considering quitting.
- **Contemplation:** The individual is not prepared to quit at present, but intends to do so in the next six months.
- **Preparation:** The individual is actively considering quitting in the immediate future or within the next month.
- **Action:** The individual is making overt attempts to quit. However, quitting has not been in effect for longer than six months.
- **Maintenance:** The individual has quit for longer than six months.

The 5 A's:
Ask, Advise, Assess, Assist and Arrange

The U.S. Public Health Service Clinical Practice
Guideline: Treating Tobacco Use and Dependence provides healthcare clinicians an onsite strategy for smoking cessation treatment that is built around the *5 A's (Ask, Advise, Assess, Assist and Arrange).* Knowing that providers have many competing demands, the 5 A's were created to keep steps simple. **Regardless of the patient's stage of readiness for a cessation attempt, the 5 A's should be utilized at every patient visit.**

Tobacco dependence and use (current or former) is a chronic relapsing condition that requires repeated interventions and a systematic approach.

If you have limited time:
ASK → **A**DVISE → **R**EFER

The Guideline recommends that all people entering a healthcare setting should be **asked** about their tobacco use status and that this status should be documented. Providers should **advise** all tobacco users to quit and then **assess** their willingness to make a quit attempt. Persons who are ready to make a quit attempt should be **assisted** in the effort. Follow-up should then be **arranged** to determine the success of quit attempts.

The full 5 A's model is most appropriate for agencies and organizations that have tobacco cessation medications and/or behavioral services available for persons with mental illnesses. For agencies and organizations that do not have tobacco cessation services readily available, we recommend the use of the first two A's (**ask** and **advise**) and then the agency can **refer** to available community services. (This is referred to as the 2 A's + R model).

Tobacco Cessation Health Coverage in Minnesota

For the best chance at a successful quit, use therapy and cessation aid(s) approved by the Food and Drug Administration (FDA):

THERAPY:
- Individual
- Group counseling
- Telephone counseling

AND

CESSATION MEDICATIONS:
- Buproprion (Zyban®)
- Varenicline (Chantix®)

AND/OR

NICOTINE REPLACEMENT THERAPIES (NRTs):
- Patch
- Gum
- Lozenge
- Inhaler
- Nasal spray

MEDICAL ASSISTANCE AND MINNESOTACARE

Legend
- ☑ = Covered
- ◈ = Coverage Varies by Plan
- ▣ = Not Covered

The Minnesota Medicaid program covers:
- ☑ NRT Gum
- ☑ NRT Patch
- ☑ NRT Nasal Spray
- ☑ NRT Lozenge
- ☑ NRT Inhaler
- ☑ Varenicline (Chantix®)
- ☑ Buproprion (Zyban®)
- ☑ Group Counseling
- ☑ Individual Counseling
- ◈ Phone Counseling

For more information, please call the Minnesota Department of Human Services at **651-431-2670** or **800-657-3739.**

As of January 1, 2016, Minnesotans insured through Medical Assistance and MinnesotaCare will have free coverage for cessation counseling and smoking cessation medications.

MNSURE

All plans in the Health Insurance Marketplace are required to cover tobacco cessation treatment with no cost sharing. Specific coverage may vary by plan. Check with your insurance plan to find out what is covered.

STATE EMPLOYEE HEALTH PROGRAM COVERAGE

The State Employees Group Insurance Program covers:
- ☑ NRT Gum
- ☑ NRT Patch
- ☑ NRT Nasal Spray
- ☑ NRT Lozenge
- ☑ NRT Inhaler
- ☑ Varenicline (Chantix®)
- ☑ Buproprion (Zyban®)
- ☑ No Tobacco Surcharge
- ☑ Individual Counseling
- ☑ Group Counseling
- ☑ Phone Counseling

Free with a Prescription

COST: As of January 1, 2016, copays on medications were removed and individual, group and phone counseling was added.

For more information, visit mn.gov/mmb/images/SoB-16-17.pdf

PRIVATE INSURANCE COVERAGE

Minnesota does not require private health insurance plans to cover cessation treatments. Cessation coverage in private health insurance plans varies by employer and/or plan. People who smoke with this type of health insurance should contact their insurance plan for information on cessation benefits.

Your health plan's quitline:
- Blue Cross and Blue Shield of Minnesota 1-888-662-BLUE (2583)
- CCStpa 1-888-662-QUIT (7848)
- BlueLink 1-888-662-BLUE (2583)
- HealthPartners 1-800-311-1052
- Mayo Medical Plan 1-888-288-1881
- Mayo Clinic Health Systems–Mankato 1-888-288-1881
- Medica 1-800-905-7430
- MCHS (formerly MMSI) 1-888-642-5566
- MCHS - City of Rochester Employees 1-800-391-1683 (option 2)
- MCHS - Olmsted County Employees 1-888-613-5476 (option 2)
- Metropolitan Health Plan 1-888-354-7526
- PreferredOne 1-800-292-2336
- PreferredOne PPO 1-888-354-7526
- PrimeWest Health 1-800-474-3186
- South Country Health Alliance (SCHA) 1-800-504-3451
- Tricare 1-866-244-6870
- UCare Minnesota 1-888-642-5566
- For anyone else, call QUITPLAN Services 1-888-354-PLAN (7526)

AMERICAN LUNG ASSOCIATION RESOURCES

AMERICAN LUNG ASSOCIATION. | **FREEDOM** FROM SMOKING®

The American Lung Association has been helping people quit smoking for over 35 years through Freedom From Smoking®. Ranked as one of the most effective programs in the country, Freedom From Smoking has helped hundreds of thousands of individuals quit smoking for good and is now available in a variety of formats. Go to **FreedomFromSmoking.org** for more information.

AMERICAN LUNG ASSOCIATION. | **N·O·T** NOT ON TOBACCO®

Not-On-Tobacco® is offered to teens only in a limited number of areas throughout the state.

AMERICAN LUNG ASSOCIATION. | **LUNG HELPLINE** & TOBACCO QUITLINE

1-800-LUNGUSA (586-4872) Our compassionate and knowledgeable HelpLine staff can provide you with the support you need and the answers you're looking for.

RESOURCES TO HELP YOU QUIT

QUITPLAN®
1-888-354-PLAN   quitplan.com

QUITPLAN® Services offers all Minnesotans free help to quit tobacco. Visit **quitplan.com** or call **1-888-354-PLAN (7526)** anytime to enroll.

INDIVIDUAL SERVICES (choose any or all)
- Text Messaging— practical advice, games and encouragement that can help you quit
- Starter Kit—two weeks of free patches, gum or lozenges
- Email Program—a series of emails with tips, advice and encouragement to help you quit
- Quit Guide—a guide to help you create a plan to quit (can be downloaded or mailed)

QUITPLAN® HELPLINE
A complete program to help you quit
- Telephone coaching
- Four weeks of free patches, gum or lozenges
- Text messaging
- Email support
- Welcome kit

COST: All QUITPLAN® Services are free.

MEDICATIONS PROVIDED:

☑ NRT Gum   ☐ NRT Inhaler
☑ NRT Patch   ☐ Varenicline (Chantix®)
☑ NRT Lozenge   ☐ Buproprion (Zyban®)
☐ NRT Nasal Spray

Source: QUITPLAN® Services, quitplan.com

American Lung Association's Stance on Electronic Cigarettes (e-cigarettes): The American Lung Association is troubled about unproven claims that e-cigarettes can be used to help smokers quit. The FDA's Center for Drug Evaluation and Research has not approved any e-cigarettes as a safe and effective method to help smokers quit.

Revised 1-2017

For more information about program locations and schedules | **651-268-7612** | **Lung.org**

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The Brief Tobacco Intervention Training Program

Fagerstrom Test for Nicotine Dependence

	PLEASE TICK (✔) ONE BOX FOR EACH QUESTION		
How soon after waking do you smoke your first cigarette?	Within 5 minutes	☐	3
	5-30 minutes	☐	2
	31-60 minutes	☐	1
Do you find it difficult to refrain from smoking in places where it is forbidden? e.g. Church, Library, etc.	Yes	☐	1
	No	☐ 0	
Which cigarette would you hate to give up?	The first in the morning	☐	1
	Any other	☐ 0	
How many cigarettes a day do you smoke?	10 or less	☐	0
	11 – 20	☐	1
	21 – 30	☐	2
	31 or more	☐	3
Do you smoke more frequently in the morning?	Yes	☐	1
	No	☐ 0	
Do you smoke even if you are sick in bed most of the day?	Yes	☐	1
	No	☐ 0	
	Total Score		
SCORE	1- 2 = low dependence 3-4 = low to mod dependence	5 - 7= moderate dependence 8 + = high dependence	

Add up the scores from the questionnaire.

Scoring the Fagerstrom Test for Nicotine Dependence

To remind you of information (covered in Module 1) about scoring the Test:

Score of 1 - 2

A patient who scores between 1 and 2 on the Fagerstrom Test for Nicotine Dependence is classified as having a low dependence on nicotine. This suggests that they may not need Nicotine Replacement Therapy (NRT), although it is recommended that they still be monitored for withdrawal symptoms.

Score of 3-4

A patient who scores 3 or 4 would be considered to have a low to moderate dependence on nicotine and could be offered patches, inhaler, lozenges or gum. Please check NRT recommendations chart (insert link).

Score of 5-7

A patient who scores 4 would be considered to be moderately dependent on nicotine and can be offered patches, inhaler, lozenge or gum. They can also be offered the combined therapy of patches with lozenge and gum. Please check NRT recommendations chart (insert link).

Score of 8 and over

A patient who scores 5 and over would be considered highly dependent on nicotine and can be offered patches, inhaler, lozenges and/or gum. They can also be offered the combined therapy of patches and lozenges or gum. Please check the NRT recommendations chart (see the chart on the next page).

SAMPLE WORK PLAN TEMPLATE

Tobacco Use and Recovery among Individuals with Mental Illness or Addiction
June 1, 2017 - June 1, 2018

Organization Goals

1. Incorporate ongoing tobacco education into staff orientation and training
2. Provide parallel wellness services between clients and staff (including tobacco cessation)
3. Work toward standardizing client assessment and referral protocols and including in EMR system
4. Work toward tobacco-free grounds policies

FOCUS AREA: Staff Orientation and Training

Objectives and Action Steps	By Whom	Timeline	Resources and Support Available/Needed or Resistance		Potential Barriers for Implementation	Communication Plan	Status
What needs to be done?	Who will take action?	By what date will the action be done?	Resources available	Resources Needed (financial, human, political, other)	What individuals and organizations might resist? How?	What individuals and organizations should be informed about/ involved with these actions?	
Goal:							
Step 1: Identify survey needs		Begins: Ends:					
Step 2:							
Step 3:							
Goal:							
Step 1:							
Goal:							
Step 1:							

Notes:

SAMPLE WORK PLAN TEMPLATE

FOCUS AREA: Client Assessments

Objectives and Action Steps	By Whom	Timeline	Resources and Support Available/Needed		Potential Barriers or Resistance	Communication Plan for Implementation	Status
What needs to be done?	Who will take action?	By what date will the action be done?	Resources available	Resources Needed (financial, human, political, other)	What individuals and organizations might resist? How?	What individuals and organizations should be informed about/ involved with these actions?	
Goal:							
Step 1: Identify survey needs		Begins: Ends:					
Step 2:							
Step 3:							
Goal:							
Step 1:							
Goal:							
Step 1:							

Notes:

SAMPLE WORK PLAN TEMPLATE

FOCUS AREA: Tobacco-Free Grounds Policies

Objectives and Action Steps	By Whom	Timeline	Resources and Support Available/Needed		Potential Barriers or Resistance	Communication Plan for Implementation	Status
What needs to be done?	Who will take action?	By what date will the action be done?	Resources available	Resources Needed (financial, human, political, other)	What individuals and organizations might resist? How?	What individuals and organizations should be informed about/ involved with these actions?	
Goal:							
Step 1: Identify survey needs		Begins: Ends:					
Step 2:							
Step 3:							
Goal:							
Step 1:							
Goal:							
Step 1:							

Notes:

SAMPLE WORK PLAN TEMPLATE
FOCUS AREA:

Objectives and Action Steps	By Whom	Timeline	Resources and Support Available/Needed		Potential Barriers or Resistance	Communication Plan for Implementation	Status
What needs to be done?	Who will take action?	By what date will the action be done?	Resources available	Resources Needed (financial, human, political, other)	What individuals and organizations might resist? How?	What individuals and organizations should be informed about/involved with these actions?	
Goal:							
Step 1: Identify survey needs		Begins:					
Step 2:		Ends:					
Step 3:							
Goal:							
Step 1:							
Goal:							
Step 1:							

Notes:

SAMPLE POLICY LANGUAGE

PURPOSE

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

_____ believes the use of tobacco products, including electronic delivery devices, on its property is detrimental to the health and safety of its employees, clients, and other visitors.

DEFINITIONS

"All Times" means 24 hours a day, seven days a week.

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

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

"Property" means all facilities, grounds, and property (including vehicles) owned, leased, rented, contracted, used, or controlled by_____.

"Smoking" means inhaling or exhaling smoke from any lighted or heated cigar, cigarette, pipe, or any other tobacco or plant product, or inhaling or exhaling aerosol or vapor from any electronic delivery device. Smoking includes being in possession of a lighted or heated cigar, cigarette, pipe, or any other tobacco or plant product intended for inhalation, or an electronic delivery device that is turned on or otherwise activated.

"Tobacco Products" means any product containing, made, or derived from tobacco and intended for human consumption, whether chewed, smoked, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means.

"Tobacco Use" means the act of smoking, the use of smokeless tobacco, or the use of any other tobacco product in any form.

"Visitor" means any person who is not an employee.

POLICY

The use of tobacco products and electronic delivery devices is prohibited at all times in or on all property _____ has the authority to control regardless of location.

Employees are prohibited from using tobacco products and electronic delivery devices while on duty.

APPLICABILITY

This policy applies to all visitors and staff on _____ property.

This policy also applies to private vehicles parked on _____ parking lots.

EXCEPTION

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

DISSEMINATION

Signage will be posted at strategic locations to notify employees and visitors of this policy.

CESSATION

_____ will identify and/or offer cessation programs and services to those ready to quit.

COMPLIANCE AND ENFORCEMENT

The success of this policy depends on the consideration and cooperation of both tobacco users and non-users. Enforcement is a shared responsibility of all staff. Individuals acting in violation of this policy will be reminded and asked to comply. Employees found to have violated this policy may be subject to disciplinary action. Visitors who violate this policy may be asked to leave the property.

EFFECTIVE DATE

This policy shall take effect in full on_____ .

_____

May 2016

Minnesota Recovery Programs Tobacco and Wellness Survey

Thank you for taking the time to complete the survey! Your responses will be completely confidential: your employer will not know whether you participated and we will not share your individual responses with your employer.

Tobacco Use Definition
Tobacco use in this document refers to smoking, use of smokeless tobacco products, and the use of unregulated nicotine products (e.g. "e-cigarettes"). It also refers specifically to the use of manufactured, commercial tobacco products, and not to the sacred, medicinal and traditional use of tobacco by American Indians and other groups.

* 1. Please identify the site you work with most regularly:

○ Location 1
○ Location 2
○ Location 3
○ Location 4
○ Location 5
○ Other (please specify)

[   ]

* 2. Which program do you spend most of your time working in:

○ Program 1
○ Program 2
○ Program 3
○ Program 4
○ Other (please specify)

[   ]

APPENDIX

* 3. How long have you been at XXX?

○ 0-1 Year

○ 1-5 Years

○ 5-10 Years

○ 10+ Years

* 4. Please indicate the degree to which you disagree or agree with each of the following statements:

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Continued tobacco use makes chemical dependency relapse more likely	○	○	○	○	○
Continued tobacco use makes chemical dependency relapse more likely	○	○	○	○	○
Continued tobacco use makes chemical dependency relapse more likely	○	○	○	○	○
Continued tobacco use makes chemical dependency relapse more likely	○	○	○	○	○
Continued tobacco use makes chemical dependency relapse more likely	○	○	○	○	○
Continued tobacco use makes chemical dependency relapse more likely	○	○	○	○	○
Stopping tobacco use increases cravings for alcohol and other drugs	○	○	○	○	○
Stopping tobacco use increases cravings for alcohol and other drugs	○	○	○	○	○
Stopping tobacco use increases cravings for alcohol and other drugs	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Stopping tobacco use increases cravings for alcohol and other drugs	○	○	○	○	○
Stopping tobacco use increases cravings for alcohol and other drugs	○	○	○	○	○
Stopping tobacco use increases cravings for alcohol and other drugs	○	○	○	○	○
Eliminating the use of tobacco will not interfere with chemical dependency recovery	○	○	○	○	○
Eliminating the use of tobacco will not interfere with chemical dependency recovery	○	○	○	○	○
Eliminating the use of tobacco will not interfere with chemical dependency recovery	○	○	○	○	○
Eliminating the use of tobacco will not interfere with chemical dependency recovery	○	○	○	○	○
Eliminating the use of tobacco will not interfere with chemical dependency recovery	○	○	○	○	○
Eliminating the use of tobacco will not interfere with chemical dependency recovery	○	○	○	○	○
Eliminating the use of tobacco may have health benefits	○	○	○	○	○
Eliminating the use of tobacco may have health benefits	○	○	○	○	○
Eliminating the use of tobacco may have health benefits	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Eliminating the use of tobacco may have health benefits	○	○	○	○	○
Eliminating the use of tobacco may have health benefits	○	○	○	○	○
Eliminating the use of tobacco may have health benefits	○	○	○	○	○
Tobacco use decreases symptoms of mental illness	○	○	○	○	○
Tobacco use decreases symptoms of mental illness	○	○	○	○	○
Tobacco use decreases symptoms of mental illness	○	○	○	○	○
Tobacco use decreases symptoms of mental illness	○	○	○	○	○
Tobacco use decreases symptoms of mental illness	○	○	○	○	○
Tobacco use decreases symptoms of mental illness	○	○	○	○	○
Tobacco dependence should be treated in chemical dependence recovery programs	○	○	○	○	○
Tobacco dependence should be treated in chemical dependence recovery programs	○	○	○	○	○
Tobacco dependence should be treated in chemical dependence recovery programs	○	○	○	○	○
Tobacco dependence should be treated in chemical dependence recovery programs	○	○	○	○	○
Tobacco dependence should be treated in chemical dependence recovery programs	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Tobacco dependence should be treated in chemical dependence recovery programs	○	○	○	○	○
Implementing tobacco-free grounds policies at XXX would infringe on client rights					
Implementing tobacco-free grounds policies at XXX would infringe on client rights	○	○	○	○	○
Implementing tobacco-free grounds policies at XXX would infringe on client rights					
Implementing tobacco-free grounds policies at XXX would infringe on client rights	○	○	○	○	○
Implementing tobacco-free grounds policies at XXX would infringe on client rights					
Implementing tobacco-free grounds policies at XXX would infringe on client rights	○	○	○	○	○
Implementing tobacco-free ground policies at XXX would infringe on staff rights					
Implementing tobacco-free ground policies at XXX would infringe on staff rights	○	○	○	○	○
Implementing tobacco-free ground policies at XXX would infringe on staff rights					
Implementing tobacco-free ground policies at XXX would infringe on staff rights	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Implementing tobacco-free ground policies at XXX would infringe on staff rights	○	○	○	○	○
Implementing tobacco-free ground policies at XXX would infringe on staff rights	○	○	○	○	○
Nicotine Replacement Therapy Products (gum, patch, lozenge) are safer than commercial tobacco	○	○	○	○	○
Nicotine Replacement Therapy Products (gum, patch, lozenge) are safer than commercial tobacco	○	○	○	○	○
Nicotine Replacement Therapy Products (gum, patch, lozenge) are safer than commercial tobacco	○	○	○	○	○
Nicotine Replacement Therapy Products (gum, patch, lozenge) are safer than commercial tobacco	○	○	○	○	○
Nicotine Replacement Therapy Products (gum, patch, lozenge) are safer than commercial tobacco	○	○	○	○	○
Nicotine Replacement Therapy Products (gum, patch, lozenge) are safer than commercial tobacco	○	○	○	○	○
Electronic Cigarettes are an effective tobacco cessation device	○	○	○	○	○
Electronic Cigarettes are an effective tobacco cessation device	○	○	○	○	○
Electronic Cigarettes are an effective tobacco cessation device	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Electronic Cigarettes are an effective tobacco cessation device	○	○	○	○	○
Electronic Cigarettes are an effective tobacco cessation device	○	○	○	○	○
Electronic Cigarettes are an effective tobacco cessation device	○	○	○	○	○
In certain circumstances, it's okay for staff and clients to use tobacco together	○	○	○	○	○
In certain circumstances, it's okay for staff and clients to use tobacco together	○	○	○	○	○
In certain circumstances, it's okay for staff and clients to use tobacco together	○	○	○	○	○
In certain circumstances, it's okay for staff and clients to use tobacco together	○	○	○	○	○
In certain circumstances, it's okay for staff and clients to use tobacco together	○	○	○	○	○
In certain circumstances, it's okay for staff and clients to use tobacco together	○	○	○	○	○
Providing clients access to tobacco treatment services is consistent with our mission to XXXXX	○	○	○	○	○
Providing clients access to tobacco treatment services is consistent with our mission to XXXXX	○	○	○	○	○
Providing clients access to tobacco treatment services is consistent with our mission to XXXXX	○	○	○	○	○
Providing clients access to tobacco treatment services is consistent with our mission to XXXXX	○	○	○	○	○

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Providing clients access to tobacco treatment services is consistent with our mission to XXXXX	○	○	○	○	○
Providing clients access to tobacco treatment services is consistent with our mission to XXXXX	○	○	○	○	○

* 5. What do you believe is the biggest barrier to incorporating tobacco treatment into the way that XXXX provides services?

○ Lack of client interest
○ Lack of client ability
○ Lack of staff interest
○ Lack of staff training
○ Eliminating the use of tobacco may negatively interfere with chemical dependency recovery
○ Eliminating the use of tobacco may increase symptoms of mental illness
○ Treatment is not effective for people with mental illness
○ Other (please specify)

[   ]

6. What tobacco dependence topics would you like more training and/or information about? (select all that apply)

☐ The basics – an understanding of the nature of tobacco dependence
☐ Tobacco treatment and recovery including withdrawal management
☐ Medical aspects of tobacco use
☐ How tobacco relates to other chemical use
☐ Psycho-social and other cultural aspects of tobacco use
☐ Marketing and advertising factors
☐ Tobacco use and mental health conditions
☐ Pharmacotherapy (interactions of medications with tobacco)
☐ Electronic Cigarettes
☐ Use and impact of tobacco in diverse populations (e.g. hookah, American Indian)
☐ Other (please specify)

[   ]

7. What wellness topics would you like more training and/or information about? (select all that apply)

☐ Finding medical providers that accept MA

☐ Understanding dental treatment plans

☐ Diabetes prevention and treatment resources

☐ Understanding medical records

☐ Specific coping skills for stress

☐ Understanding recommended dental procedures

☐ Benefits of different types of exercise and physical activity

☐ Understanding recommended health screenings

☐ Sexual health resources

☐ Other (please specify)

[   ]

* 8. How often do you start conversations with clients about the following topics?

	Never	Sometimes	Daily	N/A
Tobacco Use	○	○	○	○
Exercise	○	○	○	○
Nutrition	○	○	○	○
Sexual Health	○	○	○	○
Chronic Pain	○	○	○	○
Body Weight	○	○	○	○

9. Additional comments:

[   ]

10. If you would like to be entered into a drawing for one of four $25 Target gift cards, please provide your name and contact information. The American Lung Association in Minnesota will not share your personal information with your employer nor will your survey responses be connected to your name.

First Name [   ]

Last Name [   ]

Email Address [   ]

LIST OF ACTIVITIES

MONTH 1	Develop messaging on WHY you are implementing this policy	Assemble a tobacco-free committee or workgroup		
MONTH 2	Select a timeline and implementation date	Assess tobacco use at the worksite		
MONTH 3	Develop a comprehensive tobacco-free policy language	Review insurance change options	Discuss compliance and enforcement strategies	Develop educational material
MONTH 4	Finalize a comprehensive tobacco-free policy	Assess cessation options	Determine compliance and enforcement strategies	Disseminate educational material
MONTH 5	Disseminate educational material	Promote cessation options		
MONTH 6	Emplace enforcement strategies	Disseminate educational material	Install adequate signage and remove any smoking huts, ashtrays and receptables	Implementation day celebration
ONGOING ACTIVITIES	Disseminate educational material	Promote cessation options	Monitor and address hot spots	Evaluate effectiveness of policy

ESTIMATING THE ANNUAL COST OF A TOBACCO USING EMPLOYEE[8]

Number of Employees	×	0.144 Rate of Smoking in Minnesota	=	Number of Smokers
Number of Smokers	×	$4,056	=	Total Productivity Loses*
Number of Smokers	×	$2,056	=	Total Excess Healthcare Costs
Total Productivity Loses	×	Total Excess Healthcare Costs	=	Total Loss Due To Smoking

Productivity losses include costs associated with increased absenteeism, reduced productivity as a result of nicotine addiction, and missed work time due to smoke breaks.