

Barriers to Implementing Brief Tobacco Cessation Interventions in Clinical Settings

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Goal of Integrated Care Model

To establish the message that abstinence is critical to mental and physical health

- To have this message be given by *all* MH providers
- On repeated occasions
- In multiple mental health settings
- To all mental health patients

How to do this?

- Identified clinical champions
- Who are able to inspire their peers
- Through:
 - Education
 - Goal Setting
 - Long-Term Follow-Up

Resistance to Change

- Degree of resistance varies based on:
 - The degree of proposed change
 - Perceived benefits of change
 - Perceived costs of change
 - And, most importantly, how the change is proposed

Change required for TUC Integrated Care

- Degree of proposed change is small
 - 3 minutes counseling 2 times (pre/post quit date)
 - (relatively) simple Rx regimen
 - Necessary clinical skills are already well-established
 - Minimal training required
- Plus, our target audience (our patients) are motivated and receptive

- Potential benefits are enormous
 - Strengthened clinical care
 - Improved pt self-efficacy
 - Improved pt mood and physical health
 - Lessened clinical burden
 - Decreased pharmacy and clinic costs
- Costs are minimal

Components of Skillful Implementation Efforts

- Proactive prediction of barriers:
 - Patient Barriers
 - Provider Barriers
 - Programmatic Barriers
- Pre-emptive education to address barriers
 - Reinforces basic information
 - Dispels commonly held mis-beliefs
 - Establishes appropriate group norms & expectations

Patient Barriers

- ✓ Belief that trying to quit will only complicate other mh efforts
- ✓ Belief that smoking improves abstinence from other substances
- ✓ Belief that quitting will result in increased depression or anxiety
- ✓ Belief that it is “too late” to quit
- ✓ Passive suicidality
- ✓ Concern about weight gain
- ✓ Reliance on tobacco use for socialization and/or entertainment

Provider Barriers

- ✓ Belief that patients will be offended by intervention efforts
- ✓ Belief that interventions are complex and time-consuming
- ✓ Belief that quitting will compromise other abstinence goals
- ✓ Belief that tobacco cessation inevitably leads to increased distress
- ✓ Expectation that banning smoking breaks will result in a staff and patient backlash

Programmatic Barriers

- ✓ Leadership fails to publicly support staff who regularly provide tobacco cessation treatment
- ✓ Lack of tobacco cessation materials
- ✓ VA pharmacy discourages or prohibits open prescriptions of appropriate tobacco cessation medications
- ✓ Leadership allow staff and patients to use tobacco products inside buildings and/or near public doorways
- ✓ Units maintain smoking areas on inpatient wards or hospital grounds

Recommended Education Steps

1. Report to leaders and elicit top-down support
2. Set up team meetings to provide inspirational education and introduce protocol
 - a. Clarify the purpose of the protocol
 - b. Define clinic goals
 - c. Define the target audience
 - d. Define clinic roles (who should be doing what?)
 - e. Define clinic procedures (how will it be done?)
3. Track short- and long-term changes
4. Provide and receive regular feedback—adjust efforts accordingly

Team Meetings

A. Clarify the purpose of the protocol:

- Describe the relationship between smoking and MH
- Highlight the benefits of addressing smoking in the course of standard treatment
- Highlight the simplicity of smoking cessation treatment
- Dispel erroneous beliefs most commonly or rigidly held in your clinic

Team Meetings

B. Define Clinic Goals:

- Note higher goals, emphasize minimal standards
- Clarify the difference between required mandates and voluntary goals
- All MH pts will be screened for tobacco use at least once
- Tobacco Use Disorder will be entered as an official diagnosis in CPRS for all smokers
- All smokers will (a) be advised to quit, and (b) be asked about motivation to quit by all MH providers at least ___ times per year
- All smokers who are motivated to quit in the near future will be provided with brief interventions

Team Meetings

C. Define the Target Audience

- Smoking Status Screening: All patients who are new to MH or established patients for whom smoking status is not known
- Motivation Screening: All MH patients who smoke
- Counseling: All MH patients who smoke and want to quit, whether or not they are already enrolled (or have previously been enrolled) in the specialized smoking cessation clinic
- Pharmacotherapy: All MH patients who smoke and want to quit, whether or not they are already enrolled (or have previously been enrolled) in the specialized smoking cessation clinic

Team Meetings

D. Define Clinic Roles

- Communication *must* be explicit
- Emphasize benefits of repetition

- Smoking Status Screening: All MH providers
- Entering Diagnosis in CPRS: All MH providers
- Motivation Screening: All MH providers
- Counseling: All MH non-prescribers
- Setting up Rx Appts: All MH non-prescribers
- Pharmacotherapy: All MH prescribers
- Maintaining Patient Materials: Clinical champion
- Providing regular feedback/training: Clinical champion

Team Meetings

E. Define Clinic Procedures

- Provide a copy of brief guidelines to clinicians, and make longer manuals available if requested
- Tell clinicians where to access pt self-help materials
- Tell clinicians how to order appropriate medications
- With the guidance of team leaders and support staff, inform clinicians how medication appts will be scheduled
- Inform clinicians how change will be tracked and communicated

Tracking Clinician Change

- Tracking clinician change is helpful because it:
 - Depersonalizes the process
 - Is locally relevant
 - Is objective
- Options for tracking change include:
 - Anonymous Staff Surveys
 - EPRP, SHEP data
 - Clinical Reminders
 - VISN or local data base

Communicating Change

- In communicating change, be sure to:
 - Emphasize compliance (vs. dissent)
 - Provide feedback (i.e., progress reports) on a regular basis, and make sure this information is given to everyone on the team (not just team leaders)
 - Invite provider feedback and make changes accordingly

Keys to Successful Trainings

- ✓ Include non-clinical staff in trainings
 - Clinic & practice norms are only successfully changed when *all* staff are on-board
 - Non-clinical staff will play a key role:
 - Will they be responsible for checking out appointments?
 - Will they be responsible for making short-notice prescriber appointments?
 - Do they cue providers on missing clinical reminders?
 - Will they be maintaining waiting-room materials?
 - Do patients ever approach non-clinical staff with questions or conversations about clinic care, recommended treatments, etc.?

Keys to Successful Trainings

- ✓ **Concession making** (offer high goals, emphasize minimum standards)
- ✓ **Achievability** (goals should be simple, clear, and easily achievable)
- ✓ **Consistency** (solicit verbal or written commitment from providers)
- ✓ **Volunteerism** (vs. mandated change)
- ✓ **Beneficence** (highlight benefits of change)
- ✓ **Non-Defensiveness** (dissent and differing opinions are encouraged)
- ✓ **Flexibility** (be willing to change goals and procedures as needed)
- ✓ **Persistence** (change will require follow-up and regular re-trainings)