Build a Clinic Learning Community

2016-2017

Summary Report and Playbook

31 August 2017

The Build-a-Clinic Learning Community was developed by the Behavioral Health & Wellness Program at the University of Colorado, Anschutz Medical Campus with assistance from its partners at the University of Colorado Department of Family Medicine and The Rocky Mountain Public Health Training Center. This evaluation and playbook was written by:

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Executive Summary

The Behavioral Health and Wellness Program, with the help of its partners, recruited and trained cohorts of 9 (pilot in 2016) and 16 (in 2017) integrated primary care clinics ready to add or augment tobacco cessation services and supports into existing clinical practice operating in rural or medically underserved areas. The Build a Clinic (BaC) program participants in each cohort participated in six webinars, six collaborative learning activities, and received 3 hours of one-on-one tailored technical assistance over the course of six months. Collectively the six, themed webinars and collaborative learning activities comprise a comprehensive series on the skills and knowledge necessary to create, integrate, and operate an efficient tobacco cessation workflow within normal clinic operations.

This innovative proof of concept program suggests that learning communities can be used to successfully motivate organizational change and successfully assist practices in adding or augmenting their tobacco cessation services and supports.

The Behavioral Health & Wellness Program's Organizational Self-Assessment evaluates clinics across 9 domains of tobacco cessations services and supports, identifying 29 unique areas for improvement. All organizations improved in at least 4 of these areas—including 62% specifically improving the critical intake functions (Asking/Advising) known to positively affect patient outcomes. The average BaC participant increased in 8 subcategories (range 4-16); 62% of practices moved into stage 5 ("Currently occurring") in at least 1 of the 29 subcategories (range 1-8, average = 3.7). There was improvement in all 9 domains across the cohort.

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Introduction

Background

Despite unequivocal evidence supporting the importance of smoking cessation, a "practice gap" in the rates at which smoking cessation is addressed by practitioners in clinical settings persists. For over 15 years, best practice guidelines have recommended providers apply the 5As, namely, provide screening for tobacco use in all patients at every visit (ASK), recommend that the patient consider reducing or stopping tobacco use (ADVISE), ASSESS their willingness to quit and level of nicotine dependence, ASSIST them in their quit attempt, and ARRANGE for follow-up visits (Fiore et al., 2008). Evidence suggests that between 40% and 76% of smokers report receiving cessation advice from their physicians (AAFP, 2014; Park et al., 2015; HRSA, 2011; Hu et al., 2003; CTUMS ,2006; Longo et al., 2006). Though practitioners deliver advice to quit at these moderate rates, studies have shown that the rates of providing specific assistance with quitting ("ASSIST") (i.e. motivational intervention, counseling, self-help materials, smoking cessation medications, or follow-up support) are below 20% (AAFP, 2014; Park et al., 2015; Curry, 2000; Gottlieb et al., 2001; Young & Ward, 2001; DePue et al., 2002; Hu et al., 2003; Piper et al., 2003; Longo et al., 2006). This practice gap is substantial and has proven difficult to narrow.

Priority Populations' Needs.

Primary care clinics treat patients at multiplicative risk for smoking and related excess death and disability. While the *50th Anniversary Surgeon General's Report on Smoking and Health* shares the great progress in reducing tobacco use, the most vulnerable patients continue to smoke at very high rates (USDHHS, 2014). For example, in comparison to the general population, individuals with mental illnesses or addictions have not seen significant decreases in smoking rates. In 2013, the CDC reported that roughly 18.1% of the general population smokes (CDC, 2013), while an alarming 77-93% of people receiving care in substance abuse treatment settings continue to use tobacco (Richter et al., 2001). In fact, persistently elevated rates of tobacco use have been demonstrated for individuals across a spectrum of disparity groups including those with lower socioeconomic status and criminal justice involvement (Pavlik et al., 2014).

The time primary care providers spend with their patients is extremely valuable and physicians tend to prioritize patients' most immediate concerns. This often comes at the cost of deferring preventive care to unspecified future appointments. This deferment is even more problematic in rural areas where geographic dispersal, transportation limitations, and poverty restrict patients' ability to visit their PCPs except in emergencies (Hutcheson et al., 2008). In rural communities, a combination of risk

factors, e.g., socioeconomic status, education, combines with social norms and values and with weaker tobacco control policies to create a pervasive culture of tobacco use. According the American Lung Association (ALA), 44% of 18-34 year olds in rural areas are smokers compared to 33% in urban areas (ALA, 2012). Rural smokers also die earlier than their urban counterparts from tobacco-related illnesses (ALA, 2012). This premature death is associated with an earlier age of initiation, heavier smoking, and dual use of smoked/smokeless tobacco products at twice the rate of the national average (ALA, 2012).

Target Clinical Settings.

Primary care practice, also known as family medicine or general practice, has been identified as an important setting for intervening with tobacco users. Indeed, every primary care visit offers the potential to discuss issues surrounding tobacco use and cessation. The World Health Organization (WHO) has called for smoking cessation to be integrated into primary health care globally, as it is seen as the most suitable health system context for providing advice and support on smoking cessation (WHO, 2008; Vardavas et al., 2013). In addition to physician interventions, primary care offers the opportunity for multiple providers to intervene, e.g., nurses, psychologists, physician assistants, and navigators.

Need for Specialized Training.

Barriers to optimal cessation practice have been identified at the level of the patient, practitioner, and practice, and barriers limit the delivery; and, uptake of cessation treatments in primary care (Vogt et al., 2005). Promising strategies for overcoming these barriers include training at the provider level (e.g., motivational interventions, CO monitoring, counseling) as well as the practice level (e.g., supervision/support, workflow, billing). Such multi-component interventions have been shown to be the most effective method for increasing provider performance in the delivery of smoking cessation treatment and improving cessation rates among patients (Grimshaw et al., 2001; Anderson & Jané-Llopis, 2004; Fiore et al., 2008; Papadakis, 2010).

The Build-a-Clinic Program

Build-a-Clinic Goals

The overall aim of the Build a Clinic (BaC) project was to promote evidence-based tobacco cessation among primary care clinics nationally. In particular, we emphasized the training needs of rural primary care practices or those serving underserved populations or those in provider shortage areas, especially during the 2017 cycle. The strategy was to develop, implement, and evaluate an innovative, multi-modal tobacco cessation training program designed to meet the competing demands primary care practices face.

Goal #1. Create a web-based learning series focused not only on clinical guidelines, but also on the system redesign needed to build a tobacco cessation clinic. Despite unequivocal evidence supporting the importance of tobacco cessation, there continues to be a 'practice gap' in the rates at which tobacco cessation is addressed by primary care (Fiore et al., 2008; Park et al., 2015). Although numerous tobacco cessation trainings exist, we are unaware of any *systematic and comprehensive* education program tailored to the needs of primary care with the potential for national dissemination such as the one created for this project.

Goal #2. Pilot a cooperative learning community to supplement web-based training. We used the innovative ECHO (Extension for Community Healthcare Outcomes) model to build a cooperative learning community directed by expert-guided discussions of clinic-initiated case studies. The virtual, live environment linked academic experts and community providers, thus stimulating participant engagement. Experts and sites worked together to generate solutions to the common challenges and barriers inherent to integrating tobacco treatment into daily practice.

Project Partners

Behavioral Health & Wellness Program

The Behavioral Health & Wellness Program (BHWP) is housed in the University of Colorado, School of Medicine. BHWP's mission is to improve quality of life by facilitating evidence-based health behavior change for communities, organizations, and individuals. BaC program extended BHWP's long-standing organizational portfolio of tobacco control and prevention. Since 2006, BHWP has assisted healthcare systems to integrate tobacco cessation treatment and policies into hospital and community-based settings. We have focused on improving the effectiveness of interdisciplinary healthcare provider interventions for tobacco cessation by developing publicly accessible toolkits, performing on-site trainings and technical assistance, advising leadership on best practices, and providing web-based and interactive distance

learning opportunities. We have directly trained over 8,000 healthcare professionals in over 30 states in our DIMENSIONS Tobacco-Free Program, which provides up-to-date guidance on tobacco cessation policy, clinic infrastructure, and treatment. More on our programming and resources can be found at www.bhwellness.org

University of Colorado School of Medicine—Department of Family Medicine

University of Colorado, Department of Family Medicine is the second largest family medicine department in the country and has founded 2040 Partners for Health which convenes and facilitates health discussions, research, programs, and other community based action. One of the Department's focal areas is smoking cessation. Health coaching, including tobacco cessation coaching, is delivered by staff who have extensive training and experience in health-focused clinical and behavioral strategies.

ECHO Colorado

ECHO Colorado provides unique, cooperative learning experiences designed to help spread knowledge and understanding among health and health care professionals. The ECHO model leverages video-conferencing technology to connect specialist knowledge with providers in rural and underserved communities. ECHO learning series take actionable information presented by an expert or specialist on a specific topic and apply it to case-based examples that participants bring to the table. ECHO Colorado offers a variety public health series, designed to improve current disease prevention efforts and health promotion programs and to share best practices across programs and committees. To date there has been no application of the model to tobacco cessation treatment. This project addressed this gap.

Rocky Mountain Public Health Training Center

The Rocky Mountain Public Health Training Center (RM-PHTC) is one of 10 regional public health training centers funded by the Health Resources Services Administration (HRSA) to provide high-quality distance-based training to practitioners addressing public health issues. The RM-PHTC uses a full spectrum of training modalities ranging from one-time webinars to multi-session learning cohorts in the form of online courses and ECHO learning series. RM-PHTC specializes in the use of bidirectional video and facilitated live learning sessions to bring together practitioners separated by distance, but connected by experience. RM-PHTC is a local implementation site for ECHO Colorado. RM-PHTC is housed within the Center for Public Health Practice at the Colorado School of Public Health.

Build-a-Clinic 2016-2017

Design

BaC instructed and assisted primary care clinics across the nation to integrate tobacco cessation services into established clinical practices. The multi-modal educational design employs a combination of didactic webinars, interactive learning communities and individualized ad hoc technical assistance (TA). The purpose of this multi-modal approach was to increase provider tobacco treatment knowledge and facilitate service delivery. Didactic, expert-facilitated webinars provided an evidence-based platform for actionable clinic change. For the cohorts that participated in the learning communities, the webinars further served as a frame of reference for applied and active dialogue. Additionally, BHWP and University of Colorado partners provided personalized technical assistance to the Learning Community sites using an "office hours" format. We believe this multi-pronged model expedited knowledge and practice outcomes achievement across the measurement domains detailed in the evaluation below.

Innovations

This tobacco education program targeting clinics serving traditionally hard to reach populations provided a unique opportunity to maximize provider knowledge and skill in building and integrating tobacco services within standards of care.

Factors that influence implementation of tobacco screening, cessation, and referral to treatment in primary care environments include:

1. Competing clinic demands,
2. Clinic infrastructure,
3. Support from supervisors
4. Healthcare providers' awareness of current tobacco treatment guidelines,
5. Providers' belief that they can impact patients' tobacco use behaviors,
6. Training on how to provide tobacco screening and treatment,
7. Provider billing and reimbursement for services.

While there have been a number of past trainings and resources geared to primary care, none have provided the full spectrum of tobacco cessation treatment training that primary care clinics require.

Our first level of innovation was to provide a Build a Clinic series of national webinar trainings that address the reality-based hurdles practices face when providing tobacco cessation treatment. For example, even if providers are trained in evidence-based

interventions, uptake may be low if practices do not have the systems in place to support these new services. In this regard, we view tobacco use as one of many chronic illnesses and, as such, our training series uses Wagner's Chronic Care Model as a template for change (Wagner et al., 2001). The components of the Chronic Care Model, all of which are included in our webinar series, are:

1. An organization of health care where leadership and team engagement are prioritized,
2. Delivery system design and clinical information systems to create tobacco use registries and give providers up-to-date information about a patient's tobacco use,
3. Decision support to insure provider counseling and pharmacological treatment is based on explicit, proven guidelines,
4. Self-management which is patient-centered treatment that, in part, focuses on patient's self-efficacy in reducing tobacco use
5. A community of alliances and partnerships that foster a tobacco cessation continuity-of-care.

The second level of innovation was our Build a Clinic learning community, designed to provide participating practices a collegial forum to advance the skills necessary to treat patients with higher tobacco use prevalence, who are more physically dependent, who are often more socially accepting of tobacco, and many of which have multiple chronic illnesses. Programs like the American Academy of Family Physicians Office Champions support that, with the proper resources, significant gains can be made in institutionalizing tobacco interventions within care settings. However, such programs are typically centralized and top-down, as opposed to the case-based learning format we employ. We believe that this interdisciplinary peer learning environment complements national webinars and allows practices to take actionable next steps toward providing tobacco cessation treatment.

The third level of innovation was the use of the ECHO model to build a cooperative learning community. The ECHO model augments traditional didactic learning by having expert-guided discussions of clinic-initiated case studies. Using the Zoom web-based videoconferencing platform and the expertise of ECHO Colorado and the Rocky Mountain Public Health Training Center, the Build a Clinic project connected cohort participants with each other. This interactive, collaborative approach allowed expertise to be shared across sites. This was especially impactful for rural sites, which often face challenges of limited access to training opportunities and professional isolation. Use of

these “live learning sessions” enabled the Build a Clinic project to pilot the scalability of such a project.

Methods

Recruitment

BaC’s primary target audience were interdisciplinary primary care providers, including the over 209,000 practicing primary care physicians, 56,000 nurse practitioners, and 30,000 physician assistants practicing primary care in the U.S. (AHRQ, 2014). As stated previously, particular attention was paid to rural primary care providers. For the learning collaborative, the target was two cohorts of 10-15 community primary care practices in rural, medically underserved or provider shortage areas. There are approximately 1,200 such clinics nationwide (National Association of Community Health Centers, 2014), who are providing services to approximately 12 million smokers (Hutcheson et al., 2008). The intention of these learning collaboratives is to determine the scalability of such an interactive training structure to the U.S. overall.

Learning Cohorts

BHWP selected two learning community cohorts of primary care clinics each to engage in a 6-month process to integrate tobacco treatment into daily clinic practice. The first cohort, with 9 clinics, ran from March to August 2016. The second cohort, with 16 clinics, ran from January to June 2017. The targets were primary care clinics serving diverse patient populations, including priority populations, such as rural, low-income, behavioral health, youth, and women of child reproductive age.

Each clinic was asked to select a tobacco cessation “champion” who acted as the primary liaison for their clinic. Clinic champions committed themselves to co-lead a 6-month program, featuring sequential step-by-step instruction on how to build cessation services meeting the needs of their patient population. Champions encouraged clinic staff to attend webinars and learning community sessions based on relevance to their clinic positions.

The two clinic cohorts represented primary care practices from across the nation. The 25 participating practices in the two cohorts came from 13 states (see *Figure 1*). The first cohort participated in live webinars which were recorded, archived, and used for the second cohort. Benefits of using a two-cohort approach include: standardization of webinar content and delivery; leveraging of resources; decreasing scheduling burden across time zones; and allowing for smaller learning community groups to maximize engagement and interaction.

Similar to how BHWP has successfully recruited sites in previous learning communities, practices were recruited to participate via a Request for Applications (RFA) disseminated by multiple national organizations (*See Appendix A)*. These included: The North American Primary Care Research Group, American Academy of Family Physicians (AAFP), Collaborative Family Healthcare Association, Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), National Council for Behavioral Health, and Smoking Cessation Leadership Center.

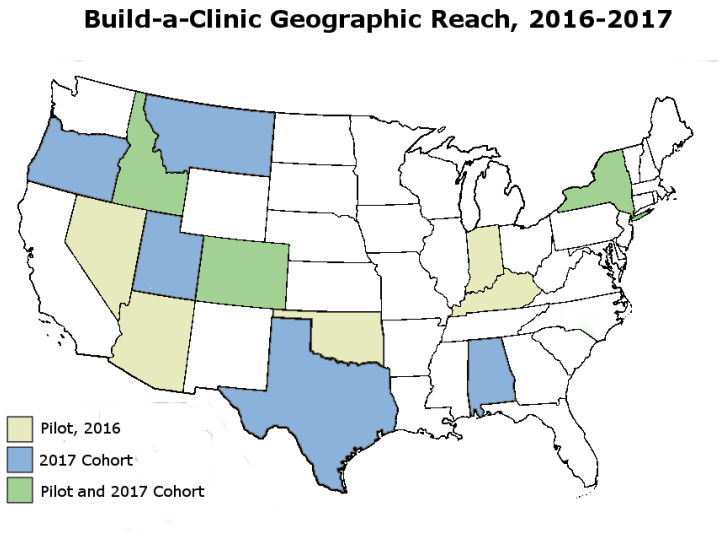


Figure 1: BaC Geographic reach

Interested practices utilized an online application process hosted on the website SurveyMonkey (See Appendix B for the application). Considered criteria for acceptance into the program were: (1) Serving a rural, underserved, or provider shortage area; (2) Commitment to building comprehensive tobacco treatment services; (3) Serving low SES and/or the targeted priority populations; (4) Commitment from a clinic champion with demonstrated interest in on-site advocacy for and participation in the Build a Clinic program. The clinics chosen were at different stages of development with some ready to launch tobacco services and others just beginning their planning stages. Those accepted into the program were issued an official letter welcoming them to the Learning Community (*see Appendix C*).

For the learning collaborative, each participating site named a Wellness Champion who participated in all aspects of the 6-month curriculum (webinars and ECHO collaborative learning sessions and technical assistance calls). Each site was also responsible for naming and holding accountable staff in multiple roles responsible for executing the various actions associated with each module, e.g., administration, human resources, prescribers, community health navigation, etc.

Education and Training

Webinars provided the foundation of BHWP's multi-modal educational design. The topic areas for the six webinars are (1) evidenced-based best practices, e.g., champions, workflows, EMR utilization, treatment planning; (2) pharmacotherapy, (3) Motivational Interviewing; (4) adapting clinical workflows; (5) special populations and (6)

program sustainability, e.g., billing. (See *Appendix D* for a list of modules and learning objectives.)

Materials for the webinars were adapted largely from existing evidenced-based training resources including *DIMENSIONS: Tobacco Free Toolkits* and special population supplements; *DIMENSIONS: Tobacco-Free Policy Toolkit*; and BHWP's nationally accredited Rocky Mountain Tobacco Treatment Specialist Certification (RMTTS-C) Program (see www.bhwellness.org). Webinars included an interactive Q&A component. BHWP ran webinars using existing GoToMeeting technology. Live presentations were recorded and archived for easy future access. We invited national participation in these webinars through announcements sent out by our many national partners, e.g., HRSA, SAMHSA, National Council.

Educational Approach of Learning Communities

The ECHO Learning model served as a set of guiding principles for the learning community process. The Rocky Mountain Public Health Training Center administered the learning sessions using its distance-learning studio and Zoom, a web-based video teleconferencing service that allows content experts and all participating practices to view each other and participate simultaneously. Six learning sessions occurred with each month's session matched to corresponding national webinars each month.

Each live learning session began with a brief 15-minute expert review of the webinar topic. This was followed by a case presentation and expert facilitated group discussion. Standardized case presentation forms were utilized to guide the process (*see Appendix E*). Participating practices volunteered to present a related experience in which they had found challenges. Sessions were recorded for review and used in the development of this evaluation and playbook of real world strategies.

Individualized Technical Assistance

Identified experts from BHWP and the University of Colorado, Family Medicine Department provided tailored assistance to participating learning community practices. Participating practices were invited sign up for "office hours" to discuss their clinic progress and individualized needs throughout the course of the program.

The Pilot

Pilot Formative Evaluation

Fourteen clinics applied, thirteen were accepted, and 11 enrolled into the first cohort ("the pilot"). Of these, two discontinued before the first session. Size and style of practice ranged from a two-person staff in rural Arizona to a large university system in Kentucky. Eight of the nine accepted practices already had electronic health records (EHR) systems in place, and were enrolled in the HRSA meaningful use program; the other was under active consideration of adding an EHR system (See *Figure 3*). Seven also had at least one HRSA designation: (1) FQHC, (2) serving an underserved area, (3) serving a provider shortage area, or (4) rural (see *Figure 2*). The remaining two had not obtained official recognition, but self-reported serving a provider shortage area or an underserved population (mental health populations with chronic medical comorbidities).

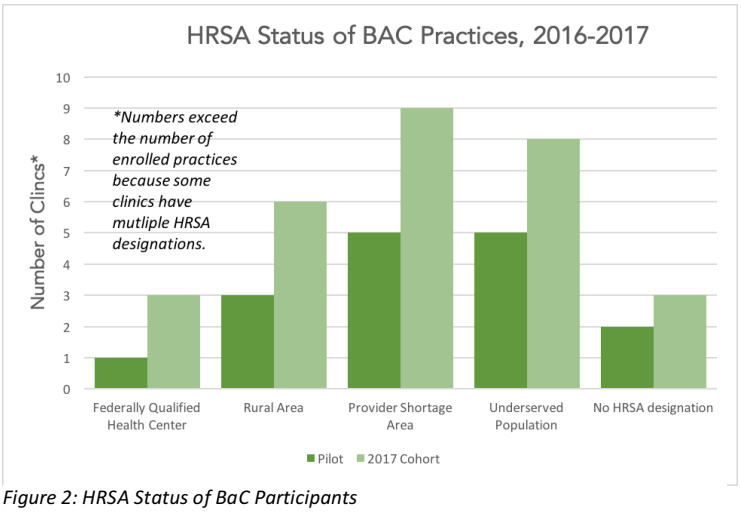


Figure 2: HRSA Status of BaC Participants

Learning Community attendance was highly variable throughout the program, ranging from three to nine practices attending any specific session.

Data on current services was collected prior to the start of the program via the application and an organizational self-assessment. The adoption of services and supports were recorded via one-on-one interviews throughout the program. Practices made progress in: adding or altering intake questions, providing educational resources including instructional brochures, and displaying educational/motivational posters in waiting areas. Most clinics were very small and were therefore restricted in their ability to dramatically alter workflows by adding new staff or assigning tobacco-specific responsibilities. However, those with more flexibility were able to invest in

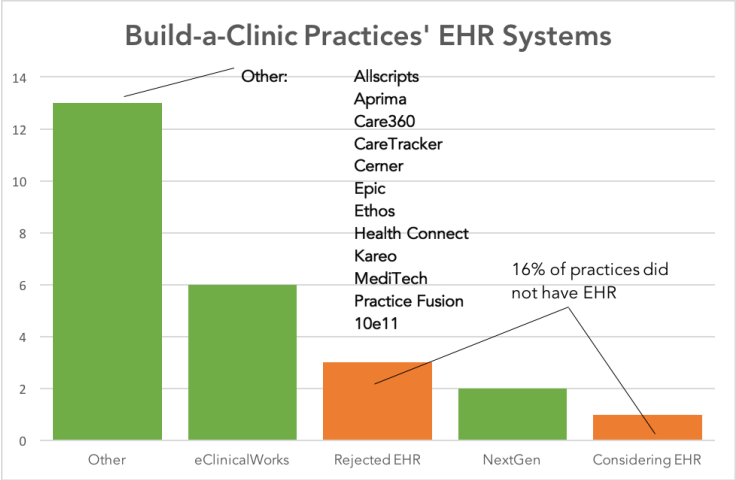


Figure 3: EHRs Used by BaC Participants

larger initiatives including providing all staff training on the burden of tobacco. Most clinics reported a greater familiarity with and understanding of the referral process to their state telephonic cessation coaching provider (e.g., Arizona ASHLine).

Lessons Learned

Most participants reported liking the curriculum and expressed having learned new skills and concepts from participating in the webinars and learning community sessions. However, time was a significant concern. Even the most motivated practices frequently ran into scheduling conflicts. One participant expressed mild criticism that the range of practices inhibited learning because the specific needs and capacities of larger systems were so different than the needs of the smallest clinics.

In planning for the second cohort, BHWP was responsive to this feedback (*see Table 1*). To decrease burden on sites, initial surveys were combined into the application process. Since BaC has prioritized connecting with rural clinics, several features have been altered to accommodate their much smaller size. In the first cohort, there were requirements to submit a full BaC team list and a staff survey. In hindsight, such requirements did not prove useful to BHWP administrators or to the clinics themselves and thus were removed. To alleviate the time burden, webinars in the second cohort were pre-recorded and able to be watched at participant's leisure. Furthermore, Learning Community live sessions previously required the completion of "Case Form" (part of the ECHO Learning Model). It was determined that this exercise was collecting redundant information. Finally, BHWP increased its recruitment efforts to enhance the amount of selectivity it can exercise in choosing appropriate participants.

Table 1: Adjustments to 2017 Cohort

Adjustments to 2017 Cohort		
	Pilot	2017 Cohort
Application process	The original application did not ask for demographic information, which required a separate enrollment process for the Learning Collaborative sessions. It also asked questions framed around the 5As collecting information similar to that collected in the Organizational Self-Assessment.	The 2017 application added demographic questions. The 2017 application embedded the Organizational Self-Assessment questions and dropped the 5As questions.
Pre-assignments	Practices accepted into the program had to fill out a list of team members (up to 6), had to sign and return a Letter of Commitment, had to send BHWP a digital copy of their logo, and fill out the Organizational Self-Assessment survey (see above).	Pre-assignments were reduced. Team lists were not required, rather a question was added to the application to collect the name of at least one and possibly two "co-leads" who would attend program activities in the Team Lead's absence. Letters of Commitment simply were not required as, evidenced by the attrition in the pilot, they did little to encourage actual commitment.
Staff Survey	In many cases, the clinic was a staff of one—the same interested party that filled out the application to start with—making it difficult to measure the effect of the program through this tool.	The staff survey was not administered for the 2017 cohort.
Case form	In the pilot, participants were to use a pre-established Case Form. It was determined that the clinics were repeating information they included in their application and which they shared with their cohort members during introductions.	For the 2017 cohort, participants were instead asked to describe their issues using the DIMENSIONS: Action Plan model— a rapid improvement planning form they were filling out and sharing with BHWP as part of the 1:1 technical assistance component of BaC.
DIMENSIONS: Action Plan (DAP)	Participants were provided a blank DAP that could be filled out electronically and sent to BHWP. BHWP would review and revise. Many practices simply did not fill out their DAPs and those that did frequently had to have them revised by BHWP staff.	BHWP staff filled out the DAPs *in situ* during TA calls. The 2017 application also added a menu of possible rapid action goals from which practices could choose.
Administration/ program management activities	The amount of pre-assignments and multiple surveys required BHWP to create both a Welcome Packet and an introductory video.	Eliminating most of the pre-assignments and using pre-recorded webinars meant the Welcome Packet was unnecessary. Similarly, the introductory webinar (pre-recorded for the pilot) was obsolete. Eliminating these two pieces reduced the workload on BHWP staff—and reduced 30 minutes from the necessary time commitment from participants.

2017 Cohort Description

BHWP expanded recruitment efforts for the 2017 cohort to include nationwide outreach to rural health agencies, state tobacco education and prevention programs, and area health education centers (AHECs). This resulted in an 85% increase in applications to the program. Of the 24 practices that applied 19 were extended invitations to join, although two of them were public health agencies and not medical practices. Both were informed that the curriculum was not designed to meet their needs, but they were welcome to join. Of these, one continued. Of the 18 admitted, two failed to attend even a single session and thus are not counted as "attrition," and another underwent a massive restructuring which caused insurmountable technological issues in addition to new time constraints, causing them to drop out after the second Learning Community session.

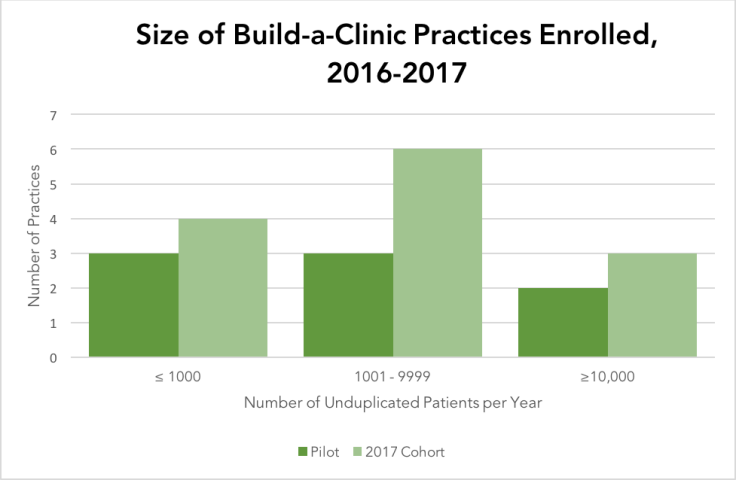


Figure 4: Size of BaC Practices

As with the pilot, enrollees represented significant diversity. The smallest practice saw an estimated 250 unique patients per year in rural New York; the largest saw nearly 11,000 unique patients per year in St. George, Utah. Although this range is still quite large (10,500), it is not as large as the range in the pilot (19,850) *(See Figure 4*). Three of the sixteen practices had rejected adding EHRs at this time. Thirteen had a HRSA designation (see Figure 2). Of the remaining three, one reported rural status, one reported serving primarily Medicaid enrollees, and one reported high tobacco use prevalence.

Attendance was much improved over the pilot with most (81%) of the remaining 16 practices attending four Live Learning Session, five attending five (31%), and two practices (13%) attending all six.

Post-Assessment Results, 2016 & 2017

Participants and Reach

The BHWP evaluation team monitored online traffic to the BaC resources on the BHWP website and attendance of individual webinars. The number of website visits and the number of participants attending each online webinar were tracked.

The BaC program had four related landing pages on the BHWP website. One page was a general page with four links: one to the active SurveyMonkey online application, one to a Frequently Asked Questions page, and one to the Build-a-Clinics materials page. This final page was the most critical to the program as it housed the webinar recordings as well as the foundational materials mentioned in this report.

Launched in February 2016, this site received no visitors during the pilot cohort. The website was mentioned frequently to participants during the pilot cohort's technical assistance calls, during the webinars, and in email follow-ups. However, pilot participants watched the webinars live and had been provided direct links to all resources in separate emails and in their welcome packets. Emails with direct links to the YouTube videos were also provided to participants in email follow-ups. Therefore, pilot participants would never have needed to access this site.

As expected, in the lead up to and during the second cohort (September 2016 to July 2017) web traffic to the BaC Materials page significantly increased with an average of 156 visitors each month. The lowest number of visitors was in November 2016 (97)[1] and web traffic peaked in the middle of the 2017 cohort (March = 280 visitors). From the beginning of recruitment to the end of the program, visits to the BaC Materials page represented 0.7% of all visits from the BHWP main page. During the active programming months (Mar-Aug 2016 and Jan-Jun 2017) visits to the BaC Materials page were 0.9% of visits from the main page. From the first visit on September 6, 2016 to the end of the program on June 30, the BaC Materials page generated over 1,600 visits—about 3.4% of visits to all BHWP pages—including its main landing page. These 1,600 visits represent 624 unique visitors—far surpassing the reach of BaC participants only. Since the end of the program the Build a Clinic materials page is still reaching nearly 100 visitors a month.

[1] *The drop in November also corresponds to a significant drop in applications to the program which surged in October (about three weeks after the release of the RFA) and again in December.*

Table 2: Recorded Module Analytics

Recorded Module Analytics				
Name	Pilot	2017	Total	External Reach
Tobacco Cessation Best Practices	225	197	422 (3 shares)	76
Pharmacotherapy	200	94	294 (8 shares)	5
Motivational Interviewing	157	80	237 (3 shares)	126
Analyzing and Adapting Clinical Workflow	106	65	171 (6 shares)	89
Special Populations & Cultural Sensitivity	56	33	89 (1 share)	56
Scalability & Sustainability	NA	26	26 (1 share)	13
TOTAL			1,239	365 (29.5%)

After being recorded live for the pilot, the videos were uploaded to YouTube. They remained available for the pilot participants the day after the associated live learning session and remained accessible to them until the release of the 2017 RFA. Each recording was made available to the 2017 cohort (and the public) the first week of each month (Module 1 in January, Module 2 in February…Module 6 in June). The videos remain there today. Table 2 documents the viewing activity of each video from the date of its first upload through September in the column labeled "Pilot." The second column documents the viewing of each video from the first week of each month to July 31, 2017. YouTube provides basic analytics which includes how many times each video was shared and by what method those videos were accessed. The BaC curriculum has earned over 1,000 views and 22 shares. A known 30% of these views come from links provided outside the BaC Materials page or emails sent directly to participants. While 30% is known to have come from outside the direct BaC-related contacts, the numbers indicate much greater external reach. For example, the pilot participants attended the webinars live, so the 225 views of Module 1 from the third week of March until September are most likely entirely non-BaC viewers. Similarly, the 2017 BaC cohort consisted of 16 practices with 1 or 2 active attendees. The remaining 181 views are likely additional staff from practices that participated in BaC or staff from practices that did not participate in BaC.

Clinical Practices

BaC participants filled out BHWP's Organizational Self-Assessment (OSA) instrument. This series of questions has been developed over several years across treatment

settings including primary care, community behavioral health, residential substance abuse treatment, and social services delivery sites, among others. It assesses the general willingness (Stage of Change) of an organization to implement evidenced-based clinical interventions across nine broad domains of the patient-centered tobacco workflow. (See Appendix I for the complete survey). The survey is given to one person at the practice to fill out prior to the program's start and we then administer the assessment again after the program's conclusion. Of the 13 medical practices[2] still enrolled and participating at the end of the 2017 program, 11 responded to the post-OSA (85%), a significant improvement over follow-up participation in the pilot (20%).

The OSA consists of 29 questions across 9 domains. Each domain also has an open response for sites to offer qualitative information on those topics. The domains in the OSA are:

A. Tobacco Education and Support (3 questions)
B. Tobacco Screening and Treatment Planning (4 questions)
C. Tobacco Usage Interventions: Onsite Nicotine Replacement Therapy and Medication Prescribing (3 questions)
D. Tobacco Usage Interventions: Onsite Psychosocial Services (3 questions)
E. Tobacco Usage Interventions: Community Referrals (3 questions)
F. Tobacco Usage Interventions: Peer Services (2 questions)
G. Tobacco Control Policy (5 questions)
H. Outcomes (2 questions)
I. Sustainability (4 questions)

Stage of Change was ranked on a five-point Likert scale with the following levels:

1. Not currently considering/decided against
2. Considering but not yet actively planning
3. Actively planning for the next 3-6 months
4. Schedule in the next 3 months
5. Currently offering

[2] *Technically 14 of the 16 admitted organizations finished the project, but Salt Lake County was not asked to complete the post-OSA since they are a public health agency and not a primary care clinic.*

Tobacco Education and Support

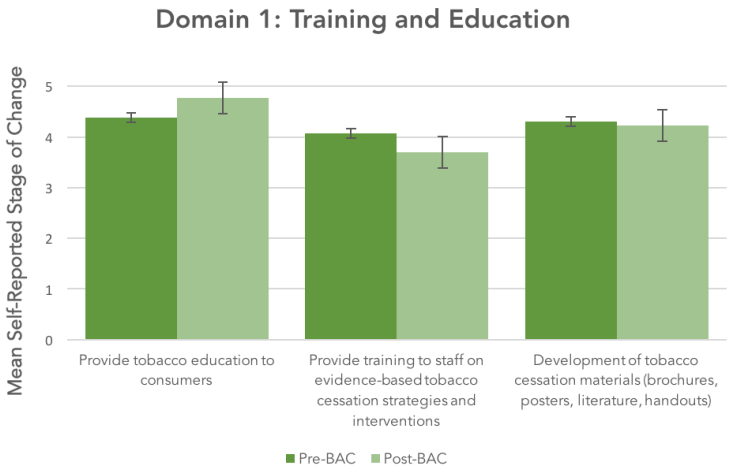


Figure 5: OSA Results, Training and Education

Over the course of the six-month program, several practices added or moved closer to adding tobacco cessation education for their patients. Looking at the aggregate data, it appears if several organization stopped providing evidenced-based training and education to staff. However, by appealing to the qualitative data we can see that, what in fact happened is that several practices provided education earlier in the learning community and those accomplished activities were not scheduled to occur again within the next six months. For example, several participants in the 2017 cohort expressed interest in educating their staff on both the 5As and pharmacotherapy. And when asked if the BaC webinars on this topic were sufficient and if they needed further resources, each replied that they had what they needed. Several had already shared these materials with the appropriate staff.

At the beginning of the BaC program, some participants were relatively unfamiliar with tobacco cessation strategies and needed access to related resources. While some participants noted that their staff had received tobacco-related training in the past, they needed updated information on tobacco cessation interventions.

Staffing was an issue for some clinics with regard to the provision of tobacco-related resources and education. However, more clinics noted that they had access to outside resources, such as brochures, posters, and their state quitline.

Tobacco Screening and Treatment Planning

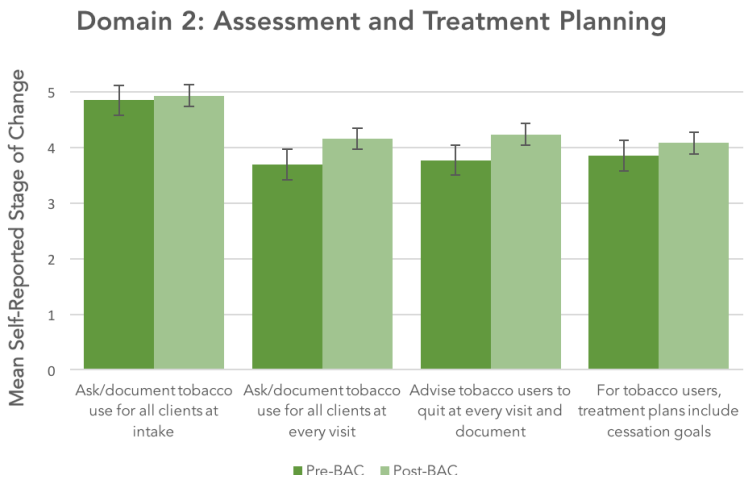


Figure 6: OSA Results, Assessment

Progress was consistently up with aggregate scores increasing in all four questions under the Screening and Treatment Planning domain. Specifically, both Asking and Advising patient *at every* visit were both improved (3.7 to 4.2 and 3.8 to 4.2, respectively). Many participants noted that tobacco screening was only documented at patient intake or was not consistently documented at every visit. Participants commonly questioned how to best document and code for tobacco use, particularly within an Electronic Health Record (EHR). In some cases where tobacco use was documented, clinics were unsure of best practices for documenting tobacco interventions.

While tobacco use measures and the documentation of tobacco use are still not always conducted at every visit, participants describe the ways in which these practices are becoming tailored to the workflow of individual clinics. As a salient example, one clinic was unable to incorporate a plan to ask and advise every patient, but did implement a strategy of asking and advising all *young adults* at every visit. They also added tobacco treatment planning for all patients with a current tobacco use who expressed an interest in quitting at intake and who respond to a follow-up call.

Onsite Nicotine Replacement Therapy and Medication Prescribing

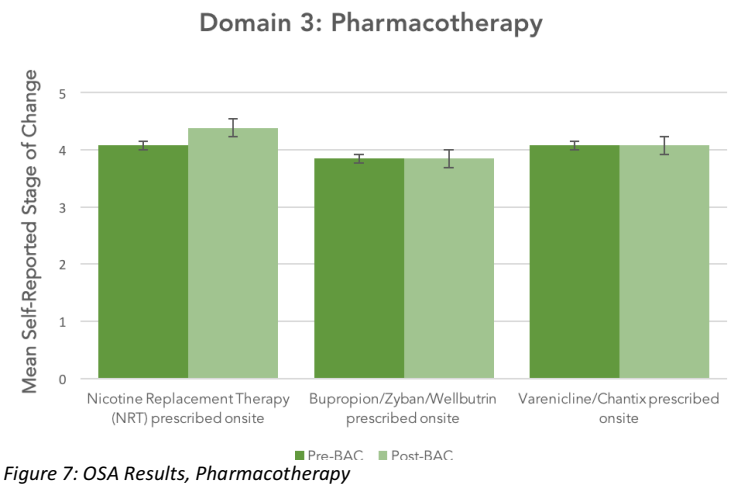


Figure 7: OSA Results, Pharmacotherapy

A number of clinics identified various ways in which NRT was not accessible for their clinic. For example, accessing medications may require extensive travel or be too expensive for the clinic to maintain.

While some clinics have decided not to provide NRT, others are continuing to discuss the

possibility of offering cessation medications. Where dispensing medications was deemed inappropriate (for example, participating local health departments), it appears that patients are referred to the state quitline.

There was a minor improvement in the onsite prescription of NRT (+0.3). The prescribing of both varenicline and bupropion remained unchanged.

Tobacco Usage Interventions: Onsite Psychosocial Services

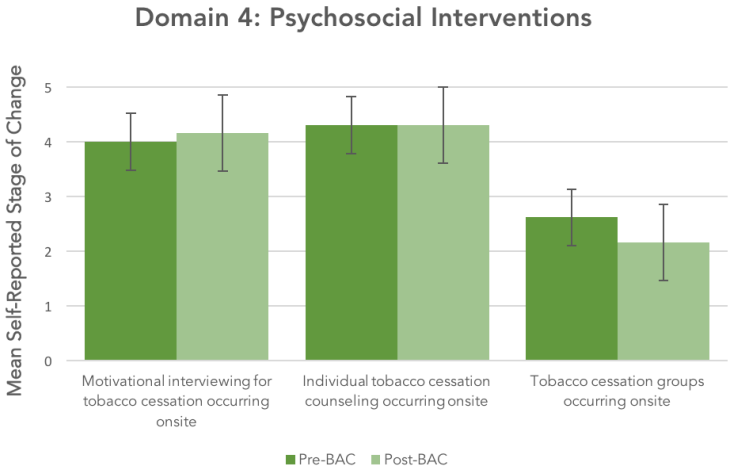


Figure 8: OSA Results, Psychosocial Interventions

Regarding the onsite provision of psychosocial services, results were mixed. Many clinics' staff members were not trained in providing psychosocial services, including Motivational Interviewing (MI). Other clinics reported not having a psychiatrist or similar behavioral health provider on staff. However, many clinics expressed an interest or reported being actively engaged in pursuing these services.

The psychosocial service that was most commonly excluded from clinic offerings was tobacco cessation groups. Many participants noted that this was because the clinic did not have enough clients or serve a large enough population to support a group. In other instances, the clinic facilities were too small to offer group activities.

The general provision of tobacco cessation counseling remained the same. However, the use of Motivational Interviewing utilized in tobacco cessation counseling increased over the six months of BaC. However, the willingness to use groups dropped. In part this reflected a few clinics' responses that were running groups and the scheduled group series had come to an end. For these site, new groups were scheduled for the future. Additionally, a few participating practices had considered running their own groups, but instead referred to already existing cessation groups in the community.

Tobacco Usage Interventions: Community Referrals

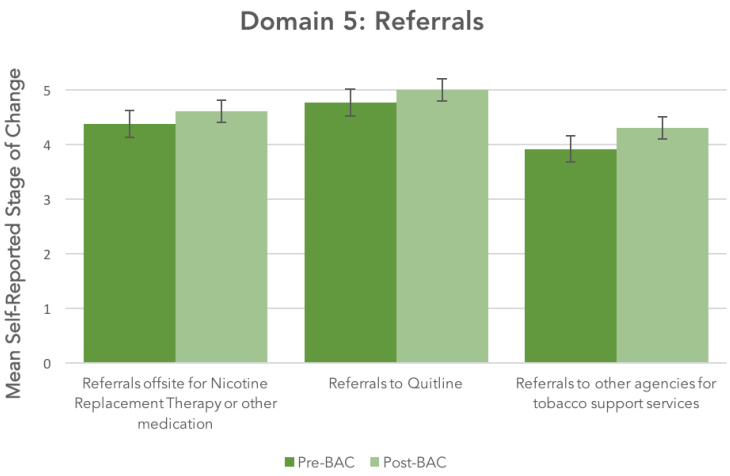


Figure 9 :OSA Results, Community Referrals

Across all three questions in the Community Referral domain, progress was consistently realized. As previously mentioned, several participants, having been connected to local community health, area health education centers, and other community resources were able to increase their referrals to those practices. With the help of a local public health department, one clinic that had previously referred no patients to their quitline, referred 100 patients in one month, 19% of which were enrolled.

Among those practices not utilizing community referrals, many of these clinics noted that, due to their location, community referral resources were limited. Although one participant noted that there were no tobacco treatment services within their community, the quitline was commonly listed as an available resource.

Tobacco Usage Interventions: Peer Services

Unlike previous learning communities in community behavioral health, substance abuse, or criminal justice where the use of peers is a fast-growing practice, among the primary care clinics in BaC it was virtually foreign territory. Very few clinics at the beginning of the program were considering peers and most had already determined they would not be using them. No clinics set goals around using peers and none asked for resources regarding the implementation of peers in their practices. BHWP remains a firm advocate of the peer model and recognizes it as a potential cost savings to those practices that adopt their use. As such, the use of peers is provided near the end of the program (in Module 6: Sustainability). Given BHWP's advocacy of the model, it is unlikely that BaC caused clinics to re-evaluate their use of peers

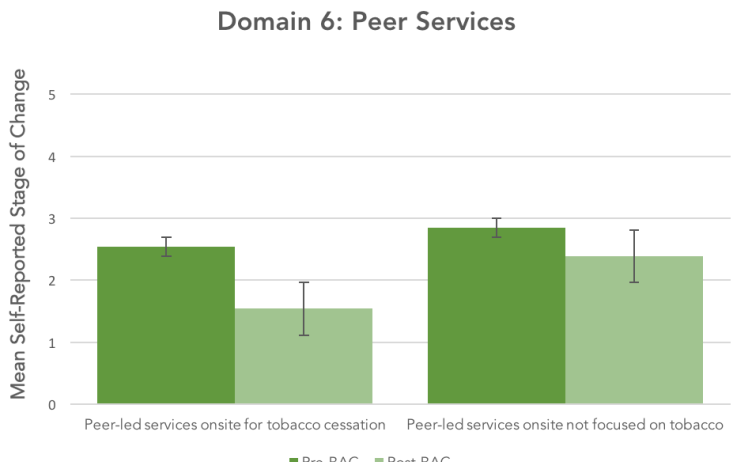


Figure 10: OSA Results, Peer-Services

for the worse. Rather, the aggregate numbers are likely capturing a few clinics who lost the capacity to even consider this augmentation, while the others remained as reluctant as they were before

Like participant responses regarding psychosocial services, participants commonly noted that they did not have a population base that would allow for them to utilize peer support services. Instead, some of these clinics noted their focus on clinical providers and sustainable workflow systems.

More participants acknowledged a desire to offer peer-led services, and a small number noted that they or a community partner would be implementing these services. However, it seems that many clinics have only begun to contemplate the use of peer-led services in their clinics. Participants again cited small populations and limited space as reasons for which they do not offer peer-led services.

Tobacco Control Policy

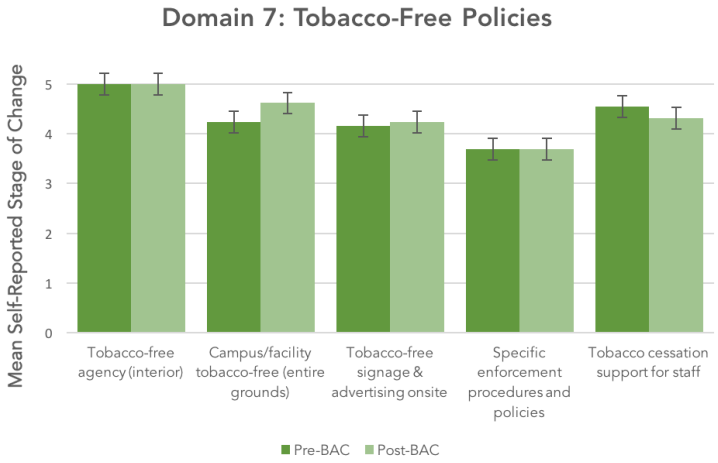


Figure 11: OSA Results, Tobacco-Free Policies

Providing tobacco cessation services to patients is not enough to guarantee the highest levels of care or project sustainability in the mid- or long-term. Rather, practices need to develop robust tobacco free policies, including providing tobacco cessation services, to their staff. These policies create a general culture of wellness that over time locks in the provision of tobacco cessation services as a series of activities embedded deeply within both organizational and staff values. BHWP asks five questions (Figure 11) on tobacco free policies. The responses to two were unchanged. For the first, on indoor tobacco free polices, practices responded both before and after BaC participation that these are "consistently being done". The other question in which there was no change regarded adoption of specific policy enforcement procedures. The question on providing services to staff saw a drop of 0.2. However, the addition of signage/advertising and tobacco free grounds both went up over the course of the program.

A number of clinics noted that, while they did not have a tobacco-free policy, they also did not currently have any employees that used tobacco. However, these clinics

expressed interested in formulating a policy for use in the event that it became necessary or enforcement became a future issue.

Only one participant noted that their facility does not have a tobacco-free policy and mentioned that the county is not in favor of such a policy.

Outcomes

BHWP worked with a few organizations on which tobacco-related treatment metrics. Program Champions were typically not, themselves, responsible for data management and workflows, and therefore struggled with with adding or changing data collection expectations. Nevertheless, a few participants did identify both the creation of new indicators and specific reporting procedures as goal, and some minor success was achieved in this category.

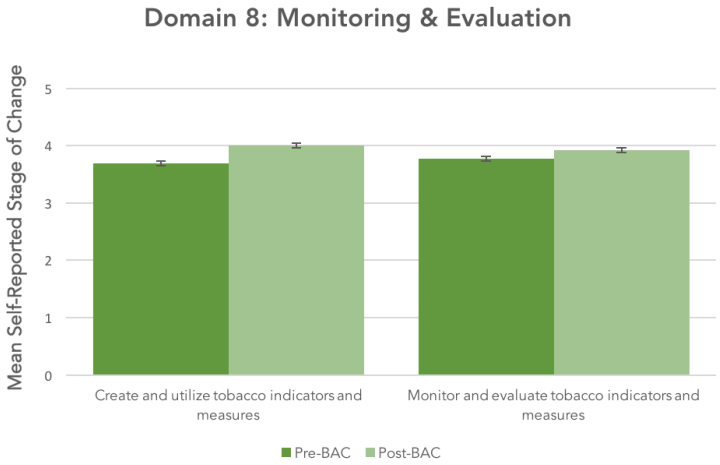


Figure 12: OSA Results, Monitoring and Evaluation

Sustainability

Across the four questions under the heading "Sustainability", practice improvements were realized. Many participating practices enhanced use of Electronic Health Records (EHRs) in regard to (1) revising questions to match recognized standards for comparison to epidemiological data, (2) making data collected in the EHR actionable for providers, and (3) processes for regular review of that data.

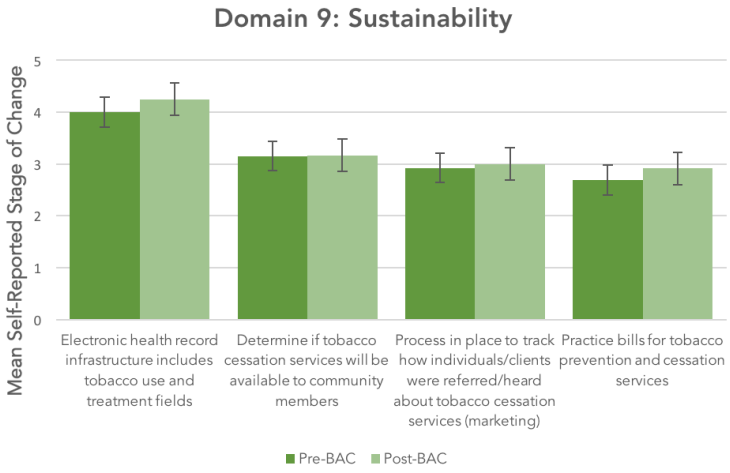


Figure 13: OSA Results, Sustainability

However, participants mentioned more uncertainties about billing for tobacco cessation services. Specifically, participants mentioned being unfamiliar with whether they meet billing rules and how they can properly bill private insurance for cessation services.

Learning Community Satisfaction

At the project's conclusion, we administered a wrap-up survey designed to assess participant satisfaction with BaC. In particular, this survey focused on the webinars and ECHO Colorado's interactive platform.

Participants were asked to rate various aspects of the webinars on a scale of 1 – 5 in order of how much they agreed with the statement provided. Two participants from the pilot and eleven from the 2017 cohort responded to this survey (Total response rate: 54.2%). Almost all respondents were satisfied with all aspects of BaC. The exception was one participant who did not like the live learning component. In fact, overall satisfaction with the program was 92.3%. The worst score was on clear presentation of materials. While 91% agreed or strongly agreed that the material was clearly presented, 9% remained neutral on the question. Nearly all respondents agreed (92.3%) that BaC provided them with practical tools they could use.

The Zoom platform stood out as a useful and well-liked aspect of the program. Most respondents (66.7%) had not participated in a Zoom presentation before, yet acceptance and praise of the platform was pronounced. Group participation in BaC and the ability to learn from other clinics was commonly cited as the best part of BaC. Eighty-five percent (85%) strongly agree that the ECHO moderators were knowledgeable on the topic discussed, and that the platform itself was satisfactory. One participant responded to an open-ended response "It is a great format. I cannot think of anything to improve it, because it served me pretty well." Another replied, "It is a great format and I am getting better with using it. Keep it up." In addition, participants liked the webinars and the tailored assistance that they received through the technical assistance phone calls.

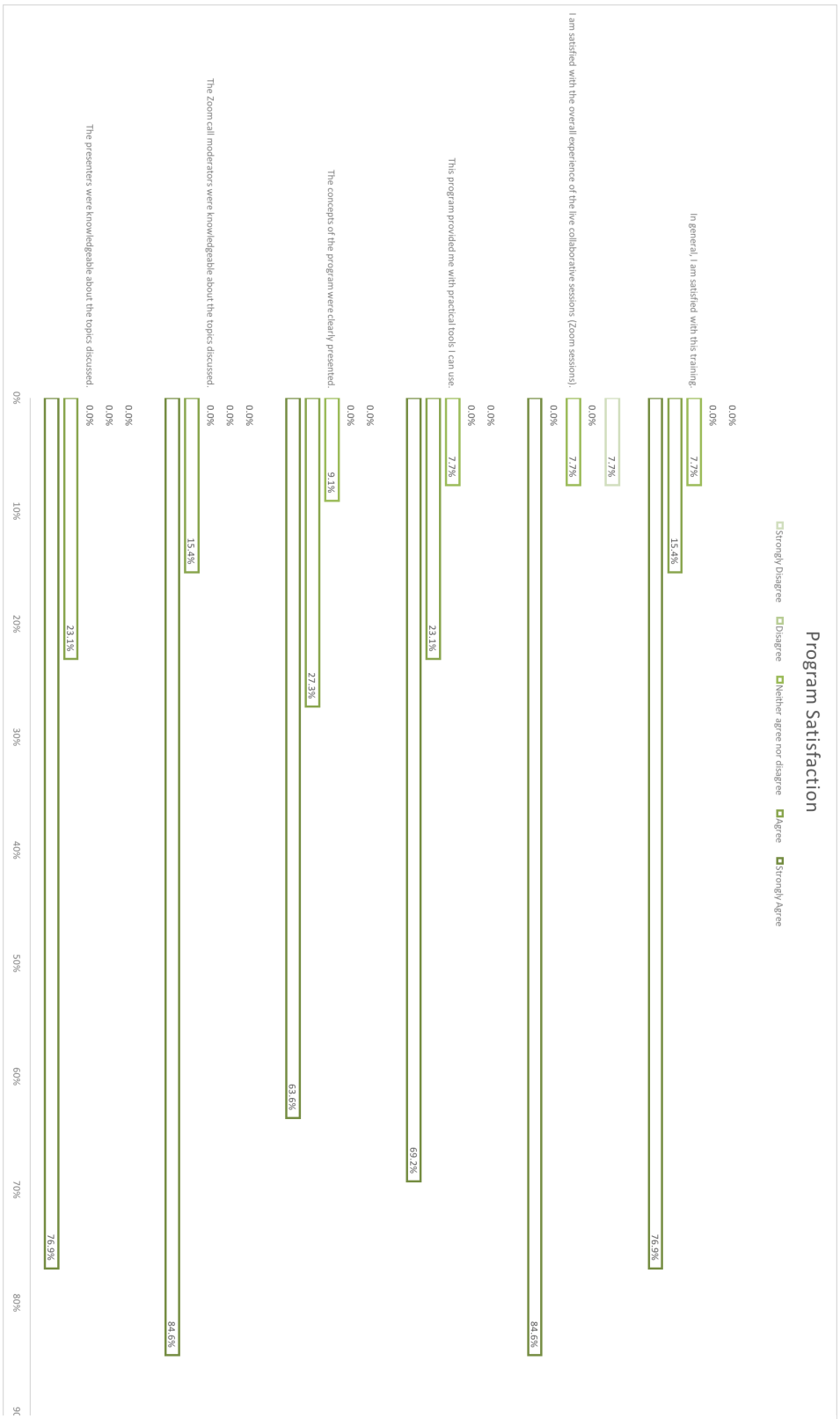


Figure 14: Overall Satisfaction with BaC

Case Study: Essex County Mental Health

Essex County Mental Health is a rural behavioral health clinic in update New York. The clinic operates in a provider shortage area and serves around 250 unduplicated patients each year. Essex County began to engage in tobacco cessation work prior to joining Build a Clinic (BaC). Accordingly, at the beginning of BaC Essex County was in the process of adding tobacco use/nicotine dependence treatment plans for patients and had contemplated adding tobacco cessation groups onsite. However, since the clinic generally sees patients on a weekly basis, the clinic had not considered asking or documenting tobacco use at each visit and clinicians were not advising tobacco users to quit. Through participation in BaC, Essex County sought to educate their staff on tobacco cessation interventions, and to educate their staff on how tobacco dependence treatment aligned with their mission.

At the beginning of BaC, Essex County reported concerns that were common among small, rural clinics: a lack of resources, limited staff capacity, difficulty accessing relevant training, and too few clients to sustain group tobacco services. These barriers aligned with those identified within the 2016 BaC cohort, in which cost was often cited as the primary barrier to offering tobacco cessation services and most small clinics reported a restricted ability to dramatically alter workflows by adding new staff or assigning staff additional responsibilities. Additionally, as a behavioral health clinic, Essex County Mental Health did not have a registered nurse on staff to help to advise patients on tobacco or to provide tobacco treatment. As a result, clinicians were hesitant to begin to engage in a discussion around tobacco cessation with their patients, fearing that other aspects of a patient's treatment would be neglected. Essex County also had to contend with traditionally held beliefs surrounding tobacco use in the behavioral health field, particularly the mistaken belief that tobacco use among clients was not a pressing concern – the idea that clients were *only* using tobacco and not other substances.

To combat the barriers that Essex County Mental Health confronted as a small rural health clinic, Essex County sought three grants to finance interrelated services that would establish an infrastructure for tobacco treatment at the clinic and ensure the stability of the clinic's tobacco-related programming.

While the most common changes in small clinics participating with the first BaC cohort included adding or altering intake questions, providing educational resources like brochures to patients, and displaying educational/motivational posters on the walls, these grants provided the resources the Essex County required to make significant workflow improvements.

The first grant that Essex County Mental Health received allowed the clinic to create a new position for a registered nurse. The nurse, now fully integrated within the clinic, asks about tobacco use at each patient health screening and receives patient referrals from clinicians for tobacco use treatment. In addition, the structure of the clinic's tobacco referrals has allowed the clinicians to easily incorporate tobacco within patient treatment. Clinicians are now able ask their clients about tobacco use, briefly discuss tobacco with clients, and refer their clients to the registered nurse without neglecting competing treatment priorities. In addition, with the nurse's assistance, the clinic has instituted a monthly utilization review to catch any missed diagnoses of tobacco use disorder and make sure that patients receive the appropriate care or referral. The first utilization review was conducted in June 2017, during which 29 cases were identified. In July 2017, the number of cases identified increased to 36.

The second grant has assisted the Essex County Mental Health in piloting a financial modeling tool. Since its implementation, this financial modeling tool has been used to track the revenue generated by the registered nurse, including tobacco cessation work. Thus far, the revenue information has been promising and the clinic plans to use the revenue data to validate the costs associated with the registered nurse position to ensure the sustainability of the position beyond the termination of the initial grant funding. Accordingly, the use of the financial modeling tool will help to ensure the continued tobacco treatment capabilities at the clinic.

The clinic is currently in the process of applying for the third grant, which would provide funding for updates to Essex County Mental Health's electronic health record (EHR) system. In addition to recently implementing a new EHR system, the clinic plans to integrate the 5As (Ask, Advise, Assess, Assist, Arrange) within progress notes throughout the EHR, thus helping the clinical team to better track tobacco use, treatment, and referrals for their clients.

To address traditionally held beliefs about tobacco within the behavioral health community, the success at Essex County Mental Health underscores the importance of providing tobacco cessation education to behavioral health providers. For instance, Essex County found that the clinic's weekly team meetings offered an opportunity to gradually shift the understanding of tobacco treatment at the clinic. At these weekly team meetings, the clinic's nurse consistently concluded the meeting with new information about tobacco treatment.

This information has helped to address clinician concerns about tobacco treatment and to foster buy-in across the clinic for additional tobacco-related work. Additionally, the clinic plans to utilize "Summer Hours," a schedule that compresses the workweek into four days during the summer to allow time for training and educational opportunities, and to share the BaC webinars with staff.

Participation in the BaC program activities has allowed the Essex County Mental Health Clinic to foster relationships within their clinic as well as between various community partners. Within the clinic, Essex County used the BaC learning community live sessions and webinars to bring together a small group (two clinicians and a nurse) on a regular basis to discuss and plan for tobacco treatment at the clinic. In addition to clinic employees, Essex County also involved a member of a partner agency, the North County Healthy Heart Network, in the BaC program activities. As a result of this collaboration, Essex County will begin to refer their clients to their North Country Healthy Heart Network for tobacco-related peer services, a program that the clinic alone would not be able to provide to clients.

According to Essex County, the most important concept that was learned during BaC was to keep moving forward with tobacco treatment efforts and to not get discouraged. Accordingly, the clinic found that the learning community call, a live, collaborative call in which all BaC participants had the opportunity to actively discuss their tobacco cessation efforts and to collectively address barriers, was the best aspect of the program. As the Essex County Mental Health moves forward with their continued tobacco treatment efforts, the clinic will to continue to track staff tobacco cessation trainings, ideally within their EHR system, as well as continue to track the tobacco use diagnosis numbers monthly to demonstrate improvements, to identify gaps, and to increase staff morale.

Review Summary

Table 3: Overall Review

Program Objectives Summary		
Goal 1: Create a web-based learning series focused not only on clinical guidelines, but also on the system redesign needed to build a tobacco cessation clinic.		
Objective	Achievement	Notes
Convene a series of planning and implementation meetings with our collaborative University of Colorado expert team made up of BHWP, Family Medicine, and the Rocky Mountain Public Health Training Center.	High	BHWP and its partners [the Dept. of Family Medicine and RMPHTC] met frequently, especially before the start of the pilot and again before the start of the 2017 cohort. All three met periodically throughout as needed.
BHWP will create a series of six thematic educational webinars tailored to primary care clinics and focused on increasing the knowledge and skills necessary to systematically create and integrate tobacco cessation services within established practice settings.	High	Six webinars were presented live to the pilot participants, recorded, and again provided to the 2017 cohort. The videos are publicly available and can be accessed through BHWP's YouTube channel or through its website.
Maximize reach across all 50 states by utilizing partnership networks to invite webinar attendance and disseminate archived webinar links.	Moderate-High	Individuals in all 50 states were contacted to recruit for and promote the program. Ultimately only 13 states were represented by participants.
Goal 2: Pilot a cooperative learning community to supplement web-based training		
Objective	Achievement	Notes
Successfully recruit two cohorts of 10-15 (20-30 total) rural primary care agencies from across the nation to participate in BaC.	High	Thirty practices were admitted into the program with 25 completing most of the program's components.
Augment knowledge and skill attainment through expert guided experiential learning. This will specifically be in the form of case-based learning and facilitated group discussion.	High	As evidenced by the OSA results and documented in follow-up survey, practices made significant improvements in most of the 9 domains of tobacco cessations services and supports. The case-guided group discussions were, with one exception, well-received.
Provide on-going ad hoc technical assistance and consultation throughout the process to amplify participant learning and resource access.	High	TA was offered on a scheduled, periodic basis throughout the program and as-needed via phone and email. Many participants availed themselves of the ad hoc TA and all attended their required TA "office hours."
Overall Objectives		
Objective	Achievement	Notes

Create a guide or "Build a Clinic Playbook" of lessons learned and strategies derived directly from the real-world experience of participating primary care clinics to subsequently be integrated into existing program materials for future use and national dissemination.	High	This evaluation and report is the playbook.
Evaluate the program and prepare recommendations for the future development of a train-the-trainer model to further "scale-up" a combination of web-based training and case-based learning collaboratives broadly across the U.S.	High	This evaluation and report is the playbook.

Table 4: Quantification of Change

Quantification of Change		
Target	Goal	Result
Practice	≥80% will accomplish rapid improvement goals	All 100% participants finished at least one rapid improvement goal.
Practice	≥80% will move one stage forward in their readiness to implement new tobacco cessation programming	93% of participants moved forward in at least four of the areas assessed on the OSA.[3] The range was 4 -16 with most clinics achieving around 8 total improvements—moving at least one stage forward.
Provider	20% increase in the staff reporting screening for tobacco use.	62% of clinics reported improvement in at least one of the Ask/Advise areas, including 2 clinics that increased 3 Stages of Change (See Essex Case Study) and one that increased 4.
Reach	All 50 states contacted	All 50 states were reached as part of the Request for Applications process. 13 states ultimately participated in the program.
Cohort participants	100% will complete assessment instruments	100% of entrants into the 2017 cohort filled out their pre-OSAs.
Cohort participants	90% will attend all webinars	33.3% of the pilot and 62.5% of the 2017 cohort attended all webinars. 76% of both cohorts' full attendance was achieved for a total of 84% total attendance.
Cohort participants	90% will attend all Live Learning sessions	Only 13% of practices attended all the Live Learning Sessions. However, most

[3] The OSA consists of 29 questions across 9 domains.

		(80%) attended 4 or more. The first two modules were attended by 87.5% of participants. Module 3 by 56.3%, Modules 4 and 5 by 62.5% and Module 6 by 50%.
Cohort participants	80% will report satisfaction with each online module,	Satisfaction with each online module averaged 4.3 on a 5-point scale.
Cohort participants	90% will report satisfaction with the interactive ECHO meetings	84.6% of respondents reported overall (Strongly Agree) satisfaction with the ECHO model.
Cohort participants	90% will report satisfaction with the Learning Community overall	92.3% of attendees reported Agreeing or Strongly Agreeing that they were satisfied overall.

Replication Manual a.k.a. The "Playbook"

Introduction

Successfully implementing a project like Build-a-Clinic (BaC) requires general program management skills. This playbook is not intended to be a guide to program management, but rather to highlight the specific tactics and techniques that emerged as important throughout the program.

Getting Started

Know your bottlenecks.

BaC's unique combination of peer-led learning (between participants) and subject matter experts (SMEs) presented potential bottlenecks. SMEs had to be available to both present hour-long didactic webinars, and then facilitate live learning sessions. This potential time barrier disappeared after the first cohort, as the initial webinars had been archived for viewing at participants' convenience.

Another bottleneck to executing the program was the limited time available for the 1:1 technical assistance (TA) office hours. Three one-hour TA calls for each participant equaled 72 hours devoted to offering this service. This became even more labor intensive as, in most cases, two or more SMEs attended each TA session. It also meant that participants had to find a free hour during their busy clinical shifts. In one instance a single TA call during the pilot was rescheduled four times before, ultimately being abandoned. Because there is no way to frontload periodic, live TA, planning for TA calls should be done at the earliest possible opportunity to provide additional flexibility.

Use your calendars

BaC has several moving pieces: webinars, supportive communications (reminders, follow-ups, resource provision), live learning sessions, individualized TA, and *ad hoc* TA. Each program element has different staff accountable, different staff that can be utilized as back-up, and different faculty that serve as SME or panelists. Making these responsibilities explicit and formalizing the commitment through a group shared calendar helps avoid last minute alterations that might delay the execution of a program component or confuse participants.

Limit Your Communications

Because each BaC component requires multiple reminders, at least one follow-up, and because unpredictable but important events emerge that require communications, participants may be receiving up to 15 or more program-related emails each month. This volume may trigger participants to ignore the content of communications. This, in

turn, can cause participants to miss out on important resources or critical information. Worse, it may cause participants to miss out on crucial program components (webinars, live learning sessions) and lead to attrition. We recommend using program management software, or some other communications campaign-building platform, to develop a clear sense of general communication strategies and combining proximate communications in order to decrease volume, while at the same time increasing the importance of each communication sent.

Clinic Recruitment

Recruitment is critical. It's important that the RFA reaches clinics that are willing and capable of shouldering the work that comes with any extra programming. There are thousands of clinics that needs the education and training that a program like BaC provides, but not all are organizationally ready for change. Ensuring that enough clinics apply to allow program faculty and staff to be selective in creating a dynamic group mix that will motivate clinics and keep them interested throughout can make or break a cohort. Recruitment periods should be long enough to allow for the RFA to filter through listservs and professional associations to clinical directors and managers and down to staffers who will be ultimately tasked as Project Champions. Recruitment periods should also be long enough that, should applications stall, an alteration in the dissemination strategy can be implemented. On the other hand, recruitment cannot be so long that it encourages procrastination on the part of potential applicants.

In BHWP's experience with BaC, three months is roughly the right recruitment window. In both rounds, the release of the RFA and subsequent activation of invested stakeholders and warm leads generated a burst of interest that died off. About two months after the initial RFA release a new wave of interest emerged. A final burst of activity in the final week, on both occasions, led to keeping the online application open past the deadline to accommodate last minute applicants.

Initial Assessment

In order to evaluate the impact of the program it is crucial to collect data before the first program component. Primary care clinics are extremely busy and each minute when a provider is not with a patient has implications for the clinics' bottom-line. At the same time, collecting outcomes is necessary to demonstrate effectiveness and to tailor content to efficiently address cohort needs. It is best to execute data gathering exercise in the most efficient, least burdensome fashion. BHWP compromised by combining the Organizational Self-Assessment (OSA), our most critical assessment instrument, into the application. This reduced redundancy and insured that 100% of incoming applicants had provided their pre-assessment.

Technical Assistance

There are several factors to consider regarding the provision of technical assistance.

Know Where to Start

Many primary care clinics understand the importance of tobacco work. In fact, across all learning communities BHWP has managed, the BaC participants had the most knowledge of the burden of tobacco and pre-established tobacco programming prior to starting the learning community. However, they were also the learning community participants most likely to not have a clearly articulated vision for their project goals or incremental steps toward success. We learned that it is imperative for BHWP SMEs to obtain a detailed description of what services the clinic was already providing, their rationale for those services, what they were willing to do next, and what they had the capacity to do next.

Support Change

Fifty years after the Surgeon General's first report on tobacco smoking and health and twenty years after over-the-counter availability of nicotine replacement therapy, the so-called "low hanging fruit" of tobacco users who find quitting a moderately easy behavior change are gone. What are often left are the "hardcore" users—heavy, life-long smokers, often from groups that have multiple health disparities and who are commonly targeted by the tobacco industry. Which is to say that tobacco cessation treatment is hard work—and, for the providers that engage in it, often unfulfilling as the odds of any one quit attempt being successful are small, and the gains often hard to see for patient and provider alike in the short term. BaC in part was intended to assist clinics to understand that their struggles in providing effective cessation services are not unique and are generalizable across the country. Participants emphasized the importance of the collaborative aspects of the BaC cohort and frequently said that it was helpful to know that integrating tobacco cessation interventions within a clinic's workflow is difficult across the cohort.

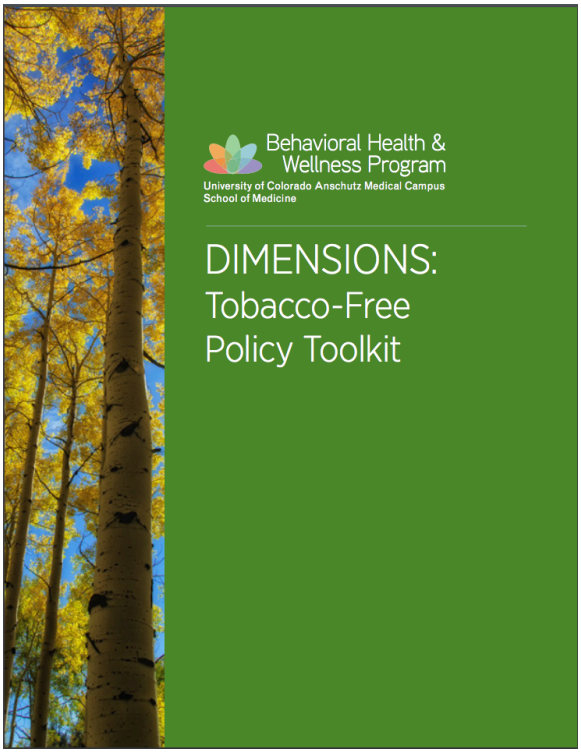


Figure 15: BHWP Tobacco-Free Policy Toolkit

Curate the Resources

The most common request for resources is funding. Beyond that, most clinics require resources—physical resources: posters, brochures, pamphlets, lapel pins, Quit Kits, provider education one-sheets, etc. Making these resources generally available is not enough. TA providers must make strong recommendations on what resources will most effectively assist participating practices. At the start of both rounds of BaC, BHWP, provided its *Tobacco Free Policy Toolkit* to participants. During TA calls when participants made it clear they sought organizational tobacco control guidance, they were asked if they had accessed the online toolkit. In most cases, they had not. Generally, there is a need to repeatedly direct participants back to the resources that will help them the most.

Manage Attrition

The most difficult problem facing learning communities is program attrition. Absence, especially in the live learning sessions acts as a signal to other participants that the absent peer does not value the program. Moreover, the live learning sessions depend on the active give and take participants provide to each other. Each missing participant is an exponential loss to a dynamic exchange. Early in the pilot it became clear that participants were struggling with the live learning sessions. We asked BaC participants privately to share what they hoped to get out of the live learning sessions. All respondents were interested in "learning what others had done." It was our common observance throughout the pilot that participants were far more interested in the passive learning model of training/education whereby patients attend/watch webinars, read educational materials, and potentially ask for and receive tools. This is potentially a result of the clinical context where passive learning, especially via recordings or written materials, are easier to fit into busy work days.

As a result of the large attrition during the pilot, reducing the burden on participants became a priority for the 2017 cohort. The difference was astounding. Not only was attendance in the live sessions more consistent, with roughly three-quarters of participants in attendance during all sessions, only two clinics (12.5%) in the second cohort dropped out (both for non-program-related reasons) whereas in the pilot 18% of clinics dropped out and the final live sessions were often down to as low as one-third of participants. Similarly, for post-OSA and follow-up surveys, 18% of pilot participants responded, compared to 85% of the 2017 cohort, a nearly 400% improvement over the pilot.

Lessons Learned

The previous sections detailed unique aspects of *managing* the BaC program. This section details lessons learned from the cases themselves using both program

administrators' and providers' perspectives: What particular barriers did the clinics face? What helped them overcome them? How would a future iteration of BaC change to accommodate these barriers?

1. Primary care clinics are busy

In BHWP's previous learning communities, one of the most common reasons for being unable to implement new tobacco cessation programming has been a lack of staff time. This has been true in community behavioral health, psychiatric hospitals, residential substance abuse, in schools and in prisons and jails. But the BaC participants vocalized this barrier more frequently than other settings. It's possible that the specific character of the practices themselves contributed to the salience of this barrier. That is, those clinics operating in medically underserved, provider shortage, or rural areas may suffer even greater time constraints than other care sites. To illustrate this point, the most successful participant in the pilot was one of the largest systems in both cohorts.

In deference to this barrier, significant alterations, already detailed in this report, sought to accommodate the need for a reduced time commitment. Some possible responses include:

- Making the time commitment for a learning community explicit in the form of a monthly or weekly calendar
- Scheduling 1:1 TA calls at the start of the program
- Requiring data provision as a component of the application, e.g., patient-level data instead of requiring this data after the learning community begins
- Reducing non-critical communications (e.g., by combining emails)
- Utilizing additional group resources, e.g., cloud-based storage for the dissemination of resources

2. Staff and system changes are unpredictable

In all learning communities, staff changes are an "unknown known" that has the power to diminish an organization's ability to participate. BaC was designed to be proactive on this issue: requiring that pilot participants name an entire team of BaC participants and, in the 2017 cohort, requiring the name of at least one co-lead. Nevertheless, while participants complied with the requests made of them, as a matter of practicality, several practices did not adequately co-train or were unsuccessful finding a co-lead that shared their interest or passion. Three practices had staff changes that affected the practices' ability to participate at least in part, and one practice had to drop out entirely when their system began a complex integration and technological realignment.

BaC participants that were not hampered by this barrier were those who made an internal decision to have the lead and co-lead attend all program components whenever possible. While this does double the staffing required to participate, it acts as a powerful defense against potential derailment of participation.

3. Primary care clinics are ready

   As a group, the two cohorts began BaC with more tobacco cessation programming already in place than other healthcare sectors. As a result, the type of technical advice and resources required was more in-depth than what is needed in other service sectors with less familiarity with both the medical burden of tobacco and the internal system and professional training necessary to provide cessation pharmacotherapy. Practices wanted practical advice on maintaining motivation after long clinical sessions, how to maintain motivation between contacts, and particulars of other sites' EHR systems.

   Future practitioners of learning communities would be wise to assess readiness early and to move directly to an initial 1:1 goal setting exercise. The provision of resources should directly respond to these early goals, and early successes should be shared with peer organizations in the Learning Community.

4. Motivational Interviewing is of high interest

   Following the above, primary care have a greater interest and a greater need for practical brief motivational interventions. Very few clients are visiting their primary care provider specifically to address their nicotine dependence. In many cases, the reason for their visit is not even secondarily related to their nicotine dependence. Providers are looking for methods to motivate quit attempts in patients with other, more immediate concerns. Even among patients who, at the time of the visit, express a willingness to quit, many fail to act on that initial willingness. Many of the BaC participants cited learning how to discuss tobacco cessation with patients in a way that motivated them, as the most important part of BaC. In particular, participants valued exposure to Motivational Interviewing (MI).

   Connecting interested providers to Learning Community focused on MI may prove useful. BaC participants receiving in-depth training in MI may use BaC program staff as technical advisors on adapting their MI skills to the tobacco cessation context.

5. Technological tools should not be a burden

   Although a majority of BaC participants enjoyed the collaborative participation facilitated by the learning community live sessions, some participants noted that

they experienced difficulty with certain technologies (including Zoom). Additionally, a small number of participants did not feel as though the use of Zoom offered the opportunity for "meaningful collaboration."

As a possible solution, it was suggested that BaC link similar programs together so that clinics could collaborate with partners that shared certain characteristics. Given that there was a great range of clinic types that were participating in BaC, this suggestion may be worth considering further. While the BaC facilitators did group clinics together for collaboration on learning communities and technical assistance calls based on geography, other factors may be just as important to consider.

6. Continuing education credits are a possibility but not critical

The BHWP team assessed offering continuing education credits to participants of the BaC learning community. Initially, the team explored offering Continuing Medical Education (CME) credits through our project partners, the Department of Family Medicine. Discussions revealed the need to broaden our scope and investigate offering CME through the University of Colorado School of Medicine (SOM).

The BWHP team queried the SOM about offering CME for BaC program participation. The SOM determined they did not have the capacity and resources to process and offer CME to BaC participants. The BWHP team also investigated the American Academy of Family Physicians (AAFP) as a potential source of physician CME which could be offered to future BaC cohorts.

When BHWP approached the University of Colorado College of Nursing (CON) with the BaC program, the Program Director for Continuing Nursing Education (CNE) was very interested in offering Continuing Nursing Education (CNE) for BaC participants. The Program Director reviewed the components of the BaC Program including application process, webinars, learning community sessions, and technical assistance calls and determined that BaC participants would be awarded 12 contact hours for their participation.

The CNE application would cover one year, so potentially two BaC cohorts could receive CNE credits. BaC CNE applications would require renewal on an annual basis. One potential strategy utilized by BHWP was to share third-party resources for tobacco-related CMEs that arose during the program.

7. Flexibility is paramount

BHWP offered live webinars to the pilot and recorded the presentations. These recorded webinars provided 2017 cohort BaC participants with flexibility in

when they viewed didactic content as well as allowed for multiple viewings and sharing with colleagues. BaC participants expressed satisfaction with the convenience and versatility of the webinars.

Building in, as much as possible, flexibility around attendance and other participatory elements of the program was a critical element of BaC's success—especially of the 2017 cohort. Learning Community organizers should be careful, though, about building in too much leeway. The crosstalk and discussions inside learning communities, the co-development of resources, and shared brainstorming sessions are crucial elements of the *community* aspect of these programs. Offering opportunities to work alone and offline may appeal to busy clinicians and many may choose to avail themselves of these options and forego the burdensome live activities that serve as the impetus of change.

8. Short timeline encourages participation

BaC participants noted that the pace of the BaC Learning Community, including monthly webinars followed by live learning community sessions 2 weeks later and interspersed TA calls, helped ensure that tobacco cessation treatment was both salient and a priority in their minds as well as served as a means of reviewing and refreshing tobacco related information.

In BHWP's long career assisting organizations of all types in going tobacco free or adding tobacco cessation services, there is always a reluctance to get started. There is often a fear that such initiatives are overly complicated, demand too much from staff, and will be poorly welcomed by patients. These fears often lead to lags in implementation and delaying major deadlines. As a result, BaC benefits from choosing participants who are ready to begin program changes on the first day. The quickness of the program encourages speed in implementation and acts itself as a ward against deprioritization of these initiatives before they reach sustainable endpoints.

Conclusion

The BaC served rural, urban, and suburban clinics in 13 states. The diversity of both readiness and capacity to alter or add specific tobacco cessation elements was a deliberate choice to provide each clinic the opportunity to be a leader and an inspiration to their peers—and an opportunity to learn from them as well. This appears to have had some of this desired effect, but the ranges—especially of capacity—should not be so great as to render the advice provided or received inapplicable.

The key feature to note to replicate and improve upon is speed. The primary care sites that apply for such a program arrive ready; and, they have no time for elements of the

program that do not provide an immediate and obvious practical use. Specific resources should be provided to meet specific requests—rather than supplying general resources (even when these are the same resources). Technology should be used efficiently with both a clear rationale for its use and sufficient technical support so as ease quickly through the necessary learning curve to use it well. The program should be short and fast-paced without overburdening the staff required to participate.

The success of the Build-a-Clinic program suggests that the learning community model can be successful in increasing readiness to add tobacco cessation programming and, in fact, assist clinics to achieve multiple rapid improvement goals in a very short time. The Behavioral Health & Wellness Program's Organizational Self-Assessment evaluates clinics across 9 domains of tobacco cessations services and supports, identifying 29 unique areas for improvement. All organizations improved in at least 4 areas—including 62% specifically improving the critical intake functions (Asking and Advising) known to positively affect patient outcomes. The average BaC participant increased in 8 subcategories (range 4-16); 62% of practices moved into stage 5 in at least 1 of the 29 subcategories (range 1-8, average = 3.7). There was improvement in all 9 domains across the cohort.

References

Agency for Healthcare Research and Quality (AHRQ). (2014). *Primary Care Workforce Facts and Stats.* Retrieved from http://www.ahrq.gov/research/findings/factsheets/primary/pcworkforce/index.html

American Lung Association (ALA). (2012). *Cutting tobacco's rural roots: Tobacco use in rural communities.* Disparities in Lung Health Series. Washington DC.

American Academy of Family Physicians (AAFP). (2014). *Office Champions Tobacco Cessation Federally Qualified Health Centers Project.* Final Report. Retrieved from http://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/office-champions-tobacco-final-report.pdf

Anderson, P., & Jané-Llopis, E. (2001). How can we increase the involvement of primary health care in the treatment of tobacco dependence? A meta-analysis. *Addiction, 98,* 299-312.

Canadian Tobacco Use Monitoring Survey (CTUMS). (2006). *Detailed information for February to June 2006 (Cycle 1).* Retrieved from http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SurvId=28850&InstaId=30140

Curry, S. J. (2000). Organizational interventions to encourage guideline implementation. *CHEST Journal, 118*(2 Suppl), 40S-6S.

DePue, J. D., Goldstein, M. G., Schilling, A., Reiss, P., Papandonatos, G., Sciamanna, C., & Kazura, A. (2002). Dissemination of the AHCPR clinical practice guideline in community health centres. *Tobacco Control, 11*(4), 329-335.

Fiore, M. C., Jaén, C. R., Baker, T. B., et al. (2008). *Treating tobacco use and dependence: 2008 update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service.

Gottlieb, N. H., Guo, J. L., Blozis, S. A., & Huang, P. P. (2001). Individual and contextual factors related to family practice residents' assessments and counseling for tobacco cessation. *Journal of the American Board of Family Practice, 14*(5), 343-351.

Grimshaw, J. M., Shirran, L., Thomas, R., Mowatt, G., Fraser, C., Bero, L., ... & O'Brien, M. A. (2001). Changing provider behavior: an overview of systematic reviews of interventions. *Medical Care, 39*(8), II2-II45.

Health Resources and Services Administration (HRSA). (2011). *Table 6B – Quality of Care Measures.* Uniform Data System (UDS) for Health Center Program. Retrieved from http://www.bphc.hrsa.gov/uds/view.aspx?q=r6b&year=2011&state

Hu, S., McAlister, A. L., Meshack, A. F., & Margolis, J. A. (2003). Physician's views and practices of smoking cessation. *Texas Medicine, 99*(11), 57-63.

Hutcheson, T. D., Greiner, K. A., Ellerbeck, E. F., Jeffries, S. K., Mussulman, L. M., & Casey, G. N. (2008). Understanding smoking cessation in rural communities. *The Journal of Rural Health, 24*(2), 116-124.

Longo, D. R., Stone, T. T., Phillips, R. L., Everett, K. D., Kruse, R. L., Jaén, C. R., & Hewett, J. E.(2006). Characteristics of smoking cessation guideline use by primary care physicians. *Missouri Medicine, 103*(2), 180-184.

National Association of Community Health Centers. (2014). *United States health Center Fact Sheet.* Retrieved from https://www.nachc.com/client//United_States_FS_2014.pdf

Papadakis, S. (2010). Delivering evidence-based smoking cessation treatment in primary care practice. *Canadian Family Physician, 60*(7), e363-e371.

Park, E. R., Gareen, I. F., Japuntich, S., Lennes, I., Hyland, K., DeMello, S., ... & Rigotti, N. A. (2015). Primary care provider-delivered smoking cessation interventions and smoking cessation among participants in the National Lung Screening Trial. *JAMA Internal Medicine, 175*(9), 1509-1516.

Pavlik, J., Young, S., Richey, R., Mumby, S., & Morris, C. (2014). *Increasing Low Income Callers' Access to and Utilization of the Colorado QuitLine.* Aurora, Colorado: University of Colorado Anschutz Medical Campus, Behavioral Health & Wellness Program. Retrieved from https://www.bhwellness.org/fact-sheets-reports/Increasing%20Low%20Income%20Callers'%20Access%20to%20and%20Utilization%20of%20the%20Cololorado%20QuitLine.pdf

Piper, M. E., Fiore, M. C., Smith, S. S., Jorenby, D. E., Wilson, J. R., Zehner, M. E., & Baker, T. B. (2003). Use of the vital sign stamp as a systematic screening tool to promote smoking cessation. *Mayo Clinic Proceedings, 78*(6), 716-722.

Richter, K. P., Gibson, C. A., Ahluwalia, J. S., & Schmelzle K. H. (2001). Tobacco use and quit attempts among methadone maintenance clients. *American Journal of Public Health, 91*(2), 296-299.

U.S. Department of Health and Human Services (USDHHS). (2014). *The Health Consequences of Smoking—50 years of Progress: A report of the Surgeon General.* Atlanta, Georgia: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking Health.

Vardavas, C. I., Symvoulakis, E. K., & Lionis, C. (2013). Dealing with tobacco use and dependence within primary health care: time for action. *Tobacco Induced Diseases, 11*(6), 1-2.

Vogt, F., Hall, S., & Marteau, T. M. (2005). General practitioners' and family physicians' negative beliefs and attitudes towards discussing smoking cessation with patients: A systematic review. *Addiction, 100*(10), 1423-1431.

World Health Organization (WHO). (2008). *The scientific basis of tobacco product regulation: A second report of a WHO study group* (No. 951). World Health Organization.

Young, J. M., & Ward, J. E. (2001). Implementing guidelines for smoking cessation advice in Australian general practice: opinions, current practices, readiness to change and perceived barriers. *Family Practice, 18*(1), 14-20.

Wagner, E. H., Austin, B. T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. *Health Affairs, 20*(6), 64-78.

Appendices

Build A Clinic

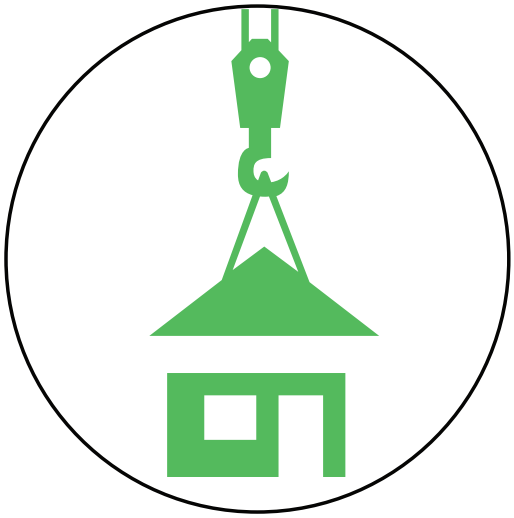
Learning Community | Tobacco Cessation | Primary Care Settings

Integrating Tobacco Cessation Screening, Assessment, Brief Intervention and Referral into Daily Practice

Request for Applications

Does your practice want to:

- Build tobacco treatment services into quality improvement initiatives?
- Create efficient and effective patient-centered work flows?
- Improve meaningful use and other billing?
- Improve data collection and reporting efforts to improve practice?



Applicant Eligibility:

Practices nationwide are eligible if they provide direct primary care services to individuals in rural, medically underserved and/or provider shortage areas.

Application Submission:

www.bhwellness.org/programs/about-the-build-a-clinic-program

SERIES TOPICS:

Sessions are conducted via live video from your home or office from 12 pm - 1pm MT

- **January 2017:** Tobacco Cessation Counseling Best Practices: An Introduction
- **February 2017:** Tobacco Cessation Counseling Best Practices: Motivational Interviewing
- **March 2017:** Tobacco Cessation Best Practices: Pharmacotherapy Options
- **April 2017:** Analyzing and Adapting Clinical Work flow
- **May 2017:** Special Populations and Cultural Sensitivity
- **June 2017:** Tobacco Clinic Scalability and Sustainability

WHAT YOU WILL LEARN TO DO:

- Screen and assess nicotine dependence
- Recommend adequate levels of cessation medications
- Analyze and adapt work flows
- Code and bill for tobacco cessation services for long term sustainability
- Integrate tobacco cessation services into quality improvement initiatives

WHAT TO EXPECT:

Use your smart phone, tablet or laptop with a camera to connect:

- 1-on-1 technical assistance with your clinic
- Monthly webinar with experts
- Monthly live learning sessions with peers

RMPHTC Rocky Mountain Public Health Training Center
A Member of the Nation's Network of Public Health Training Centers

Behavioral Health & Wellness Program
University of Colorado Anschutz Medical Campus
School of Medicine

Build A Clinic

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Build a Clinic Application (2)

The University of Colorado (CU), Behavioral Health and Wellness Program, with the help of the CU Department of Family Medicine and School of Public Health, is looking for primary care practices operating in rural, medically underserved or provider shortage areas who are ready to add tobacco cessation services and supports into existing clinical practice or augment services already in place. The participating practices in the Build a Clinic program will partake in six monthly webinars, six monthly collaborative learning activities, and participate in several one-on-one tailored technical assistance sessions with nationally recognized subject matter experts in the areas of tobacco cessation and workflow redesign. Collectively, the six themed webinars and collaborative learning activities will comprise a comprehensive series on the skills and knowledge necessary to create, integrate, and operate an efficient tobacco cessation workflow within daily practice operations.

Applicant practices should be (1) primary care practices (2)* working in rural, provider shortage, or medically underserved areas (3) ready and able to adopt or augment tobacco cessation services into existing clinical practice.

Please answer the following questions as best you can given your knowledge of current practices. Utilize statistics from EHR systems or recent chart audits if available. Because the BAC encourages a whole-practice approach, the person(s) who should fill out the application may vary by practice. The person who would serve as the lead Point of Contact or Program Supervisor should be involved, as well as the person with the most knowledge of current tobacco cessation strategies—this is especially true if your practice extends across more than one physical site. The composition of the collaborative as a whole will influence the final evaluation of the fit of individual practices.

The most important criterion for inclusion is that participating sites are ready to add or augment tobacco cessation services from the start of the program. Unlike other programs, success in the Build a Clinic program requires practices to make a plan, attempt to execute that plan, and share your successes and your barriers with other participants. If you're ready to work toward your goals, we're ready to help you achieve them.

Participation in the Build a Clinic program is limited and the amount of applications for the program will exceed that capacity. Be sure to apply early! Applications will be accepted until December 23, 2016, 5pm (Mountain).

View the PDF RFA here.

For additional program information, visit the BHWP website.

The following application should take about 10-15 minutes.

*"Rural," "medically underserved," and "provider shortage areas" each have federal definitions and federal designations. However, the BAC program does not require that practices meet those definitions or have those designations. Rather, you will be given an opportunity to provide statistics or other evidence that your practice merits consideration for one or more of these terms.

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Build a Clinic Application (2)

1. Practice Information

Project Leader Name

Project Leader Job Title

Practice/Clinic Name

Address

Address 2

State

COUNTY

ZIP/Postal Code

Email Address

Phone Number

2. What is your title or clinical role?

- MD
- DO
- PA
- NP
- CNS
- Other (please specify)

3. Sex

- Female
- Male
- Different Identity
- Prefer not to respond

4.

All webinars should be viewed by at least one representative from each practice (typically the Project Leader); and participation in the live, collaborative learning sessions is required. As such, we ask that each practice name at least one back up to attend these activities in the event the Project Leader is unable to.

Who is/are your practice's co-leader(s)?

Co-Lead 1

Co-Lead 1 Email:

Co-Lead 2

Co-Lead 2 Email:

5. How many unduplicated patients did your practice see in 2015?

6.

Does your practice have an official Health Resources and Services Administration (HRSA) designation? Check all that apply.

- [ ] We are operating in a medically underserved area.
- [ ] We are operating in a provider shortage area.
- [ ] We are a designated rural clinic.
- [ ] We are a Federally Qualified Health Center (FQHC).
- [ ] We do not have a designation.
- [ ] We have another designation:

Build A Clinic

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Build a Clinic Application (2)

7. It is not a requirement that BAC participants have an official HRSA designation. However, clinics/hospitals should still be operating in medically underserved, provider shortage, or rural areas. What characteristics of your service catchment area support this idea?

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Build a Clinic Application (2)

8. Does your practice use an Electronic Health Record (EHR) system?

- Yes
- No

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Build a Clinic Application (2)

9. Which EHR system does your practice use?

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Build a Clinic Application (2)

10. Are you adding an EHR system or considering adding an EHR system in the next 12 months?

- ○ Our practice is considering adding an EHR system.
- ○ Our practice is actively shopping for an EHR vendor.
- ○ Our practice has considered but rejected adding an EHR system at this time.

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Build a Clinic Application (2)

The next set of questions asks you to report on your practices readiness to adopt tobacco cessation services and supports across nine areas. Please choose the option that most corresponds to your understanding of your practice's status.

If your practice does not currently offer this service, is it considering adding it? Is your practice in the process of planning it right now? Has the execution of this service been planned already and will it be added in the near future?

If you are not offering a service please use the optional text block following each area to explain if this is a service you have considered but decided not to offer (and briefly why) or whether this is a service you would like assistance in adding during your time in the Build a Clinic program and (briefly) what obstacles have prevented you from adding this service already. This section is optional, but will help us determine if Build a Clinic will be an effective program for your practice.

11. Tobacco Education and Support

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Provide tobacco education to consumers	○	○	○	○	○
Provide training to staff on evidence-based tobacco cessation strategies and interventions	○	○	○	○	○
Development of tobacco cessation materials (brochures, posters, literature, handouts)	○	○	○	○	○

12. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

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Build a Clinic Application (2)

13. Tobacco Screening and Treatment Planning

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Ask/document tobacco use for all clients at intake	○	○	○	○	○
Ask/document tobacco use for all clients at every visit	○	○	○	○	○
Advise tobacco users to quit at every visit and document	○	○	○	○	○
For tobacco users, treatment plans include cessation goals	○	○	○	○	○

14. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

15. Tobacco Usage Interventions: Onsite Nicotine Replacement Therapy and Medication Prescribing

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Nicotine Replacement Therapy (NRT) prescribed onsite	○	○	○	○	○
Bupropion/Zyban/Wellbutrin prescribed onsite	○	○	○	○	○
Varenicline/Chantix prescribed onsite	○	○	○	○	○

16. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application (2)

17. Tobacco Usage Interventions: Onsite Psychosocial Services

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Motivational interviewing for tobacco cessation occurring onsite	○	○	○	○	○
Individual tobacco cessation counseling occurring onsite	○	○	○	○	○
Tobacco cessation groups occurring onsite	○	○	○	○	○

18. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

19. Tobacco Usage Interventions: Community Referrals

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Referrals offsite for Nicotine Replacement Therapy or other medication	○	○	○	○	○
Referrals to Quitline	○	○	○	○	○
Referrals to other agencies for tobacco support services	○	○	○	○	○

20. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

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Build a Clinic Application (2)

21. Tobacco Usage Interventions: Peer Services

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Peer-led services onsite for tobacco cessation	○	○	○	○	○
Peer-led services onsite not focused on tobacco	○	○	○	○	○

22. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

23. Tobacco Control Policy

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Tobacco-free agency (interior)	○	○	○	○	○
Campus/facility tobacco-free (entire grounds)	○	○	○	○	○
Tobacco-free signage & advertising onsite	○	○	○	○	○
Specific enforcement procedures and policies	○	○	○	○	○
Tobacco cessation support for staff	○	○	○	○	○

24. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build A Clinic

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Build a Clinic Application (2)

25. Outcomes

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Create and utilize tobacco indicators and measures	◯	◯	◯	◯	◯
Monitor and evaluate tobacco indicators and measures	◯	◯	◯	◯	◯

26. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build A Clinic

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Build a Clinic Application (2)

27. Sustainability

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Electronic health record infrastructure includes tobacco use and treatment fields	○	○	○	○	○
Determine if tobacco cessation services will be available to community members	○	○	○	○	○
Process in place to track how individuals/clients were referred/heard about tobacco cessation services (marketing)	○	○	○	○	○
Practice bills for tobacco prevention and cessation services	○	○	○	○	○

28. If your practice currently bills for tobacco prevention and cessation services, who do you bill? Please mark all that apply.

- ☐ Not applicable to my practice-we do not currently bill for tobacco cessation services
- ☐ Grants
- ☐ Medicare
- ☐ Medicaid
- ☐ Private Insurance

Other (please specify)

29. If you are not currently billing for these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application (2)

The Behavioral Health & Wellness Program strongly advises the adoption of rapid improvement techniques. Rapid improvement goals are realistically achievable within 3 months given the time, money, and other resources your practice is ready to devote to them. To get you started, please pick at least two choices from the menu of options below that your practice is ready to work on implementing **right now**. There is also a space for your to write your own customized goal. You can pick as many as you would like to work on during the 6 months BAC runs, but pick at least two.

30. DIMENSIONS: Action Plans

- [ ] Assess current intake questions and align them with surveillance standards
- [ ] Add the use of a validated assessment tool of nicotine dependence to our patient intake process
- [ ] Display educational materials or promotional materials (e.g., for our state Quit Line) in waiting areas
- [ ] Promote practice's tobacco free policy in highly trafficked areas
- [ ] Educate staff in the significance of tobacco's harms to our clients and/or to themselves
- [ ] Educate staff on how tobacco dependence treatment aligns with our practice's mission and values
- [ ] Train staff on tobacco cessation interventions (assessment instruments and/or brief counseling)
- [ ] Train staff in advanced, intensive counseling modalities (e.g., Cognitive Behavioral Therapy, Motivational Interviewing)
- [ ] Train staff on effective referral strategies
- [ ] Train counselors and prescribers on current pharmacotherapy option and evidence-based recommendations, especially for priority populations (e.g., racial/ethnic minorities, chronic condition comorbidities, behavioral health pops)
- [ ] Learn strategic planning best practices regarding adding tobacco cessation services
- [ ] Learn strategic planning best practices regarding designing and executing an practice-wide tobacco free policy
- [ ] Or write your own custom goal:

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Build a Clinic Application (2)

31.

In order to for BHWP to track the success of the Build a Clinic program and to make improvements for future sessions certain questions from this survey will be asked again at the program's conclusion.

We will also be sending a survey that needs to be sent out to all staff with patient interactions. This survey briefly measures staff attitudes, knowledge and behaviors regarding providing tobacco cessation services. This survey will also need to be sent out and responded to at the program's beginning and again at the end.

Please check below that you understand these requirements and agree to them.

- [ ] I understand that the questions regarding the provision of services will be asked again at the program's conclusion.
- [ ] I understand and agree that my practice's project lead will send out a survey to all staff with direct patient interaction to assess their tobacco cessation-related knowledge, attitudes, and behaviors at the start and end of the Build a Clinic program.

Build a Clinic Application (2)

Thank you.

BHWP and its partners will be reviewing applications shortly. Announcement of our selections will be sent out by the end of October.

If you have any questions or concerns about this application process, please refer to the Build a Clinic FAQ. If you need additional information. please contact Jim Pavlik, Program and Policy Analyst at the Behavioral Health & Wellness Program (jim.pavlik@ucdenver.edu).

26 February 2016

Name
Title
Organization
Address

Dear Name,

Congratulations! The University of Colorado, Behavioral Health & Wellness Program and Department of Family Medicine, and ECHO Colorado are pleased to announce that your organization has been selected to join the 2016 Build a Clinic Learning Community. Your application materials were rated very highly among an especially talented group of applicants. We are thrilled to have the opportunity to work more closely with you over the next seven months.

This project will kick off with a conference call on Tuesday, March 15th, 2016, 12:00p – 1:00p MST. Please hold this date on your team's calendar. You will be receiving a Welcome Packet the week of February 29th with further details, including a timeline, of this program.

To confirm your participation in the 2016 BAC, we ask that you please complete the following items by 5:00p MST on Wednesday, March 9, 2016:

1. Fill out the Letter of Commitment (found in your Welcome Packet) and send to Jim Pavlik;
2. Fill out the Build a Clinic Wellness Committee form (also in Welcome Packet)
3. Send your agency's logo to Jim Pavlik (in .JPG, .TIF, .GIF, .PDF, *or* .PNG formats);
4. Have your Team Lead complete this brief survey on behalf of your organization.

Also, to join the introductory session and the 6 collaborative learning sessions, participants will need access to Zoom, a video conferencing program. Please click here to download the browser extension.

Again, congratulations and thank you for your participation. If you have any questions, please email them to Jim.Pavlik@ucdenver.edu.

Warm regards and continued success,

Chad D. Morris, PhD
Director, Behavioral Health & Wellness Program
Chad.Morris@ucdenver.edu

Build a Clinic: Integrating Tobacco Cessation Services into Primary Care

Module Title 0: Introducing the Build a Clinic Program		
Date	March 15, 2016	NA
Facilitator/Moderator	Jamie Pfahl	NA
Presenter(s)	Jim Pavlik	NA
Panelist(s)	NA	NA
Module Title 1: Tobacco Cessation Counseling Best Practices: An Introduction		
	Webinar	ECHO
Date	March 22, 2016	March 29, 2016
Facilitator/Moderator	Jim Pavlik	Jim Pavlik & Jamie Pfahl
Presenter(s)	Dr. Chad Morris	Dr. Chad Morris
Panelist(s)	NA	Drs. Matthew Simpson & Shandra Brown Levey
Module Title 2: Tobacco Cessation Counseling Best Practices: Motivational Interviewing		
	Webinar	ECHO
Date	April 12, 2016	April, 26, 2016
Facilitator/Moderator	Jim Pavlik	Jamie Pfahl
Presenter(s)	Kathie Garrett	Kathie Garrett
Panelist(s)	NA	Dr. Rebecca Richey
Module Title 3: Tobacco Cessation Best Practices: Pharmacotherapy Options		
	Webinar	ECHO
Date	May 10, 2016	May 25, 2016
Facilitator/Moderator	Jim Pavlik	Jamie Pfahl
Presenter(s)	Dr. Christine Garver-Apgar	Dr. Christine Garver-Apgar

Panelist(s)	NA	Dr. Matthew Simpson and/or Liza Wilson
Module Title 4: **Analyzing and Adapting Clinical Workflow**		
	Webinar	ECHO
Date	June 14, 2016	June 28, 2016
Facilitator/Moderator	Jim Pavlik	Jamie Pfahl
Presenter(s)	Drs. Shandra Brown Levey & Matthew Simpson	Drs. Shandra Brown Levey & Matthew Simpson
Panelist(s)	NA	Drs. Matthew Simpson & Shandra Brown Levey
Module Title 5: **Special Populations and Cultural Sensitivity**		
	Webinar	ECHO
Date	July 12, 2016	July 28, 2016
Facilitator/Moderator	Jamie Pfahl	Jamie Pfahl
Presenter(s)	Jim Pavlik	Jim Pavlik
Module Title 6: **Tobacco Clinic Scalabillity and Sustainability**		
	Webinar	ECHO
Date	August 16, 2016	August 30, 2016
Facilitator/Moderator	Jim Pavlik	Jamie Pfahl
Presenter(s)	Dr. Chad Morris	Dr. Chad Morris
Panelist(s)		Drs. Matthew Simpson & Shandra Brown Levey

Module Objectives

Introduction to the Build a Clinic Program	• Discuss program modules and deadlines • Discuss participants' responsibilities • Explore the basics of using Zoom video-conferencing platform
Tobacco Cessation Counseling Best Practices: An Introduction	• Discuss clinical practice guidelines for treating tobacco dependence • Explore how to utilize the "5As (Ask-Advise-Assess-Assist-Arrange)" and the "2As and an R (Ask-Advise-Refer)" models • Analyze your practice's current workflow
Tobacco Cessation Counseling Best Practices: Motivational Interviewing (MI)	• Discuss MI fundamentals • Demonstrate how to use MI techniques for tobacco dependence
Tobacco Cessation Best Practices: Pharmacotherapy Options	• Identify the seven FDA-approved tobacco cessation medications • Review prescribing guidance • Discuss how to respond to the common use of e-cigs and vaping products
Analyzing and Adapting Clinical Workflow	• Identify team-based, efficient workflows • Examine how to apply the "5As" to practice redesign efforts • Utilize electronic medical records to enhance outcomes and billing
Special Populations and Cultural Sensitivity	• Identify commonly treated "at-risk" populations • Develop tailored treatment plans (?) • Identify treatment barriers • Employ strategies to address treatment barriers
Tobacco Clinic Scalability and Sustainability	• Distinguish between the costs and benefits of tobacco treatment • Identify internal and external supports • Discuss best practices to ensure sustainability
Lessons Learned and Looking Forward	• Discuss major themes • Discuss barriers and productive innovations • Report your practice's next steps

Build A Clinic
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Build A Clinic ECHO Case Form

The purpose of sharing a case is to allow you to gain feedback and insight from your peers as well as subject matter experts. This is a chance for you to ask questions, discuss the barriers that you are experiencing, and share lessons learned that are specific to your work and clinical setting.

Please take some time to address the following questions. These questions are meant to guide you in preparation for sharing your case and help you think through some of the questions you may have or the barriers you might be experiencing. You will have approximately 3-5 minutes to share this information during the ECHO session.

1. **Briefly describe your clinic setting and the populations you serve.** Consider your organization size, geographic location (rural vs. urban), staffing, and the demographic characteristics of the populations you serve.

2. **Describe any relevant characteristics of your current clinical workflow as it relates to tobacco treatment.**

3. **What are some of the barriers or challenges you have encountered or expect to encounter in reaching your organizational goals around tobacco treatment?**

4. **What are some of your lessons learned from this project thus far? What has worked and what hasn't worked?**

5. **Develop at least one question that you would like to receive feedback on from the other Build A Clinic participants**.

DIMENSIONS Action Plan

Reset Form

Name: _____ **Date:** _____

Training Location: _____

Organization Name: _____

_____

Best Way to Contact You:

☐ Email: _____

☐ Phone: _____

Position (check all that apply):

☐ Administrator
☐ Peer Advocate
☐ Provider
☐ Other (specify): _____

DIMENSIONS training attended:

☐ Tobacco Free Policy – Fundamentals
☐ Tobacco Free Program – Advanced Techniques
☐ Tobacco Free Program – Fundamentals
☐ Well Body Program – Advanced Techniques
☐ Well Body Program – Fundamentals
☐ Other (specify): _____

Readiness for change (check one):

☐ Pre-contemplation: *Not considering change*
☐ Contemplation: *Considering change*
☐ Preparation: *Making concrete plans for change*
☐ Action: *Actively taking steps toward change*
☐ Maintenance: *Sustaining changes already made*

Based on readiness for change, I will work to achieve the following goal(s) over the next 3-6 months.
Consider SMART goal criteria (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely).

Goal #1:
Completion of Goal #1 will be evidenced by:
Potential barriers to achieving Goal #1:
Goal #2:
Completion of Goal #2 will be evidenced by:
Potential barriers to achieving Goal #2:

Signature: _____

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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

Welcome

Thank you for completing this brief survey about tobacco use and treatment.

We are conducting this survey because we have been selected to participate in an intensive 6-month learning community designed by the Behavioral Health & Wellness Program at the University of Colorado, School of Medicine. The survey results will help us to get a current snapshot of employee knowledge and attitudes about tobacco. They will also provide information about what is currently being done to address tobacco use with the people we serve.

The results of this survey will help BHWP to evaluate the impact of your practice's participation in the Build a Clinic program over the past 6 months and allow us to make improvements to this program for future sessions.

Your participation is confidential and anonymous.

Build A Clinic
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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

Information

*** 1. Organization:**

*** 2. Age:**

- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65+

*** 3. Gender:**

- ○ Female
- ○ Male
- ○ My gender is not listed
- ○ Prefer not to disclose

*** 4. Race/Ethnicity (check all that apply):**

- ☐ White/Non-Hispanic
- ☐ Hispanic/Latino
- ☐ Black/African American
- ☐ Asian
- ☐ Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Other (please specify):

*** 5. Role/Position:**

- ○ Senior Leadership/Executive
- ○ Program Manager
- ○ Clinical Supervisor
- ○ Intake Counselor
- ○ Clinician/Counselor
- ○ Case Manager
- ○ Administrator - Reception/Front Desk
- ○ Support Staff - Security/Facilities/IT/HR
- ○ Other (please specify):

Build A Clinic

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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

*** 6. Please indicate how much training you have received around tobacco use and cessation:**

- ○ No training
- ○ Some training
- ○ Extensive training

*** 7. Which of the following categories describe the populations you serve (check all that apply)?**

- [ ] Low-socioeconomic
- [ ] Pregnant/postpartum women
- [ ] Mental illness
- [ ] Addictions
- [ ] Incarcerated/justice-involved
- [ ] Patients with chronic conditions (e.g., diabetes, hypertension, CVD, COPD, etc.)
- [ ] Lesbian, gay, bisexual, transgender (LGBT)
- [ ] Other (please specify):

*** 8. Have you ever REGULARLY used any tobacco product(s) in your lifetime? ("Regularly" is at least a few times every few days.)**

- ( ) Yes
- ( ) No

Build A Clinic

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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

*** 9. In your lifetime, which tobacco products have you REGULARLY used (check all that apply)?**

- [ ] Cigarettes
- [ ] Smokeless tobacco (e.g. chewing tobacco, snuff, snus)
- [ ] Cigars
- [ ] Pipe
- [ ] E-cigarettes or vaping
- [ ] Hookah/waterpipe
- [ ] Other tobacco products (please specify):

*** 10. Have you used any tobacco in the past 3 months?**

- ( ) Yes
- ( ) No

Build A Clinic

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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

*** 11. Which of the following best describes you? (check all that apply)?**

- [ ] I have successfully quit within the past 3 months
- [ ] I have tried to quit unsuccessfully within the past 3 months
- [ ] I would like to try to quit over the next month
- [ ] I would like to try to quit over the next 6 months
- [ ] I have no interest in quitting

2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

Knowledge

Please answer the questions below even if you do not have direct contact with clients.

*** 12. Which category describes your knowledge of the following interventions for tobacco cessation and prevention (regardless of whether or not you use these services)?**

	No Knowledge	Little Knowledge	Some Knowledge	Good Knowledge	Extensive Knowledge
Asking about tobacco use	○	○	○	○	○
Advising not to use tobacco	○	○	○	○	○
Documenting tobacco use status in the electronic health record or patient chart	○	○	○	○	○
Nicotine replacement therapy (e.g., patches, gum, nasal spray)	○	○	○	○	○
Other cessation medications (e.g., Chantix, bupropion)	○	○	○	○	○
Cognitive behavioral strategies	○	○	○	○	○
Motivational interviewing and enhancement	○	○	○	○	○
Individual or group tobacco cessation counseling	○	○	○	○	○
Referral to a quitline	○	○	○	○	○
Referral to web-based or mobile phone cessation programs and resources	○	○	○	○	○
Evidence-based messaging around Electronic Nicotine Delivery Systems (ENDS) (e.g., e-cigarettes)	○	○	○	○	○
Culturally competent/ tailored interventions to priority populations	○	○	○	○	○
Tobacco-free policies	○	○	○	○	○

Build A Clinic
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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

Attitudes

*** 13. Please check how much you agree or disagree with the statements below.**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Given my existing roles and responsibilities as a primary care provider, supervisor, or administrator, it is feasible to also provide tobacco prevention and cessation services.	○	○	○	○	○
Smoking cessation is possible for the populations we work with.	○	○	○	○	○
It is important for the populations we work with to receive tobacco prevention and cessation services.	○	○	○	○	○
We do not have sufficient time during a routine visit to help a client quit.	○	○	○	○	○
I believe there is no safe level of exposure to secondhand smoke.	○	○	○	○	○
People are less likely to seek services if an agency is tobacco-free.	○	○	○	○	○
I would/do support a tobacco-free policy at this agency.	○	○	○	○	○

Build A Clinic
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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

*** 14. Do you currently provide direct evaluation, assessment, or clinical services as part of your job?**

- ◯ Yes
- ◯ No

Build A Clinic
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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

Behavior

Please answer the questions below as they relate to the population and age range that you primarily serve.

*** 15. How often do you currently provide the below tobacco cessation and prevention services?**

	Never	Rarely	Sometimes	Often	Always
Ask if patient/client/consumer uses tobacco	○	○	○	○	○
Advise patient/client/consumer not to use tobacco	○	○	○	○	○
Document tobacco use status in electronic health record or patient chart	○	○	○	○	○
Encourage/prescribe nicotine replacement therapy (e.g., patches, gum, nasal spray)	○	○	○	○	○
Encourage/prescribe other cessation medications (e.g., Chantix, bupropion)	○	○	○	○	○
Use cognitive behavioral strategies	○	○	○	○	○
Use motivational interviewing and enhancement	○	○	○	○	○
Provide individual or group tobacco cessation counseling	○	○	○	○	○
Refer to a quitline	○	○	○	○	○
Refer to web-based or mobile phone cessation programs/resources	○	○	○	○	○
Provide culturally competent and tailored interventions	○	○	○	○	○
Provide evidence-based messaging around Electronic Nicotine Delivery Systems (ENDS) (e.g., e-cigarettes)	○	○	○	○	○
Promote tobacco-free policies	○	○	○	○	○

Build A Clinic

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2016 Build a Clinic: Staff Knowledge and Behaviors Survey (1post)

Thank you for your time in completing this survey. Your input is greatly appreciated.

If you have any questions regarding this survey, please contact Jim Pavlik, Build a Clinic Program Manager at **jim.pavlik@ucdenver.edu** or by phone at 303.724.8007.

Build a Clinic Application OSA (post)

The University of Colorado (CU), Behavioral Health and Wellness Program and the CU Department of Family Medicine and School of Public Health are pleased to congratulate you on your successful completion of the Build a Clinic program. We hope not only that you found the didactics and technical assistance (TA) useful, but that you were able to turn the knowledge and expertise into practical clinical transformation to improve outcomes for your patients.

As you know, this was the second round of the Build a Clinic program, which itself was an outgrowth of individual consultation that the Behavioral Health and Wellness Program has conducted over the past 11 years. The responses to this post survey resulted in a very different program than the one we ran in 2016. We reduced the length of our data gathering tools and eliminated some altogether. We modified the format of the Learning Community sessions, and restructured the TA calls. That's our way of saying, "Your feedback matters...a lot."

This work is important and the task of getting current tobacco users to alter their habits is more difficult today than it was 25 years ago. We need to make sure that programs like this reach more points of care, but they must deliver programming that makes a difference.

With that in mind, please answer the following questions to the best of your knowledge. Most of the questions will look familiar to you as they are directly from your application (it would be best, if possible, to have the same person fill out this post-survey as filled out the application).

The survey should only be filled out once per participating organization. If more than one person on your team receives Build a Clinic emails, please decide which of you is best able to answer the questions.

Thank you in advance.

Build a Clinic Application OSA (post)

1. Practice Information

Project Leader Name

Project Leader Job Title

Practice/Clinic Name

Address

Address 2

State

COUNTY

ZIP/Postal Code

Email Address

Phone Number

2. What is your title or clinical role?

- MD
- DO
- PA
- NP
- RN
- CNS
- Social Worker
- Wellness Coordinator
- Other (please specify)

3. Sex

- Female
- Male
- Different Identity
- Prefer not to respond

Build a Clinic Application OSA (post)

4. Does your practice use an Electronic Health Record (EHR) system?

- ○ Yes
- ○ No

Build a Clinic Application OSA (post)

5. Which EHR system does your practice use?

Build a Clinic Application OSA (post)

6. Are you adding an EHR system or considering adding an EHR system in the next 12 months?

- ○ Our practice is considering adding an EHR system.
- ○ Our practice is actively shopping for an EHR vendor.
- ○ Our practice has considered but rejected adding an EHR system at this time.

Build a Clinic Application OSA (post)

The next set of questions asks you to report on your practices readiness to adopt tobacco cessation services and supports across nine areas. Please choose the option that most corresponds to your understanding of your practice's status.

If your practice does not currently offer this service, is it considering adding it? Is your practice in the process of planning it right now? Has the execution of this service been planned already and will it be added in the near future?

If you are not offering a service please use the optional text block following each area to explain if this is a service you have considered but decided not to offer (and briefly why) or whether this is a service you would like assistance in adding during your time in the Build a Clinic program and (briefly) what obstacles have prevented you from adding this service already. This section is optional, but will help us determine if Build a Clinic will be an effective program for your practice.

7. Tobacco Education and Support

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Provide tobacco education to consumers	○	○	○	○	○
Provide training to staff on evidence-based tobacco cessation strategies and interventions	○	○	○	○	○
Development of tobacco cessation materials (brochures, posters, literature, handouts)	○	○	○	○	○

8. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

9. Tobacco Screening and Treatment Planning

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Ask/document tobacco use for all clients at intake	○	○	○	○	○
Ask/document tobacco use for all clients at every visit	○	○	○	○	○
Advise tobacco users to quit at every visit and document	○	○	○	○	○
For tobacco users, treatment plans include cessation goals	○	○	○	○	○

10. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

11. Tobacco Usage Interventions: Onsite Nicotine Replacement Therapy and Medication Prescribing

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Nicotine Replacement Therapy (NRT) prescribed onsite	○	○	○	○	○
Bupropion/Zyban/Wellbutrin prescribed onsite	○	○	○	○	○
Varenicline/Chantix prescribed onsite	○	○	○	○	○

12. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

13. Tobacco Usage Interventions: Onsite Psychosocial Services

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Motivational interviewing for tobacco cessation occurring onsite	○	○	○	○	○
Individual tobacco cessation counseling occurring onsite	○	○	○	○	○
Tobacco cessation groups occurring onsite	○	○	○	○	○

14. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

15. Tobacco Usage Interventions: Community Referrals

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Referrals offsite for Nicotine Replacement Therapy or other medication	○	○	○	○	○
Referrals to Quitline	○	○	○	○	○
Referrals to other agencies for tobacco support services	○	○	○	○	○

16. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

17. Tobacco Usage Interventions: Peer Services

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Peer-led services onsite for tobacco cessation	○	○	○	○	○
Peer-led services onsite not focused on tobacco	○	○	○	○	○

18. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

19. Tobacco Control Policy

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Tobacco-free agency (interior)	○	○	○	○	○
Campus/facility tobacco-free (entire grounds)	○	○	○	○	○
Tobacco-free signage & advertising onsite	○	○	○	○	○
Specific enforcement procedures and policies	○	○	○	○	○
Tobacco cessation support for staff	○	○	○	○	○

20. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

21. Outcomes

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Create and utilize tobacco indicators and measures	○	○	○	○	○
Monitor and evaluate tobacco indicators and measures	○	○	○	○	○

22. If you are not currently performing any of these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

23. Sustainability

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Electronic health record infrastructure includes tobacco use and treatment fields	○	○	○	○	○
Determine if tobacco cessation services will be available to community members	○	○	○	○	○
Process in place to track how individuals/clients were referred/heard about tobacco cessation services (marketing)	○	○	○	○	○
Practice bills for tobacco prevention and cessation services	○	○	○	○	○

24. If your practice currently bills for tobacco prevention and cessation services, who do you bill? Please mark all that apply.

- [ ] Not applicable to my practice-we do not currently bill for tobacco cessation services
- [ ] Grants
- [ ] Medicare
- [ ] Medicaid
- [ ] Private Insurance

Other (please specify)

25. If you are not currently billing for these activities, please briefly describe why not. Or, if you would like to add any other comments about this area of services, please do so here.

Build a Clinic Application OSA (post)

26. Please provide feedback regarding your experience of the Build a Clinic program overall by selecting how strongly you agree or disagree with the following statements.

	Strongly disagree	Disagree	I am neutral	Agree	Strongly agree
The presenters (on the webinar recordings) were knowledgeable about the topics discussed.	○	○	○	○	○
The Zoom call moderators (Mary and Jim) were knowledgeable about the topics discussed.	○	○	○	○	○
The concepts of the program were clearly presented.	○	○	○	○	○
This program provided me with practical tools I can use.	○	○	○	○	○
In general, I am satisfied with this training.	○	○	○	○	○

27. Please answer the following questions on the Build a Clinic Program as a whole

What was the most important concept you learned during the course of the program?

Please describe the aspect of the program you liked best.

Please describe the parts you would change or add to improve this program.

28. Please rank the Build a Clinic Program overall on the following topics

	Not at all satisfied.	Not very satisfied.	Neither satisfied nor unsatisfied.	Somewhat Satisfied.	Very satisfied.
The overall content of the webinars.	○	○	○	○	○
The overall experience of the live collaborative sessions (Zoom sessions)	○	○	○	○	○
The BAC program overall.	○	○	○	○	○

29. If you missed a module or if you stopped attending program activities, what can BWHP do for future participants to help maintain their interest?

Build a Clinic Application OSA (post)

30. Prior to your participation in the Build a Clinic program had you ever participated in a Zoom session before?

- ○ Yes
- ○ No

31. The live collaborative sessions using the Zoom video conferencing software are a critical component of the Build a Clinic program, but this is a relatively new technology and the ECHO learning model is under constant refinement. In your opinion, what is one thing that BHWP and ECHO Colorado can do to improve the ECHO experience for participants?

Build a Clinic Application OSA (post)

Thank you for your time in completing this survey. Your input is greatly appreciated.

Please continue to check our website for additional resources. Also remember that BHWP staff are perpetually open to technical assistance requests. You are more than welcome to call Mary or Jim, or (even better) send requests for advice, resources, or technical assistance directly to bh.wellness@ucdenver.edu. We will be sure to get your question routed to the most appropriate staff and answered as rapidly as possible.

If you have any questions or concerns, please contact Jim Pavlik, Program and Policy Analyst at the Behavioral Health & Wellness Program (jim.pavlik@ucdenver.edu).

Build A Clinic

Learning Community | Tobacco Cessation | Primary Care Settings