# 2019 Request for Proposals (RFP)

HAWAI'I COMMUNITY FOUNDATION

## Hawai'i Tobacco Prevention and Control Trust Fund Community Grants Program - Tobacco Cessation Services for Priority Populations

Online Application Deadline: Friday, March 29, 2019, 4:00 p.m. HST

### BACKGROUND

#### Hawai'i Tobacco Prevention and Control Trust Fund

The Hawai'i Tobacco Prevention and Control Trust Fund (Trust Fund) was created by state law following a Master Settlement Agreement (MSA) between most US states and territories and the tobacco industry[1]. The Hawai'i Community Foundation (HCF) has held and managed the Trust Fund on behalf of the Hawai'i Department of Health (DOH) since 2000.

Pursuant to the contract with the DOH, HCF implements a community grants program as one component of a statewide comprehensive tobacco prevention, education, and cessation strategy to reduce and eliminate tobacco consumption based on the Centers for Disease Control and Prevention's (CDC) goal for comprehensive tobacco control programs. Hawai'i's statewide tobacco cessation strategy is implemented through a coordinated effort between DOH's Tobacco Prevention and Education Program, public health advocates, private and non-profit organizations, policy makers, and various communities throughout our state.

#### Tobacco Use in Hawai'i & Focus on Priority Populations

Tobacco use in Hawai'i continues to be a serious public health problem, where roughly 1,400 deaths each year are attributable to smoking.[2] Estimates of annual smoking-caused monetary costs in Hawai'i include $526M in health care costs, $387M in lost productivity costs, and account for $141M of all Medicaid expenditures.[3]

Hawai'i's adult smoking prevalence rate in 2016 was 13.1% (about 140,700 adult smokers), a statistically significant decline since 2002[4]. However, as stated by the Truth Initiative, tobacco is not an equal opportunity killer[5]. Despite the overall decline in tobacco use, certain groups in Hawai'i still have disproportionate rates of tobacco use, and therefore disease and fatality, as evidenced by the Hawai'i Behavioral Risk Factor Surveillance System (BRFSS)[6] and other surveys[7]. Those with higher smoking rates include:

- Native Hawaiians (18%)
- Persons with mental health and/or substance use challenges (examples include: diagnosed depression 25.1% and heavy drinking 35.5%)
- Lesbian, Gay, Bisexual, Transgender (LGBT) communities (22.4%), and

[1] Hawai'i Revised Statutes 328L-2 (2010).
[2] Campaign of Tobacco Free Kids (2018) - http://www.tobaccofreekids.org/facts_issues/toll_us/Hawaii.
[3] Campaign of Tobacco Free Kids (2018) - http://www.tobaccofreekids.org/facts_issues/toll_us/Hawaii.
[4] 2016 Hawai'i Behavioral Risk Factor Surveillance System (2016 BRFSS), accessible through the Hawai'i Health Data Warehouse at http://www.hhdw.org/ under BRFSS Reports. Tobacco Use, Prevalence and Tobacco Use Prevention and Control Tracker.
[5] The Truth Initiative - https://truthinitiative.org/tobacco-use-hawaii.
[6] 2016 BRFSS, http://www.hhdw.org/ under BRFSS Reports, Tobacco Use, Prevalence.
[7] See, for example, Hawai'i Health Data Warehouse - http://www.hhdw.org/.

- Low socio-economic status populations (examples: low income 21.3% and low educational attainment 23.6%).[8]

In addition, the statewide smoking rate for pregnant women during the last trimester of pregnancy was 8.1% in 2015.[9] This has long-term consequences for the next generation as smoking during pregnancy causes significantly higher rates of premature birth, low birth weight, sudden infant death syndrome (SIDS), and attention deficit hyperactivity disorder (ADHD).[10]

The focus of this RFP and the HCF Tobacco Cessation Grants Program is to provide intensive, evidence-based cessation services to the populations above ("priority populations") to help them to stop using tobacco.

### Hawai'i's Tobacco Strategic Plan, 2016-2019 Cessation Grant Program, Hawai'i Tobacco Quitline

Hawai'i's tobacco cessation and prevention effort and this RFP is guided by the State's 2016-2020 Tobacco Use Prevention and Control Five-Year Strategic Plan ("Strategic Plan") which focuses on reaching and serving priority populations in Hawai'i.[11] The Strategic Plan was developed through community input throughout Hawai'i.

In 2016, HCF released a tobacco cessation community grants RFP seeking to reduce smoking prevalence rates among priority populations. Sixteen organizations across Hawai'i were awarded grants that started on July 1, 2016 and is set to end on June 30, 2019 ("current program"). The focus of the 2016 RFP was to provide intensive, evidence-based cessation services to priority populations through program innovations and adaptations that help these populations quit smoking. Program evaluation results from July 2016 through December 2017 revealed that a total of 4,510 unique tobacco users received tobacco treatment; 97% of participants came from priority populations; 74% of participants received stop-smoking medication for free through the grant or assistance to get it from another source (such an insurance); 80.2% overall achieved a 24-hour quit attempt rate; 25.7% overall achieved a 30-day abstinence rate; and 88% were very or mostly satisfied with the program. Grantees implemented a variety of program innovations and adaptations to reach and serve priority populations (see Appendix 1 for a list of innovations and adaptations used). This RFP seeks to build on the momentum and lessons learned from the current grant program.

In conjunction with the HCF Cessation Grant Program, Hawai'i smokers who want to quit smoking can also access help from the Hawai'i Tobacco Quitline. The Quitline provides free cessation counseling services through a toll-free telephone line (1-800-Quit-Now) or online (www.hawaiiquitline.org). The Quitline and the current cessation grant program are complementary as the cessation grant program is intended to provide free in-person services for individuals from priority populations, while the Quitline provides free telephone and online services to all interested smokers in all communities statewide. Both programs provide services to individual smokers and can distribute free FDA-approved nicotine replacement therapies to eligible smokers.

### Evaluation of Programs

The current HCF Cessation Grant Program and the Hawai'i Tobacco Quitline is heavily evaluated by Professional Data Analysts, Inc. (PDA), an external evaluator. The purpose of the evaluation is to assess performance for the purposes of program improvement and accountability, and to document successes and lessons learned. Grantees of this RFP will be required to work with an external evaluator to track and measure program results for positive

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[8] 2016 BRFSS, http://www.hhdw.org/ under BRFSS Reports. Tobacco Use, Prevalence, and Tobacco Use Prevention and Control Tracker.
[9] *Early Childhood Indicator Report: Hawai'i State and Counties.* Health, page 5. He, S.J. & Pobutsky, A. (2015). University of Hawai'i, Center on the Family - http://uhfamily.hawaii.edu/publications/brochures/bf021_COF_ECISState&CountyReport_2015_1001.pdf.
[10] For example, see "Centers for Disease Control and Prevention, Smoking During Pregnancy (2018) https://www.cdc.gov/tobacco/basic_information/health_effects/pregnancy/index.htm.
[11] Hawai'i Department of Health 2016-2020 Tobacco Use Prevention and Control in Hawai'i, Five-Year Strategic Plan. https://health.hawaii.gov/tobacco/files/2013/04/2016TobPlanR.pdf

performance. The evaluation is a major component of the program and applicants to this program should expect to devote time and attention to the program evaluation. Please see Appendix 3 for a full description of the evaluation.

## PURPOSE & EXPECTATIONS

To align with federal and state goals for tobacco prevention and control and to reduce tobacco use prevalence and consumption, reduce tobacco-related morbidity and mortality and decrease tobacco related disparities, the HCF community grants program announces the availability of funds for cessation programs that accomplish the following:

- Provide intensive, evidence-based tobacco treatment services to adult smokers (18 years and older), including persons using electronic smoking devices or other emerging products containing nicotine, from identified priority populations (as listed above) to help them quit smoking.
- Reach and provide intensive interventions that are adapted to the needs and circumstances of the priority populations based on available best practice[12] or evidence-based programming for tobacco cessation. Some examples of best practices and evidence-based methods targeted to priority populations are listed in Appendix 1.
- Help tobacco users from priority populations become ready and willing to quit. When appropriate, engage with the smoker's family members and support groups.
- Provide Nicotine Replacement Therapy (NRT) and other approved pharmacotherapy to tobacco users when they are ready to quit.
- Establish tobacco screening and referral partnerships with agencies in the same service area serving the same priority populations in order to increase access to services, as appropriate.
- Participate in evaluation of the program by working directly with the external program evaluator hired by HCF.
- Work in collaboration with the Hawai'i Tobacco Quitline to provide comprehensive cessation services for all people of Hawai'i.
- Participate in grantee gatherings and trainings as required by HCF to increase staff knowledge and build program capacity, to network with other cessation providers, and to meet other grantees of the Trust Fund.
- Hire and train certified Tobacco Treatment Specialists (TTS) to perform tobacco cessation services.
- Perform all grant expectations listed in Appendix 4.

## ELIGIBILITY

To be eligible for funding under this RFP:

1. The applicant must be a non-profit organization with a 501(c)(3) tax-exempt status.
2. The applicant must have a history of successful programmatic implementation and experienced personnel. Funding will not be provided for start-up organizations.
3. Applicants must not have any outstanding final reports due to HCF.

## GRANT FUNDS & GRANT TERM

All grant awards under this RFP are contingent on HCF and the Hawai'i State Department of Health entering into a 5-year contract effective July 1, 2019. If the contract is not entered by July 1, 2019, grant awards may be delayed, deferred or cancelled. HCF will notify awardees of the expected grant start date. HCF is not liable

[12] Centers for Disease Control and Prevention: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm; Public Health Service Treating Tobacco Use and Dependence Clinical Practice Guidelines (2008), Hawaii Department of Health Tobacco Prevention and Education Program.

for any work, contract, costs, expenses, loss of profits, or any damages whatsoever incurred by applicants and grantees under this RFP prior to the grant start date.

- Grants will be awarded for a four-year period with a general grant award of $150,000 per year. However, larger grant awards may be considered for applications proposing cessation strategies that are scalable to serve more smokers through partnership sub-contract arrangements for coordinated cessation outreach, screening, referral and treatment, or to cover more than one island or more than one priority population.
- The grant term is expected to begin on July 1, 2019 and end on June 30, 2023, contingent on HCF's award of a long-term contract by the Hawai'i State Department of Health as mentioned above.
- Continuation of the grant for each year of the four-year grant term will depend on the grantee demonstrating adequate progress in the grant work plan. HCF reserves the right in its sole discretion to discontinue grant funding if progress is determined unsatisfactory. Grant payments are also contingent on the availability of funds from the Trust Fund.
- A total of two and a half million dollars ($2.5M) has been budgeted in calendar year (CY) 2019 for this cessation grant program and an additional $2.5M is expected to be budgeted in each of CY 2020, CY 2021, and CY 2022, subject to availability of funds.
- Grant funds must only be used for the purpose of this RFP and as outlined in the grant expectations (see Appendix 4).
- Tobacco Cessation Grants will not fund the following:
    - Capital improvements, including capital campaigns, construction or renovations (minor capital improvements to implement programs are allowable).
    - Establishment of or operating funds for a statewide quitline.
    - Debt reduction or third-party reimbursement.
    - Tobacco cessation and prevention/education services to minors age 17 and under.

## TRAINING AND OTHER SUPPORT

Cessation services funded by this grant program must be delivered by certified Tobacco Treatment Specialists (CTTS). For more information on CTTS training and other trainings, please see Appendix 5. Grantees of the program are encouraged to continuously keep up to date on the tobacco prevention and control field. Grantees are encouraged to seek training opportunities for their staff to attend and may use grant funds to support this activity. If funded, HCF will regularly send out potential training opportunities and resources to assist grantees in reaching their program goals. For resources related to tobacco prevention and control, please see Appendix 6.

In addition to the grant, awarded organizations will receive training, technical assistance, and other support from HCF that may include:

- Training:
    - Tobacco Treatment Specialist certification (TTS)
    - Motivational interviewing and brief intervention skills
    - Providing cessation services for priority populations
    - Education on electronic smoking devices (e-cigarettes or vapes) and other emerging tobacco products
- Technical assistance:
    - Implementation of program evaluation (i.e. assistance with the evaluation tools)
    - Use of the evaluation results (i.e. assistance with interpreting and using evaluation report findings)
- Other support:

- Regular grantee gatherings to provide updates on cessation services, to share successes and challenges to improve services, and to learn from evaluation results.
- Coordination of grant activities with the Department of Health, the Coalition for a Tobacco-free Hawaii, and other tobacco control stakeholders.
- Access to and assistance on how to use current population-based survey data from the Department of Health.
- Support for grantees' local communications, media, and public education efforts, coordinated with the HCF Tobacco Trust Fund's communications vendor.

## APPLICATION INFORMATION

Submission of proposals for the HCF Cessation Grant program must be completed online through Hawai'i Community Foundation's Nonprofit Gateway at https://nexus.hawaiicommunityfoundation.org/nonprofit. Applicants must establish an online account with HCF to access the online application. Note: If you are requesting an account, it may take a few days for you to receive the account information. It's highly recommended you request your account early to allow adequate time to complete the application by the submission deadline.

### Timeline

1. Release of RFP: Early February 2019.
2. Online Applications Due by: Friday, March 29, 2019 at 4:00 pm HST.
3. Notification of awards will be sent in June 2019.
4. As mentioned above, grants funds are contingent on HCF being awarded a contract with the Hawai'i State Department of Health anticipated to start on July 1, 2019. If funding is not available by July 1, 2019, HCF will notify awardees of the expected start date.
5. First grant payment will be mailed upon the finalization of grant terms and agreement requirements and any other contingencies outlined in the award letter from HCF.
6. Initial meetings with the program evaluator to discuss evaluation design and data collection tools to occur within the first few months of the grant award.

### Parts of Application

The application consists of five main parts:

Part 1. Proposal Narrative (to be submitted through HCF's Nonprofit Gateway)
Part 2. Program Work Plan Form (template provided; to be uploaded with application) - To include SMART objectives for innovations and adaptations.
Part 3. Program Benchmarks Form (template provided; to be uploaded with application)
Part 4. Program Budget (template provided; to be uploaded with application).
Part 5. Other required documents must be uploaded with the application and are listed below under Required Forms.

### Instructions

- Only complete applications will be accepted. Applications missing any required documents will be administratively denied.
- The online application has fillable boxes with character limits. The character counts in MS Word may not match the character counts in the application. If you cut and paste your work into the application, please be sure your text fits the space provided.

- We recognize the significance of diacritical markings in written Hawaiian as pronunciation guides; however, the online application system is unable to accept diacriticals. Please do not include these in your narrative as it may cause errors in the way the online system processes your proposal.

### Proposal Review Process

Proposals will be reviewed by a review team comprised of HCF staff and external individuals selected for their expertise, skills, and knowledge related to the focus of this RFP who do not have any controlling or financial interest in any of the entities submitting proposals. The review team will analyze the merits of each proposal and make recommendations to HCF. HCF will make the final decision on all grant awards. The strongest proposals will be those that specifically address all the criteria listed below.

## CRITERIA FOR PROPOSAL REVIEW

The strongest proposals will be those that meet all or most of the following criteria.

- Organization demonstrates that it has history of successful programmatic implementation, strong operational and fiscal administration, and experienced personnel who can effectively lead and oversee cessation services provided under the grant.
- Organization demonstrates that it has substantial relevant experience in smoking cessation services or related public health services addressing addiction and behavioral change.
- Organization demonstrates a clear strategy to reduce smoking in its service area by providing effective cessation services to individual smokers from priority populations.
- There is a clear rationale for the strategy that is tied to known best practices or evidence-based methods to help people quit smoking or become ready to quit smoking and is designed to address the needs and circumstances of individual smokers from priority populations.
- Organization demonstrates clear, realistic, measurable, and achievable benchmarks and results, and has the capacity to deliver cessation services under the grant, including the evaluation requirements.
- Organization has strong partnerships with other service providers in its service area that will support the creation of tobacco outreach, screening, brief intervention, and referral protocols to increase utilization of the organization's cessation services.

## PROPOSAL NARRATIVE QUESTIONS

*The following character counts are approximate to the specified page lengths based on single-spacing in Arial 12-point font with 1-inch margins.*

1. For your organization as a whole, please describe the mission of your organization, the community your organization serves, including who you serve, the geographic areas you serve, and the needs you are working to address or the opportunities you are working to provide. (*max 2,000 characters = 1/2 page*)

2. For the staff who will be managing and delivering cessation services under your proposal, please describe their experience, knowledge, and background related to tobacco control and prevention. Please indicate their names and position titles, experience in tobacco cessation work, certifications and degrees, and if they are nationally certified as Tobacco Treatment Specialists (TTS). What do you anticipate will be their training and professional development needs to better serve smokers from priority populations during the grant term? How is the work of these staff members integrated with other services provided by your organization? (*max 4,000 characters = 1 page*)

3. Which priority populations (as defined in this RFP) will you (and/or your partner organization, if applicable) serve with intensive tobacco cessation services? How are they currently served by your organization? Please explain how you will reach and promote priority populations to your cessation program and/or how they will be referred to your program (if referred by a partner organization, please identify the organization). *(max 4,000 characters = 1 page)*

4. What tobacco cessation programs, services or activities is your organization already providing to priority populations? How does your organization determine which cessation programs, services or activities to implement? In other words, of all the things your organization could do to achieve its desired results in tobacco cessation, why have you chosen the programs, services or activities that you offer? (If your organization is not doing tobacco cessation work at this time, then describe the programs, services or activities your organization is using to address addiction or other behavioral change public health issues in the community.) *(max 4,000 characters = 1 page)*

5. Please describe what your organization achieved in tobacco cessation *over the "past year"* (either fiscal or calendar year is acceptable). Specifically, how much did your organization achieve and what difference did your efforts make for the community and priority populations you serve? If your organization has experience offering tobacco cessation services, please share the organization's history offering these services and how it may have evolved over the years in making a difference for the community and priority populations you serve. (If your organization is not doing tobacco cessation work at this time, then describe what your organization achieved through its services addressing addiction or other behavioral change public health issues in the community.) *(max 4,000 characters = 1 page)*

6. How has your organization measured results in its tobacco cessation services (if any) to date? Please describe what data you collect, how and how often it is collected, and how you analyze and use this information to improve services and make decisions. If possible, please include a description of how your organization measures the quality of its tobacco cessation activities, i.e., how well it performed the services it provided (for example customer satisfaction, performance against standards or industry benchmarks, level of participation, etc.). Please indicate the staff person that will work directly with HCF's contracted evaluator. (If your organization is not doing tobacco cessation work at this time, then describe how your organization measures results in its services addressing addiction or other behavioral change public health issues in the community.) *(max 4,000 characters = 1 page)*

7. Please elaborate on the summary information you are providing in the Program Work Plan form (download template) by describing in greater detail your scope of work including the major strategies you would implement and your rationale for doing so. How will you (and your partner organizations, if applicable) provide cessation services to specific priority populations? Please explain in detail the evidence-based intensive interventions you will use in your delivery of cessation services. Please share the program innovations and adaptations that you will provide to priority populations, and if applicable, please indicate if they are based on a best practice, evidence-based model or program, cultural practice, or other proven strategies. For a list of program innovations and adaptations, please see Appendix 1. *(max 10,000 characters = 2 ½ pages)*

8. If you plan to partner with other agencies to refer participants and/or deliver cessation services, please indicate each agency you will work with and share how your organization will work with them to increase access and effectiveness of your program in its delivery of cessation services to priority populations? *(max 2,000 characters = 1/2 page)*

9. How does your organization as a whole financially support its overall activities and infrastructure? Please describe your organization's typical sources of income or revenue. Please describe any additional sources of income (other than this grant) that will support the proposed tobacco cessation services. Please include any information on revenue for tobacco cessation services from medical insurance, Medicare, or Medicaid reimbursement. *(max 2,000 characters = 1/2 page)*

## REQUIRED FORMS - ATTACHMENTS TO BE UPLOADED WITH THE APPLICATION

Proposals missing any of the required forms will be administratively denied.

1. Program Budget Form (download template)
2. Program Work Plan Form (download template)

3. Program Benchmark Form (download template)
4. One-page board or leadership group list with professional affiliations
5. Financial Statements (audited, if available) for the two most recently completed fiscal years
6. Organization's current and previous year's board-approved Operating Budget
7. If applicable, documentation of any partnership arrangement described in your proposal (supporting letter, MOU, etc.)

## QUESTIONS ABOUT THIS RFP

Please visit the HCF Tobacco Cessation Grant Program page of our website for more information: https://www.hawaiicommunityfoundation.org/grants/tobacco-cessation.

If you have any questions about registering your nonprofit online or about the online application process, please contact Lisha Kimura at 808-566-5558 or lkimura@hcf-hawaii.org.

If you have any questions about the RFP, you may contact: Larissa Kick at 808-566-5565 or lkick@hcf-hawaii.org or Tom Matsuda at 808-566-5549 or tmatsuda@hcf-hawaii.org. Neighbor Islands may call our toll-free number at 1-888-731-3863.

## APPENDIX 1 - Program Innovations and Adaptations

The 2016-2019 HCF Cessation Grant program design was based on extensive available research from national sources that identified evidence-based programs and technologies that can help tobacco users quit.[13] For example, research showed that:

- The first step in becoming tobacco-free is making a quit attempt.[14]
- Being ready to quit is a significant predictor of successful quitting.
- With the use of behavioral interventions (e.g. counseling[15]) and pharmaceutical interventions (Nicotine replacement therapies and/or pharmacotherapies) tobacco users who can make a quit attempt, even if for a short period of time like 24-hours, have a higher probability of sustained abstinence (e.g. quitting tobacco in the long term).[16]
- Intensive interventions[17] for tobacco dependence have greater success at quit attempts than brief interventions.

However, despite these successes and the long-term decline in the statewide prevalence rate, the continued persistence of higher prevalence rates in priority populations indicates that the national standardized interventions do not always work. Cessation providers have found, for example, for some priority populations, it is harder to persuade smokers to be ready to quit, more counseling interventions are necessary, relapses are more common, and family or support group approaches can be more effective than one-on-one counseling. The community input for the 2016-2020 Strategic Plan recognized these differences and encouraged the use of innovative cessation strategies that are better suited to the needs and circumstances of those priority populations. To be effective, innovative strategies should be derived from standardized evidence-based interventions but adapted to fit the unique circumstances of individual smokers in these specific populations. Similar to the 2016-2019 grant program, a major goal of this RFP is to encourage such innovation and adaptation.

Each smoker is unique and so are his or her motivations to quit. Thus, a successful grantee's tobacco treatment specialists and other staff may need to carefully assess the circumstances and needs of each individual smoker, and then be prepared to select the most appropriate counseling and intervention approach from a variety of available options. This may be particularly important when the smoker comes from more than one priority group. Grantees will be expected to share their "toolbox" of strategies and innovations, including successes and challenges, with other grantees through regular grantee gatherings and networks during the grant term. For program evaluation, HCF and the program evaluator will work with grantees to develop effective and accurate methods to measure successful outcomes for innovative strategies, and to allow for learning, adjustment, and improvement in strategies throughout the term of the grant.

The following are examples of program innovations and adaptations:

- Integrating tobacco screening and cessation services into the grantee's existing client services, with all staff having client contact being trained in motivational interviewing, brief intervention (see Appendix 5 for more information), and other basic tobacco cessation services.

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[13] Institute of Medicine for National Academies (2016), http://sites.nationalacademies.org/Tobacco/SmokingCessation/TOBACCO_051286

[14] Fiore MC, Jaén CR, Baker TB, et al., *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

[15] Counseling may involve individual and group formats which are both effective in tobacco use treatment.

[16] 2011 Professional Data Analysts, Cessation Grants Aggregate Evaluation Report to HCF

[17] According to the Public Health Service, Treating Tobacco Use and Dependence: 2008 Update, the more intense the intervention, the greater the rate of abstinence. Interventions may be intensified by increasing the length of the individual intervention sessions and/or the number of intervention sessions.

- Utilizing partnership relationships with organizations that have trust and credibility with priority populations but do not have tobacco cessation services or expertise, so that the grantee and its partners serve the same individual smoker together to provide appropriate smoking cessation services as part of a comprehensive, patient-centered service team. (Partnership relationships can be supported by subcontracts from the grantee where appropriate.)
- Increasing access to cessation services for smokers from priority populations who live in remote areas with no public transportation by providing regular outreach services to locations closer to their residences, or through partnership relationships with organizations that can do such outreach.
- Increasing access to cessation services for non-English speaking smokers from priority populations by providing bilingual/bicultural cessation staff, interpreters, translated written materials, and other language access services, or through partnership relationships with organizations that have such language capacity.
- Increasing access to cessation services for Native Hawaiian smokers by providing culturally appropriate outreach and counseling services through bicultural cessation staff, or through partnership relationships with organizations that have capacity to provide such services.
- Increasing access to cessation services for smokers with mental health and/or substance use challenges by training staff about mental health, substance abuse, and effective strategies to serve those populations, or through partnership relationships with organizations that already effectively serve those populations.
- Increasing access to cessation services for pregnant women and new moms by promoting cessation services to pregnant women and new moms, partnering with clinics and other organizations that serve pregnant women for referrals, and tailoring your cessation program to best serve pregnant women, new moms and dads, and the family unit.
- Incorporating evidence-based models and programs that are effective in reaching and treating priority populations. Some examples include the *Baby & Me Tobacco Free Program*[18] for pregnant women and new moms (explained in Appendix 5) and the *Learning about Health Living: Tobacco and You*[19] program for smokers with mental illness.
- Using appropriate incentives to encourage smokers to participate in cessation services. Examples of incentives include vouchers to local farmers markets and quit kits consisting of items that help smokers quit.
- In conjunction with your cessation services, providing public education and information about the risks of electronic smoking devices (e-cigarettes or vapes) and other emerging devices containing nicotine.
- Providing cessation staff and program partners with training and education on the latest tobacco products.
- Improving utilization of available insurance coverage from private health insurers and Medicaid for tobacco screening and cessation services, in order to achieve long-term tobacco program sustainability.[20]
- As part of your cessation program, adopting workplace and/or campus wide no smoking policies at all grantee and partner facilities to set a good example for clients and staff.
- Engaging organization staff that smoke to participate in tobacco cessation through the organization's cessation program, another grantee site, or to the Hawai'i Tobacco Quitline.
- Adopting evening and weekend office hours for cessation services to increase access for working smokers.

[18] Baby & Me Tobacco Free Program. http://www.babyandmetobaccofree.org/

[19] Learning About Living Healthy: Tobacco and You.
https://www.nysmokefree.com/ConfCalls/CCNYSDownloads/UMDNJLearningAboutHealthyLiving.pdf

[20] Private health insurance and Medicaid may provide some coverage for tobacco screening, cessation interventions, and NRTs. Applicants who have billing systems that are able to access these coverages to generate revenue can provide even more cessation services and NRTs to more smokers, in addition to grant-funded cessation services.

## APPENDIX 2 – Grant Program Key Definitions

The following are key definitions of this grant program:

- Benchmarks: Evidence-based performance measures for grantees that will be established for intensive interventions.
- Best Practice: Refers to methodologies, policies and procedures that provide guidance based on past experiences and evaluation and are proven to be effective. (For example, see the CDC Best Practice Guides in Appendix 6.)
- Cessation services: Includes the full range of services to help a smoker quit smoking, for example:
    - Outreach to smokers and their families or support groups, to provide educational information about the harms of smoking, the benefits of quitting, and the availability of help to quit smoking;
    - Regular screening of clients for tobacco use during an intake process followed by brief intervention for those who screen positive;
    - Appropriate engagement with smokers to encourage them to try quitting;
    - For smokers who are ready to try quitting, referral to trained, qualified cessation counselors to provide intensive interventions and nicotine replacement therapies;
    - Multiple service interactions with smokers who need multiple quit attempts to become tobacco-free;
    - Participation in data collection, data tracking, and evaluation of services in order to learn, improve, and ultimately increase the numbers of smokers who quit smoking.

  In a grant proposal that includes a partnership arrangement with other organizations, a grantee and the partner organizations could each provide different components of a full range of services so long as all component services are coordinated to serve smokers effectively.
- Innovations and Adaptations: Activities other than the provision of intensive interventions (described below) that will be conducted to meet the objectives of this RFP. Note that innovations and adaptations may be related to intensive interventions (e.g. incorporating tailored counseling approaches for specific populations), as well as other areas described above, such as recruitment, screening, referral and cost-sharing.
- Intensive intervention: Four or more sessions (individual or group), at least 10 minutes each, with someone formally trained in tobacco cessation accompanied by discussion about and/or use of applicable nicotine replacement therapy and/or pharmaceutical quit smoking aids.
- Priority populations: Tobacco users (including persons using electronic smoking devices or other emerging products containing nicotine) who are or who self-identify as one or more of the following:
    - Native Hawaiian
    - Persons with mental illness and/or substance use disorder
    - Lesbian, Gay, Bisexual, Transgender
    - Low socio-economic status (Low SES)
    - Pregnant women
- Quit Attempt: Abstinence from tobacco use for at least 24-hours sometime between enrollment in the program and the seven-month follow-up survey. This is a benchmark for intensive interventions.
- Quit Rate: Abstinence from tobacco use for thirty (30) days prior to being surveyed seven months after enrolling in the cessation program. The community grants evaluation design adopts the calculation for quit rates designed by the North American Quitline Consortium (NAQC) which suggests that only those participants who respond to a survey be used to calculate quit rates. In general, this produces higher quit rates than alternate calculation methods. This is a benchmark for intensive interventions.

- SMART Objectives: Performance measures for grantees that will be established for activities related to innovation and adaptation. See Appendix 3 for more information.

# APPENDIX 3 – Program Evaluation

Grantees will be expected to participate in an external evaluation led by a contracted evaluator. The purpose of the evaluation is to demonstrate accountability, identify strengths and opportunities for improvement, facilitate grantee sharing, and to encourage learning and build knowledge. Results will be shared with grantees, HCF, DOH and other stakeholders.

## Program Evaluation Components

Grantees will be expected to contribute to the evaluation in the following three areas:

1. Program roadmap. The evaluator will work with each grantee to develop a program roadmap, or logic model, that provides a visual roadmap of how the program's activities lead to the program's intended outcomes and impact. The grantee can expect to participate in a phone call or site visit with the evaluator near the start of the grant to create the program roadmap, and work with the evaluator at least annually to update the roadmap, as needed.

2. Intensive intervention process data. Process data for the intensive interventions will be collected by program staff using instruments developed by the evaluator. Data will include *participant characteristics* collected at the time a participant enrolls in an intensive intervention, and *program utilization* data collected at the time that a counseling session is provided. These process data will also help measure progress towards achieving benchmarks for number served and percent of participants from priority populations. Grantees will be expected to collect these data in real-time using either paper or electronic forms and submit the data quarterly via a web-based portal.

   Additionally, intensive intervention outcome data will be collected via a 7-month follow-up survey of program participants led *by the evaluator*. The outcome data will help measure progress towards achieving benchmarks for program satisfaction, stop-smoking medication use, quit attempts, and the quit rate. Please see below for more information about the benchmarks for intensive interventions. Grantees will not be responsible for conducting 7-month follow-up surveys for the purposes of the evaluation.

3. Process and outcome data related to innovations and adaptations. Grantees will be expected to identify key innovations and adaptations that they are working on and develop SMART objectives to track their progress. Grantees will be expected to engage in interviews with the evaluator, at least biannually, to report on their progress and to share successes, challenges, and lessons learned regarding their innovations and adaptations. Progress on SMART objectives may be collected by the grantee's own internal tracking or through interviews with the evaluator.

## Benchmarks for Intensive Interventions

Grantees will be asked to establish benchmarks for their programs in the following areas. These benchmarks relate to grantees' performance in intensive interventions. Innovations and adaptations will be assessed separately via SMART objectives (see next section). Applicants should indicate in the Benchmark Form their criteria for success for each benchmark category below, and a rationale for why that criteria was chosen, especially if it differs from the standard, evidence-based criteria. Some variation in benchmarks is to be expected based on each grantees' unique environment and target population(s). Applicants' criteria for success may change over time as activities become established, so benchmarks may be renegotiated with HCF as needed and deemed appropriate. Benchmarks are primarily used for program improvement purposes; however, HCF may elect to use the information for future funding decisions. Benchmarks 1 and 2 will be derived from process data collected by the grantee (see intensive intervention process data) described previously. The remaining benchmarks will be derived from the seven-month follow-up survey conducted by the evaluator (see intensive intervention outcome data) described previously.

1. Number served: This is defined as the number of tobacco users who receive at least some intensive counseling services. The criteria for success should consider the funding amount, who is being served, and the percent of time and budget devoted to intensive interventions. We encourage you to calculate a cost per enrollee as part of your planning process.[21] We also encourage you to consider how the number of tobacco users you plan to serve will impact your program's ability to produce a quit rate.[22]
2. Priority populations: This is defined as the percent of participants who meet the priority population criteria. Most grantees in the current funding cycle set this benchmark at 80%, and all of them are achieving this goal.
3. Program satisfaction: This is defined as the percent of participants who are very or mostly satisfied with the services they received. We consider 80% to reflect strong program satisfaction, and this is being achieved by most grantees in the current funding cycle.
4. Medication use: This is defined as the percent of participants who report using stop-smoking medication between enrollment and the follow-up survey. We consider 75% to be a strong stop-smoking medication use rate, and most grantees are achieving this in the current funding cycle.
5. 24 hour quit attempt: This is defined as the percent of participants who are able to quit using tobacco for at least 24 hours sometime between enrollment and the follow-up survey. We consider 80% to 90% to be a strong 24-hour quite attempt rate, and most grantees are achieving this in the current funding cycle.
6. 30-day abstinence quit rate: This is defined as the percent of participants who are able to quit using tobacco during the 30 days prior to the follow-up survey. We consider 30% to be a strong quit rate, and most grantees are achieving a 25% to 30% quit rate in the current funding cycle.

### SMART Objectives for Innovations and Adaptations

A SMART objective is Specific, Measurable, Attainable, Relevant, and Timely. The SMART objectives are separate from the benchmarks because they are used to measure innovations and adaptations rather than evidence-based practices. The SMART objectives should be developed for major innovative/adaptive strategies for each year of the grant, as it is possible that criteria for success will change over time as an activity is developed, implemented, and mastered. Some adjustments to innovations/adaptations and corresponding SMART objectives are expected throughout the grant cycle. SMART objectives are primarily used for program improvement purposes; however, HCF may elect to use the information for future funding decisions. Below are a few examples of innovations and corresponding SMART objectives.

| Innovation/Adaptation | SMART Objective |
|---|---|
| Integrate tobacco use screening and referral into EHR system to identify tobacco users, connect them with treatment, and increase program enrollments. | 1. Add tobacco use screening and referral components to EHR by Jan 31, 2020.<br>2. Train all staff on new tobacco use screening and referral system by Mar 31, 2020. |

[21] In previous grant rounds, cost per enrollee was typically between $500 to $1,000. The cost per enrollee is the total dollars your project wishes to allocate to intensive interventions, divided by the number of persons you wish to serve. Based on this initial calculation, you may wish to adjust your dollar amount or numbers served. It is important to consider that certain kinds of interventions or reaching certain groups may be more expensive and require a higher cost per enrollee.

[22] We estimate that a project would need to serve about 160 people with intensive services over the course of the grant to calculate a quit rate that could be used for internal purposes. If a program wishes to publicize its quit rate, about 315 or more enrollees would need to be served.

| | |
|---|---|
| | 3. Monitor adherence to screening and referral protocols, aiming for an 80% screening rate from Apr-Jun 2020. |
| Establish partnerships with community-based organizations to increase access to cessation services among priority populations. | 1. Develop 2 new partnerships by Dec 31, 2019.<br>2. Provide intensive interventions at these new partnering sites by Jun 30, 2020. |
| Use participants' insurance first to connect them with NRT to make efficient use of available NRT. | Of all participants receiving stop-smoking medication in Year 1, at least 50% will receive insurance assistance for at least some of their medication. |

### Evaluation Reports

The evaluator will produce reports throughout the funding cycle. Each grantee will receive their own individual report that describes their process and outcome data from their intensive interventions as well as their innovations and adaptations. Grantees can use these reports to celebrate and share successes, identify opportunities for improvement, and demonstrate accountability. HCF and DOH will also receive evaluation reports that assess the performance of the grant program as a whole. Key evaluation findings may be shared at grantee gatherings and used to tailor grantee sharing and technical assistance opportunities.

## APPENDIX 4 - Grant Expectations

If your organization is awarded a grant, you will be required to review and sign a document entitled "Grant Terms and Agreement" or GTA and submit to HCF. The signed GTA must be received by HCF prior to release of any grant payments.

Grantees will be expected to:

1. Perform the scope of work as described in the proposal and/or negotiated at the time of the award.
2. Fully implement the work plan included as part of the proposal and/or negotiated at the time of the award.
3. Share performance information with HCF and, as appropriate, with other grantees.
4. Consistently meet established benchmarks and SMART objectives defined in the work plan included as part of the proposal and/or negotiated at the time of the award.
5. Participate in HCF site visits, grantee gatherings, and trainings.
6. Coordinate with any HCF media campaigns if programs have a media component.
7. Offer/refer clients to the Hawai'i Tobacco Quitline, as appropriate.
8. Accept referrals of clients from the Hawai'i Tobacco Quitline, as appropriate.
9. Have not less than two full-time equivalent (FTE) paid staff positions at all times during the grant term that are responsible to deliver the services described in the GTA and work plan (with Tobacco Treatment Specialist national certification), or an alternative staffing plan that assures that grant services will be provided at all times during the grant term. Alternative plans can include staff positions provided under a partnership agreement.
10. Submit progress reports to HCF (narrative and financial reports) consistent with the timeline developed by HCF and a final report within thirty days of the grant end date.
11. Notify HCF of any changes to the grant budget and complete a Budget Modification document that must be approved by HCF prior to spending grant monies. See Budget Modification Template Example below.
12. Cooperate with and implement the evaluation designed for this RFP to assess processes and outcomes achieved by each funded program and the initiative as a whole as measured by the benchmarks and SMART objectives. Specifically, the grantee will be expected to:
    a. During the first 3 months of the first grant year, work with the program evaluator to develop logic models based on the work plans for the proposed services, which will provide the basis for evaluation protocols and requirements during the grant term.
    b. Collect and submit data electronically on a quarterly basis using evaluation protocols and participate in other evaluation activities as described below.
    c. Review evaluation reports and other data as necessary to assess strengths and opportunities for improvement.
    d. Attend evaluation training sessions and telephone calls to ensure quality evaluation data.
    e. Make appropriate adjustments and develop solutions to areas for improvement identified in the evaluation, as necessary.
    f. During the grant term, allocate between 5% to 10% of budgeted personnel expenses to participation in evaluation-related activities under the guidance of HCF's contracted evaluator.

## Budget Modification Template Sample

| | | | | |
|---|---|---|---|---|
| **2019-2023 Tobacco Cessation Program** | | | | |
| **Budget Modification** | | | | |
| **Organization:** | | | | |
| **PROGRAM BUDGET** | | | | |
| Program Year | | | **Year 1** | |
| Period | 7/1/19 - 6/30/20 | 7/1/19 - 6/30/20 | 7/1/19 - 6/30/20 | |
| Date Submitted: | | | | |
| Category | Approved Budget | Budget Modification Request | Modification (+/-) | Justification |
| **REVENUE** | | | | |
| Total requested from HCF Tobacco Prevention & Control Trust Fund | | | $ - | |
| **TOTAL REVENUE** | $ - | $ - | $ - | |
| **EXPENSES** | | | | |
| **PERSONNEL** Note by asterisk (*) person responsible for program evaluation | | | | |
| Name of staff, Title, FTE | | | $ - | |
| Example: *Jane Smith, TTS, 1.0 FTE | | | $ - | |
| **Total Personnel Salaries** | $ - | $ - | $ - | |
| | | | | |
| **FRINGE BENEFITS** | | | | |
| Name of staff, Title, FTE | | | $ - | |
| Example: *Jane Smith, TTS, 1.0 FTE | | | $ - | |
| **Total Fringe Benefits** | $ - | $ - | $ - | |
| | | | | |
| **PARTNERSHIP/SUBCONTRACT** | | | | |
| (List Partner/Subcontractor) | | | $ - | |
| **Total Partnership/Subcontract** | $ - | $ - | $ - | |
| | | | | |
| **TRAVEL/PROGRAM SERVICES** | | | | |
| Interisland Travel - Airfare, Hotel, etc. | | | $ - | |
| Mainland Travel - Airfare, Hotel, etc. | | | $ - | |
| Mileage | | | $ - | |
| Parking | | | $ - | |
| Per Diem | | | $ - | |
| **Total Travel** | $ - | $ - | $ - | |
| | | | | |
| **SUPPLIES** | | | | |
| Office supplies | | | $ - | |
| Nicotine Replacement Therapy | | | $ - | |
| Incentives (if applicable) | | | $ - | |
| **Total Supplies** | $ - | $ - | $ - | |
| | | | | |
| **OUTREACH/MARKETING** | | | | |
| (List outreach/marketing) | | | $ - | |
| **Total Outreach/Marketing** | $ - | $ - | $ - | |
| | | | | |
| **EQUIPMENT** | | | | |
| (List equipment) | | | $ - | |
| **Total Equipment** | $ - | $ - | $ - | |
| | | | | |
| **TRAINING/STAFF DEVELOPMENT** | | | | |
| Conference fees | | | $ - | |
| Consultant | | | $ - | |
| Interisland Travel - Airfare, Hotel, etc. | | | $ - | |
| Mainland Travel - Airfare, Hotel, etc. | | | $ - | |
| Ground Transportation | | | $ - | |

# APPENDIX 5 - Training & Other Supporting Programs

For informational purposes, the following is a list of trainings, certifications, and programs that help cessation staff increase their knowledge and capacity to deliver cessation services.

## Tobacco Treatment Specialist Training & Certification

### Certified Tobacco Treatment Specialist

Certified Tobacco Treatment Specialists, or CTTS, are professionals who are specially trained to provide treatment for individuals seeking to stop using tobacco.

Certified Tobacco Treatment Specialists:

1. Understand the science behind tobacco addiction, nicotine withdrawal symptoms, and effective treatments for tobacco use.
2. Provide clear and accurate information about the causes and consequences of tobacco use.
3. Develop individualized treatment plans using comprehensive, evidence-based assessments and treatment strategies including: Clear and accurate information about effective medications Effective, practical, cognitive-behavioral strategies for quitting and staying quit.
4. Provide effective treatment for all forms of tobacco and nicotine use.
5. Work with a variety of specific populations including those with specific health issues.
6. Use specific, well-accepted methods for tracking individual progress, record keeping, program documentation, outcome measurement, and reporting.
7. Serve as educational resources for organizations, healthcare providers, and the general public regarding tobacco use treatment issues.

### The Council for Tobacco Treatment Training Programs (CTTTP)

The Council for Tobacco Treatment Training Programs (CTTP) is the accrediting body for tobacco treatment Specialist Training Programs. Accreditation documents that an independent panel has carefully reviewed the training program and determined that it meets the Tobacco Treatment Specialist Core Competencies. For a list of accredited programs visit https://ctttp.org/accredited-programs/.

### National Certificate in Tobacco Treatment Practice (NCTTP)

The National Association for Alcoholism and Drug Abuse Counselors (NAADAC), in partnership with the Association for Treatment of Tobacco Use and Dependence, Inc. (ATTUD), and the Council for Tobacco Treatment Training Programs (CTTTP) offers the National Certificate in Tobacco Treatment Practice (NCTTP). This national certificate program was created to standardize and unify tobacco competencies, knowledge, and skills on a national level and provide national, unified recognition of professionals who obtain this prestigious certificate. By obtaining the NCTTP, tobacco use professionals are demonstrating to employers, third-party payers, and clients their advanced education in evidence-based tobacco treatment competencies, skills, and practice. For more information about the National Certificate in Tobacco Treatment Practice visit https://ctttp.org/accredited-programs/.

## Brief Intervention Training

The Hawaii Edition of the Basic Tobacco Intervention Skills Certification, Level 1, is a four-hour training for professional and community members interested in delivering basic intervention to tobacco users. This course

consists of six modules based on the current U.S. Department of Health, Public Health Service Guideline: *Treating Tobacco Use and Dependence*. The training has been customized for Hawaii based on the original course developed by the University of Arizona. The maximum instructor to student ratio is one instructor to six students. Courses can have multiple instructors in the room to increase class sizes. This training program is intended to provide an evidence-based process for delivering a brief intervention for people using tobacco. A brief intervention is based on the five A's (ask, advise, assess, assist, and arrange) and typically lasts three to five minutes.

If you are interested in this training and for more information, please contact the Hawai'i State Department of Health, Tobacco Prevention and Education Program at 808-586-4613, Toll Free 1-888-810-8112, or by Fax 808-586-8252.

## Baby & Me Tobacco Free Program

### The BABY & ME – Tobacco Free Program™

#### Program Information

The BABY & ME – Tobacco Free Program™ is an evidence based, smoking cessation program created to reduce the burden of tobacco on the pregnant and postpartum population. The program's design has proven effective in decreasing the number of women who smoke during and after pregnancy, as well as improve birth outcomes among babies born to women enrolled in the program.

The program uses a cessation support design specific to pregnant women. This design is multi-pronged and successfully targets low socioeconomic groups by combining brief cessation counseling with bio-marker feedback, while offering practical incentives as positive reinforcement to maintain smoking cessation. The BABY & ME – Tobacco Free Program collaborates with local agencies that provide services to our target audience.

#### How the Program Works

- Pregnant women eligible to enroll into the program are referred to their local agency implementing the program.
- Women attend four prenatal counseling cessation sessions to receive education and support for quitting smoking and staying quit, and test using a carbon monoxide (CO) monitor (breath test).
- At prenatal sessions 3 and 4, women may receive their first two diaper vouchers, if they test tobacco free.
- After the birth of the baby, women return monthly to continue CO monitoring and if proven to be smoke-free, receive a monthly diaper voucher for up to twelve months postpartum.
- Diaper vouchers can be used for any brand or size of diapers at Walmart and/or local participating stores when applicable.
- A smoker who lives with the pregnant women can also enroll into the program and if successfully quits smoking may receive diaper vouchers during the postpartum period.

#### Training and Technology

A one-day training class provides agencies and facilitators with the information and materials necessary to implement and enroll women into the program. At the conclusion of the training each attendee is certified as a program Facilitator, which allows them to enroll women into the program and conduct counseling sessions.

#### Success Rates

Data from the BABY & ME – Tobacco Free Program, implemented from 2008 to 2011 by Rocky Mountain Health Plans Foundations, Grand Junction CO., showed that two-thirds of the counties in Colorado participated in the program. Within the statewide program, over 2,000 women enrolled and over 6,500 cessation sessions were conducted; resulting in 1,450 women who quit smoking and remained quit. Rocky Mountain Health Plans Foundation

distributed over 7,000 diaper vouchers to smoke-free women. In 2013, the Colorado program's data results indicated a 72% success rate at 6-months postpartum.

As of January 2019, 21 U.S. States participate in the program. For more information regarding the BABY & ME Tobacco Free Program please visit www.babyandmetobaccofree.org.

## APPENDIX 6 - Resources

Resource List: The following is a partial list of resources to provide a general introduction to available resources.

### General:

Centers for Disease Control and Prevention. (2014). *Best Practices for Comprehensive Tobacco Control Programs – 2014.* https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf

Centers for Disease Control and Prevention – Office on Smoking and Health (OSH). (2019). *2019 Year of Cessation*. https://www.cdc.gov/tobacco/about/osh/pdfs/1010-year-of-cessation-overview-508.pdf

The National Cancer Institute (NCI). *Smokefree.gov – Quit Plan tool*. https://smokefree.gov/

U.S. Department of Health & Human Services. (2018.) *Tools for Smokers Who Want to Quit.* https://betobaccofree.hhs.gov/quit-now/index.html

### Tobacco – related Health Equity:

*Achieving Health Equity in Tobacco Control.* (2015.) https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Documents/FactSheets/achieving-health-equity-v1.pdf

Centers for Disease Control and Prevention. (2015.) *Best Practices User Guide: Health Equity in Tobacco Prevention and Control.* https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf

Hawai'i Health Matters. (2019.) *Tobacco Use Prevention & Control Tracker.* http://www.hawaiihealthmatters.org/indicators/index/dashboard?id=83016762154173692

### Native Hawaiian:

'Imi Hale Native Hawaiian Cancer Network. http://www.imihale.org/education_materials.htm#SmokingCessation

National Center for Biotechnology Information, US National Library of Medicine, National Institutes of Health. (2008.) *Culturally Informed Smoking Cessation Strategies for Native Hawaiians.* https://www.ncbi.nlm.nih.gov/pubmed/19301474

### Mental Health:

American Psychological Association. (2013.) *Smoking and Mental Illness.* https://www.apa.org/monitor/2013/06/smoking.aspx

National Behavioral Health Network. (2019.) https://www.bhthechange.org/

National Association of State Mental Health Program Directors. (2010.) *Tobacco-Free Living in Psychiatric Settings – A Best-Practice Toolkit Promoting Wellness and Recovery.* https://www.integration.samhsa.gov/pbhci-learning-community/Tobacco-Free_Living_in_Psychiatric_Settings_Toolkit.pdf

Rutgers Robert Wood Johnson Medical School. (2012.) *Learning About Healthy Living Tobacco and You.* https://www.nysmokefree.com/ConfCalls/CCNYSDownloads/UMDNJLearningAboutHealthyLiving.pdf

University of Colorado Denver, Department of Psychiatry, Behavioral Health and Wellness Program. (2009.) *Smoking Cessation for Persons with Mental Illnesses – A Toolkit for Mental Health Providers*. https://www.integration.samhsa.gov/Smoking_Cessation_for_Persons_with_MI.pdf

Substance Use Disorder:

The American Psychiatric Association. (2010.) *Practice Guideline for the Treatment of Patients With Substance Use Disorders* (includes a section on nicotine dependence). http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

Pregnant Women:

American College of Obstetricians and Gynecologists. (2011). *Smoking Cessation During Pregnancy – A Clinician's Guide to Helping Pregnant Women Quit Smoking – 2011 Self-instructed Guide and Tool Kit.* https://www.acog.org/~/media/Departments/Tobacco%20Alcohol%20and%20Substance%20Abuse/SCDP.pdf

Centers for Disease Control and Prevention. (2018). *Tobacco Use and Pregnancy*. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/index.htm