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

DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

SUPPLEMENT
Priority Populations: Low-Income

Behavioral Health & Wellness Program

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The DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers Supplement
Priority Populations: Low-Income was developed by the
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Click here for access to the complete DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

Priority Populations: Low-Income

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Why Focus on Low-Income Populations?

Low-income populations use tobacco at more than twice the rate of high-income populations.[1] Although tobacco use has declined nationally, individuals who are low-income or living in poverty continue to have significantly higher rates of tobacco use.[2]

- 27.9% of adults living below the federal poverty line use tobacco compared to 17.9% of those living at or above the federal poverty line.[3]
- Individuals living in poverty also use tobacco for almost twice as long (40 years versus 22 years) as higher income individuals.[4]
- Individuals at or below the poverty line are also less likely to quit tobacco than those at higher income levels.[5]
- Residents in low-income neighborhoods and housing sites experience greater unwanted exposure to tobacco even if they do not live with a current tobacco user.[6]

In addition, individuals living with low incomes:

- Have poor access to evidence-based tobacco cessation treatment;
- Are less likely to use treatments that are available;
- And have poorer cessation outcomes.[7]

Definition of Low-Income

For this toolkit, low-income includes all individuals who encounter economic barriers to achieving a healthy lifestyle. This includes people living in poverty, working families, and individuals with higher incomes who face health challenges due to economic limitations.

About This Toolkit

This supplemental toolkit provides guidance for healthcare providers who want to provide evidence-based treatment for tobacco cessation to persons with low-incomes. The goal is to provide low burden methods for assisting patients in making changes to embrace a tobacco free lifestyle. Tobacco cessation for the low-income population is very similar to evidence-based strategies for the general population. However, providers may feel unprepared or ill-equipped to address tobacco use with patients facing economic challenges. Low-income populations also face additional challenges to quitting, such as low literacy levels and specific targeting by marketing campaigns for tobacco use, and therefore need more focused support from healthcare providers to counter misinformation.

This supplement provides information about this population and how to partner with patients to help them reach their health goals. It also supports healthcare providers to adjust their practice for new tobacco cessation requirements through meaningful use provisions of the Patient Protection and Affordable Care Act (ACA). It is designed to be used in conjunction with the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers, which contains evidence-based information about assessment, skills building, and interventions to provide support and resources to patients around tobacco cessation.

Prevalence of Tobacco Use

It is clear that tobacco use is higher among populations with low-incomes. Tobacco use prevalence rates decline significantly as income increases and with greater educational attainment.[11] Healthcare providers should not presume that their low-income patients are using tobacco, yet they need to be aware that the prevalence rate is significantly higher among patients with lower incomes and that assessment and intervention is essential. In addition, there are specific sub-populations among low-income populations that require particular focus because of higher rates of tobacco use.

Rural Residents

Nationally, residents living in rural areas have lower incomes than those living in urban centers[12] and experience greater health burdens from tobacco use.[13]

- Adults living in rural regions of the country are significantly more likely to smoke (22.2%) than those living in suburban (17.3%) or urban (18.1%) areas.[14]
- 27% of rural women and 31% of rural men report regular smoking.[15]
- Rural residents also use smokeless tobacco at significantly higher rates with some estimates suggesting rural use is three times higher than urban use.[16]
- Higher rates of tobacco use in homes and work settings are also found in rural areas due to fewer policy protections regarding tobacco exposure in public places.[17]
- Rural residents face greater barriers to education, prevention, and cessation treatment, including transportation, paying for treatment, low rates of health insurance, limited media resources focused on changing unhealthy habits, and minimal access to cessation services.[18]

Did you know...Tobacco Outlet Density and Advertising are Higher in Low-Income Areas?[19]

- The higher density of tobacco outlets in poor and racially/ethnically diverse neighborhoods is consistent even when population density is accounted for.
- The higher density of tobacco outlets is consistent in poor communities regardless of whether the community is urban or rural.
- The higher number of tobacco outlets affects tobacco use and may contribute to continued disparity in tobacco prevalence rates.

Regardless of whether the higher density is a result of specific targeting or increased demand, it is clear that the increased access to tobacco in low-income communities increases disparities in tobacco prevalence and associated health problems.

Individuals who are Homeless

Individuals who are homeless use tobacco at an alarming rate. In addition, they are a population with complex chronic medical conditions in part due to poor healthcare access.

- 73% of homeless adults report current tobacco use (primarily smoking).[20] This represents tobacco use in three-quarters of an estimated 2.3 to 3.5 million people in the United States.[21]
- Only 54% of homeless report having received advice from a health professional to quit.[22]
- Homeless smokers share the desire to quit and do not differ in this desire from non-homeless smokers.[23]

This high prevalence rate and lack of appropriate treatment leads to a tragic outcome:

- Homeless individuals experience tobacco-related deaths at twice the rate seen by individuals with stable housing.[24]
- Lung disease accounts for one-third of these deaths.[25]

As a population facing greater barriers, it is even more important that healthcare providers offer evidence-based treatment for tobacco cessation. Providers need to address tobacco use; discuss long-term health despite acute and immediate stressors; and encourage and support homeless individuals who want to quit tobacco.

The Homeless Have Been Targeted

Homeless populations have been specifically targeted by marketing from tobacco companies. See DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers box on Project SCUM.

"As the disease effects of smoking became better understood, more affluent and educated people were the most likely to quit. Cigarette companies thus increasingly marketed towards lower income, less educated, and minority segments of the U.S. population."[26]

In addition to targeting homeless populations in marketing, the tobacco companies actually gave away cigarette brand logo products to the homeless, such as cigarette brand labeled blankets. In addition, cigarette samples were donated to homeless shelters and organizations.

Beyond the overt targeting of the homeless, the tobacco companies developed strong relationships with homeless organizations through charitable contributions.

Tobacco Use and Health

It is well known that tobacco contributes to the development of numerous major medical diseases and causes premature death. Decades of research on health disparities demonstrate that having a low-income can also contribute to chronic disease and premature death. This combined with the evidence that tobacco use remains higher in low-income populations creates a stark reality for individuals with limited resources.

QUICK FACTS...

- Low-income populations die sooner than their more wealthy counterparts and this disparity is increasing.[27]
- People with low-incomes also get sick more often and are at greater risk for almost all major diseases including cancer, heart disease and diabetes. Tobacco use is a significant contributor to all of these diseases.[28]
- Lower-income populations report fewer average healthy days.[29]
- Preventable hospitalization increases as income decreases.[30]

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Consequences of Tobacco Use

Income and education both impact a person's health. Health outcomes improve with higher income and education levels. Individuals living with the poorest income and education levels have the worst health outcomes.[31] Even individuals living with moderate levels of income and education are less healthy than individuals living with the most wealth and education.[32] As a result, ethnically and racially diverse and low-income communities experience an unequal burden of chronic disease including Type 2 Diabetes, hypertension, and hyperlipidemia as well as other diseases.[33, 34, 35]

Cancer

As income declines, cancer mortality from all cancers increases. In the United States, individuals living in areas rated as "deprived" – defined by lack of educational and employment opportunity, high poverty rates, and poor housing conditions – are at greatest risk. In fact, the most deprived group based on these factors had a 19% higher cancer mortality rate than those in the least-deprived group (individuals living in areas with greater access to education, employment, low poverty rates, and good housing).[36] Tobacco use has an important role in this increased mortality. As low-income populations continue to use tobacco at greater rates, they also experience greater disparities in lung cancer mortality. Conversely, as individuals with higher incomes have stopped smoking, their risk for lung cancer has declined and thus, the disparity in mortality has grown.[37]

Cardiovascular Disease and Stroke

Low-income populations also experience an increased incidence of stroke,[38] with greater stroke severity and lower survival rates.[39] A low-income level is also related to increased cardiovascular risk. Differences in physical activity, smoking status, and obesity explain some of the relationship between low-income status and increased cardiovascular heart disease.[40]

Diabetes

Adults with diabetes who have a family income below the federal poverty level face a mortality rate from diabetes twice as high as adults living with the highest incomes.[41] Tobacco has a significant impact on diabetes mortality with one study estimating that mortality rates from diabetes could be reduced by 7.5% if current tobacco users quit.[42]

Reduced Life Expectancy

The difference in life expectancy between loww-income and high-income populations is growing.[43] Men with the lowest income have a life expectancy that is 7 years shorter than men in the highest income levels. For low-income women, life expectancy is 4.4 years shorter than their more wealthy counterparts.[44] Race and educational attainment (closely tied to income level) are also important factors in life expectancy. White men with 16 years or more of education by age 25 live 14.2 years longer than African-American men with fewer than 12 years of education by age 25. Similarly, White women in the higher educational group live 10.3 years longer than African-American women in the lowest educational group.[45]

Contributing Factors

Stigma and Discrimination

In addition to added health risks, individuals who are living in poverty and who use tobacco often experience stigma and discrimination. Economic discrimination may be an important factor that influences the effects of poverty on physical health.[46]

- Low-income individuals believe that the greater society views them as a burden, lazy, irresponsible, and "choosing" an "easy life" by disregarding opportunities.[47]
- Perceived discrimination can have a significant negative effect on mental and physical health. It also produces heightened stress and may lead to unhealthy behaviors.[48]
- Healthcare providers contribute to stigma and may be impacting patients' engagement in services as well as their health outcomes.

Stigma towards low-income status and tobacco use combined make access to appropriate healthcare even more challenging for individuals. For these reasons, it is fundamental that healthcare providers increase their self-awareness about any bias or stigma they hold and build tools for engaging their patients to develop strong alliances that can enhance health outcomes.

Limited Access to Healthcare

Low-income populations face significant barriers in managing increased health risks due to limited access to healthcare. Lack of healthcare results in:

- Delayed diagnosis and identification of more advanced disease, requiring a higher level of care and service;[49]
- Going without care, including preventative services to promote health and reduce risk for chronic disease.[50]

MYTH: Low income patients are too stressed with daily living to make changes for long-term health

Many healthcare providers believe that the stressors of housing instability, food insecurity, raising children, and unsafe neighborhoods are overwhelming. In addition, they view people with low-incomes as living in "chaos" or continual "crisis." As a result, providers shy away from discussing chronic disease, believing their patients have "enough" to manage and can't tackle yet another problem.

FACT: Low-income patients die as a result of unaddressed chronic disease

Although providers are trying to be empathetic with patients, this is a dangerous decision for patients and furthers health disparities for this population. It is vital that healthcare providers balance patient "crisis" with long-term health.

Food Insecurity

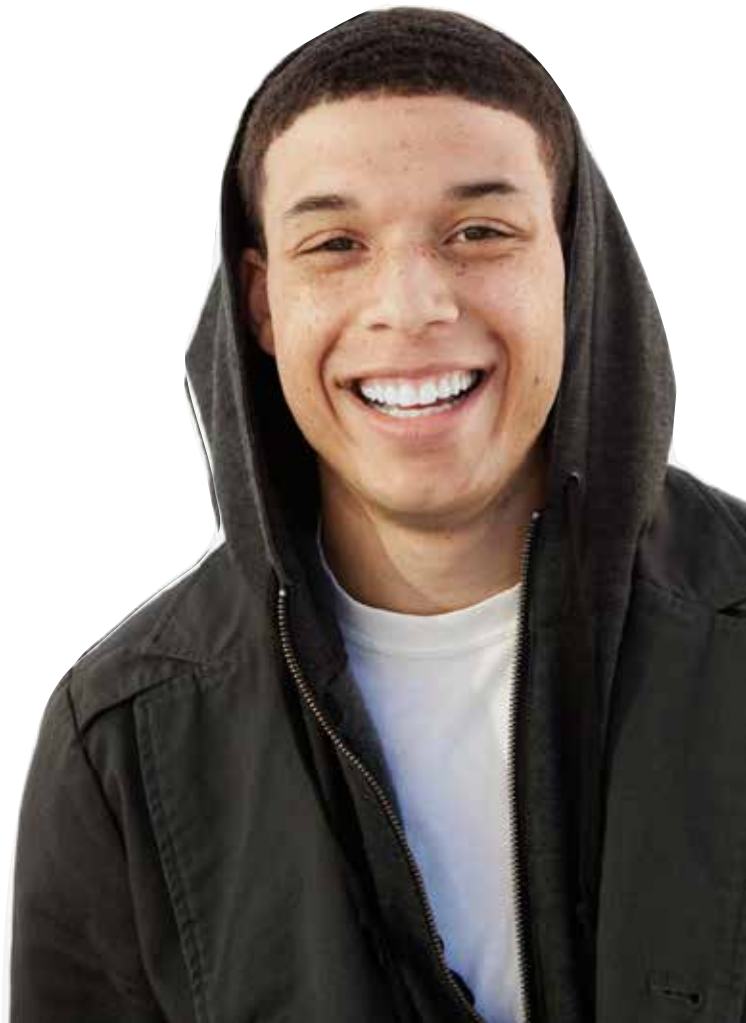
Food insecurity, the inability to afford nutritionally adequate and safe foods, is connected to negative health outcomes for children and adults. For low-income populations, tobacco use and food insecurity can represent a doubling of risk for health problems. Tobacco users often buy tobacco over food due to the addictive nature of tobacco. And living with a tobacco user doubles the rate of both child and adult severe food insecurity.[51]

- 17% of children living with a tobacco user experience food insecurity compared to 9% in households without a tobacco user.[52]
- 25% of adults living with a tobacco user experience food insecurity compared to 12% in households without a tobacco user.[53]

Take an important step towards assessing and improving patient risk for chronic disease. Ask about food insecurity for patients who use tobacco.

Please see the DIMENSIONS: Well Body Toolkit for Healthcare Providers Supplement, Priority Populations: Low Income for more specific information on nutrition and weight management issues for the low income population.

http://www.bhwellness.org/toolkits/WB-Toolkit-Supp-Low-Income.pdf



Assessment and Intervention Planning

Many individuals living with low-income want to stop their tobacco use and are motivated to change, but they often lack the knowledge and resources to learn how to live tobacco-free. It is important for providers to discuss tobacco cessation with all tobacco users at every visit.

Quick Fact...

Out of 506 smokers from a low-income practice, 4% wanted to continue to smoke and 51% wanted to quit now and never smoke again.[54]

Socially disadvantaged tobacco users attempt to quit at a similar rate as all smokers; however, they are less likely to be successful. Factors that contribute to this discrepancy include higher rates of nicotine dependence, fewer prompts to quit, using smoking as a way of coping with daily stress, and social or environmental factors.[55] Individuals with low-incomes are also more likely to engage in quit attempts by going "cold turkey" rather than using evidence-based cessation supports.[56] For some, cessation aids are too expensive and for others, they are suspicious of tobacco cessation medications and other strategies. Therefore, providers who engage patients through greater education specifically matched to patient's literacy levels, sufficient support, and evidence-based interventions can have a significant impact with this population.

Healthcare Providers Have a Vital Role to Play

Low-income populations have greater risk for tobacco use and related health problems; however, they also have the most room for improvement. Healthcare providers can make dramatic improvements reducing risk and chronic disease for low-income populations. Addressing tobacco use through evidence-based cessation treatment can improve lives.

- Comprehensive tobacco cessation programs can reduce the prevalence of smoking in high-risk populations.[8]
- Low-income populations may benefit from more specific support for quitting.[9]
- Healthcare providers are critical to helping low-income patients identify specific support needs (e.g., peer or group support, self-care, access to free cessation aids, etc.) and then developing a realistic plan to obtain those supports.[10]

Interventions

Building Strong Relationships

The most powerful tool a provider has is their relationship with their patient. A strong trusting relationship between healthcare providers and their patients is the best foundation for conversations that can lead to successful partnerships towards obtaining health.

Patients living with a low-income who use tobacco cause concern for healthcare providers. Providers may feel ill-equipped to address the challenges these patients face. They may also have to overcome their low expectations that their patients can improve. In addition, they may struggle how best to use limited clinic time to address the variety of skills patients need to make healthy lifestyle changes. Additionally, the income disparity between physicians and low-income patients can make the therapeutic alliance more challenging.[57]

For a Short Educational Ad for Patients: **CDC "Tips from Former Smokers-" on YouTube.**

These can be great tools for waiting room or exam room screens. http://www.youtube.com/watch?v=d6iS44aHy4s

There is growing evidence that healthcare providers can have a significant impact on their patients' health. 70% of all smokers are seen by a physician each year, and even simply asking about stopping tobacco use has shown to be an effective intervention.[59] It is important for physicians to normalize how difficult tobacco cessation can be, provide coping strategies for short-term nicotine cravings, and maintain focus on the long-term rewards of improved health and increased disposable income.

Practice Strategies for Low-Income Patients[58]

- Use simple language and visual tobacco cessation aids for low-literacy patients.
- See the Center for Disease Control "Simply Put: A guide for creating easy-to-understand materials" http://www.cdc.gov/healthliteracy/pdf/simply_put.pdf
- Demonstrate empathy for the patient's experience.
- Request help from other providers, social caregivers, and specialists who can support patients with other stressors (child care, housing, food acquisition, etc.).
- Provide free medication samples or tobacco cessation medication enrollment programs offered by pharmaceutical companies.
- See the Pfizer Varenicline Program https://www.chantix.com/index.aspx
- Adjust the patient's medication plan to match their resources. For example, not all patients are able to use combination therapies due to cost.

Motivational Interventions

Health reform and specifically Meaningful Use standards have resulted in tobacco screening being a standard in clinic practice. This essential new "vital sign" requires follow up and care planning. It is critical for providers to follow screening with motivational interventions to explore with patients their readiness for quitting and assist them in creating a plan for change. In fact, assistance with creating a plan and arranging follow-up become even more important for low-income populations. Providers who place a greater emphasis on these components of tobacco cessation could go a long way to improving cessation rates for their low-income patients.

As providers explore ways to increase their assessment and motivational interviewing skills, these two videos can expand understanding of how motivational interviewing ideally looks. Providers are encouraged to watch the "Ineffective Physician" video first and then the "Effective Physician" video to identify effective clinical interviewing questions and styles.

The Ineffective Physician: http://www.youtube.com/watch?v=80XyNE89eCs

The Effective Physician: http://www.youtube.com/watch?v=URiKA7CKtfc

Screening Isn't Enough

According to self-reports, many primary care providers who work with low-income populations ask about tobacco use and advise individuals to quit. However, few providers assist in creating a plan for quitting or arrange for follow-up.[60]

- While providers asked about tobacco use 92% of the time and advised low-income individuals to quit 82% of the time;
- Providers only assisted in creating a plan 32% of the time and arranged follow-up 21% of the time.[61]

However, research examining physician adherence to recommended screening protocols differs from these self-reports. The National Ambulatory Medical Care Survey found[62]:

- Only 62.7% of office visits included tobacco screening;
- Tobacco screening occurred more often for patients with private insurance (64.8%) than those with Medicaid/SCHIP (63.4%) or patients who self-pay (63.7%).
- Among patients who were identified as current tobacco users, only 7.6% received a prescription or an order for a medication associated with tobacco cessation.

Both of these studies point to the critical need for providers to screen for tobacco and to follow up with assessment, planning, and assistance.

Tobacco Cessation and ACA Meaningful Use

Changes recently made through the Patient Protection and Affordable Care Act are designed to address barriers to treatment; however, uninsured patients will still be at the greatest risk.

Meaningful Use Criteria

The Patient Protection and Affordable Care Act, the Centers for Medicare and Medicaid Services decision on tobacco cessation counseling, and other recent policy has significant implications for primary care providers. While a full review of meaningful use is beyond the scope of this guide, providers will be clearly mandated by 2014 to offer some level of tobacco use screening and tobacco cessation services to many of their low-SES patients. Meaningful Use Criteria insure that tobacco users are identified, while clinical quality measures track the tobacco cessation services providers offer.

Final regulations for Meaningful Use Criteria were issued in July 2010, incentive payments begin in 2011, and mandatory use begins in 2014. The Meaningful Use Criteria for smoking in Stage 2 directs:

- Providers to screen the smoking status of more than 50% of all unique patients, who are 13 years old or older.
- Tobacco use assessment and cessation intervention is also one of the three core clinical quality measures practitioners will be required to report.
- Primary care clinicians will specifically need to track the percentage of patients 18 years of age and older who are current tobacco users, who are seen by a practitioner during the measurement year, and who receive advice, cessation interventions, or recommendations to use cessation medications and/or other strategies.

For more information please see:

http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures/record-smoking-status

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9_Record_Smoking_Status.pdf

about ACA Meaningful Use.

When working with low-income patients, healthcare providers need to spend more time on three of the A's (Assess, Assist, and Arrange). More time may be required for assessing barriers to change, and then assisting and arranging resources to address those barriers. When time is tight, focus on the 2A's and R model: Ask, Advise, and Refer. This is an important role that can be played by non-physician team members in health homes and other growing team based approaches. Nurses, care coordinators, behavioral health consultants, and others can facilitate these essential conversations.

2A's and R Discussion: Ask, Advise, and Refer

This brief video can help demonstrate physician use of 2A's and R (6 min):

http://www.cdc.gov/tobacco/campaign/tips/groups/health-care-providers.html

Treatment

Tobacco cessation treatment for low-income populations is not different from the general population. As already reviewed, what is more important for this population is thorough assessment and planning with a focus on linking individuals to needed resources. The role of support and encouragement is vital for patients that want to stop using tobacco.

STAY INFORMED

The FDA Periodically Changes Labeling for Nicotine Replacement Therapies

http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm345087.htm

Essential Elements of TobaccoCessation Treatment

1. Cessation aids, including nicotine replacement therapies (NRT) and other FDA-approved tobacco cessation medications, focused on treatment of physical withdrawal symptoms. In low-income populations, this may require assistance with finding low-cost ways to obtain cessation medications.
2. Behavioral treatments assisting people to change behavior and habits.
3. Supportive education about tobacco use, the process of quitting, and ways to overcome perceived barriers.
4. Referral and arranging resources for individuals to support the quit process.
5. Emphasizing social supports in quitting and maintaining a tobacco free life.

See the following resources to assist with cost of cessation medications

Tobacco Cessation Treatment: What is Covered?
http://www.lung.org/stop-smoking/tobacco-control-advocacy/reports-resources/tobacco-cessation-affordable-care-act/what-is-covered.html

Health Resources and Services Administration—Tobacco Prevention and Smoking Cessation
http://www.hrsa.gov/stopsmoking.html

Smoking Cessation $9 Dollar Starter Kit
http://www.commissiononhealth.org/ModelProgram.aspx?Recommendation=63925&Story=64763

Center for Disease Control—Coverage for Tobacco Use Cessation Treatments
http://www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/reimbursement_brochure.pdf

Smoke Free.Gov Education on Medications and Links
http://smokefree.gov/explore-medications

Behavioral Therapies and Supportive Programming

Tobacco Cessation by Non-Physician Staff

Primary care providers are feeling the crunch—under growing pressure to do more with patients while keeping appointments brief. The reality is that many providers are not able to spend the time needed to provide sufficient preventive services and chronic care support. Assisting patients to engage in self-management techniques is a critical adjunct to providers' tobacco cessation treatment.

Medical assistants have been used to coach low-income patients in self-management of chronic disease (Type 2 Diabetes, hypertension, and hyperlipidemia) with success.[63] Training medical assistants in tobacco cessation support and use of the 5A's may be an extension that promotes efficiency in primary care settings.

Patient Navigators have been used to perform Assess, Assist, and Arrange, and can arrange follow-ups with patients to help sustain the tobacco treatment intervention in a primary care setting.[64]

In addition to traditional cessation treatment, low-income populations need more emphasis on therapeutic approaches and behavioral interventions. Approaches that encourage the use of cessation medications and assist with adherence to medication as well as targeting stress reduction by increasing coping skills may enhance cessation with low-income populations.[65]

Resources for Provider Education and Additional Supports:

A Report of the Surgeon General that advises how to help patients quit.
http://www.cdc.gov/tobacco/data_statistics/sgr/2010/clinician_sheet/pdfs/clinician.pdf

A presentation that reviews the theory and importance of social support of tobacco cessation.
http://www.legacyforhealth.org/content/download/751/8398/version/1/file/Mermelstein.pdf

The DIMENSIONS: Tobacco Free Program is an evidenced-based tobacco cessation program designed to teach providers and peers the necessary information and skills they need to promote successful tobacco cessation within their organization.
http://www.bhwellness.org/programs/tobaccofree/

Resources for Patient Education and Additional Supports:

The American Cancer Society has a tobacco support group called Fresh Start
http://www.cancer.org/acs/groups/content/@highplains/documents/document/freshstartbrochurefinalpdf.pdf

Educational resource for individuals regarding how to quit smoking tobacco
http://www.cancer.org/acs/groups/cid/documents/webcontent/002971-pdf.pdf

Educational resource for individuals regarding how to quit smokeless tobacco
http://www.cancer.org/acs/groups/cid/documents/webcontent/acspc-035551-pdf.pdf

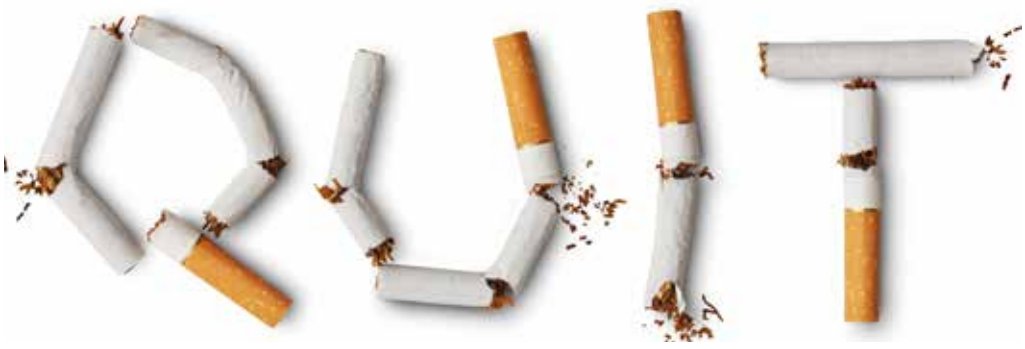
ExCommunity is a free online quit smoking program
http://community.becomeanex.org/

Resource for friends of smokers with quick tips on how to support loved ones in quitting
http://smokingcessationleadership.ucsf.edu/socialsupport.htm

Resource for tobacco users to gain support 24/7 from experts
http://smokefree.gov/talk-to-an-expert

Website that offers support during quit attempts and provides brainstorming through tough moments in the quit process
http://www.cancer.org/healthy/stayawayfromtobacco/quitting-smoking-help-for-cravings-and-tough-situations

Resource for educating tobacco users on smoking cessation products
http://www.fda.gov/forconsumers/consumerupdates/ucm198176.htm



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Finding Local and National Resources

Resource	Description
State Public Health Departments	Learn about state based programs and ask for information regarding local County Public Health Departments in your area to learn about regional specific programming for tobacco cessation for residents.
State Quitlines	The North American Quitline Consortium has an interactive national mapping website showing quitlines in each state with details regarding contacts and information about the quitline. http://map.naquitline.org/ They also have additional quitline information on their home website such as resources for quitlines partnering with Medicaid. http://map.naquitline.org/
State Medicaid Departments	Many low-income individuals qualify for Medicaid programs or insurance under the ACA expansion of Medicaid. Learn what your state's Medicaid plan covers for tobacco cessation and what other resources are available for individuals. The National Conference of State Legislatures has additional information and a grid of State Medicaid tobacco cessation programs. http://www.ncsl.org/research/health/tobacco-cessation.aspx
Centers for Disease Control and Prevention	This resource includes general information on tobacco cessation as well as links to information on quitlines, coverage for tobacco cessation, and clinical practice guidelines. http://www.cdc.gov/tobacco/

End Notes

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The Behavioral Health and Wellness Program's DIMENSIONS: Tobacco Free Program is designed to train peers and providers to assist people to live a tobacco-free life. The DIMENSIONS: Tobacco Free Program Advanced Techniques training supports tobacco cessation through motivational engagement strategies, group process, community referrals, and educational activities. Contact the Behavioral Health and Wellness Program at bh.wellness@ucdenver.edu for more information.

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