D. Tobacco Recovery and Wellness for the Behavioral Health Community

D.1. Overall Aim and Key Objectives.

Our primary goal is to reduce unnecessary death and disability due to tobacco use among persons with mental illnesses and addictions.

Together, the University of Colorado, Behavioral Health & Wellness Program (BHWP) and the National Council for Community Behavioral Healthcare (the National Council) have the necessary national reputations, relationships and capabilities to continue to help peers, providers, and behavioral healthcare agencies build practical cessation skills and sustained organizational steps toward change. Our primary objectives are to:

1) Reach over 37,000 organizational leaders, direct service providers, and peers with mental illnesses and addictions across the United States through evidence-based training, technical assistance, and practical resources.
2) Measure the effectiveness and sustainability of outreach, training, and technical assistance through a robust impact evaluation.

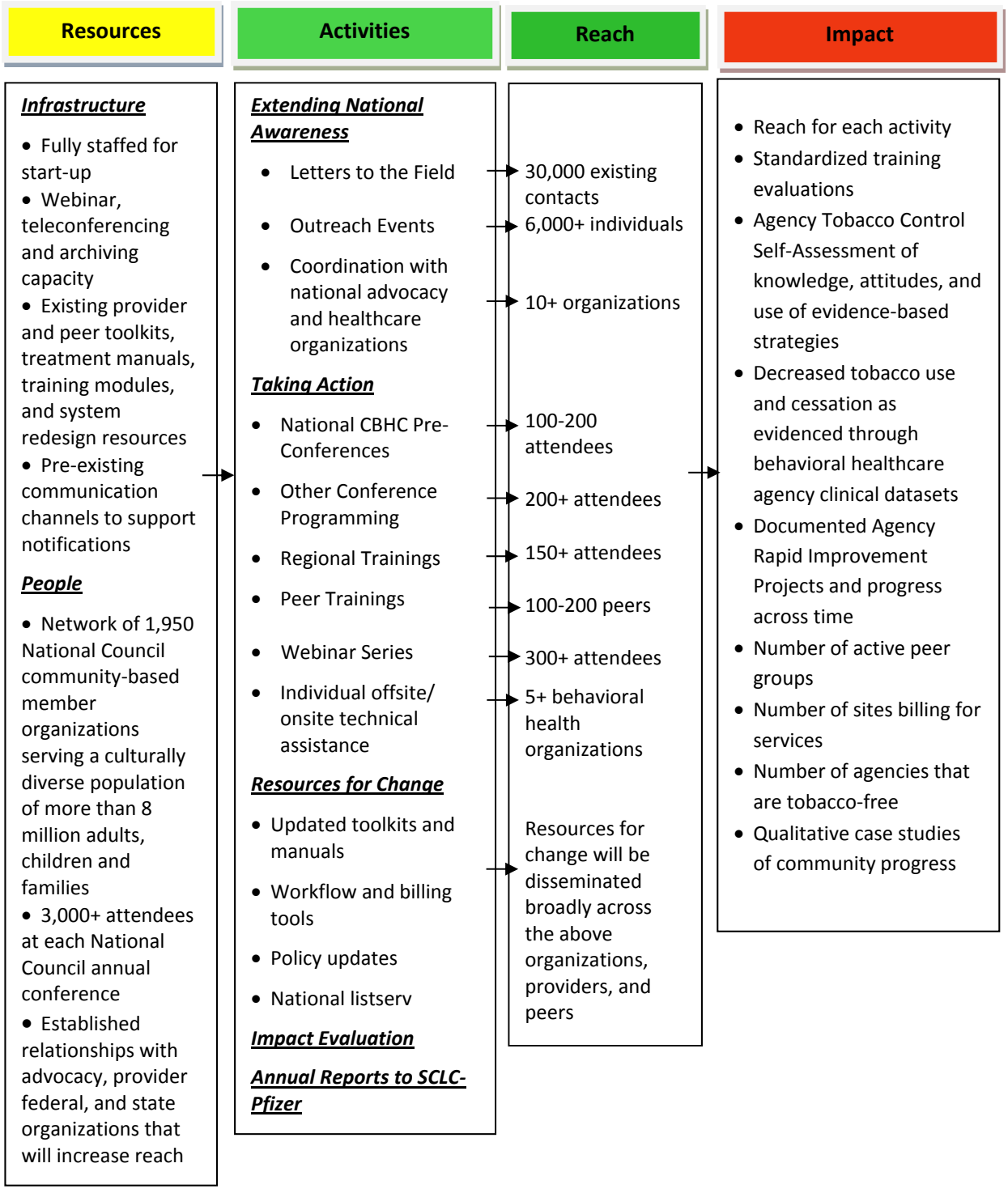
We also have a secondary objective to:

1) Reduce tobacco use across the United States among staff and employees of community healthcare facilities.

Tobacco use causes more than 430,000 deaths per year, and approximately 200,000 of these deaths occur in people with mental illnesses and addictions (Mauer, 2006; Williams & Ziedonis, 2004). It is unacceptable that persons with behavioral health conditions are dying on average 25 years earlier than the general population largely due to modifiable behaviors (Colton & Manderscheid, 2006). Fortunately, there are promising practices and evidence-based solutions to this healthcare crisis. While there are special considerations for this population, these individuals respond to the same evidence-based approaches to tobacco cessation as the general population, including tobacco-free policies, screening, assessment, pharmacotherapy, counseling, and referral.

Leveraging our current infrastructure, programming, resources and numerous national partners, we will reach all 50 states with sustainable tobacco control training, tools, and consultation to help close the “science-to-service” gap. We will continue to shift the culture and climate of behavioral healthcare systems to include tobacco control as an essential service offering, and we will also use a tested peer-to-peer model of care to extend the impact of provider-driven healthcare initiatives. Our project logic model (see ***Figure 1***) details the resources BHWP and the National Council bring to this project, key activities, reach, and expected impact.

***Figure 1*. Project Logic Model**



D.2. Needs Assessment Despite recent progress, tobacco dependence remains the largest preventable cause of death and disability in the United States and worldwide (Schroeder, 2008). In the U.S., 19.3% of adults are current smokers (Center for Disease Control [CDC]). A great success story of modern public health is the steady decline in tobacco use over the past 50 years, but unfortunately this is not the case for persons with mental illnesses and/or addictions (i.e., behavioral health conditions). Only 4% of smokers nationally successfully quit smoking each year and most quit attempts are unaided (Fiore et al., 2008). But the picture for persons with behavioral health conditions is even more critical. These individuals are typically more nicotine dependent and are not afforded the same opportunities for cessation services in comparison to the general population. Addressing the needs of this population is key to achieving desired gains in overall population health (Schroeder & Morris, 2010). The 45.9 million, or around 1 in 5 American adults, experiencing a psychiatric illness in the past year (SAMHSA, 2011):

- Smoke at 2-4 times the rate of the general population (Kalman et al., 2005)
- Represent over 44% of the US tobacco market, and consume over 34% of all cigarettes smoked (Lasser et al., 2000)
- Experience psychiatric illnesses exacerbated and even caused by tobacco use
- Report wanting to quit smoking at the same rate as others, but receive far less tobacco cessation support (Prochaska et al., 2007)
- Are more likely to be of a low socioeconomic status and have an increased likelihood of being uninsured or having lower levels of coverage, which reduces health care access and their likelihood of receiving smoking cessation treatment or early disease detection (Parnes et al., 2002; Lucan & Katz, 2006)
- Spend disproportionately on their addiction (Steinberg et al., 2004)

The relatively high prevalence of nicotine dependence in persons with behavioral health conditions reflects biological, psychosocial, and cultural factors plus targeting by the tobacco industry. At the same time, persons with mental illnesses and addictions use tobacco for the same reasons as the general population: as part of a daily routine to relieve stress and anxiety. Unfortunately the culture of mental health and substance abuse care has too frequently reinforced tobacco use in treatment settings, residential facilities, and housing (Schroeder & Morris, 2010). In public behavioral health settings, nicotine dependence may be documented in as little as 2% of mental health records, and only 1.5% of persons treated by a psychiatrist receive attention to smoking cessation (Montoya, 2005). Behavioral health providers also have high smoking prevalence rates--30-35%, thereby impeding tobacco cessation efforts (Schroeder & Morris, 2009).

BHWP and the National Council have further documented the tobacco cessation needs of the behavioral health population through the following research and evaluation studies:

• ***A study of the prevalence of tobacco use among community behavioral health clients*** (Morris et al., 2006). Among 111,984 persons who received public services in Colorado, 39% of the sample (N=43,508) used tobacco.

- ***Qualitative statewide data regarding the tobacco cessation needs of this population and community input on the development of interventions*** (Morris et al., 2009). Focus group participants (n=62) generally expressed the desire to quit smoking and learn more about tobacco use and the associated health effects. Although the desire for treatment was common, participants reported tremendous barriers to both being informed about and accessing existing tobacco treatment services. A common theme emerging from the needs assessment was the desire for peer-driven services to augment provider treatments.
- ***Exploratory study of community-based cessation interventions for persons with behavioral health conditions*** demonstrated that both quitline services and cessation groups administered by community mental health clinicians assisted individuals with serious mental illnesses reduce and quit tobacco use. The most effective strategy was a combination of quitline services and community groups. The interventions led to smoking reduction, reduced psychiatric symptoms, and improved health (Morris, Waxmonsky et al., 2011).
- An ongoing ***impact evaluation of the Peer-to-Peer Tobacco Recovery Program*** that shows that peer-led groups lead to reduced tobacco use. There was no worsening of psychiatric symptoms. Group attendees further reported decreased nicotine dependence and a significant increase in both motivation to quit and confidence to make a quit attempt.
- ***A statewide study of behavioral health providers' current knowledge of evidence-based tobacco control strategies and cessation interventions, current provision of tobacco cessation services to patients, and perceived effectiveness of tobacco cessation interventions*** among 462 providers and administrators from 20 statewide community agencies (Morris et al., 2011). This point in time snapshot revealed widespread systemic deficiencies in public behavioral health providers' knowledge, perceived effectiveness, and use of proven tobacco cessation strategies.
- ***A study of the smoking characteristics of youth with behavioral health conditions*** found that 44% of youth receiving behavioral healthcare services currently used tobacco (Morris, May et al., 2011). Encouragingly, almost half of youth of smokers were motivated to quit. But we found that behavioral health continues to reinforce, if not directly condone, tobacco use among youth.
- BHWP recently partnered with the National Council, which operates the SAMHSA-HRSA Center for Integrated Healthcare Solutions, to ***assess the tobacco control activity among national SAMHSA-HRSA Primary and Behavioral Health Care Integration (PBHCI) grantee sites***. Grantees varied greatly in their stages of readiness and action regarding tobacco control initiatives. The assessment confirmed there is ample need for ongoing technical assistance and training. A clear technical assistance and training target are the many sites reporting no action. But even most sites that had some level of tobacco services, did not report using evidence-based practices such as screening, assessment, referral, and prescription of nicotine replacement therapy or other cessation medications. There was also no mention of tobacco-free policies

Although real progress has been made in the attitudes and actions of the behavioral health community, the above research and evaluation efforts reinforce that there is much work still to be done. The behavioral healthcare systems are an important point of intervention because

agencies and providers typically have long-standing therapeutic relationships with clients, have behavior change skill-sets which can be applied to tobacco dependence interventions, are recovery oriented, and are philosophically aligned with co-occurring mental health and addictions services.

D.3. Technical Approach, Design, and Methods. The below proposed objectives are created to insure that persons with behavioral health conditions have the same opportunities to quit smoking and live in smoke-free environments as anyone else. Core methods of changing the behavioral health culture will include building awareness, enhancing knowledge, and insuring that cessation services are integrated into standards of care through system redesign, policy, measurable rapid improvement initiatives, and dissemination of "lessons learned" through conference presentations and other communication channels. We will strive to meet behavioral healthcare agencies "were they are at" and then help create buy-in for their next steps toward comprehensive tobacco control.

All project activities are "recovery oriented" and "strength based". We define recovery is "a way of living a satisfying, hopeful, and contributing life, even with the limitations caused by illness" (Anthony, 1993). Our team has striven to keep recovery first by meeting both clients and agencies where they are at in their recovery process and offering support for whole health and wellness. BHWP and the National Council have developed program services that are flexible and which can be individualized based on client's and organizations' paths toward recovery. We embrace a participatory process in all our proposed activities. While our tobacco control strategies are evidence-based, we expect that they will evolve with continuous input from peer leaders, clients, advocacy organizations, and behavioral health providers. We also recognize that behavioral health disorders cut across all race/ethnicities, religions, gender, age, sexual orientation, and socioeconomic status. To insure cultural and linguistic responsiveness of services, we will seek the expertise of diverse groups as we develop and improve upon trainings and resources.

Extending National Awareness. BHWP and the National Council have experience and expertise leveraging our relationships with provider organizations to draw attention to critical issues in the field; for example, over the past 10 years, the National Council has used its position as a platform to raise awareness about the importance of primary care integration strategies to make integration a reality. Through this initiative, our project team is prepared to use this experience to raise awareness about smoking cessation and the resources created.

• ***Letters to the Field***. To kick off our project activities, the first in a series of Smoking Cessation Letters to the Field from the National Council President/CEO, Linda Rosenberg, will be sent to the over 30,000 email contacts. Letters will be sent three times a year calling for all behavioral health treatment settings to enact cessation treatment and smoke-free policies. Letters will have expert and peer columns, and highlight various aspects of evidence based practices, system redesign, and policy. They would also feature information/resources from the CDC's Tips from Former Smokers. We will solicit content from a range of national experts. These

letters will be strategically scheduled to further engage agencies, providers, and peers in pre-conference, conference, regional trainings, webinars, rapid improvement projects and agency self-assessments.

• ***Maximizing National Collaborations.*** BHWP and the National Council will work with other national organizations to leverage additional advocacy and healthcare networks, conferences, events, and websites to promote tobacco control initiatives for persons with behavioral health conditions. We will collaborate with at least 10 national organizations. This list will include, but not be limited to, the Smoking Cessation Leadership Center, National Association of State Mental Health Program Directors, North American Quitline Consortium, Association for the Treatment of Tobacco Use and Dependence, Society for Research on Nicotine and Tobacco, National Alliance on Mental Illness, Mental Health America, Faces and Voices of Recovery, HRSA, SAMHSA, and the CDC.

Taking Action. We will offer interactive webinars, conferences, regional trainings, and individualized technical assistance and training to community agencies. We will use these modalities to emphasize proven strategies for screening, assessment, psychosocial and medication treatment, behavior change models, continuity-of-care, tobacco-free policy, the overlap between behavioral health and other priority populations (e.g., youth, offenders, different races and ethnicities), tobacco cessation offered in integrated care setting, quitline services, healthcare reform, workflow, billing, and sustainability planning. We have utilized Wagner's Chronic Care Model to create a compressive technical assistance and training approach that prepares practices and activates client/patient involvement by developing community resources and policies, self-management supports, delivery system design, decision support, and clinical information systems.

• ***Pre-Conference Institutes*** will be held at the annual National Council conferences in April 2013 and 2014. The Pre-Conference Institutes will have multiple concurrent training tracks. There will be three tracks: 1) Evidence-based clinical treatment, 2) Policy and system redesign, and 3) Peer-to-peer services. The clinical track will include assessment, treatment planning, motivational enhancement, cessation groups, cessation medications, and community referral. For the policy and system redesign track, BHWP will utilize its existing Tobacco Free Toolkit for Community Health Facilities developed with SCLC and Los Angeles Department of Public Health. Policy trainings will provide ten steps toward success in creating tobacco-free campuses and residential treatment settings. The core elements for the third track, peer-to-peer services, are elaborated upon below. All three tracks will include a contextual discussion about the policy and financing opportunities available for smoking cessation; we view this as a critical component of ensuring implementation of sustainable practices that have the potential for replication at other provider organizations. As detailed in the project evaluation section, we will ask that attendees from all three tracks create rapid improvement projects for tobacco cessation. Rapid Improvement Projects will document the measurable goals to be accomplished at attendees' agencies over the following six months. We expect that 50-100 organizational representatives will attend the Tobacco Recovery pre-conference each year.

• ***The Peer-to-Peer Tobacco Dependence Recovery Program*** will be an integral component of all training and technical assistance. Peer-to-peer interventions, now a central part of the behavioral health recovery movement, are an important augmentation to provider-driven cessation strategies. The "recovery movement" suggests that adjuncts to formal treatment, involvement in self-help groups, and social opportunities in community and institutional settings foster empowerment and self-efficacy (Davidson, Chinman, Sells, & Rowe, 2006; Knight, 2006). Wellness is sustained through positive social networking, and peers are an effective means of building and sustaining cultures of wellness. BHWP has developed a Peer-to-Peer Tobacco Recovery Program that is a train-the-trainer model now active in 14 states. Through this proven train-the-trainer model, peers will gain skills in awareness building, building positive social networks, a brief motivational intervention, and a 6-session cessation group. Trained peers are also invited to join a national peer network with monthly teleconferences and a listserv administered by BHWP. We will train up to 100 peers at National Council pre-conferences and/or regional trainings.

• ***Annual Conference Presence.*** At the National Council Annual Conferences in April 2013 and 2014 we will have an outreach table with resources and information regarding technical assistance opportunities for the 3,000+ attendees each year. Also, tobacco cessation conference programming for the priority population of persons with behavioral health conditions will be created in coordination with the Council's Policy Office and Center for Integrated Healthcare Solutions (CIHS). We estimate that this conference programming will be attended by 100 conference attendees per year.

• ***Regional Trainings*** will reinforce the programming from the National Council Pre-Conference and Annual Conference activities. Regional trainings will be utilized to: 1) Correct many of the misconceptions or "clinical lore" about tobacco—such as "tobacco is not a real drug," "it's too hard to address all the substances together," and "quitting tobacco will definitely worsen other substance recovery"; 2) Share knowledge about the most recent evidence base regarding prevention and cessation assessment, treatment, policy, and community referrals (e.g., quitline, local public health agencies). We will stress a continuity-of-care model so that individuals do not "fall through the cracks" as they move between public systems of care; and 3) Build rapid improvement plans tailored to agency readiness for change and need. We will strategically determine what regions of the country to target for trainings in collaboration with the Smoking Cessation Leadership Center and Pfizer. To the extent possible we will leverage travel through concurrent regional events and existing local relationships allowing for the extended national coverage we propose. We will complete two regional trainings per year with 75+ attendees per training.

• ***A Webinar Series*** targeting treating behavioral health and integrated care clinicians, as well as peers will focus on effective techniques/strategies to support clients in stopping smoking. We anticipate 4 webinars with a total of 300+ attendees.

• ***Individual Technical Assistance*** will capitalize on organizational readiness for change. This one-on-one work with behavioral healthcare agencies will allow the project team to engage in academic detailing including workflow analysis, assist sites implement rapid improvement projects and assess tobacco-free policy implementation. Over the course of the project, we will work with 5+ behavioral health organizations identified at pre-conferences, annual conferences, regional trainings, and through agency tobacco self-assessment data described in this proposal's evaluation section.

Resources for Change. BHWP and the National Council will create and/or update a number of practical tobacco control resources which will be disseminated through our websites, National Council electronic newsletters and magazine, conferences, webinars, and national partners such as SCLC and Pfizer. Specific resources and tools will include:

• ***Return-on-Investment.*** We will create community behavioral healthcare best practices for demonstrating return-on-investment (ROI) for tobacco control initiatives. ROI will be described at multiple levels including the organization level, provider level, and client level.

• ***Workflow and Billing Tools*** will be created and disseminated. The key to sustainable tobacco cessation services is a sound business model. These resources will describe what specialties/peers can provide tobacco cessation services, which staff can be reimbursed, under what coverage, using what codes.

• ***Provider and Peer Toolkits*** will be updated to reflect the growing evidence base as well as ongoing themes from national training evaluations. For example, BHWP will revise toolkits and training manuals to reflect best practices regarding cessation medications, quitline services, youth interventions, integrated care settings, tobacco-free policy, peer services, and provider payment.

• ***Policy Updates.*** The National Council will develop Smoking Cessation "Letters to the Field", providing a policy discussion, updates on innovative practices, and resources for stakeholders to access to promote smoking cessation activities. Letters to the Field will be sent to over 30,000 email contacts 3 times per year and shared with partner organizations for further dissemination.

• ***National Learning Community.*** The project team will administer a National listserv with broad membership from the national behavioral healthcare sector. We will foster an ongoing dialogue regarding timely subjects such as meaningful use, health home models, electronic cigarettes, and tobacco industry strategies.

D.4. Evaluation Design. Our project team has a long history of providing program evaluation services across chronic care conditions. We will be employing mixed qualitative and quantitative evaluation methods. Throughout the project and will stress a participatory-based design and Utilization Focused Evaluation values (Patton, 2008). By this we mean that any evaluation data will be of high utility to the communities, agencies, providers, and peers who are providing information.

Our team will promote effective management and discipline by mapping out inputs, processes, outputs and outcomes to ensure that all stages of the project and its evaluation are logically linked and coordinated to fully complete all measurable activities. We will use the Logic Model (see ***Figure 1***) as a living document that will be updated at project start-up and as the project evolves to ensure that our team, SCLC, and Pfizer have the same mutual understanding of deliverables, timelines, and accountability.

Tobacco Control Self-Assessment. To set the stage for change, the project team has *already* developed and piloted an agency self-assessment to gauge behavioral health and integrated care agencies' organizational readiness to implement evidence-based tobacco control strategies. Pre-conference attendees, 89 HRSA-SAMHSA integrated care grantee sites, and approximately 100 alumni of past learning communities will participate in the self-assessment. The self-assessment will also be used by attendees of the regional trainings, and by sites receiving individualized technical assistance and consultation. The Tobacco Control Self-Assessment has three levels of utility:

- At the local agency level, assessment results assist sites to identify successes, gaps, and appropriate next steps for program development, technical assistance, and training. It will also allow grantees to track change over the two grant years and beyond.
- At a TA and training level, BHWP and the National Council will receive real-time assessment results providing a clear snapshot of agencies' activities, where site support needs to begin, and what conference programming and regional trainings need to emphasize.
- At a national level, the assessment will provide the project team, SCLC and Pfizer standardized data across sites. If the assessment is completed annually, this will allow the project team to track change longitudinally across two years.

Reach. For all activities we will report reach in several ways: 1) Reach will be reported as numbers of providers, peers, and organizations receiving outreach, training, consultation, and technical assistance; and 2) We will also estimate the number of clients and agency employees that are impacted by project activities. Through previous statewide contracts with the Colorado Department of Public Health and Environment, BHWP has built formulas for conservative estimate of reach based on an unduplicated count of state funded behavioral health clients.

• Formula for calculating client reach by behavioral healthcare agency = # of agencies x 2,000 smoker/non-smoker behavioral health clients x 35% (i.e., conservative tobacco use rate)

• Formula for calculating client reach by provider or peer specialist = # of providers/peer specialists x 75 clients who smoke

• Formula for calculating reach for policies at behavioral healthcare agencies = # of agencies x 2,000 smoker/non-smoker behavioral health clients + 100 employees per agency

We will fine-tune these formulas with SCLC-Pfizer as needed to most accurately capture reach.

***Standardized Training Evaluations*.** For all trainings and consultation we will keep lists of attendees with contact information. We will use training evaluations to measure satisfaction and to collect ways in which we can continuously improve. We will report aggregate training evaluation results annually.

Rapid Improvement Projects. Preconference attendees, regional training attendees, and sites receiving technical assistance will be asked to create rapid improvement plans for tobacco control. Attendees and sites will be asked to evaluate organizational readiness for change and develop realistic and measurable tobacco control actions to be implemented over the next six months. BHWP successfully piloted this planning strategy in regional trainings across California and Colorado regions utilizing established rapid diffusion strategies (e.g., Plan-Do-Study-Act cycles). We have created an agency motivational ruler whereby agency staff self-reports importance of specific tobacco control strategies, confidence in implementing change, organizational readiness for change, and amount of control over implementation strategies. Using this ruler, we assist agency staff to fine-tune incremental change strategies. Six month goals are then written using SMART (specific-measurable-attainable-relevant-timely) objectives. We will follow up with these sites at six months to a year to evaluate progress toward goals.

Case Study. An integral component of our evaluation will be telling the story of how behavioral health agencies make system and clinical changes to integrate tobacco cessation into daily practice. For one or more sites receiving individual technical assistance, the BHWP anthropologist, Dr. Virginia Visconti, will document site(s) progression through organizational stages of change. We will capture the depth of change through site observations, key stakeholder interviews, and document review.

Tracking the Numbers. Annually, we will track uptake of tobacco control strategies of those trained. We will be measuring the "stickiness" of tobacco control strategies. For instance, whether or not prevention and cessation services are maintained or discontinued and what steps organizations are taking to engage and maintain clients/patients in treatment. The following will be specifically assessed: 1) Active number of peer programs running, 2) Sites offering evidence-based medication and behavioral services, 3) Sites with tobacco-free policies, and 4) Agencies that are billing for cessation services, and the billing mechanisms that being successfully utilized. Some of these indicators are captured by the Tobacco Self-Assessment. We will add items regarding billing and disseminate the survey annually to those trained via web-based survey methods that we have successfully applied through state-specific as well as national program evaluations.

For the above evaluation plan, BHWP will be responsible for data collection, data entry, cleaning and analyses via Microsoft Excel and PASW, Version 18 (2009) and QSR NVivo (2009) data management and analytic software. Our team will analyze quantitative and qualitative outcomes longitudinally from trainees and community implementation sites.

E. Detailed Work Plan and Deliverables Schedule:

Although BHWP and the National Council will be full project partners, Dr. Chad Morris will have ultimate responsibility for the project's fiscal management, and all aspects and timeliness of deliverables. BHWP and the National Council will utilize a detailed project management plan created by the project team with Microsoft Project software. The project management plan includes specific tasks, responsible parties and target dates for completion of grant activities, providing an accurate and up-to-date tracking mechanism.

The project leads for BHWP will be Drs. Chad Morris and Cindy Morris. The project leads for the National Council will be Chuck Ingoglia and Jenny Crawford. ***Table 1*** details activities and leads for each key deliverable, and the below budget narrative breaks down activities by approximate cost. We propose that all project leads have a start-up meeting with SCLC-Pfizer in early January 2013 to finalize goals and the working logic model. The project leads will then meet telephonically and/or by Skype several times a month during lead up to the first annual pre-conference/ conference and have monthly project team meetings thereafter. Planning meetings will be used to regularly measure our progress and will provide a forum for all team members to identify potential barriers and to propose viable solutions. Complementing these meetings will be the written annual project status and progress reports that all members of the team will contribute to and receive upon completion. The project team will have further face-to-face planning time at the Annual National Conference occurring in April of 2013 and 2014.

***Table 1*. Work Plan Schedule.**

Activity/Deliverable	Lead Agency & Staff	Year 1				Year 2			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Finalize Logic Model	BHWP* (Morris)								
Finalize Council Sub-Contract	BHWP, (Smith)								
Letters to the Field/ Web-Based & Print Resources	Council, (Rosenberg)								
Collaboration with other National Organizations	BHWP (Morris), Council (Ingoglia)								
Pre-Conference, Peer-to-Peer and Conference Registration	Council (Crawford)								
Tobacco Control Self-Assessment	BHWP (Brannon)								
All Day National Council Pre-Conference (April)	BHWP (Morris), Council (Crawford)								
Annual National Council Programming and Outreach Table (April)	BHWP (Morris), Council (Roth)								
Peer-to-Peer Training	BHWP (Morris)								
Regional Trainings	BHWP (Morris),								

Activity/Deliverable	Lead Agency & Staff	Year 1				Year 2			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Council (Crawford)								
Webinars	Council (Crawford)								
Individual Site Technical Assistance	BHWP (Morris)								
Return-on-Investment Resources	BHWP (Morris)								
Workflow and Billing Tools	Council (Fricks)								
Toolkit Updates	BHWP (Morris)								
Policy Updates	Council (Dayak)								
National Listserv	Council (Roth)								
Case Study	BHWP (Visconti)								
Evaluation Data Analysis	BHWP (Brannon)								
Annual Reports to SCLC-Pfizer	BHWP (Morris), Council (Crawford)								

*Behavioral Health & Wellness Program

Both BHWP and the National Council have seasoned national training and technical assistance teams. We are intimately familiar with the "hidden" resources and time commitment necessary to successfully market and register attendees at conferences, plan for regional and onsite training and consultation, develop and vet resources and tools, collect, clean and analyze evaluation data, and create data-driven reporting. We can accomplish the proposed package of deliverables for the following reasons:

- BHWP and the National Council have partnered on national technical assistance and training over the last two years already, and have a strong working relationship and established communication strategies.
- We will leverage both our existing infrastructure and staff to accomplish project activities. For example Linda Rosenberg and Larry Fricks at the National Council and Dr. Virginia Visconti, Shawn Smith, and Jennifer Hasbrook at BHWP will be providing in-kind services made possible through other existing contracts and agreements.
- Training and planning technology (e.g., webinar capacity) is already in place.
- We have excellent relationships with national and community partners that will be instrumental in marketing technical assistance and training.