System-Level Barriers to Delivering Tobacco Treatment to Veterans with Serious Mental Illness:

A Qualitative Analysis

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Abstract

Introduction: Tobacco treatment has been a VA priority since 2008, which has increased access to treatment. Additional system-level efforts are needed to reduce the disparities in smoking rates and tobacco treatment access that have persisted between Veterans with and without serious mental illness (SMI).

Materials & Methods: This project was deemed minimal risk and, thus, exempt from IRB oversight by the local IRB. We interviewed 20 VA SMI providers and analyzed qualitative data using a rapid analysis matrix approach to determine how system-level barriers, such as administrative factors and social norms, influenced tobacco treatment delivery.

Results: Providers often tried to stay current on VA tobacco treatment resources, but said that too much or too little information would stymie efforts. For example, high volumes of information sent via email and available on the intranet made it challenging to find smoking-related resources, while restricted information about changes to medication availability complicated prescribing. Providers described these barriers as interfering with their delivery of smoking treatment. Some also viewed tobacco discussions as antithetical to their mission of providing veteran-centered care, which

dissuaded them from initiating such discussions. Finally, the ease of coordinating care between prescribers and non-prescribers facilitated tobacco treatment delivery.

Conclusions: Tobacco treatment resources are available in VA, but providers in our sample had difficulty accessing them and worried that these resources would be inaccessible to Veterans with SMI. Coordination between tobacco treatment lead clinicians, frontline providers, and operational partners that aims to increase provider exposure to tobacco treatment resources without exacerbating information overload can help increase the accessibility of available tobacco treatment resources in VA, particularly for providers working with Veterans with SMI.

Introduction

Tobacco smoking-related conditions are the leading cause of preventable death, globally, and contribute to major health inequities.[1,2] Service members and veterans have higher smoking rates than their civilian counterparts.[3] It is estimated that the Veterans Health Administration (VA) spends approximately 2.7 billion (2008) USD annually on smoking-related conditions. Though tobacco abstinence rates among VA health care enrollees are comparable with civilian abstinence rates,[4] Veterans diagnosed with a serious mental illness (SMI; schizophrenia-spectrum, bipolar-spectrum, and other psychotic disorders[5]) have higher smoking, lower cessation, and higher return-to-smoking rates than veterans without SMI.[4,6]

In response to high smoking rates and smoking-related health care expenditures, VA has prioritized practices that support smoking cessation.[7] These include expanding prescription privileges for medications approved by the Food and Drug Administration (FDA) for smoking cessation, developing smoking cessation practice guidelines, eliminating the veteran co-payment for tobacco counseling, requiring facilities to have a tobacco treatment lead clinician to disseminate smoking-related resources, and implementing annual tobacco screening reminders within the electronic health record.[7,8] These practices broadened the reach and impact of tobacco treatment in VA.[9,10]

VA's Tobacco Use Treatment National Program Office, within the Office of Mental Health, shares tobacco-related resources with VA employees through SharePoint (a web-based Microsoft Office platform), conducts trainings for VA employees, and supports clinical research and quality improvement devoted to expanding the reach of tobacco treatment, including to Veterans with mental health and substance use concerns.[11–13] Even after expansion of smoking treatment and resources within VA,

smoking rates among Veterans with SMI remain high.[4,6] Individuals with SMI die 16.2 years earlier than their peers, largely due to smoking-related conditions.[14] An overwhelming majority (70%) of Veterans with SMI want to quit smoking,[15] but Veterans with SMI are less likely to be prescribed tobacco medication (adjusted RRs by diagnosis = 0.74 – 0.90)[16] and Veterans with schizophrenia are less likely to receive physician advice to quit (OR = 0.69, 95% CI[0.58-0.81])[6] than Veterans without these conditions. In VA, only 11-18% of those with SMI are prescribed tobacco medication.[10,16] Additional efforts are needed to expand the reach of tobacco treatment to Veterans with SMI.

VA remains committed to reducing ongoing health disparities that persist between Veterans with and without SMI who use tobacco.[7] Understanding what and how system factors,[17] like administrative factors and social norms,[18] influence tobacco treatment delivery could inform quality improvement efforts to expand the reach of tobacco treatment to Veterans with SMI. This study interviewed 20 SMI providers from a Mid-Atlantic VA health care system to better understand their views of how system-level factors influence their delivery of tobacco treatment.

Methods

Recruitment

Methods are reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.[19] This project was deemed exempt from institutional review board (IRB) review by the affiliated university's IRB. Eligible participants were non-licensed providers (e.g., peer specialists) and licensed independent providers (e.g., social workers, physicians) employed by a VA medical center who had at least 30% clinical time and worked with veterans in the psychosocial rehabilitation and recovery center (PRRC), mental health intensive case management

(MHICM), or outpatient psychiatry. Recruitment occurred via staff meetings, flyers, and direct emails. The study team used purposeful sampling[20] to recruit 20 providers from various disciplines, about a third of 55 total local providers. The sample size was chosen for its potential to yield sufficient information power, given the study's focused aim, theory-informed design, and study team expertise[21] and achieve thematic saturation.[22,23]

Interview guide and theoretical foundation

CK and KBD developed the interview guides, which were pilot tested and refined before use with participants. Providers were asked about current treatment practices, knowledge of smoking and tobacco treatment, attitudes towards smoking, and factors influencing tobacco treatment delivery. *A priori* domains were attitudes, self-efficacy, and norms and guided by the Theory of Planned Behavior.[18] In this framework, attitudes reflect beliefs, preferences, and emotions shaped by expected outcomes; self-efficacy refers to one's perceived control over their behavior; norms relate to peer influence and motivation to conform; and each interacts with one another to influence behavioral intent and subsequent behavior.[18]

Study team

The study team operated from a VA research center. CK was a postdoctoral research fellow and licensed clinical psychologist who led the project as the study PI, conducted interviews, and analyzed data. ET was a bachelor's-level psychology technician who assisted with protocol development, conducted interviews, and analyzed data. RG and KBD were research investigators at the center and co-investigators for the project who oversaw study procedures. As the team's qualitative expert, KBD also assisted with data analysis. None of the study team members are Veterans, but CK and KBD have immediate Veteran family members. CK was the primary interviewer due to her experience as a mental health provider and with evidence-based tobacco treatment,

which supported higher-quality interview probes. CK conducted 18 interviews and ET conducted two.

Data collection and analysis

Data was collected between May and August 2024. After reviewing the information sheet with the provider, all providers gave verbal consent for interviews and audio recording. Interviews used a semi-structured format and were conducted via the worksite's Microsoft Teams platform and transcribed verbatim by a VA-approved service. Afterward, participants provided demographic information. Per VA policy, no financial compensation was offered, but participants received a list of local VA tobacco treatment resources at the end of the interview.

CK and ET independently summarized the first two interviews in a Microsoft Word template that documented key points by question and domain and reviewed. The summaries were then consolidated using a consensus approach. For the remaining interviews, CK or ET completed the primary summary and each audited 25% of the others' work, which involved using track changes to add, remove, or edit summary points. After each summary's finalization, transcripts were reviewed to extract exemplar quotes and refine question and domain-level summaries. Finally, question and domain-level summaries were compiled into a participant x domain matrix[24] to identify themes within domains. CK, ET, and KBD met weekly to finalize summaries, review the matrix, develop the data dictionary, and finalize themes. Data was analyzed using a rapid matrix analysis approach,[24] which is appropriate for projects with a focused approach to data collection, restricted resources, and a need for the qualitative findings to inform other project components:[22] This project was used as preliminary data for a grant application aiming to improve tobacco treatment delivery in VA SMI clinics. Data was first categorized according to *a priori* domains and then subsequently divided by

shared meaning into themes within each domain. This manuscript focuses on findings from the norms domain.

Results

Twenty VA SMI providers were interviewed: 7 (35%) were psychiatric prescribers and 13 were non-prescribers; 70% were White, 85% were female, and the average years in practice was 16.5 (SD = 8.6). On average, 78% (SD = 26.5) of each provider's caseload was diagnosed with SMI. The average interview lasted 26.9 minutes (SD = 7.41).

In regards to the 5As,[1,25] 12 providers (60%) *Asked* about smoking, six (30%) *Assessed* interest in quitting, 0 (0%) *Advised* quitting, 14 (70%) *Assisted* Veterans with brief counseling, referrals, psychoeducation, or medication, and three (15%) *Arranged* smoking follow-ups.

Social norms

Several providers shared the view that checking-in about smoking would, in some ways, be inconsistent with the VA's mission to provide Veteran-centered care. "I'm really focused on building rapport…So I don't want to like put anyone off or make them feel like [quitting is] what I'm pushing." Another provider shared a similar concern that following-up about smoking is not veteran-centered, "…[sessions are] [Veteran]-directed, you know, kind of work on what they want to work on. So I don't go in there with an agenda like that." 217. In response to a question about whether she would follow-up with a Veteran who expressed that they were not interested in quitting during a prior smoking conversation, 215 said, "…I don't like to make them feel like I'm trying to infuse my thoughts for their recovery on them." 201 echoed the perceived dissonance between smoking discussions and veteran-centered care,

> *We're very focused in our recovery model on Veteran-led care…I have responsibility to bring some things up, but if the Veteran's…not interested in spending time on smoking cessation, and we're…trying to make some progress on other things I think it's a lot easier for [smoking discussions] to, like, fall way back to the back burner, in my mind.*

Care coordination is ingrained into the VA's culture as an integrated health care system. For example, many multidisciplinary providers are co-located, and instant messaging platforms (Microsoft Teams) facilitate instant inter-provider communication. Many non-prescribers described coordinating with prescribers when Veterans expressed interest in tobacco medication. Some non-prescribers were also concerned about discussing medication with Veterans because they didn't want to operate outside of their scope of practice. Some non-prescribers more routinely interacted with prescribers than others. For example, the community-based intensive case management team has a shared caseload and meets regularly together to coordinate Veteran care. This process reduced barriers to contacting prescribers in more traditional clinics, where finding overlapping availability to coordinate care was sometimes a challenge.

Administrative barriers

Information overload

Providers who had worked in other VA settings, like inpatient settings, cited benefits of compartmentalizing care by subspecialty and working in proximity with these providers, which promoted efficient referrals. In outpatient settings, providers had to initiate efforts to learn about myriad VA resources and their referral processes. Providers know that VA supplies valuable resources for providers in a centralized location called SharePoint, a common collaboration software by Microsoft, and disseminates important information through email. However, the functionality of the

SharePoint site and volume of information sent via email were difficult to navigate. Searching for answers to smoking-related questions was overwhelming and sometimes futile, which dissuaded search attempts, as described by 211,

> *There's so much information about all of the things…I try to have my little email system where I file things away for when I need them later.…So I would attempt my filing system, which sometimes works and sometimes fails. I would probably get stuck spending more time than I would care to Googling, going through the various SharePoint sites, which are really challenging to navigate.… I would kind of go through…SharePoint in the hopes that one of them would link to something related to smoking cessation. And I presume that on that SharePoint…all of the tools…would probably be accessible there.*

If information is disseminated, like through newsletters, it can frequently get buried by other emails. 201, 206, 211, and 215 were aware of VA tobacco treatment resources, like the facility tobacco lead clinician, Tobacco Use SharePoint site, and tobacco newsletter, but did not know how to access these resources.

Resource accessibility

Community-based providers in MHICM played a particularly important role for Veterans that would otherwise have low access to services and reiterated how technology and transportation barriers impacted the types of VA tobacco services their Veterans could access:

> *The other challenge with [SMI] folks …specifically, is…many of our veterans don't even have cell phones and a lot of the new tools and things that are being shared are like apps…[and] phone numbers you can call. And we just have like a, a real gap in terms of kind of what [resources] folks have access to. 211*

> *…we're out here on our own. Most of the things our Veterans just are never able to, to participate in…we have a lot of people that don't have access to internet…And we have…a big issue with giving out written literature because a lot of it's just almost [beyond their reading comprehension level]…And even though they might be able to read, they do better with more simple information and instructions…[For in-person groups] if they're eligible for door to door [transportation], then they have to… get a van to ride into the clinic to get on the shuttle [for a 2-hour ride, one-way]…it's a whole day to participate in one group.218*

Cumbersome order sets

The two medications that stood out to some prescribers as particularly effective were either no longer available (inhaler) or the most time-consuming to prescribe (varenicline).

> *I found out from the pharmacist the last time I tried to prescribe [the Nicotrol inhaler]…that they're no longer making that…but I find that…unfortunate because, at least for some people, I thought that that was a useful tool to be able to have something to do with their hands and mouth…207*

Order sets for varenicline (formerly Chantix), specifically, were described as “very clunky and… inconvenient.” 203 shared this reflection,

> *[Y]ou've got to jump through a bunch of hoops [to prescribe varenicline]…It just creates yet another barrier or obstacle where an already busy…provider can just say, ‘This alternative is much easier.’ But varenicline is more effective. So we're…disincentivizing its use in ways that we shouldn't…from a rational risk benefit calculation.*

207 appreciated updates to how frequently a pharmacist would authorize its prescription:

> *I have been encouraged by the fact that with the Chantix the pharmacy has been willing at times to let us [prescribe] it again…[W]hen I first started using it, it was sort of like, 3 months and done. And now I've noticed that…if someone's going to give it another try, [pharmacy will] let us try it again, which I'm encouraged by.*

However, not all prescribers took issue with this order set, with one provider expressing appreciation for the detailed dosing instructions that the order sets provided. At one point, there was a shortage of Chantix, which resulted in restrictions on its prescribing and created more work for prescribers. Upon reflection, 208 realized that she had been prescribing Chantix less after the shortage,

"I was like, 'am I writing for Chantix as much as I had before the shortage?' And I think the answer is 'no.' So that's something that I need to kind of get back in the habit of doing." 208 also expressed frustration towards order sets unexpectedly changing,

> *Probably one of my biggest pet peeves as a [prescriber] is we're never included on when a pharmacy…decides to change things. We're the end user…but nobody ever tells us anything. So…they'll change it and we won't know.*

In other words, if a medication is missing from its original order set, a provider could either choose to search for it or assume that it is no longer offered – both of which limited prescribing.

Discussion

Over half of providers asked about tobacco use, but few followed-up on tobacco use after initial discussions. Providers often tried to stay current on VA tobacco treatment

resources, but too much or too little information would stymie efforts. For example, numerous providers noted that copious information on the VA SharePoint made it challenging to identify where the smoking-related resources were, while a lack of information about where and how to order medications would change without notice. Many providers directly attributed these administrative barriers to impeding tobacco treatment, particularly medications.

Although smoking information from the VA's Tobacco Use Treatment National Program is stored in a SharePoint site, many providers were not aware that it existed; some also tried to find it but were unable to. The current model of disseminating tobacco treatment in VA relies on a facility-level tobacco treatment lead clinician, which is recommended but not guaranteed to have protected time for relevant activities.[26] The tobacco lead is responsible for conducting direct outreach and training to facility clinicians and liaising with the national program office. The site's lead clinician may need to adjust their communication strategies to ensure resources are trickling down to front line mental health providers.

Optimizing SharePoint search parameters to reduce the number of irrelevant or outdated results when searching for the tobacco treatment SharePoint drive could make it easier for providers to access VA's tobacco resource library and serve as a starting point for increasing tobacco treatment in mental health settings. Also, educating providers about VA tobacco resources during periods of time that providers already have dedicated to administrative work, like during all-staff meetings, could help increase exposure to tobacco resources without exacerbating information overload. Finally, coordination between the VA's tobacco use program, facility informatics departments, and front-line clinicians could explore options for notifying providers of medication order set changes. Creating pop-ups in the order sets themselves to alert providers to changes

could help providers stay apprised of order set updates without exacerbating information overload. Reducing these administrative barriers to learning about and delivering tobacco treatment could facilitate rates of *Assisting* and *Arranging* tobacco follow-up.

For many providers, tobacco treatment did not align with their view of veteran-centered care. However, patients often welcome conversations about tobacco use with health care providers because most are contemplating quitting and interested in treatment options.[15,27] Thus, tobacco treatment lead clinicians should counter myths about tobacco discussions not being veteran-centered. This education could empower front-line providers to inquire about tobacco use and increase opportunities for discussions about interest in quitting and available treatment.

Unlike another VA study on mental health provider tobacco treatment practices, providers in the present study identified care coordination as a facilitator, not a barrier, to tobacco treatment.[28] This difference may be attributed to treatment philosophy differences between VA SMI and general mental health providers. SMI clinics like PRRCs and MHICM use a team-based treatment approach, which overcomes many care coordination barriers.[29]

Providers also described how Veterans with SMI face numerous barriers to engaging with VA tobacco treatment resources. Veterans receiving services through MHICM lived in rural areas and were often several hours away from a medical center, which made in-person tobacco treatment appointments infeasible. Additionally, many did not have sufficient literacy to understand educational pamphlets, did not have smartphones to access the VA Stay Quit Coach application, and did not have computers to facilitate participation in virtual support groups. Integrating smoking treatment into existing mental health care appointments can overcome many access issues and lead to more successful quit attempts. For example, in one VA project, mental health providers in

10 VA post-traumatic stress disorder clinics underwent three hours of training to integrate tobacco and post-traumatic stress disorder treatment.[30,31] Veterans who received integrated care received more tobacco-focused counseling, used tobacco medication more frequently, had greater odds of quitting, and had higher sustained abstinence rates at 12 and 18 months compared to those referred out for tobacco treatment.[30,31] Evidence-based components of tobacco treatment, like *Assessing* willingness to quit and *Assisting* with medication and brief counseling, do not require specialized training and fall within the scope of practice for prescribers and non-prescribers. Thus, the 5As can be feasibly integrated into existing appointments with pharmacists, primary care providers, and specialty mental health providers.

In sum, tobacco treatment resources are available in VA, but providers in our sample had difficulty accessing them, as did some Veterans with SMI. Coordination between tobacco treatment lead clinicians, frontline providers, and operational partners that aims to increase provider exposure to tobacco treatment resources without exacerbating information overload can help expand the reach of available tobacco treatment resources in VA to Veterans with SMI.

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