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Integrating Evidence-Based Tobacco Cessation Interventions in Free Medical Clinics: Opportunities and Challenges

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Abstract

Background—Free medical clinics serve a critical role in health care delivery of America's uninsured population, who are less likely to receive tobacco cessation counseling and 1½ times more likely than the general population to use tobacco. The authors evaluate the opportunities for and challenges to implementing the U.S. Public Health Service Guidelines for tobacco cessation in free clinics.

Methods—Six free clinics participated in this pilot study. Five objectives were targeted: implementation of a tobacco user identification system, education of all clinic staff and volunteers, dedication of a program champion, use of evidence-based treatment, and creation of a supportive environment that reinforces provider behavior. Key informant interviews and focus group data were used to describe the opportunities and barriers of implementing the Public Health Service Guidelines.

Results—All clinics adopted a user identification system, dedicated a program champion, adopted evidence-based counseling, and created an environment conducive for cessation. Common challenges included getting volunteers to attend on-site training programs, accessing nicotine replacement therapy, and promoting Quit Line usage, all of which are part of evidence-based treatment.

Conclusion—With more than 1,200 free clinics nationwide, it is very important to understand the opportunities and barriers of implementing tobacco cessation services and systems in free clinics.

Keywords

uninsured; tobacco; quitting; PHS guidelines; free clinics

BACKGROUND

Free clinics serve a critical role in health care delivery among America's uninsured population (Isaacs & Jellinek, 2007). They are nonprofit private entities distinct from other safety net providers. They do not accept reimbursement from any third-party payers, do not charge patients for health care services, do not receive government funds for their services, depend heavily on private and charitable donations, and rely extensively on volunteer health care professionals (Fleming & Mills, 2005; National Association of Free Clinics [website: <http://freeclinics.us>]). Free clinics are the medical home for many uninsured patients

(Buettgens & Hall, 2011; Felt-Lisk, McHugh, & Howell, 2002). In addition to addressing acute health care needs, they provide chronic disease management, including diagnostic, laboratory, and routine follow-up. Because of regular contact with these patients, free clinics are in a unique position to provide tobacco cessation advice and support to the uninsured.

Free clinics' reliance on volunteers and resource constraints presents unique challenges in terms of adoption of the U.S. Public Health Service (PHS) clinical practice guidelines for "Treating Tobacco Use and Dependence" (Fiore et al., 2008). Also known as the PHS Guidelines, recommendations include the following: (a) implement a tobacco user identification system in *every* clinic to recognize *every* tobacco user, (b) educate all clinic staff in tobacco control, (c) dedicate specific tobacco control personnel responsible for organizing each clinic's cessation efforts, and (d) use effective, evidence-based treatments for tobacco cessation, including counseling and pharmacologic treatments.

Few published studies have documented the effectiveness of tobacco cessation programs in safety net settings, and none have addressed the process of integrating the PHS Guidelines in free clinics (DePue et al., 2002; Haskell et al., 2006). One report of implementation of the PHS guidelines in 14 community health centers in Rhode Island showed that average provider performance rates for smoking cessation increased after instruction of staff and implementation of the PHS Guidelines (DePue et al., 2002). Rates were highest at yearly physical visits compared with sick visits or follow-up of chronic conditions. Haskell et al. (2006) studied a comprehensive cardiovascular risk reduction intervention delivered in free clinics in Santa Clara County, California. Only 12.2% of participants were current smokers, likely because of the large percentage of Hispanics served (57%)—a demographic group known to have lower rates of smoking. There was a 4% decrease in current smoking in the usual care group compared with an 8% drop in the intervention group. In addition, cessation counseling by physicians, including brief advice to quit, has been shown effective in general primary care settings (Fiore et al., 2008; Kreuter, Chheda, & Bull, 2000; Taira, Safran, Seto, Rogers, & Tarlov, 1997).

In the unique environment of free clinics, where volunteer health care providers may fluctuate day-to-day, it is important to consider the opportunities and challenges of integrating tobacco cessation services. This is especially important in light of the considerable opportunities to enhance such services in free clinics (Foley & Sutfin, 2008). Uninsured smokers are about one third to one half as likely to receive such services, which may contribute to their excess disease burden and poorer survival (Fiore et al., 2008; Kreuter et al., 2000; Parnes, Main, Holcomb, & Pace, 2002; Taira et al., 1997). Using data collected through interviews and focus groups with participating free clinic staff, we summarize the experience of developing and implementing a clinic- and provider-based intervention to increase free clinics' adoption of the PHS Guidelines.

METHOD

Sample

North Carolina free clinics were eligible for the study if they (a) provided medical and/or dental services, (b) were open at least 2 days/week, (c) were located within a 3-hour radius of the research team to facilitate data collection, (d) were not offering comprehensive tobacco services as defined as at least 8 (of 12) PHS recommended services (assessed by screening), and (e) were willing to participate. Thirteen clinics were eligible for inclusion, and 6 were randomly selected to participate. All clinics were contacted by e-mail and telephone to enlist their participation. One clinic refused, and a subsequent clinic was randomly drawn from the remaining pool of eligible clinics. We also selected two *best practice* clinics who self-described as providing comprehensive tobacco cessation strategies.

These clinics helped the research team identify relevant questions to ask key informants at the intervention clinics and to identify strategies that they had successfully employed to reduce tobacco use among their patients.

Baseline Data Collection

Key informant, semistructured interviews were conducted at baseline and between 3 and 6 months postintervention among key staff and volunteers in the free clinics ($n = 6$). The in-person baseline interview included the following: (a) documentation of patient smoking status for all patients, (b) inclusion of tobacco use as a vital sign, (c) use of computerized or chart reminders that encourage providers to advise and assist patients to quit, (d) provision of training in tobacco cessation interventions for free clinic providers, (e) provision of advice and assistance to all tobacco users and how this is assessed, (f) referral to community resources, (g) availability of smoking cessation literature, and (h) availability of no-cost prescription and over-the-counter medications to help patients quit. All interview protocols, surveys, and intervention materials were approved by the institutional review boards at the Wake Forest School of Medicine and Davidson College.

Program Development

Program planning and implementation relied extensively on organizational development and diffusion of innovation (DOI) theories, which have demonstrated success in integrating new innovations within health and service organizations (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Rogers, 1995, 2003). Organizational development is the use of behavioral and social sciences to improve organizational effectiveness (Goodman, Steckler, & Kegler, 1997). Implementation theories are one type of organizational development focused on the activities used to ensure the success of organizational change—in this case, the implementation of the PHS Guidelines. Porras and Robertson (1987) created a typology of organizational change theories, including an expanded review of implementation theory. This typology highlights the utility of implementation theory to diagnose, plan, intervene, and evaluate organizational change within an institution. Diagnosis and evaluation of organizational change focuses on the assets and barriers within an organization that affect the success of an intervention.

Aspects of DOI theory were also used to guide implementation study (Rogers, 1995). Consistent with this theory, integration of best practices in tobacco prevention and cessation depends first on awareness of the need to amend existing clinical practices (Goodman et al., 1997). Adoption of effective strategies were believed to be dependent on the following: commitment to tobacco prevention and cessation for uninsured clients, relative ease with which strategies can be implemented, adequate internal resources to implement the strategy changes, a program champion committed to integrating best practices, and the favorability of the environment (e.g., commitment of volunteers) to sustaining and institutionalize these change (Shediac-Rizkallah & Bone, 1998). These factors influenced the semistructured questionnaires and focus group guides.

Each clinic was asked to identify a program champion who would ensure implementation of provider- and clinic-based strategies—the champion represents an initial commitment to the tobacco cessation program and is critical to program adoption and sustainability. Based on the unique environments of the free clinics, we offered a tool kit of resources to maximize flexibility of program implementation. Flexibility is necessary in the free clinic environment because of the uniqueness of each organization (e.g., demographics of clients, geography), limited resources, and extensive volunteer networks. The tool kit also allowed program champions the latitude to identify strategies that would offer the greatest relative advantage

given other services, compatibility with the organization's values and existing resources, and experimentation (Greenhalgh et al., 2004, Greenhalgh et al., 2005; Rogers, 1995, 2003).

In-person, semistructured interviews were conducted with directors and key staff from two best practice clinics following PHS guidelines to identify barriers to integrating tobacco cessation practices, strategies used to overcome these barriers, perceived benefit of these services to the clinic and its patients, and general "tips" they would offer other free clinics interested in integrating tobacco cessation services. In addition, the PHS Guidelines and Essential Elements of an Effective Practice-Based Tobacco Cessation System were reviewed to determine the key strategies for a comprehensive tobacco cessation program within a clinical setting (Fiore et al., 2008; Solberg, 2000). Using these tools, along with lessons learned from the best practice clinics, we developed objectives, goals, and strategies for integrating tobacco cessation strategies into free clinics (see Table 1).

Program Implementation

Academic detailing was used to support free clinics in their implementation of the PHS guidelines by providing training to the program champion (Allen et al., 2007). The goal of academic detailing is to promote treatment decisions that are cost-effective and evidence based by providing clinics with a repertoire of effective tobacco prevention and cessation strategies that are evidence based. Academic detailing was coupled with the Centers for Disease Control and Prevention's (2006) *Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment* to ensure theoretical and practical application of the program.

All clinics received an on-site training program that covered the five objectives outlined in Table 1. Physicians received continuing medical education credit for attending. The clinics were also given access to an online training program in tobacco cessation, which mimicked the in-person training and also provided continuing medical education credit. During this training, the program champion received a tool kit that included chart prompts (e.g., stickers, stamps), posters, brochures, North Carolina Quit Line fax referral forms, and North Carolina Quit Line prescription pads. The North Carolina Quit Line provides free, confidential telephone counseling (and occasionally nicotine replacement therapy, if eligible) for persons who want to quit tobacco. The tool kit was compiled using publically available, free or low-cost materials so that clinics could obtain them after the research study ended. Clinics were contacted shortly after the visit to identify any additional needs of the clinics. Clinics also received brochure holders to display their materials and vital signs stamps that the research team created with input from the clinics. Last, a booster email was sent to all clinics 5 months after the onsite training program that included preliminary data of tobacco cessation outcomes pre- and postintervention.

In three clinics, the intervention was delayed to test whether the onsite training affected program implementation. In the early intervention clinics ($n = 3$) the training was delivered by a physician who runs a hospital-based tobacco cessation clinic. In the delayed intervention clinics ($n = 3$), the training was delivered by a training expert employed by the statewide professional advocacy organization for free clinics. This training used a video of the physician and included an opportunity for questions and answers at the end. There were no statistically significant differences between these two groups of clinics and thus they were combined for all analyses.

Postintervention Data Collection

Telephone interview—A telephone interview with the program champion ($n = 6$) was conducted between 3 and 6 months after the onsite training program to assess the following:

(a) use of the tool kit of materials, (b) use of a vital sign stamp with tobacco, (c) applicability of the onsite training and how information about the training was disseminated to providers, (d) flexibility of the intervention, (e) adoption of new strategies to promote cessation not suggested by the research team, (f) whether clinics contacted other clinics for assistance with implementing the strategies, (g) the most difficult strategies to adopt at the clinic, (h) changes the clinic would like to adopt but has been unable to do so, and (i) priority given to tobacco cessation at the free clinic.

Focus group—Near the conclusion of data collection, key staff participated in a focus group at the annual North Carolina Association of Free Clinics conference to share their experiences with the research project. Five of six clinics participated. All program champions attended, and two clinics had other key staff attend (a medical director, an executive director, and paid nursing staff). The focus group centered on strategies that worked well and did not work well with program implementation, sustainability of the strategies, unique strategies tailored to the different clinics, and improvements needed for statewide dissemination of the strategies.

Analysis

Summary descriptions of the interviews and focus group were completed by the principal investigator, four coinvestigators, and one student project manager providing input and guidance regarding the key themes that emerged during the interviews and focus group. We describe: (a) characteristics of free clinics participating in this pilot study, (b) adoption of provider- and clinic-based strategies to promote tobacco cessation at baseline and postintervention, (c) clinic autonomy and innovation, and (d) barriers to implementation of PHS guidelines and recommendations for intervention modification by program champions organized by our program objectives (Table 1). In the discussion, we summarize recommendations for broad dissemination of the U.S. PHS guidelines in free clinics.

RESULTS

Characteristics of the Clinics

The six free clinics served between 400 and 4,000 unduplicated clients each year, had been in operation between 1 and 22 years, employed 2 to 11 full-time staff, and had annual operating budgets between \$110,000 and \$1.4 million. One clinic used electronic medical records (EMRs) at the time of the baseline visit; two others had a computerized tracking system, but they retained paper charts for patient visits. There were four urban clinics, two of which served homeless clients served by partner, independent agencies. They all served exclusively uninsured clients and relied extensively on volunteers.

Objective 1: Implementation of tobacco user identification system—At baseline, all clinics documented smoking status on intake in the paper or EMRs. Smoking status was not recorded as a vital sign, and neither stamps nor stickers were used to cue providers for counseling. Smokeless tobacco use was not routinely assessed. After the intervention, four clinics used vital sign stamps that included tobacco use. Three clinics used stickers for a chart prompt. In two cases, EMRs has completely replaced paper charts in one clinic, which alerts the provider to ask about tobacco use at every visit. In another clinic, the transition from paper to electronic records is ongoing and both are being used.

Objective 2: Education of all clinic staff in tobacco control—There was no systematic training among staff or volunteers regarding PHS strategies for tobacco cessation prior to the intervention. After the on-site training program, program champions were favorable regarding the content, but they were concerned about the lack of attendance by

their extended network of volunteers. An average of 6 (range 1–10) clinic staff and volunteers attended the onsite training; few availed themselves of the web-based training. In most cases, the program champions indicated that they wished they had done more to promote the in-person and online training. As one clinic noted, it was important to have the paid staff present because they are the ones who consistently see patients in the clinic. In two clinics, all paid staff attended the training.

Several clinics suggested that we transition to a “train-the-trainer model” of provider education. They indicated that rather than have providers attend a single meeting the tobacco champions could attend regional meetings and then create a system for disseminating the training to their staff and volunteer providers. Regional meetings would also provide a venue for networking with other clinics about tobacco cessation strategies. Although one clinic suggested a webinar option for their providers, most generally liked the idea of the “train-the-trainer” model and suggested that the webinar serve as a complement rather than a substitute for in-person training.

Objective 3: Dedication of a specific tobacco control personnel (i.e., program champion)—At baseline, there was no one person dedicated to ensuring the PHS guidelines and strategies were implemented. All clinics, however, appointed someone to serve in this capacity as part of the research ($n = 6$). It is noteworthy that the program champion was a paid staff member in five of the clinics ($n = 4$ executive directors; $n = 1$ breast and cervical cancer prevention coordinator), whereas one clinic had a volunteer serve in this role. There was value in each these approaches (paid vs. unpaid). The paid program champions were in a position to integrate the PHS guidelines into the organization “mandate” without receiving ‘buy in’ from upper-level administration. However, they had competing demands (administrative responsibilities and clinical responsibilities) that meant their investment in implementation of PHS Guidelines was diverted to other responsibilities. The value of having a single designated volunteer devoted to the project was evident. She fully devoted her attention to addressing tobacco cessation without competing demands of other clinical or administrative duties. She met with patients one-on-one, followed up by phone, and created a tracking system on the extent and types of counseling, materials, and referrals provided. Overall, the volunteer was more “innovative” in her approach in terms of addressing tobacco cessation. It is unclear, however, what would happen if this volunteer left the clinic, as no system was established to ensure sustainability of tobacco cessation services.

Objective 4: Use effective, evidence-based treatment for tobacco cessation—At baseline, no clinics provided routine assessment of tobacco use *at every visit*. Most key informants indicated that they believe providers ask about tobacco use and offer cessation counseling, but there was no formal way to assess whether and how cessation advice and assistance was offered. There was no system to provide follow-up for patients interested in quitting, except in one clinic where these patients were invited back for a follow-up visit. There were no referral mechanisms in place for the Quit Line or other community resources. The program champions did not know the extent of pharmacotherapy prescribing and use.

After the intervention, the program champions reported that providers had begun implementing all components of tobacco cessation treatment but with varying degrees of success. All champions reported an increase in providers asking about tobacco use. Two champions noticed an increase in chart noting for cessation counseling. Two of the program champions have established tracking systems and a follow-up protocol for patients who were interested in quitting. One clinic created a line item in their budget to purchase nicotine replacement therapy (NRT). However, there was no systematic strategy among clinics to evaluate prescribing patterns of NRT or other prescription medication for nicotine addiction.

In addition, program champions were dissatisfied with the Quit Line because they indicated there was no mechanism to determine what happened after they faxed the referral form—they wanted follow-up to determine if the Quit Line resource had been acted on and was successful.

Objective 5: Create an environment that reinforces clinic practices—At baseline, two clinics had brochures about tobacco cessation—these were handed out by providers to patients. Two facilities had antitobacco posters located in clinical examination ($n = 1$) or dental rooms ($n = 1$) of 26 rooms observed in the six free clinics. There were no signs or brochures in waiting areas, in the front office, or break rooms. One clinic had a designated smoking area outside the front entrance. The remainder had no additional signage outside the clinics.

After the intervention, the clinics had created tobacco-free and cessation-supportive environments. Clinics opted for different strategies regarding brochures. In one clinic, the program champion assembled relevant brochures for tobacco-using patients prior to the patient's visit and placed the packet in the patient's chart for the nurse during the clinical encounter. Other clinics placed brochures openly in the examination rooms and waiting rooms for patients to select and providers to give to patients. Several clinics placed the brochures in a vital sign and/or triage area. In one instance, the clinic had run out of brochures and ordered more. Posters were evident throughout the clinics in waiting rooms and clinical exam rooms. Participants in the focus groups reported that the clinics liked the tool kit of resources, including posters, brochures, and chart prompts as they acted as cues for providers and patients to discuss tobacco cessation.

DISCUSSION

Initial interviews with clinic staff revealed very little knowledge about the PHS guidelines but a clear and consistent message that smoking cessation is important to the free clinic patients. Consistent with DOI theory, the early commitment to the program, flexibility with program adoption, and the use of low-cost/low-tech strategies led to successful dissemination of the PHS Guidelines in free clinics. After the intervention, there were several notable positive changes in all clinics, including a dedicated and consistent program champion, use of media resources that encouraged cessation, and clinic-level cues to prompt the provider to counsel about tobacco use.

Provider attendance at the on-site training program varied by clinic, and some clinics were more creative and innovative in their implementation of the PHS guidelines. Last, all clinics acknowledged that their clinic had undergone significant changes that were sustainable approximately 6 months after the initial intervention activities.

Several clinics also created new systems at their free clinics to encourage tobacco cessation, demonstrating program flexibility and clinic innovation. One program champion adopted the language “What are you doing to quit” and “How can you afford NOT to quit” with their tobacco users and reported getting an excellent response. One clinic created a new “follow-up” form for each client who had expressed a willingness to quit. The form includes several questions related to personal tobacco use and tobacco use in the home, a designated quit date, a follow-up phone call date for the provider, and details about the materials that were provided to the patient. One clinic provided YMCA applications at the same time as counseling to address concerns about weight gain after quitting. YMCA will often provide free or low-cost memberships to individuals who meet income eligibility requirements. Another clinic suggested an online website (Sparkpeople.com) that is devoted to the prevention of weight gain, which also offers general advice on quitting tobacco. Although

clinics were given autonomy to adapt the intervention components in ways that integrated easily into their clinic's culture, we found that they remained 'true' to the intervention recommendations limited modifications.

There were three common barriers to program fidelity across the clinics: (a) access to pharmacotherapy, (b) training new providers, and (c) successfully using the Quit Line.

Pharmacotherapy presents a unique problem in free clinics. Clinics may have onsite pharmacies, use the \$4 copay programs at Walmart or Target, or may use the prescription assistance program to receive low-cost/no-cost medications. Most likely, clinics use some combination of these services. Over-the-counter medications (e.g., NRT) must be built into annual budgets, and only those items deemed critical are purchased. Given limited resources, NRT is often not considered critical. Only one clinic purchased NRT for its patients, and the remaining requested that the research team find a way to provide NRT for future dissemination. However, provision of NRT by the study team would create a major challenge for sustainability after the study ended, which is a major challenge when translating research to practice.

Another barrier is the need for an ongoing PHS training program given clinic's reliance on volunteer providers. At the time of the focus group, the clinics had not institutionalized a standard approach for addressing tobacco cessation counseling and pharmacotherapy for new volunteers and staff. By providing the clinics with web-based training for cessation counseling and pharmacotherapy and by offering continuing education credits for those providers who complete the training, the research team had created a low-cost training option for the free clinics. Unfortunately, clinics had not tapped into this valuable resource, perhaps because it was not needed at the time or because web-based tutorials are not a good fit with their volunteer pool. Another option is to routinely include tobacco cessation in volunteer orientation, with "booster" sessions for existing volunteers. Embedding cessation training into orientation is cost-effective and fits within the existing infrastructure of all clinics—key elements of sustainability.

A final crosscutting barrier is the clinic's perception of the Quit Line. Our provider training included information on the Quit Line as a valuable referral source for patients. Furthermore, we provided each clinic with Quit Line fax referral pads that could be sent in for the patient. Program champions expressed uncertainty and unfamiliarity regarding both the process and goal(s) of this service. This proved to be an important gap in our intervention training, suggesting that Quit Line representatives should be included in future dissemination of the intervention.

In response to our question "Will you continue what you've started in your clinics?" there was overwhelming agreement of sustaining the tobacco cessation strategies. As one clinic director commented, "Yes, it's part of our culture now!" The major challenge to sustainability will be ensuring that a program champion remains dedicated to the strategies that have begun, that a system is in place to train new volunteers and staff, and that the clinic sees value in the work that they are doing. Furthermore, for the program to have long-term success, more resources need to be devoted to pharmacotherapy options for uninsured patients.

CONCLUSIONS

Comprehensive clinic-based interventions significantly improve quit rates among tobacco-using patients (Fiore et al., 2008). We address the gap between research discovery and program delivery by evaluating the opportunities and challenges of integrating the PHS Guidelines in the free clinic setting using theory and practice to guide our intervention and

evaluation. Although small and nonrepresentative, there are universal characteristics of free clinics that suggest the findings have broad applicability. With more than 1,200 free clinics nationwide the potential relevance of this study is practical and significant.

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TABLE 1

Intervention Objectives, Goals, and Strategies (Adopted From the U.S. Public Health Service Guidelines and Strategies Used by Best Practice Clinics): A Tool Kit for a Successful Tobacco Cessation Program

Objective 1. Implementation of a tobacco user identification system in every clinic to recognize every smoker

Goals

- 1 Charts are labeled to identify current use, recent (past year) use, former use, and nonuse
- 2 Prominent flags call attention to this information, for example, using a colored identification sticker or stamp (current, former, never)
- 3 Nursing staff or aides will ask all patients with unknown status about their tobacco use when patients are placed in the examining room
- 4 Electronic medical records can prompt providers to obtain status and provide brief advice

Strategies

Advise clinics to collect information on tobacco use on patient intake forms (both smoking and smokeless)

Advise clinics to add chart prompts to all patient records (including electronic and paper, if applicable) when the patient self-identifies as a tobacco user. Research team provided chart prompts as a resource for clinics to use

For clinics where electronic medical records are maintained, include a field code for smoking status

Objective 2. Education of all clinic staff in tobacco control

Goals

- 1 All clinic staff and key volunteers will have an understanding of best practices in clinic-based tobacco cessation
- 2 Clinics will establish an on-site training program for additional staff and faculty to promote sustainability and organizational capacity building regarding tobacco cessation programs

Strategies

The research team provided an overview of best practices in tobacco control and the significance of program delivery among the uninsured. All clinic staff and key volunteers will be invited to participate

Encourage internal program champion to offer additional onsite training for other volunteers and staff to encourage sustainability and organizational capacity building

Objective 3. Dedication of specific tobacco control personnel responsible for organizing each clinic's efforts

Goals

- 1 Each clinic will dedicate at least 1 person committed to organizing the clinic's efforts related to tobacco control. This person will be deemed the "program champion"

Strategies

Advise clinic to identify a program champion. Help clinics brainstorm regarding the most viable option for the champion in light of other organizational commitments and personal interest

Objective 4. Use effective, evidence-based treatment for tobacco cessation (e.g., brief or long counseling sessions)

Goals

- 1 Clinical staff will understand and use the 5As (ask, advise, assess, assist, and arrange follow-up) in tobacco cessation counseling
- 2 Clinic staff will know about counseling resources on-site, community programs, and Quit Line services
- 3 Clinics will offer pharmacotherapy to patients addicted to tobacco

Strategies

Clinic staff were trained on the 5As and will discuss effective ways to encourage volunteer health care providers to implement these in clinical practice

The research staff provided a tutorial on the pharmacotherapy options and current best practices for pharmacotherapy for addicted tobacco users, as well as strategies for obtaining low or no-cost pharmacotherapy

Objective 5. Create an environment that reinforces clinic practices

Goals

- 1 On-site media alerts in waiting room and patient rooms
- 2 Indoor and outdoor tobacco bans

Strategies

Research staff provided clinics with free or low-cost brochures, pamphlets, and posters regarding tobacco prevention and cessation. Posters were geared toward low-literacy populations and were matched to the demographics of the clinic (e.g., Spanish-language posters for clinics with Hispanic patients)

Research staff provided a “contact sheet” to replace brochures, pamphlets, and other promotional items when they were gone

Research staff encouraged clinics to enforce a no-tobacco policy inside and surrounding their clinics