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American Academy of Pediatrics
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INTRODUCTION

The Healthy People initiative presents a comprehensive, nationwide health promotion and disease prevention agenda for improving the health of all Americans. Over the last three decades, this initiative has highlighted emerging issues as identified by the US Department of Health and Human Services. Moreover, it aligns chapter programmatic work to AAP priorities identified in the Agenda for Children to assure that the national organization and its affiliated chapters have the greatest impact on improving child health.

In 2002, the AAP Board of Directors approved the Healthy People Grant Program for Chapters and assigned the oversight role for this grant program to the District Vice Chairpersons (DVCs) Committee. The overall goal of the program is to help chapters establish networks in their communities to support the development and implementation of programs that address pediatric objectives within the US Department of Health and Human Services’ Healthy People initiative.

In May 2010, the DVCs reviewed the Healthy People pediatric objectives and determined that children’s tobacco prevention and control was the topic area on which the Healthy People Grant Program should focus. Specifically, the DVCs noted that Focus Area 27: Tobacco Use and the following Healthy People objectives for consideration:

27-2: Reduce tobacco use by adolescents.
   Reduction in tobacco use by students in grades 9 through 12.
   27-2a: Tobacco products (past month)
   27-2b: Cigarettes (past month)
   27-2c: Spit tobacco (past month)
   27-2d: Cigars (past month)

27-3: Reduce the initiation of tobacco use among children and adolescents (dev).

27-4: Increase the average age of first use of tobacco products by adolescents and young adults.
   27-4a: Adolescents aged 12 to 17 years.

27-7: Increase tobacco use cessation attempts by adolescent smokers.

27-9: Reduce the proportion of children who are regularly exposed to tobacco smoke at home.

Through the support of the AAP Friends of Children Fund, the AAP offered a grant opportunity to chapters to help them develop and implement programs that focused on children’s tobacco prevention and control. Four chapters were awarded grants of $20,000 each to fund their programs. The period of performance began on July 1, 2010 and concluded on July 30, 2012. As stipulated in the terms of the agreement, chapters were required to submit final reports at the conclusion of the grant period. Highlights from those reports are included in this publication.
The program summaries described in this compendium provide four different approaches to promoting a healthy lifestyle by reducing children and adolescents’ tobacco usage and their exposure to secondhand smoke. The summaries include information on the program description; collaboration; evaluation and measurement; outcomes; barriers and lessons learned; and future plans. Contact information is provided for each project director to gain more information about a particular program.

Each of these pilots demonstrates promising practices that warrant further study to determine their long-range effectiveness. In the short term, all four chapters forged new partnerships, activated communities to address this important issue, and have plans to continue this work.
PROGRAM SELECTION CRITERIA

A Request for Proposals was mailed to all chapter presidents, vice presidents and executive directors. Each program was required to adhere to the following criteria:

- Specifically address an objective within the Healthy People 2010 leading indicator relating to tobacco prevention and control
- Create a new program, or include an innovative component that builds on existing community resources
- Include a letter of support from the chapter (only one application per chapter)
- Include a description on how the program is integrated into the chapter’s activities and strategic plan
- Include an evaluation component to promote project sustainability
- Include a concrete timeline for goals to be accomplished

Priority was given to proposals that:

- Demonstrated innovative and creative approaches
- Addressed hard-to-reach/high risk populations
- Demonstrated continuation of the program beyond initial funding
- Illustrated collaboration with other organizations to promote a healthy lifestyle by reducing children and adolescents’ tobacco usage or their exposure to secondhand smoke

Using the above criteria as a guideline, a score sheet was created to assist the DVCs in assessing and ranking the applications. Committee members used the criteria to score the proposals. In an effort to encompass a variety of programs, a concerted effort was made to select chapters with dissimilar activities and target populations. The process for narrowing the number of chapters who were finalists as well as those who ranked in the top 50 percent was also discussed. Ultimately, the Alaska, Massachusetts, Pennsylvania and Tennessee Chapters were selected as recipients of the Healthy People 2010 tobacco prevention and control chapter grants.
TOBACCO PREVENTION AND CONTROL PROGRAM SUMMARIES

ALASKA CHAPTER
“I Quit for My Baby’s Breath!”

Primary Contact/ Project Director: Lily J. Lou, MD, FAAP
Chapter Vice President
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PROGRAM DESCRIPTION

The purpose of the project “I Quit for My Baby’s Breath!” was to decrease smoking in parents of a highly vulnerable population – Neonatal Intensive Care Unit (NICU) babies. NICU babies have a high incidence of smoke exposure and parents of these babies have been shown to be particularly successful at changes in lifestyle around the birth of a child. There is an extended window of opportunity as lengths of stay are proportionately long for those at highest risk.

The following Healthy People 2010 objectives were addressed by this project:

- Reduce tobacco use by adolescents
- Reduce tobacco use by students in grades 9 through 12
- Reduce the initiation of tobacco use among children and adolescents
- Increase the average age of first use of tobacco products by adolescents and young adults
- Increase tobacco use cessation attempts by adolescent smokers
- Reduce the proportion of children who are regularly exposed to tobacco smoke at home

This project had more impact than expected on Focus Area 27-6 (Increase smoking cessation during pregnancy) because the materials (ie, posters and buttons) were eagerly received by the obstetric and pediatric community. The project has impacted Focus Area 27-18 (Eliminate state laws that preempt stronger local tobacco control laws) by increasing referrals to the Alaska Quit Line. The chapter plans to target objectives in all 3 categories of the Healthy People 2010 objectives. Although qualitative measurements were challenging, the impact and number of people served are specified in the evaluation and measurement section of this report.

The project consisted of 4 main strategies:

1) Develop a compelling image that is positive, and baby- and parent-relevant, to assist the center in gaining an awareness of the issue and the importance of quitting. NICU graduate babies and parents were used as volunteer models to produce educational posters and buttons for public awareness and display in the NICU.

2) Provide education to chapter staff in a one-hour lecture format. An expert on tobacco exposure in children (Alaska AAP Chapter Champion/Pediatric Allergy and Immunology Specialist) provided this education, which consisted of live presentations
that were videotaped and archived electronically on the chapter’s HealthStream Web site as a continuing education resource. Staff was given 6 months to complete the training.

3) Capitalize on existing state-supported Alaska Quit Line resources rather than training all staff in formal smoking cessation treatment and adding to the existing workload of the nurses. Cardholders highlighting the Alaska Quit Line’s toll-free number were produced to facilitate easy referral of interested and receptive families. This service provided 8 weeks of counseling and pharmacological support, Nicotine Replacement Therapy (NRT), for quitting.

4) Teach Motivational Interviewing (MI) to the NICU staff to help support families in the important effort of quitting smoking. As a validated strategy to support people in making positive lifestyle change, MI originated in drug and alcohol abuse, and has relevance to almost everything that is done in working with patients’ families. A nationally recognized trainer in MI developed a NICU-tailored 4-hour workshop in MI to support people in making positive lifestyle changes. This was presented live, and a 3-hour video was produced for continued access to the lecture on HealthStream. Staff was allowed 6 months to complete this required training.

COLLABORATION

Listed below are the names and designations of those directly involved in the project:

- Lily Lou, MD, FAAP: Neonatologist; Medical Director of the NICU; Project Coordinator; Alaska Chapter Vice President
- Melinda Rathkopf, MD, FAAP: Pediatric Allergist/Immunologist; Content expert for tobacco; Chapter champion for tobacco cessation
- Chris Wakem: NICU nurse; Creator of and instructor for the parent discharge class
- Leslie Simmons: NICU nurse; International Board Certified Lactation Consultant (IBCLC); Instigator of the NICU lactation support and donor milk programs; Coordinator for post-discharge follow-up calls
- Kathleen Lochmann: Providence Alaska Marketing and Communication
- Sarah Dewane: Clinical Psychologist with Providence Family Medicine Program; MI trainer
- Ginny Shaffer: NICU Parent Navigator (paid position in Family Support Program)
- Stacey Thurman: Designer
- Kraig Haver: Photographer
- Alan Blanco: Videographer

The chapter also had support from the NICU manager/administrative assistant and the Alaska State Tobacco Control Manager, Laura Muller. Through weekly pediatric grand rounds and the All Alaska Pediatric Partnership Forum, updates on the project were shared. Additionally, the state Women’s, Children’s and Family Health office distributed project materials. The project was also presented at the national AAP Annual Leadership Forum and in a Quality Improvement (QI) forum at the AAP District VIII Perinatal Section’s Annual Conference. Project posters can be seen in many individual physicians’ offices, Woman, Infants and Children (WIC) offices, and the nursing boutique at the Providence Alaska Medical Center.
EVALUATION AND MEASUREMENT

Measurement was very challenging for this project, as the chapter was focused on more than immediate results. There were 100 nurses and 45 respiratory therapists, neonatal nurse practitioners, occupational therapists, physical therapists and health unit clerks served within the NICU. These individuals received training in tobacco exposure and MI. It is anticipated that 580 hours of continuing education units (CEUs) will be awarded and 550 families each year will be educated and offered support to quit smoking.

Many pediatricians have requested materials for their practice sites, including the following: Mother-Baby Unit, Labor and Delivery and Prenatal units; other hospitals throughout Alaska; community pediatric and obstetrical offices; WIC offices; the All Alaska Pediatric Partnership; and the Alaska State Office of Women, Children and Family Health.

OUTCOMES

Project materials are available for adaptation. A complete packet has been produced, including the following: 1) summary of the program; 2) CD copy of all graphics for posters, banners and buttons; and 3) DVD copies of both the 1-hour *Tobacco Exposure in Children* lecture and the 3-hour MI workshop.

The chapter had a very positive reception to the live educational offering and they are continuing the process of providing archived educational opportunities to their staff. It is hoped that there is an improvement in the support provided to families to quit smoking over the next few years, as training has been completed for chapter staff. The chapter’s goal is for every family to receive screening and assessment for tobacco use while they are in the NICU, as well as support appropriate for their stage of quitting. It is believed that the benefits of training in MI transcend the tobacco cessation issue and will develop staff significantly in all they do to support families. It is also hoped that this education will positively influence some of the chapter’s own staff to quit smoking.

Parents have expressed interest in and appreciation for the information provided. Several families have called after discharge to request contact information for the Alaska Quit Line.

BARRIERS AND LESSONS LEARNED

There are a number of barriers and lessons learned from this project. Following is a list of lessons learned:

1) Objective evaluation is extremely challenging in this type of project. Rather than quantitative measures of smoking cessation success, only concrete measure numbers of staff and families served can be reported. Instead, the chapter gained qualitative information about what was helpful and the timing of support offered.

2) Although smoking in this target population remains a real problem, the majority of families do not smoke. Feedback from families suggests that the campaign be called “Quit for your Baby’s Breath!” instead of “I Quit for My Baby’s Breath!”

3) Many parents do not smoke themselves, but have family members or friends who smoke in their home. In the future, those sources of exposure might be targeted more explicitly.
4) The appeal of this campaign transcended the target NICU population. The materials and educational offerings were aimed at NICU staff and parents. In the future they may be edited slightly to assure relevance to a wider audience.

FUTURE PLANS

The chapter plans to complete the initial phase of training of the entire NICU staff of 145. This training—on both Tobacco Exposure in Children and on MI—will become part of the standardized orientation for all new staff. The chapter is also considering adapting this program to qualify as an MOC-Part 4 project, using intervention and qualitative data collection.
National surveys demonstrate that pediatricians lack confidence in tobacco counseling. While smoking parents are receptive to cessation interventions from their child’s doctor, they are rarely received. As parents often see their child’s pediatrician more than their own providers, this yields unique potential for tobacco control.

A pilot program at the Boston Medical Center (BMC) pediatric clinic involving an electronic medical record (EMR)-based system to facilitate screening, counseling and referral for environmental tobacco smoke (ETS) has had success in increasing physician confidence around ETS and utilization of community cessation resources. The intervention provides easy access to screening prompts, decision support for motivational interviewing (MI), ETS educational literature, and simplified referral to a free, state telephone smoking cessation program called Quitworks.

The chapter sought funding to launch the EMR system for ETS management in the Boston area community health centers using the Logician EMR and providing pediatricians with education around ETS and the new system. The program was assessed by comparing pre- and post- rates of screening and referral, follow-up outcomes and quit rates among parents referred to Quitworks. It was anticipated that access to counseling support and simplified referrals to an evidence-based community resource like Quitworks would enhance ETS management.

The program aimed to reduce household tobacco smoke exposure (Focus Area 27-9) and in the long term, initiation of tobacco use among children and adolescents (Focus Area 27-3) given that children who live with smokers are three times more likely to become smokers themselves.

To date, programming has been completed and an EMR-based system has been launched to facilitate ETS screening, counseling and referral by pediatric clinicians. The program has also been implemented at BMC and affiliated community health centers. Additionally, a corresponding training program and printed and online materials have been developed with support from members of the Center for Tobacco Treatment Research and Training at the University of Massachusetts Medical School. Pediatricians at BMC and BMC-affiliated community health centers (South Boston, South End, Mattapan, Greater Roslindale, Codman Square, Dorchester House and Whittier Street) have also been trained and coached to use the EMR-based tobacco management tool.
Finally, the evaluation of the impact of this QI initiative has begun and generalizable information has been obtained on the value and effectiveness of this EMR-based system to facilitate ETS screening, counseling, and referral by pediatricians at BMC and BMC-affiliated community health centers during routine health care maintenance visits. This was accomplished by evaluating changes in ETS screening and counseling rates before and after implementation via collection of anonymous, aggregate data from the Massachusetts Health Disparities Data Repository (MHDDR). It should be noted that this repository does not contain unique identifiers; all data is de-identified.

**COLLABORATION**

Project leaders collaborated with multiple groups including the Massachusetts Chapter of the AAP; BMC; community health centers; Boston Public Health Commission (BPHC); Department of Public Health’s Quitworks program; and the Center for Tobacco Treatment Research and Training at the University of Massachusetts Medical School. Following are details about additional collaborative efforts:

- The BPHC team, particularly Margaret Reid, RN, BS and Snehal Shah, MD, MPH, were critical to addressing key challenges and moving the work forward with support and guidance throughout the project’s planning, implementation and evaluation.

- Jonathan Winickoff, MD, MPH, FAAP, provided guidance around how to provide training to the community-based health center staff and approach challenges and analyses. Dr. Winickoff was a consistent resource throughout the project and very helpful to addressing challenges and improving the quality of the project.

- The University of Massachusetts Medical School team helped to develop the appropriate language for the provider training. They were also very helpful for revising the text.

- The Quitworks program helped to streamline the referral process and provide information on referral rates.

- Bill Adams, MD, FAAP and the Information Technology (IT) team at the BMC were critical in creating the modified logician smoke screening and referral toolkit and implementing it across sites.

- Collaboration from the community health centers, their IT staff, and clinic providers were instrumental in facilitating the trainings and translating information into their systems.

- Piloting the project at BMC led to restructuring of the training. Participation of the BMC training providers in the evaluation was helpful.

**EVALUATION AND MEASUREMENT**

The project evaluation involved a comparison of pre- and post-intervention rates of screening and referral as documented via collection of anonymous, aggregate data from the MHDDR. Again, it should be noted that this repository does not contain unique identifiers; all data is de-identified. Further exploration on subjective data from provider surveys as part of the needs assessment and follow-up was also completed before and after the pilot program at BMC. This
allowed for the assessment of subjective markers of confidence in and barriers to ETS management both before and after the intervention.

OUTCOMES

Preliminary Results

- Successfully developed and implemented an EMR-based tool for ETS screening, counseling and referral at BMC and community health centers.

- Completed an evaluation of the impact of the initiative at BMC. Initial results were presented as a poster at the 2011 Pediatric Academic Societies (PAS) meeting. A manuscript was also submitted for consideration to the *Pediatrics* journal.

- At BMC it was found that implementation of an EMR-based ETS management tool led to a significant increase in counseling and referral, and rates of QuitWorks referral as measured by the state quitline agency. It is anticipated that the high rates of pediatrician satisfaction with the new ETS management tool and increased subjective skill in screening and counseling associated with this intervention, may lead to greater referral to state quitlines in the future.

- Began a preliminary evaluation of the impact of the intervention at BMC-affiliated community-based health centers. Figure 1 below demonstrates overall numbers of referrals at each site. Further evaluation of pre- and post- comparisons of ETS counseling and referral rates is in process.

**Figure 1: Overall Referrals at each Site**
BARRIERS AND LESSONS LEARNED

The greatest challenge of this project was in coordinating training sessions at the community health centers. As this was expected to some extent given the demanding schedules of the pediatricians at these sites, alternative options were explored to limit the time commitment required. Additionally, a series of webinars were launched hoping to accommodate differing schedules; however, these sessions yielded extremely low attendance. There were also attempts to identify a champion at each site (ie, an “ambassador”) to facilitate the training and serve as a reference for colleagues. Identifying these ambassadors proved to be a challenge at each community health center. Ultimately, the approach was modified, and it was decided that staff would attend a provider educational meeting at each center; create standardized handouts and booklets; deliver follow-up e-mails; and offer to return for booster sessions. Although the presence of a champion was encouraged at each site, there was no reliance on that person to conduct trainings or coaching at their respective sites.

A second challenge involved implementation of the Tobacco Management Tool at each community health center. There was no budget for funding the IT departments for their efforts. As such, the IT departments provided “in-kind” services, which was ultimately critical to the success of the project. As each community health center had a varying degree of IT support and relevant expertise, there was some time delay. There were also several meetings with the BMC IT department, who was extremely helpful and provided detailed assistance to every challenging site.

FUTURE PLANS

One of the unique advantages of this program was the inherent sustainability of the EMR. It does not appear that there is a significant need for future funding to sustain this intervention. The EMR tobacco management resources will remain available to providers and can continue to be augmented and enhanced through subjective and objective feedback offered by the analyses and continued use over time.

The findings of this study may offer generalizable data on how EMR systems can be utilized in low cost and simple ways in order to facilitate ETS management and coordination between the clinical setting and community resources, such as Quitworks.
PROGRAM DESCRIPTION

Parental smoking is a preventable risk to fetal and child health. Unfortunately, women who quit smoking during pregnancy typically rebound within 6 months. An opportune time to target parental smokers to stay quit, or to encourage cessation, occurs during the transitional time precipitated by the birth of a new child. Tobacco use is highest among the younger, lower-income, and less educated, many of whom are without access to health care. Parent-smokers often belong to this group. The main objective of this pilot project was to reduce the number of rural Pennsylvanian children exposed to second-hand smoke beginning in the prenatal period and extending throughout childhood.

The Healthy People 2020 Objectives addressed in this pilot project were as follows:

- Reduce tobacco use by adults
- Increase smoking cessation attempts of adult smokers (using evidence-based strategies)
- Increase recent smoking cessation success by adult smokers
- Increase smoking cessation during pregnancy
- Increase tobacco screening in health care settings (office-based and hospital ambulatory care settings) *
- Increase tobacco cessation counseling in health care settings (office-based and hospital ambulatory care settings)*
- Reduce the proportion of non-smokers exposed to second-hand smoke (children aged 3-11; adolescents aged 12-17)
- Increase the proportion of smoke-free homes

*This reflects the screening of adults at their own visits, not their child’s appointment, as was the setting in the pediatric clinics during the study.

Project Goals

Goal 1: GHS physicians and nurses will skillfully and confidently provide cessation counseling to pregnant women and parents of young children

a) Develop and conduct training to implement brief intensive counseling strategies across prenatal, obstetric and pediatric clinics
b) Identify and train a cohort of smoking cessation experts and resources within each of the clinical areas (one day train-the-trainer workshop)

Goal 2: GHS physicians and nurses will have accessible resources within each specialty area

a) Design, provide and refine resources for clinical settings, such as methods for immediate referral and access to resources

b) Foster GHS trainers’ skills and confidence through ongoing periodic contact with training resources

Goal 3: Motivated parents will receive assistance to initiate cessation attempt

a) Clinicians will activate the referral system and provide cessation materials to women/parents

Goal 4: Outcomes will be examined within and across the clinical areas

a) Examine provider feedback regarding cessation counseling skills/confidence

b) Track use of referral system and resources across the intervention sites and service areas

c) Examine the changes in the number of young children who live in a tobacco-free home, as documented in the EHR

This pilot focused on 3 different phases described as follows:

**Phase I: Education of Providers**

Research presented at the 74th Annual International Scientific Assembly of the American College of Chest Physicians, CHEST 2008, showed that 87% of physicians and other medical professionals receive less than 5 hours of training on tobacco dependence. According to a recent Cochrane library review, health care professionals do a better job of helping people quit smoking when they are trained in smoking cessation techniques.

The first phase of this pilot focused on cessation training for health care professionals. Education was provided to physicians, nurses and other providers across prenatal, childbirth and pediatric settings. Another priority goal was to synchronize the messages and interventions regarding cessation to provide consistent and recurring cessation care across service lines. Educational sessions were conducted over a 3-month period using two complementary approaches.

**Train-the-Trainer Workshop**

The initial all-day educational session was held on January 7, 2011. It was designed to train a cohort of physicians and nurses about smoking cessation resources within clinical settings. Attendees included 5 pediatricians and 18 nurses who represented each of the 8 targeted clinical areas (3 prenatal clinics, 1 childbirth unit and 4 pediatric clinics). Trainers received evidence-
based training of all components of cessation intervention during this training. Objectives of the training were as follows:

1) Understand the importance of addressing prenatal/parental smoking, with advice on how to protect children from second-hand smoke (SHS) and third-hand smoke (THS).

2) Learn strategies for applying evidence-based smoking cessation counseling techniques to smoking parents.

3) Motivate pregnant women and parents to consider quitting smoking or reducing their child’s SHS exposure while acknowledging the barriers faced by smokers as they try to quit.

4) Learn the process at GHS for referral to the Clinical Outcomes Group, Inc. (COGI) for cessation counseling and nicotine replacement therapy (NRT); learn the role of NRT and other smoking cessation medications in obstetric and pediatric practices.

At the conclusion of the training, attendees were provided thumb drives containing the information presented by the educators for future reference. Continuing medical education (CME) and continuing education units (CEUs) were also provided.

**Clinic-based educational sessions**

The educational component of the workshop continued in the form of on-site sessions provided at the clinic level. The clinic-based training emphasized assessment and motivational counseling, using an abbreviated form of the trainer curriculum. Although educational sessions were open to all interested GHS staff, multiple sessions were planned and conducted for pediatricians and nurses working in targeted clinical areas.

As much as possible, the education was integrated into standing unit meetings and educational forums to disseminate information to the entire clinic staff. Each session was facilitated by a project leader or consultant in conjunction with the clinic leader who attended the train-the-trainer workshop. Ongoing educational opportunities within the Geisinger system for trainers and other staff were presented by Michele Neff-Bulger, DO, FAAP, FACOP at pediatric/pediatric osteopathic grand rounds, pediatric department meetings, pediatric resident noon conferences, and the Center for Health Research Conference. David Zanis, PhD, also presented at obstetrical grand rounds.

Those who were unable to attend the conferences, or who were not on campus, were provided information about the project and the referral process as published in *Geisinger’s Pediatric Quarterly Newsletter*. Training was also available through a Web-ex broadcast, facilitated by Jenny Wagner, MS, a masters-level trained substance abuse counselor provided on March 24, 2011. The one-hour training covered the same material as the clinic-based training and was recorded for future use.

**Phase II: Implementation of an involuntary smoking screening tool into the EHR**

An involuntary smoking screening tool, the Best Practice Alert (BPA), was implemented into the EHR for use in pediatric clinics. Built specifically for this project, this new tool was designed to “fire” at the onset of a pediatric visit occurring at the pediatric study sites. Children seen at these
clinics are there for a wide variety of health needs, including well-child exams, acute visits and pediatric subspecialty visits such as pulmonology and cardiology.

Prior to the BPA being built, no such documentation was done consistently and never in a fashion retrievable from the EHR. The BPA began to fire in the EHR on February 28, 2011. Although its development was costly and time consuming, the BPA is now an established feature in the EHR for pediatric patients. Most importantly, the BPA can easily be turned on and implemented throughout the health systems’ other pediatric clinics. Although the BPA was built specifically for this grant that focused on young children, it fired for all children from birth through 18 years of age. Therefore, data was obtained and reported for all age groups.

As a result of the increased awareness of the role of NRT in tobacco cessation, the Department of Obstetrics added NRT to the inpatient formulary. It is now available to women during their hospitalization in the hospital labor and delivery unit.

Phase III: Establishing referral source for cessation services

Collaboration was leveraged between clinicians who had recurring contact with young families and the community-based COGI, which provides wellness and cessation services (including NRT) at no cost to clients. Pregnant smokers were assessed for smoking status and readiness to quit at each prenatal clinic visit. Parent/caregiver-smokers were assessed for smoking status and second-hand smoke exposure of their child at each pediatric clinic visit by the rooming nurse. Parent/caregiver-smokers were then assessed for readiness to quit by the physician. Along with consistent messages, smokers were offered a referral for community-based cessation counseling at the COGI. When accepted, a referral form developed in collaboration with COGI, was faxed and contact was initiated within 24 hours. If the referral was declined, the Pennsylvania Quitline number was offered in addition to brief counseling.

COGI provided counseling services for cessation and smoke-free homes was implemented by masters-level trained counselors. Counselors also provided NRT after educating clients on the proper use, risks and benefits of medications. The types of NRT available to clients included lozenges, gum and patches. Cessation plans were individually tailored and the duration of services varied according to the smoker’s preference.

COLLABORATION

Phase I: Education of Providers

Collaborators for the educational component of this pilot included Ms. Dottie Schell, Dr. David Zanis, and Ms. Jenny Wagner. Ms. Schell is a member of the AAP Richmond Center for Excellence faculty expert panel and a public health nurse currently employed by the Montgomery County Department of Health. Dr. Zanis is the past-president of the Board of Directors of the COGI, a Temple University Professor, and an accomplished researcher, with multiple awarded grants and publications on substance abuse. As noted in Phase I of the project goals, Ms. Wagner is a masters-level trained substance abuse counselor and health educator for the COGI. All three educators facilitated the train-the-trainer session on January 7, 2011.

Pilot staff continued to collaborate with COGI to educate physicians and nurses at the clinic level. Educational sessions were planned and conducted for physicians and nurses working in the targeted clinic-based areas. The clinic-based training emphasized assessment and
motivational counseling, using an abbreviated form of the trainer curriculum. One-hour training sessions were facilitated by Ms. Wagner. Six training sessions were held at prenatal and pediatric clinic unit meetings, all of which were conducted during scheduled work hours and attended by the majority of staff. It should be noted that 2 of the 8 targeted sites house prenatal and pediatric clinics in the same building, necessitating only one session per site an opportunity for discussion and shared learning.

**Phase II: Implementation of an involuntary smoking screening tool into the EHR**

The BPA was constructed in collaboration with colleagues at the Geisinger Clinical Innovations Center and Information Technology. This tool addressed the lack of readily available outcome data in the EHR regarding child exposure to tobacco smoke. The grant’s evaluation plan required development of an electronic-tracking system to replace narrative progress notes regarding exposure to second-hand smoke. The electronic platform was designed to replace documentation in narrative progress notes with discrete, numeric data. The BPA fires at all pediatric visits in the pilot clinics and is completed by physicians, nurses and other providers. Its design and implementation is based on a logic model with responses saved in a spreadsheet.

**Phase III: Establishing referral source for cessation services**

The pilot leveraged collaboration between clinicians who had recurring contact with young families, and the COGI, funded in-part by the *Tobacco Master Settlement Funds*. As the Geisinger Medical Center does not offer tobacco cessation services for parents, particularly those who are uninsured, outreach to the community for resources was necessary. Although COGI provides services regardless of insurance status, applicable Medicare/Medicaid reimbursements are sought to offset the costs of services.

**EVALUATION AND MEASUREMENT**

**Phase I: Education of Providers**

Provider feedback regarding cessation counseling skills and confidence was collected using an electronic survey that was specifically developed to evaluate the effectiveness of the training on clinical practice. All training attendees received the survey via e-mail. Results were collected electronically by a third party who provided the study team with de-identified data.

**Phase II: Implementation of an involuntary smoking screening tool into the EHR**

Primary outcomes, derived from medical records, included prenatal patient and parental reports of smoking status and behaviors, sustained cessation beyond pregnancy, and maintenance of tobacco-free homes and cars. Within the current EHR (EPIC), retrievable data sets within the prenatal and childbirth centers provided data regarding maternal smoking during pregnancy. The BPA provided metrics regarding the screening and documenting of children’s second-hand smoke exposure and the smoking status of the caregiver accompanying the child to the pediatric care visit. Outcome data were collected for the target group, birth through 3 years of age, as well as for children 3-18 years of age.
Phase III: Establishing referral source for cessation services

The outcome data, collected by COGI staff and cessation counselors, included documentation of the referral process and referral-initiated counseling. Reports were sent on a monthly basis.

OUTCOMES

Phase I Outcomes: Education of Providers

Train-the-Trainer Attendee Evaluations

The evaluation of the train-the-trainer was accomplished using the objectives as described in the program description. The objectives were rated on scale of 1 (not met) to 5 (fully met). Before the training, the objectives averaged a 3.44 rating. Following the training, the objectives averaged a 4.6 rating.

Clinic-based Training Evaluations

Six clinic-based educational sessions were attended by 64 nurses, physicians and other clinical staff. A week following each session, attendees were asked to evaluate the relevance and effectiveness of the smoking cessation training along with their confidence to use the counseling strategies in clinical practice. The survey consisted of 15 items, rated on scale of 1 (weak) to 7 (highly effective). Developed by the research team, the survey draws on best practice standards and research findings. Reliability and validity data have not been examined. The survey was accessed by attendees through an e-mailed link. It was then compiled by a third party who de-identified the data.

Data were collapsed into 4 categories: ratings of 6 and 7 were recoded as highly effective; ratings of 4 and 5 were recoded as effective; ratings of 2 and 3 were recoded as somewhat effective; ratings of 1 remained as weak, unchanged. Most attendees rated relevance of cessation strategies and confidence with abilities to provide cessation care as highly effective or effective.

Attendees also assessed their clinical practice experience. Of the 64 attendees, 90% felt that they face patients who see no reason to stop smoking because their children encountered no health problems. One-hundred percent of the attendees recognized stress in the patients as contributing to their difficulty in quitting smoking. The participants rated nurse/provider interactions in their own clinics. Twenty-nine nurses/providers either always or often used a team approach to smoking cessation. Additionally, 32 providers either always or often reinforced information provided by a nurse.

Phase II Outcomes: Electronic smoking screening tools

Peri-partum EHR Data

As prenatal smoke exposure has been shown to be associated with significant morbidity and mortality, a study goal outcome was to see a decline in pregnant smokers. Cessation interventions were initiated in prenatal care and continued throughout pediatric visits. A sub-population was examined to evaluate the effectiveness of this strategy. The sub-population included a mother and child that were electronically linked from the prenatal period through delivery post-partum care and pediatric care (approximately 1,000). The overall trends reflect a
decrease in tobacco use for women (Figure 3). It should be noted that this data is sensitive to the absolute number of women receiving care in each time period. This is particularly apparent in the March to April 2012 delivery and post-natal data, in which a low number of patients had reportable data. This causes the percentages to appear quite high, when the actual number of patients smoking is low.

**Figure 1: Peri-partum Tobacco Use**

![Mother Self Reported Tobacco Use](image)

When the number of prenatal visits, with positive tobacco use assessments, is examined against the number of prenatal visits where tobacco use was assessed, a clear decline in use is apparent. A similar decline in use is noted at the time of delivery and during post-partum.

**Pediatric visits: Parental Reports**

During the study period of March 1, 2011 through April 30, 2012, data was collected regarding 16,804 pediatric patients. The only inclusion criteria were that the child be under the age of 18 and visit at one of the 4 study sites where the BPA was firing. This group of pediatric patients were Caucasian (94%) with a mean gestational age of 38.3 weeks and a mean birth weight of 3.2 kg. The sample consisted of 8,686 (52%) females and 8,118 (48%) males. In 13 months, the 16,804 patients had a total of 44,320 clinic visits. The BPA fired at each of these visits although responses were documented at 69.25% of the visits.

Interestingly the BPA fired at each clinic visit was acted upon differently across the 4 clinics. Clinic I had the fewest patients (857), with the fewest total visits by these patients (1,225) during the study period. At this clinic site, the BPA had documentation rate of 20.2% by either a nurse or a physician. Clinic 2 had more than twice the documentation rate at 46.1% for the 872 patients during their 2,951 visits. Clinic 3, a clinic staffed by pediatric residents and general pediatric attending physicians, had 24,963 visits of 6,851 distinct patients; the BPA had documentation of SHS exposure +/- other tobacco screening information 61.7% of the time. Clinic 4, which houses a multi-specialty pediatric group and general pediatric clinic, was the most compliant with documentation in the BPA for 91.6% of the 15,181 visits.

Screening for SHS exposure was very important to implement into the system. The first question in the BPA was, “Is your child exposed to anyone who smokes?” Throughout the
duration of the study, this question was answered on the average of 69.6% during the 0-6 month old visits; 69.18% in the 6-12 month old visits; 68.2% during the 12-24 month old visits; and 69.12% during the 24-36 month old visits. The frequency with which the exposure question was asked stayed fairly consistent. However, when comparing March-May 2011 to March-May 2012 it is notable that, in every age range, there has been an increase in the percentage of SHS exposure screening (range of increase 1.4% - 4.8%).

The responses to the SHS exposure screening question at the initiation of the pilot established an overall exposure rate in the study population of 32%. With the exception of the 0-6 month age group, all other age groups demonstrated an overall decrease in SHS exposure after one year of implementing the tobacco screening tool and cessation counseling (Figure 2). The project objective was to reduce secondhand smoke exposure in non-smokers to 47% in the 3 to 11 year age range and 41% in the 12-17 year age range. In this study population, a reduction of secondhand smoke exposure was demonstrated in the 3-11 year age range to 27% and 29.7% in the 12-18 year age range.

**Figure 2: Pediatric Visits with Positive SHS Exposure Responses**

![Graph showing percentage of encounters with positive SHS exposure responses over time.]

* Data obtained from the BPA fired at pediatric clinics within the study cohort

Questions from the BPA were also posed to the adult accompanying the child to the visit regarding their relationship to the child and their personal smoking status. In 79-90% of the cases, the accompanying adult was the mother. The second most frequently accompanying adult was the father, accounting for a total of 94-99% of the visits being with one or both of the child’s parents. These accompanying adults reported an average incidence of smoking of 19.5% during the pediatric visits of children ages 0-6 months and 2-18 years of age. The smoking rate
was much lower for the 6-12 month visits at 13% and the 12-24 month visits at only 7%. This may be due to the timeframe of the study having the opportunity to show its effectiveness as this group of children, aged 6-24 months, would have been born to mothers who would have received tobacco screening and counseling across the service lines of obstetrics into pediatrics.

If the accompanying adult was a smoker, they were also asked the quantity of cigarettes smoked per day and if they were interested in quitting. The majority of smokers had these responses documented in the BPA and reported smoking a half a pack per day.

Parents of newborns and infants reported smoking fewer cigarettes than the parents of older children. The tendency to smoke in the presence of their children increased linearly with the age of the child. This outcome trend may be due to several factors. Many parents/women quit or cut back their tobacco use during pregnancy but relapse with time. Parents may also see their child as less at risk for complications from SHS as they get older, particularly if the child has not suffered any obvious consequences to date. Finally, as children become more verbal and cognizant at their doctor’s appointments, they may “tell on” their caregivers for their tobacco use and location of such use.

**Phase III Outcomes: Referrals to community-based cessation services**

Beginning January 2011, after the train-the-trainer educational seminar, referrals to COGI were initiated by providers – despite the fact that the clinic education had not been completed nor the BPA 'gone live.' A dramatic increase in the number of referrals occurred after Phase I and Phase II (February 3, 2011) were completed. Throughout the study period, the average number of monthly referrals from the 8 sites was 46. This was higher during the first 8 months (51 per month versus 41 per month) than the second 8 months, likely due to staff turnover and the need for re-education.

The COGI’s outreach protocol is 3 phone call attempts followed by a letter. Once contact is initiated, the client either accepts or declines services. If they accept services, they meet by phone or in person, for their initial counseling service to form an individualized quit plan.

The total number of physician-fax referrals to the COGI was 737. The majority (75%) of the referrals were for females, likely reflecting the frequency with which the mother or female caregiver accompanied the child to the pediatric health visit. Of the referrals made to COGI, 476 (65%) were contacted by a COGI representative. Of those contacted, 358 clients (75.2%) went on to enroll in at least one session of counseling; 48 (10%) declined to participate in counseling at that point. The remaining 70 clients (14.7%) were contacted by COGI but never followed through with counseling. Overall, the enrollment rate approaches a ratio of 1:2 clients participating in counseling for every referral. This far exceeds the typical participation after a quit-line referral. The outcome may reflect the supportive role of the clinic physicians and nurses or the proactive, counselor-initiated contact within 24-hours of the clinic visit.
The COGI clients were followed, beginning with the last counseling session or client contact. Of the 87 clients contacted at 30 day post-counseling follow-up, 56% reported a 30-day quit rate and 85% reported a smoke-free home (Figure 4).

At 90 days post-counseling, the 29 clients contacted reported a 62% quit rate and an 86% smoke-free home rate (Figure 4).

Six months from the final counseling session for 14 of the clients, 50% reported to be tobacco-free and 93% maintained a smoke-free home. Follow-up with clients is on-going, as the length of counseling varied and was defined by each client. The follow-up reports are limited to clients that have completed counseling.

**BARRIERS AND LESSONS LEARNED**

Some of the barriers noted were staff turnover and the associated need for re-training. The number of referrals declined approximately 9 months after the initial educational sessions were held. While there were plans to re-train clinical staff at 6 months after initiation of the pilot, to address staff turnover, the system saturation experienced at COGI precluded participate in additional educational workshops. COGI plans on revisiting clinics in the near future to educate providers on counseling and referral process.

Barriers and lessons learned are as follows:

- The BPA can be “ignored”. This resulted in less than 100% participation. At GHS, several different BPAs fire during a patient visit and some pediatricians do not complete all – or any – of the BPAs as none are mandatory. The initial section of the BPA is completed by a nurse, as part of a rooming tool, in an attempt to address this barrier; however, this is not always successful. It was found that both nurses and pediatricians did not complete the alert. Perhaps linking BPA completion to provider incentives would increase utilization.

- Pediatricians and pediatric residents were unwilling, or uncomfortable, passing out NRT samples in the clinic to parents. This was anticipated and providers were educated on the American Medical Association (AMA) policy statement H-490-917 (2005) and the AAP Policy on Tobacco Use (2009) which supports the pediatrician providing NRT to the parent. As GHS has a firm, no free-drug sample policy, this likely played a role in provider’s apprehension. However, the exception to GHS’s policy exists for clinical studies such as this pilot.

- The COGI staff became overwhelmed by the number of referrals. An additional counselor was hired to handle the referrals. Although this created a job in the community, COGI
functions on a fixed income from the Master Settlement Funds, which were cut by a million dollars in Pennsylvania this year. This, along with the cost of providing services and NRT to clients, has resulted in COGI going over budget. The initial plan anticipated that referrals would be generated by staff in the 8 study sites. However, referrals came from many different locations, both in- and out-patient sites, as providers throughout the system learned of a referral source. In fact, 45% of the referrals originated from GHS sites other than one of the original eight clinics.

• Only 64% of the referrals made to the COGI were able to be contacted for services. Although the majority of smokers wanted to quit, their desire to do so waxed and waned. At the time that the pediatrician offered the referral for cessation services, and they accepted, the smoker was ready to make an attempt. Unfortunately, by the time they were contacted by COGI, their desire to quit had been dampened. A more beneficial model may involve point-of-service contact with a cessation counselor to initiate therapy and NRT.

• The childbirth unit was not conducive to cessation counseling, possibly due to maternal fatigue and stress. Also, pediatricians and nurses have a lot of information to teach new parents. Support from social services may be useful as an alternative.

**FUTURE PLANS**

Future plans for the project include expanding the BPA into all pediatric clinics within the GHS. The grant supported the initial cost of the BPA build and implementation into the 4 current pediatric clinics. The BPA will continue to fire at these sites until program staff or the director of pediatrics direct otherwise. Expanding into the other pediatric clinics should be a cost surmountable by the Department of Pediatrics.

Additionally, forming a *Tobacco Cessation Team* on campus for point-of-service contact to provide cessation services would be ideal to capture smokers ready to quit. COGI is very interested in subcontracting with GHS to help form this team. It would be in COGI’s financial interest, and GHS would benefit greatly by their expertise and stature in the community. Many patients served at the GHS carry the Geisinger Health Plan (GHP) insurance. If services of the *Tobacco Cessation Team* were covered by GHP, the health plan and the health system would stand to save millions in health care costs due to fewer smokers and fewer involuntary smokers.

A new study at GHS is examining pediatric primary hypertension and its modifiable risk factors. Dr. Neff-Bulger will be leading the tobacco use/exposure arm of the study using this pilot as a template for provider education, tobacco screening and referral. Program staff will likely collaborate with COGI to build an on-site *Tobacco Cessation Team* and study its effectiveness with this population.

The success of this pilot, leveraging the physician fax referral system, provides support for future collaboration with the Pennsylvania Department of Health QUIT-LINE and GHS. Currently, in Pennsylvania, the QUIT-LINE does not have this option. Linking the EHR to the QUIT-LINE for seamless referrals is the ideal goal.
PROGRAM DESCRIPTION

This program addresses the Healthy People Focus Area 27-3 (Reduce the initiation of tobacco use among children and adolescents). The project’s research group proposed an evaluation of a project designed to teach physicians how to reduce the availability of tobacco products to children of parents who smoke. The project was initially planned as a pre-post, group-controlled trial of a physician-administered intervention to reduce children's access to tobacco. Two physician practices were initially recruited - one of which to serve as the intervention practice and one of which to serve as the control practice. The intervention practice received brief training from the team to demonstrate how to address the issue of tobacco control with parents from a MI perspective. The physicians then incorporated the intervention into their usual practice. A one-month follow-up evaluation was obtained from parents. Unfortunately, there were problems recruiting participants for the control group and data could not be collected.

Given that this was the initial trial of a new program, the primary interest was in feasibility. As such, the central focus was to show that the pediatrician intervention could significantly change parental outcomes, including attitudes about smoking, knowledge about smoking and home tobacco control policies. The ultimate goal was to gather initial data that could be used to support a larger, National Institute of Health (NIH) proposal.

Study Aims

1) Develop, implement and evaluate a program to train physicians how to interact with parents about tobacco control using a MI framework.

2) Examine whether pediatricians’ knowledge about smoking, attitudes towards smoking, and other outcomes changed from baseline (prior to the training program) to follow-up.

3) Examine the efficacy of the physician-delivered intervention on parent outcomes (ie, knowledge, attitudes and tobacco control behaviors) at one-month follow-up.
COLLABORATION

Given the limits of this small scale study, multiple practices were not able to be recruited per arm of the investigation. Instead, two pediatric offices initially agreed to serve as testing grounds for a control and a treatment group. The Raleigh Group Primary Care in Memphis, Tennessee, led by Susan Hillebert, MD, FAAP, was used for the treatment condition. The 4 full-time pediatricians and 1 part-time pediatrician saw 42,000 patients in 2009, primarily from unemployed, poor, working and middle-class families. Before beginning the study, it was estimated that approximately 20% of patient parents were smokers and 11% of patients were between 9-13 years of age (based on Clinical Effort Against Secondhand Smoke Exposure findings).

Initially, there were plans to have a control condition from a practice in Johnson City, Tennessee; however, there were no referrals from this practice.

EVALUATION AND MEASUREMENT

Before the study began, pediatricians were surveyed about their own beliefs concerning the dangers of tobacco, potential barriers to intervention, and their efforts to address tobacco use with parents and children. This same questionnaire was repeated after the intervention was complete in order to determine whether physicians’ attitudes and beliefs had changed. In addition, physicians participating in the intervention condition were asked to complete a program evaluation form after finishing their training in MI.

Two young professionals aiming for medical school admission screened patients’ parents in the waiting room. Parents who used tobacco and had children of the relevant age were consented into the study. While waiting to see the physician, parents completed a baseline questionnaire regarding their attitudes toward tobacco, knowledge about dangers associated with smoking, and home tobacco control policies. Students put a notice on the chart placed outside of the patient’s room to notify pediatricians of eligible parents.

As parents were escorted into the treatment rooms, those in the treatment condition participated in a 10-15 minute conversation with pediatricians, based in MI, including the role parents’ tobacco products may play in their child’s odds of smoking and the methods of preventing their children from obtaining their tobacco. Baseline data and consent forms were collected by health educators, who then called parents a month later for a follow-up assessment.

OUTCOMES

Recruitment and Follow-up with Pediatricians

Ten pediatricians, 4 from the treatment practice and 6 from the control practice, participated originally in this study. Baseline data on these pediatricians is presented here.

First, we asked whether the pediatrician’s role involves addressing tobacco use among children/teens. Notably, 50% reported that it was often required, whereas the other 50% reported that it was always a necessity. In this highly motivated sample of physicians, 80% reported feeling comfortable at baseline in discussing tobacco use with patients; however, only half believed that their patients would be honest with them if asked about tobacco use.
Interestingly, there was a bimodal distribution on an item assessing whether pediatricians believed they could prevent cigarette smoking. Half of the physicians believed they could have little prevention effect, whereas the other half believed they could have a lot of impact on prevention. When it comes to smoking cessation, the pediatricians were even less encouraged: 80% believed they could have little effect on teen smoking cessation, and only 20% thought they could have a lot of impact on helping adolescents quit.

Pediatricians were also asked about their current practices in following the Agency for Health Care Policy and Research (AHCPR) Smoking Cessation Clinical Practice Guideline guidelines. According to their reports, 70% of the pediatricians often asked about their patients’ tobacco use and 90% advised against smoking often or always. Only 20% reported sometimes helping to arrange for a teen to quit. None of the group of pediatricians reported scheduling a follow-up visit to see how a patient was doing with quitting. In addition, none reported prescribing smoking cessation medication for their patients.

Other items assessed barriers that pediatricians might encounter that could interfere with their ability to discuss tobacco use with their patients. Twenty percent reported that they were not sure what to say. More frequently, there were concerns about the parent: 40% indicated that they were unsure about approaching the topic with a parent present. Half of the pediatricians reported that limited time was a concern, and 20% simply believed that their efforts to address the topic would not influence the child’s smoking.

Regarding conversations with parents, only 10% of the doctors reported that they felt it was always part of the pediatrician’s role to discuss tobacco use among parents. Twenty percent thought it was never appropriate, 40% thought it was rarely appropriate, and 30% thought it was sometimes part of the pediatrician’s role.

It should be noted that the above data concerning physician behavior and attitudes should be considered suggestive only. The small sample size limits the possibility of generalizing to the larger population of physicians. Nonetheless, it does give information about the particular pediatricians enrolled in this study.

**Recruitment and Follow-up with Parents**

The original proposal called for 120 parents to be recruited into each arm of the study, or 60 in the treatment condition and 60 controls. Given the number of patients seen annually, the estimated parental smoking rate, and estimated percent of the parents with age-eligible children, it was expected that 462 eligible cases would present within 6 months.

As it turned out, far more parents were screened (1176) for the study than anticipated. Only 5.6% of the parents screened were eligible. Of the 63 eligible parents approached about the study, only one declined participation, suggesting that parents are receptive to clinical research on tobacco in primary care settings. Of the 62 parents recruited, only 41 (66.1%) completed the one-month follow-up.

**Characteristics of the Parent Sample**

Data on the characteristics of the parents were as follows: 92% of the sample was female, with an average age of 36 years. African Americans comprised 39% of the sample, 48% were Caucasian, and 11% were of other ethnicities. Only 27% were married; of the rest, 47% were never married, 12% were divorced, 2% widowed, and 12% separated. Educational level was
generally low, with 61% of the sample having a high school education or less. Annual income was similarly depressed; 47% of the parents made only $10,000 to $19,000 a year.

Turning to smoking practices, 95% of those recruited to the study reported using tobacco. Of the remaining participants, 5% smoked more than a pack per day (ppd), 32% smoked a ppd, 47% smoked about ½ a ppd, and about 8% smoked less. Notably, 75% of the parents were in the contemplation stage of change at the beginning of the study, whereas 26% were in pre-contemplation (that is, not considering quitting). Approximately 29% of the smokers had managed to quit for at least a week in the past.

Regarding their attitudes at baseline toward physician intervention, most of the smoking parents believed it was very important for pediatricians to discuss tobacco use with children and teens (87%). However, they were not hopeful that such discussions could actually decrease the odds of children smoking. Only 27% reported that pediatrician intervention could prevent smoking “a lot.” They were similarly doubtful about pediatricians’ ability to help children quit smoking. Only 37% believed that pediatricians could help youth who smoke to stop. Parents were even less likely to believe that pediatricians or their own doctor could assist their own quit attempt.

Parents were also asked about their personal feelings if they were asked about their own tobacco use by a physician. Only 14% of our smoking parents reported that they would be “very” or “somewhat upset” if their child’s pediatrician discussed their own tobacco use. In contrast, 42% of the sample reported that they would not care, and 42% reported that they would be “somewhat” or “very relieved” to be asked about their smoking. Parents were even more receptive when asked about their reaction to their personal physician’s inquiry about smoking.

Finally, parents were asked about the importance of pediatricians discussing tobacco use with parents. Over half (55%) reported that they considered this to be “very important.” Another 31% viewed a discussion about tobacco as “somewhat important.” Only 13% regarded a pediatrician/parent discussion about smoking as “somewhat” or “very unimportant.”

**Changes in Pediatricians’ Beliefs over Time**

Due to the short-term involvement of the control practice, follow-up data on only the four physicians in the treatment condition were available. Thus, the analyses lacked the power needed to identify statistically significant changes over time. Instead, these findings are being reported as descriptive data on this group of pediatricians.

The perceived prevalence of smoking simply measures the proportion of the population that adolescents believe smoke. The higher the teens’ perceived prevalence of smoking, the more likely they are to take up tobacco. There was interest in the degree to which pediatricians might also show this bias toward overestimating tobacco use. In fact, the physicians did overestimate the prevalence of smoking among high school students at pretest (27%) and at posttest (30%) despite receiving information on the correct rate of use (20%). Further, the physicians overestimated tobacco use among parents at pretest (41%), although their post-test estimate (25%) was much closer to the actual average (21%). It appears that more powerful messages are needed to ensure that pediatricians will not inadvertently assume that smoking among both teens and parents is more common than it is.
Other analyses focused on pediatricians’ perceptions that they can help prevent child and adolescent smoking. Despite the small sample size, the results revealed a marginally significant increase in the perception that they could be effective in preventing tobacco use. Other variables generally showed change in a positive direction, although a shift over time could not be detected statistically.

**Changes in Parents’ Beliefs & Knowledge over Time**

**Parental Attitudes toward Smoking among Children and Teens**

Parents were asked about their attitudes toward smoking among children and teens in two separate questions. Both were rated on 4-point Likert scales, with high scores indicating more disapproval of underage smoking. Analysis revealed no changes over time in both variables. Inspection of the pretest data (Table 1) suggested the reason for this lack of change. At pretest, all parents except one reported that they strongly disapproved of their child smoking. Parents’ opinions about teens’ smoking were not as extreme, but almost all reported disapproval at pretest. Thus, the scores were so extreme at pre-test that a ceiling effect prevented any statistical change over time.

| Table 1: Changes in Attitudes toward Youth Smoking |
|------------------------------------------|-----------------|-----------------|
| Variables                               | Pre-Test (n = 41) | Post-Test (n = 41) |
|                                         | M (SD)           | M (SD)          |
| Approval of children smoking            | 2.98 (0.15)      | 2.98 (0.15)     |
| Approval of teens smoking               | 2.80 (0.51)      | 2.90 (0.30)     |

This study, using a longitudinal sample of approximately 7,000 teens, showed that by the time Caucasian adolescents reach the middle of high school, they believe their parents do not care if they smoke. It should be noted, however, that the current study was largely composed of people of color. Thus, the degree of disapproval of child/adolescent smoking that was observed in the current study may partly be a reflection of normative anti-tobacco beliefs among parents of color.

**Parental Knowledge about the Effects of Smoking**

Two standard questions about the dangerousness of smoking were asked. First, the question was asked about whether it is safe for children or teens to smoke only for a year or two, as long as they quit. Second, the question was asked about whether smoking causes serious illness in children and teens while they are still young. Both items called for ratings on 4-point Likert scales, with higher scores indicating stronger agreement.

Once again, both variables were quite skewed toward agreement (Table 2). Thus, even at pretest, the majority of parents were well aware of the dangers smoking poses to children and teens. Not surprisingly, given this restricted range, there were no significant changes on both variables.
Table 2: Changes in Knowledge on Youth Smoking Dangers

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M (SD)</td>
</tr>
<tr>
<td>Safe for children or teens to smoke a year or two</td>
<td>40</td>
<td>2.90 (0.30)</td>
</tr>
<tr>
<td>Smoking causes serious illness in children and teens</td>
<td>41</td>
<td>2.54 (0.59)</td>
</tr>
</tbody>
</table>

Parents’ Estimates of the Perceived Prevalence of Smoking

Parents were asked to estimate the prevalence of smoking among parents in 10 families. Similar questions were asked about the prevalence of smoking among both middle school students and teens. Researchers wondered whether it would be helpful to give parents accurate information about smoking prevalence among teens and children. The question about parents’ estimate of the prevalence of smoking among other parents was used on an exploratory basis.

It should be noted that the physician intervention focused on tobacco control and only briefly referred to information about smoking prevalence among children, adolescents, or parents. However, the handout for parents did report that about 20% of adolescents and 8% of children smoke. It did not address the prevalence of parental tobacco use.

The results of the questions about prevalence were interesting. At baseline, parents believed that 61.8% of parents smoke around their children, a value that did not change significantly over time. This is a strong overestimate of the prevalence of parental smoking.

Further, at baseline parents believed that 42.5% of middle school youth used tobacco. This estimate is a gross overestimate of smoking in middle school. Despite providing correct information in the parent brochure on smoking among middle school children, no changes were observed over time in this estimate.

Parents estimated at baseline that 61.6% of high school students used tobacco, a figure that is also an overestimate. Once again, no significant changes in perceived prevalence occurred over the course of the study.

In summary, these smoking parents greatly overestimated smoking frequency. It appears that a stronger message than that offered in this study is necessary in order to change these perceptions.

Changes in Parents’ Behavior over Time

The central purpose of the project was to get parents to increase their efforts at tobacco control. This point was emphasized by the pediatricians delivering the intervention to parents, and it was also covered in the brochure designed for parents.

Potential changes in tobacco control were measured in a number of different ways. One item asked parents how difficult it would be to keep their tobacco products away from their children. Parents responded on a Likert scale ranging from “extremely difficult” (0) to “very easy” (3). Thus, higher scores indicated that parents believed it would be easy to control their children’s
access to tobacco. The analyses showed a significant improvement over time. At pre-test, these smoking parents reported that it was relatively difficult to keep tobacco away from their children; at post-test, they were more likely to report that this was somewhat to very easy.

Parents were asked how many methods they used to restrict their tobacco from their children. At pre-test, they reported using on average only 2.6 of 8 possible ways of restricting tobacco. At post-test, they used an average of 3.6 ways of limiting tobacco, a statistically significant improvement.

Results also indicated that at post-test, parents were significantly more likely to count the cigarettes in their packs than they were at pre-test. Similarly, they were more likely to count the packs they had than at pre-test. Parents were also significantly more likely to keep their tobacco at work and to keep their tobacco with them, rather than leaving it where children could get it.

Surprisingly, parents also reported increased restriction of smoking for adults in their homes. This variable was measured on a 3-point Likert scale ranging from “no smoking is allowed anywhere in my home” (0) to “smoking is allowed anywhere in my home” (2). Thus, smaller scores indicated more tobacco control at home. At pre-test, parents reported a strong tendency to control smoking in their homes. However, at post-test, their efforts toward tobacco control for adults were even greater. Notably, a similar question regarding rules against smoking at home for children showed no significant change over time. However, parents almost uniformly reported that they did not allow their children to smoke at home at baseline. Thus, a floor effect made improvements virtually impossible.

**Second-hand Smoke Exposure**

To measure children and teens’ exposure to second-hand smoke, specific questions were asked about how often in the past week their children were exposed to smoke at home or in a car. Overall (combining both answers), significant decrease was found from pre-test to post-test in the number of days children were exposed to smoke in both places.

When the car and home settings were explored separately, it was found that parents reduced their child’s exposure significantly only in their car. In the home, exposure did not change over time. It should be noted that few parents admitted to home exposure at pre-test, a situation that produced a floor effect.

**Parents’ Perceptions of Pediatricians**

Smoking parents were asked how they would feel if their pediatrician addressed their tobacco use with them. Their responses were measured on a 5-point Likert scale, ranging from “very annoyed” (0) to “very relieved” (4). Thus, high scores were associated with greater acceptance of pediatricians’ interventions. Even at pre-test, parents were relatively positive about physician communication about smoking. However, they became even more positive over the course of the intervention. These data suggest that pediatricians should not fear that addressing tobacco use will alienate their patients’ parents. In fact, addressing tobacco use is associated with positive feelings on the parents’ part.

After the intervention, parents were more likely to believe that pediatricians can prevent smoking in children and teens.
Parents’ Knowledge of Cessation Strategies

Although the central purpose of the intervention was not to have parents quit smoking, it is suspected that a number of parents would ask about smoking cessation. Analyses showed that these smoking parents were more likely to report they had received pamphlets about quitting, tended to report they were helped to identify a quit date, and were provided with a follow-up appointment. Overall, parents were much more likely to report that they had talked with a pediatrician about their smoking after the intervention than before.

Pediatricians’ Evaluation of the Intervention

Program evaluation forms were completed only by the 4 pediatricians in the treatment condition. After they finished the study, a series of questions designed to determine how feasible the training and intervention were asked. Most questions were assessed on 4-point Likert scales. Pediatricians were quite positive about the overall program, the training, and likelihood that they would continue to use the information in their practices.

BARRIERS AND LESSONS LEARNED

At the time the grant was submitted, the practice of Dr. Jill Wireman of Johnson City Pediatrics was recruited to serve as the control group. (It should be noted that Johnson City is an extended drive away from Memphis.) Health educators were sent to Johnson City at the beginning of the first phase of research to complete the training process. This was an abbreviated version of the training that was done with the treatment practice, because no intervention was planned for this group. Instead, the focus was only on the identification and recruitment of parents who smoke, along with procedures for ensuring confidentiality and mailing data back to the researchers. All study materials were left with the practice, and one of the health educators maintained weekly contact with the practice’s study liaison to facilitate support should any problems arise. At the time of the training, the practice seemed enthusiastic and no problems were reported.

Within a month, however, it became apparent that no data was coming from the control practice. Pre-stamped envelopes were provided so that the liaison could mail completed surveys directly to project staff. When attempts were made to contact the liaison, there was little response. The practice eventually reported that they simply did not have smoking parents in their practice. Although this is certainly possible, it seems unlikely, given the smoking rates in East Tennessee, a tobacco-growing area. Unfortunately, several months passed, with reassurances from the control practice that they were still trying to recruit participants. Thus, by the time it was realized that they would not be a source of control group participants; there was not adequate time in which to recruit another practice.

In contrast, the treatment practice, led by Dr. Susan Hillebert, executed the study nearly flawlessly. Feedback was provided throughout the grant, including information about evaluating survey instruments, brochures written for patients, proposed research procedures, training materials, among other things. Program staff is grateful for Dr. Hillebert’s support, as she substantially improved the methods and developed the patient flow pattern. Two aspiring medical students were instructed to screen patients’ parents in the waiting room. If they were eligible, the students put a notice on the chart to remind the physician that the parent was appropriate for interviewing. Throughout the study, students informed the research team of how many parents were recruited for the investigation. Working with the head of the practice proved to be extremely important for ensuring the flow of the intervention did not disturb patient care.
Before the actual intervention could begin, pediatricians had to be trained. The training program was completed at a routine Saturday morning meeting, a time that worked well for everyone. Breakfast was provided by the team, and Dr. Robinson began with a PowerPoint overview of facts about tobacco use in general, including the hazards of child and adolescent smoking; its incidence; the sources of tobacco for children; the impact of physician interventions on teens who smoke; and the rationale for the study. Next, a step-by-step, behavioral overview of the planned intervention with parents was provided. Dr. Robinson role-played the intervention with a doctoral student in psychology to illustrate how to elicit parents’ cooperation. The participants then paired up to role-play the intervention, while Dr. Robinson rotated, giving suggestions where needed. Several role-play scenarios were provided to illustrate how to handle typical versus more problematic parents. A notebook with a basic study overview, contact information for the research team, a line-by-line example of the planned intervention, copies of all parent forms and relevant articles on MI and adolescent tobacco use was provided to each participant. Additionally, pocket-sized tip-sheets briefly outlining the intervention proved to be quite popular. Participants were provided with brochures for parents, noting which steps parents planned to take to control their child’s access to tobacco. Participants were also trained to write a prescription collaboratively with parents for behavioral changes around the area of tobacco control. After a half-hour of role play, they were encouraged to ask questions and share any problems that they anticipated.

One potential problem noted involved language barriers; many of the practices’ patients were not English-speakers. Significant attempts were made to have the measures translated into Spanish, but in the short time-frame of the grant, locating a translator who could do it quickly and within the budget was not feasible. Although participants expressed concern about whether the parents would listen to them, a concern that is very common among health care providers, they were eager to try the intervention.

It was soon evident that the intervention was being implemented well and with enthusiasm. One of the pediatricians in the treatment group even generalized the MI component to address a child’s obesity. This outcome is considered one of the greatest advantages of training pediatricians in behavioral methods.

Following are the major lessons learned in terms of feasibility:

1. It is essential to have buy-in up front from a leading member in a medical practice. The review of instruments, training procedures and study flow was invaluable.

2. Researchers should carefully explain the clinical and the academic purposes of the research. The treatment practice displayed considerable interest in the presentation on tobacco use among children.

3. Remember that each member of a practice already has a job. It is inadvisable to ask any member of a busy practice to consent patients or otherwise engage in research procedures. Fortunately, in this case, two students were assigned to collect data, and health educators were sometimes used for this purpose as well.

4. It is essential to be on site during the data collection phase. It was difficult for the control practice to follow procedures once researchers were no longer on site. Problem-solving long-distance was also found to be extremely difficult. It is recommended that future researchers limit study involvement only to practices that are within easy driving distance. It is also
important that study practices have a high degree of commitment to the project with leadership from a head pediatrician.

5. Handouts were found to be very helpful. Pediatricians were delighted by the pocket-sized tip sheet on the intervention. They also seemed to appreciate the research literature provided on MI and tobacco use among children.

6. Flexibility was found to be important. Once it was realized that the control practice was not participating, the process of posting the survey on-line began as a method of gathering data from parents who did not complete the intervention program. Although these data are not yet available, it is believed that they will strengthen the proposal to the NIH.

FUTURE PLANS

The primary long-range goal of this research is to determine whether pediatricians can serve as interventionists to help parents reduce children's smoking rates. In this initial study, the proximal goal was tested, that is, whether the intervention would be associated with subsequent improvements in parental control over parents' tobacco products. Given the small size of this study, the principal interest was in feasibility.

The results showed that it is feasible to implement an intervention with smoking parents into the ongoing operations of a busy pediatric practice. Pediatricians in the intervention group were receptive to the training program; the tip sheet was viewed as helpful; and the parent brochures were seen as an easy way to give concrete results of the consultation to parents. The results were extremely promising for such a small-scale study.

Despite the small sample of pediatricians, the results revealed a marginally significant increase in pediatricians’ perceptions that they could be effective in preventing tobacco use. Turning to the effects on parents, the results showed that at post-test, parents were significantly more likely to count the cigarettes in their packs than they were at pre-test. Similarly, they were more likely to count the packs they had than at pre-test. Parents were also significantly more likely to keep their tobacco at work and with them, rather than leaving it where their children could access it. In addition, parents also reported increased restriction of smoking for adults in their homes. Significant changes in second-hand smoke exposure were also found. There was a significant decrease from pre- to post-test in the number of days children were exposed to smoke. Finally, parents became even more positive about pediatricians’ communication concerning smoking over the course of the study. Overall, parents rated pediatricians as significantly more effective in preventing and reducing tobacco use in children and their parents at post-test. Clearly, pediatricians can approach conversations with parents who smoke with the reassurance of knowing their efforts will be, for the most part, positively received.

Acknowledgement should be given for the limitations of these data. First, the types of attitudinal and behavioral changes reported by parents should be validated by direct observation in a larger-scale study. Similarly, biochemical measures of child exposure to second-hand smoke are essential to validate changes over time. Second, a randomized controlled trial is needed to verify these changes. Finally, a longer follow-up would be helpful to determine if these changes are sustained. Ultimately, additional studies will be needed to determine if the strategy impacts the acquisition of the tobacco habit by teenagers.
Nonetheless, these research findings are encouraging. The next step is an application for a larger investigation, one with adequate funding for validation checks, multiple practice involvement, a control arm, and a longer follow-up. As the NIH would be a logical funding source for this application, the program team is in the process of planning the proposal.
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<th>Title</th>
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</tr>
<tr>
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<td>CA1 (IX)</td>
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*Updated 10/8/12*
The AAP Julius B. Richmond Center of Excellence (RCE) is dedicated to the elimination of children’s exposure to tobacco and secondhand smoke. The Richmond Center, named for pediatrician and former Surgeon General Dr. Julius B. Richmond, is supported by grants from the Flight Attendant Medical Research Institute (FAMRI) and the Legacy Foundation and an unrestricted educational contribution from Pfizer. Since 2006, the AAP Richmond Center has worked to ensure that all clinicians are asking the right questions about tobacco and secondhand smoke, and that all pediatricians have tools to help them address elimination of tobacco from children’s lives through the development and dissemination of clinical practice tools, research and improvement of community health.

As a virtual center, the Richmond Center is constantly updating its available resources to ensure that clinicians, academics and community public health workers, have the most current information on tobacco control easily accessible. A summary of the Richmond Center’s funding opportunities and resources is provided below. For more information, please visit www.aap.org/richmondcenter.

**Funding Opportunities**

In an effort to support pediatricians, child health advocates, and researchers in gaining the knowledge and means to protect children from tobacco and secondhand smoke, the Richmond Center offers several funding opportunities as follows:

**Julius B Richmond AAP/FAMRI Scholarship Program** – The AAP Richmond Center supports academic general pediatricians and sub-specialists working on children’s secondhand smoke exposure and means to reduce such exposure, with the goal of training future leaders in research and community advocacy focused on the reduction and elimination of children’s secondhand smoke/tobacco exposure. The fellowship awards are for two years and up to $25,000 each year.

**Visiting Lectureships Program** – The AAP Julius B. Richmond Visiting Lectureships Program provides up to $3,000 for two-day educational events focused on tobacco control. These events provide opportunity for multiple institutions to collaborate on tobacco control issues, and must occur within two years of receiving the award.

**Julius B Richmond New Investigator Grants** – These grants are designed to stimulate involvement of pediatricians and other child health researchers in innovative research to protect children and eliminate exposure to secondhand smoke. The awards are for up to $12,000.

**Julius B. Richmond CATCH Grants** – The AAP Community Access to Child Health (CATCH) grants support pediatricians in the development and implementation of programs
that address child health issues at the community level. The AAP Richmond Center funds CATCH projects that address eliminating children’s exposure to secondhand tobacco smoke. Up to $12,000 is awarded each year for these projects.

**Downloadable PowerPoint Presentations**

The Richmond Center offers PowerPoint presentations about a variety of tobacco control topics, which may be downloaded for professional use by clinicians, advocates, community organizations, and educators. Topics include, but are not limited to, motivational interviewing, tobacco use in special populations, teens’ tobacco use helping families quit smoking, promoting cessation, and pediatricians as smoking cessation counselors. Each presentation includes a slide set, speaker notes, and references. The slides can be personalized to reflect the person presenting the slides and the audience. Access to the decks is free of charger; however, the AAP Richmond Center should be credited with preparation of slide sets. Using the slides with the Center's logo is sufficient for noting the slides' origin. Individuals interested in tobacco control and prevention are encouraged to download the available slide decks to aid in presenting the tobacco control agenda with their respective peers and communities. For more information, visit [www2.aap.org/richmondcenter/PowerpointPresentations.html](http://www2.aap.org/richmondcenter/PowerpointPresentations.html).

**Additional Resources**

- **2012 State Tobacco Information** – Each packet features state-specific information about tobacco and secondhand smoke, including data and reports from the AAP, Centers for Disease Control and Prevention, the American Lung Association, and the North American Quitline Consortium. E-mail richmondcenter@aap.org to request a state packet.

- **Tobacco Prevention Policy Tool** – Pediatricians, other healthcare professionals, and other advocates who are interested in focusing their efforts on secondhand smoke and tobacco control policy at the practice, school, community, state, or national levels will discover innovative, evidence-based strategies and resources.

- **AAP Richmond Center Webinar Series** – The Richmond Center hosts webinars about tobacco control and prevention. Topics have included adolescent tobacco use, tobacco control advocacy, cessation and prevention efforts in the clinical setting, social media, and smoke-free multi-unit housing. Regular webinars will continue in 2012. These webinars are offered for continuing education credit and are archived on the RCE Web site.

- **Tobacco Control Issue Briefs** – The Richmond Center, in collaboration with the AAP Division of State Government Affairs, has released four issue briefs about Tobacco Cessation & Treatment Programs; Tobacco Control Funding; Tobacco Product Control; and Tobacco-Free Environments. The concise documents provide current overviews of the topics and ways members can get involved.

- **Richmond Center E-mail List** – Sign up to receive up-to-date information about tobacco and secondhand smoke initiatives, including funding opportunities, upcoming meetings and conferences, research tools, and more! Go to [www2.aap.org/richmondcenter/listserv.cfm](http://www2.aap.org/richmondcenter/listserv.cfm) to join the listserv today!
Solving The Puzzle - Resources for Pediatric Tobacco Control – This interactive guide includes resources for health care clinicians, guidance on working with youth and families, cessation materials, and strategies to keep communities smoke-free on multiple levels.

Faculty Expert Panel – Nationally-recognized experts in tobacco child health advocacy, clinical interventions, and public health interventions are available to speak at grand rounds, CME sessions, or other professional events.

For more information about these and other resources, please visit [www.aap.org/richmondcenter](http://www.aap.org/richmondcenter), or contact the Richmond Center at [richmondcenter@aap.org](mailto:richmondcenter@aap.org).
APPENDICES
Provider Training

New Logician Tool for Tobacco Screening, Counseling and Referral
Background

- Tobacco smoke exposure is linked to multiple poor pediatric health outcomes:
  - asthma exacerbations
  - increased respiratory tract infections
  - ear infections
  - sudden infant death syndrome

- Children living with a smoker are 3 times more likely to begin smoking themselves.

- 36% of children live with a smoker
Caregivers often see their child's pediatrician more than their own doctors, especially in the child’s first year of life.

A unique role and opportunity for pediatricians in promoting smoking cessation

National surveys of smoking caregivers indicate that although it is acceptable for pediatricians to ask about smoking, this rarely happens.
Background

**Barriers** for pediatricians around tobacco screening and counseling include limitations in:
- time/resources
- outcome expectancy/fears of negative reaction
- self-efficacy

**Office based systems** that aid providers in screening and counseling help!
- recall/reminder systems
- preventative service prompts
- patient education materials
Our Role

**ASK!**
About smoking and readiness to quit.

**ASSIST!**
A doctor’s recommendations do make a difference. Provide info regarding risks to child and support to the parent.

**REFER!**
Provide resources for counseling and cessation medications.
Our Role

The good news....

- You don’t have to do it all during a clinic visit!
- Use the resources available to you!
The Massachusetts Smokers' Helpline, funded by the Massachusetts Department of Public Health, provides the QuitWorks counseling services.

- Up to five calls to make contact with your patient
- Intake, assessment and brief motivational call
- Five telephone-based counseling sessions
- Referral to a website for smokers (www.makesmokinghistory.org)
- Referral to community tobacco treatment programs
- Follow-up calls at seven months

Increase screening, counseling and referral for environmental tobacco smoke (ETS) during primary care visits by utilizing the electronic medical record to support clinicians with:

- Screening prompts
- Decision Support
- Easy Printing of Handouts and Referral form
**New Logician Format**

ASK!

Screening for smoking and readiness to quit

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<td>Interested in quitting?</td>
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<td>Guns in the Home?</td>
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<td>TB Risk:</td>
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<td></td>
<td>Yes - more than 6 mo</td>
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**CLICK SMOKING**

Comments

Last PPD:

Result:
New Logician Format
## Assessment Categories

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<td>Thinking about quitting later – date not specified</td>
<td>Yes more than 6 months</td>
</tr>
<tr>
<td>Thinking about quitting later</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
</tbody>
</table>
New Logician Format

ASSIST!

Tips for Helping Smokers

Decision support reminders
# Tips for Helping Smokers

Stopping smoking involves a process of change that takes place in stages over time. It often takes many attempts to quit before a tobacco user achieves long-term success. This "stages of change" model defines five stages in the process of quitting. Parents will benefit from different intervention approaches at every stage.

The goal is to help the smoker *convince themselves* of the need for change

<table>
<thead>
<tr>
<th>IF THE PARENT IS...</th>
<th>THEN YOUR GOAL MIGHT BE TO...</th>
</tr>
</thead>
</table>
| **Not ready to quit**  
- is neither considering stopping nor actively paying attention to tobacco and health information. Does not see him/herself as vulnerable to health risks. | **Raise doubt** - and provide a strong recommendation to quit. Describe treatment supports available. Repeat at each visit.  
- Provide Second Hand Smoke info sheet |
| **Thinking about stopping - soon**  
- has considered strategies to help him/herself stop. | **Support setting a quit date soon.**  
- Discuss strategies to quit including counseling support and medications  
- Refer to QuitWorks program  
- Provide Second Hand Smoke info sheet |
| **Thinking about stopping - later**  
- is actively paying attention to information about the effects of tobacco use and ways to stop. | **Identify pros and cons** - of continuing to use tobacco in order to tip the balance toward making a quit attempt.  
- Provide Second Hand Smoke info sheet |
New Logician Format

Decision support based on readiness to quit
Smoking Handout

BEFORE YOU LIGHT UP, LOOK DOWN.

Learn how to protect your children and give them smoke-free lives.

What is secondhand smoke? Secondhand smoke is breathing in other people's tobacco smoke. Secondhand smoke sticks to clothing, hair, furniture, curtains, and expects even after a cigarette is put out. Secondhand smoke can make children and adults sick. Children are even more at risk because they breathe faster and take in more toxins that damage their developing bodies.

Secondhand smoke contains poisons. Secondhand smoke contains over 4,000 chemicals and poisons, including lead and arsenic. When you breathe secondhand smoke, you inhale the same chemicals as smokers do.

No amount of secondhand smoke is safe. Secondhand smoke is dangerous, even if you can't smell it. Opening a window, sitting in a separate room, or using air filters or a fan does not get rid of secondhand smoke.

Secondhand smoke in children causes more frequent rates of:
• Ear infections, "colds" and pneumonia
• Sudden infant death syndrome
• Wheezing and coughing
• Heart disease and many types of cancer

Secondhand smoke and asthma. Children with asthma have worse attacks and have attacks more often. A severe asthma attack can put a child's life in danger.

Give your children smoke-free lives.
• Do not let anyone smoke around your children.
• Make your home and car smoke-free.
• Ask guests or family members who smoke to smoke outdoors.

Consider quitting.
If you smoke, the best way to protect your children is to quit. You will be more likely to quit successfully if you use the patch, gum, or prescription medicine, instead of trying to quit on your own.

MassHealth and many health insurance plans pay for quit-smoking medicines. Learn which medicines your health insurance covers at www.makesmokinghistory.org.

If you feel you just can't quit right now, smoke outdoors, away from others.

Remember, most smokers try to quit a few times before they quit for good. If you've tried to quit before, you can try again.

FREE TELEPHONE SUPPORT IS AVAILABLE FOR ALL SMOKERS AND THEIR FAMILIES AT 1-800-TRY-TO-STOP (1-800-879-8278).

To learn more: www.makesmokinghistory.org Massachusetts Department of Public Health.
Quitworks Referral

Parent completes

Provider completes

Massachusetts Enrollment Form
Tobacco users can also call 1-800-To-Stop (1-800-829-8078) to receive services

QUITWORKS

I authorize this provider to release the information on this enrollment form to QUITWORKS and any other health care provider listed on this form.
## Quitworks Referral

### QUICKWORKS

**Quick Guide to Pharmacotherapy in Tobacco Treatment**

### NICOTINE REPLACEMENT OPTIONS

#### PATCHES

<table>
<thead>
<tr>
<th>Product</th>
<th>Initial</th>
<th>MAX</th>
<th>Treatment Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicoderm® CD</td>
<td>7 mg, 14 mg, 21 mg</td>
<td>Same as above</td>
<td>1 patch/24 hrs.</td>
</tr>
</tbody>
</table>

#### LOZENGES

<table>
<thead>
<tr>
<th>Product</th>
<th>Initial</th>
<th>MAX</th>
<th>Treatment Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicorette®</td>
<td>2 mg, 4 mg</td>
<td>20 pieces/24 hrs.</td>
<td>1 piece every 1-2 hrs.</td>
</tr>
</tbody>
</table>

#### INHALER

<table>
<thead>
<tr>
<th>Product</th>
<th>Initial</th>
<th>MAX</th>
<th>Treatment Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicotin利® Inhaler</td>
<td>10 mg/lit</td>
<td>6-16 puffs/day (max</td>
<td>3-6 months</td>
</tr>
</tbody>
</table>

#### NASAL SPRAY

<table>
<thead>
<tr>
<th>Product</th>
<th>Initial</th>
<th>MAX</th>
<th>Treatment Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicotin利® NS</td>
<td>1-2 doses/day</td>
<td>5 doses/err or 40 doses/day</td>
<td></td>
</tr>
</tbody>
</table>

#### NON-NICOTINE MEDICATIONS

<table>
<thead>
<tr>
<th>Product</th>
<th>Initial</th>
<th>MAX</th>
<th>Treatment Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varenicline®</td>
<td>0.5 mg/day/day 1-3</td>
<td>2 mg/day</td>
<td>Up to 12 weeks</td>
</tr>
</tbody>
</table>

---

Make smoking history.

---

*Product and Dosage Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. For insurance benefit information, the patient will need to contact their insurer directly. The cost or provision of these medications is not included as any part of the Quid Pro Quo. Please review the benefit information with your healthcare provider.*
Practice Primer

Tips for Tobacco Screening and Counseling
Ask for permission

“I am concerned about [your child’s] health [include personalized information e.g. asthma, ear infections etc]. Is it OK if we discuss how second hand smoke might be part of the problem?”

Provide relevant facts

“When children are exposed to second hand smoke it is as if they are smoking themselves”

“Children who are exposed to second hand smoke have more ear infections, asthma ….”
Engaging the Parent

- Elicit parent’s thoughts
  - “What are your thoughts and concerns about this?”

- Reflect the parent’s concerns
  - “You would really like to find a way to help avoid these asthma attacks.”
  - “You have made a big step in smoking outside”

- Assess readiness to quit
  - “What are your thoughts about quitting?”
Not Ready to Quit

- Parent clearly states little or no interest in quitting
  - Documentation in Logician - NO
  - Resources in Logician - Second Hand Smoke handout

- Sample responses
  - “I understand you are not ready to consider quitting right now. There are other ways that you can protect your child, such as only smoking outside. Here is some information that you can take home to read.”
  - “Thanks for taking the time to talk with me about this today. This is such an important topic that I will bring it up again so I can be sure to help when you are ready to quit.”
  - “When you are ready there is free help from experts and medications that make quitting easier.”
Interested in Quitting

- Parent indicates interest in quitting
  - “It's great that you are thinking about quitting. What are your thoughts about when you might be ready?”
Thinking about Quitting – Soon

- Parent is ready to quit in the near future
  - Documentation in Logician – Yes, next 30 days
  - Resources in Logician – QuitWorks referral form
- Goal: set quit date, provide support and resources
- Sample responses:
  - “It’s great that you are ready to give this a try. If it’s OK with you I would like to tell you about some programs that are available to help make quitting easier.”
  - Provide information about QuitWorks and MassHealth
Parent is thinking about quitting in the future

- Documentation in Logician – Yes, more than 6 month (default response unless parent identifies a specific date >30 day but < 6 mos)
- Resources in Logician – Second Hand Smoke handout

Goal: Identify pros and cons, inform about resources

Sample responses

- “It can take time to make the decision to quit. When you are ready to quit there is free help from experts and medications that can make it easier. I would like to just let you know what they are.”

- Provide information about QuitWorks and MassHealth
Sponsors

- Made possible by funding from:
  - The Department of Health and Human Services through the Boston Public Health Commission
  - &
  - The Massachusetts Chapter of the American Academy of Pediatrics
Evaluation of an Electronic Medical Record Based Tool for Tobacco Screening, Counseling and Referral: A Quality Improvement Intervention

Mona Sharifi, MD1, William G Adams, MD2 and Renée Boynton-Jarrett, MD, ScD2.

1Department of General Pediatrics, Children’s Hospital Boston, Harvard Medical School, 2Department of General Pediatrics, Boston Medical Center, Boston University School of Medicine.

Dr. Sharifi is supported by Grant No. T32 HS194485-01 from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services.

BACKGROUND
- Environmental tobacco smoke (ETS) exposure is linked to multiple childhood morbidities.
- Living with a smoker increases risk of smoking initiation three-fold.
- National surveys indicate low rates of ETS screening, counseling, and referral by pediatricians despite acceptability by parents.

OBJECTIVE
To assess the efficacy of an electronic medical record (EMR) based tool in facilitating ETS screening, counseling, and referral during pediatric routine healthcare maintenance (RHCM).

METHODS
Subjects/Setting: 48 physicians (34 residents and 14 attendings) working in a teaching hospital-based, urban pediatric primary care clinic in Boston
Measures:
- (1) Pooled client data from state quitline (QuitWorks) for referral rates.
- (2) Provider surveys assessing attitudes and practice around ETS management during RHCM.
Data Analysis: Descriptive statistics with chi-square tests for categorical variables

RESULTS: SURVEY DATA
Table 1. Characteristics of Survey Participants

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention (N=37)</th>
<th>Post-Intervention (N=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Gender</td>
<td>59%</td>
<td>57%</td>
</tr>
<tr>
<td>Resident (vs. Attending)</td>
<td>70%</td>
<td>68%</td>
</tr>
<tr>
<td>Years at this Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;2</td>
<td>70%</td>
<td>68%</td>
</tr>
<tr>
<td>≥2-3</td>
<td>30%</td>
<td>32%</td>
</tr>
<tr>
<td>Clinic Sessions / Week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 half-day</td>
<td>59%</td>
<td>57%</td>
</tr>
<tr>
<td>2-3 half days</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>&gt;3 half days</td>
<td>16%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Table 2. Self-Reported Physician Practice

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention (N=37)</th>
<th>Post-Intervention (N=28)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for ETS</td>
<td>54%</td>
<td>71%</td>
<td>0.154</td>
</tr>
<tr>
<td>(often/always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ETS Counseling</td>
<td>46%</td>
<td>71%</td>
<td>0.039</td>
</tr>
<tr>
<td>(often/always)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offering referral for</td>
<td>30%</td>
<td>50%</td>
<td>0.006</td>
</tr>
<tr>
<td>smoking caregivers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(often/always)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RESULTS: QUITWORKS DATA
- Quitline counselors were able to reach 56% of all referred parents, of whom all received literature, 68% received either counseling (66%), nicotine replacement therapy (63%), or both.

SUMMARY
- Implementation of an EMR-based ETS management tool lead to a significant increase in physician self-reported counseling and referral, and rates of QuitWorks referral as measured by the state quitline agency.
- Physicians reported high rates of satisfaction with the new EMR system and felt they were more skilled in ETS screening, assessing stage of change, motivational interviewing and counseling post-intervention.

LIMITATIONS
- Small sample size of providers limits power of physician attitude analysis.
- Absence of control population does not account for changes in attitudes and practice around ETS management secondary to forces outside of this intervention.
- Relative short course of study does not adequately assess sustainability of change in practice.
- Survey data is prone to potential observer bias, selection bias and response bias toward “correct or pleasing reply.”

IMPLICATIONS
- High rates of physician satisfaction with the new ETS management tool and increased subjective skill in screening and counseling associated with this intervention may lead to greater referral to state quitlines.
## Tips for Helping Smokers

Stopping smoking involves a process of change that takes place in stages over time. It often takes many attempts to quit before a tobacco user achieves long-term success. This "stages of change" model defines five stages in the process of quitting. Parents will benefit from different intervention approaches at every stage.

The goal is to help the smoker **convince themselves** of the need for change

<table>
<thead>
<tr>
<th>IF THE PARENT IS...</th>
<th>THEN YOUR GOAL MIGHT BE TO...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not ready to quit:</strong></td>
<td><strong>Raise doubt</strong> and provide a strong recommendation to quit. Describe treatment supports available. Repeat at each visit.</td>
</tr>
<tr>
<td>- is neither considering stopping nor actively paying attention to tobacco and health information. Does not see him/herself as vulnerable to health risks.</td>
<td>- &quot;I understand you are not ready to consider quitting right now. There are other ways that you can protect your child, such as only smoking outside. Here is some information that you can take home to read&quot;</td>
</tr>
<tr>
<td>✓ Document “No” in Logician</td>
<td>✓ Provide Secondhand Smoke info sheet</td>
</tr>
<tr>
<td><strong>Thinking about stopping - soon</strong></td>
<td><strong>Support setting a quit date soon.</strong> Discuss strategies to quit including counseling support and medications</td>
</tr>
<tr>
<td>- has considered strategies to help him/herself stop.</td>
<td>- &quot;It’s great that you are ready to give this a try. If it’s OK with you, I would like to tell you about some programs that are available to help make quitting easier&quot;</td>
</tr>
<tr>
<td>✓ Document “Yes next 30 days” in Logician</td>
<td>✓ Referral to QuitWorks if desired</td>
</tr>
<tr>
<td><strong>Thinking about stopping - later</strong></td>
<td><strong>Identify pros and cons</strong> of continuing to use tobacco in order to tip the balance toward making a quit attempt.</td>
</tr>
<tr>
<td>- is actively paying attention to information about the effects of tobacco use and ways to stop.</td>
<td>- “It can take time to make the decision to quit. When you are ready to quit, there is free help from experts and medications that can make it easier. I would like to just let you know what they are.”</td>
</tr>
<tr>
<td>✓ Document “Yes, &gt;6 months” in Logician</td>
<td>✓ Provide Secondhand Smoke info sheet</td>
</tr>
<tr>
<td><strong>No longer using tobacco</strong></td>
<td><strong>Prevent relapse</strong> by reviewing benefits of staying quit and of successes experienced.</td>
</tr>
<tr>
<td>- has been without tobacco for up to six months. This is a crucial period in terms of relapse.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintaining abstinence</strong></td>
<td><strong>Encourage another quit attempt.</strong> New referral to QuitWorks program, educational literature, support.</td>
</tr>
<tr>
<td>- has been without tobacco for over six months and is establishing long-term abstinence.</td>
<td></td>
</tr>
<tr>
<td><strong>Back to regular smoking</strong></td>
<td></td>
</tr>
<tr>
<td>- has recycled to any of the first three stages.</td>
<td></td>
</tr>
</tbody>
</table>
## Tips for Tobacco Screening and Counseling

<table>
<thead>
<tr>
<th>STEPS FOR THE PROVIDER</th>
<th>WHAT YOU MIGHT SAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Ask for permission:</strong> asking for permission to discuss a topic can feel awkward, but many clinicians find it a quick and effective way to reduce resistance. It conveys respect for the parent’s decision-making ability and engages them as a partner in the care of their child.</td>
<td>“I am concerned about [your child’s] health [include personalized information e.g. asthma, ear infections, etc]. Is it OK if we discuss how second hand smoke might be part of the problem?”</td>
</tr>
<tr>
<td><strong>2. Provide relevant facts:</strong> this gives the parent the opportunity to consider the facts and apply them to their personal situation.</td>
<td>“When children are exposed to second hand smoke it is as if they are smoking themselves.” “Children who are exposed to second hand smoke have more ear infections, asthma…”</td>
</tr>
<tr>
<td><strong>3. Elicit parent’s thoughts:</strong> Giving the parent an opportunity to express their own concerns helps them to begin to verbalize some of their own reasons to change their smoking behavior.</td>
<td>“What are your thoughts and concerns about this?”</td>
</tr>
<tr>
<td><strong>4. Reflect the parent’s concerns:</strong> reflecting back to the parent what you hear about their concerns to them demonstrates that you have heard them and respect their point of view. Try to reflect anything you hear that can be linked to a reason to quit.</td>
<td>“You would really like to find a way to help avoid these asthma attacks.” “You have made a big step in smoking outside.”</td>
</tr>
<tr>
<td><strong>5. Assess readiness to quit:</strong> If the parent has not yet expressed their thoughts about quitting this is a good time to ask. This type of open ended question helps to reduce resistance.</td>
<td>“What are your thoughts about quitting?”</td>
</tr>
</tbody>
</table>
Fax Referral To: Clinical Outcomes Group, Inc.
Attention: Kelly Ann Pegg Fax #: 570-628-5899
Geisinger Prenatal to Pediatrics
Tobacco Cessation/Smoke-Free Home Referral Form

1. Name _____________________________________
   First                                                                 Last

2. Address _____________________________________
   Street                                                               City
   PA State Zipcode

3. Telephone _______________________   _______________________   _____________________
   Home                                                             Cell                                                            Work

4. Best time to contact _________________    E-mail Address ________________________________
   _______________________________________________________ _____________________
   Signature of Client                          Date

I, ________________________________________ (printed name), hereby authorize Geisinger Medical Groups staff to release my contact information to Clinical Outcomes Group Inc. for provision of tobacco cessation or smoke-free home services, who has partnered with Geisinger Medical Groups in this endeavor. I understand that Clinical Outcomes Group Inc. will not share this information with any other group or organization without my written consent. I also understand that Clinical Outcomes Group Inc. will contact me to set up an appointment for tobacco cessation or smoke-free home services. Participation in this agreement in no way binds the client to services with Clinical Outcomes Group, Inc. The purpose is to serve the client who desires, even slightly, to quit tobacco use or learn harm-reduction techniques in order to protect others from second-hand smoke. All information provided is confidential.

As the physician of the client listed, I approve the use of Nicotine Replacement Therapy (NRT). At least one of the following MUST be indicated.

☐ I recommend the following NRT:  
   - 21 mg patches
   - 14 mg patches
   - 7 mg patches
   - 4 mg gum
   - 2 mg gum

☐ I prescribe the following medications:
   - Chantix
   - Nasal Spray
   - Zyban
   - Inhaler

☐ I prescribe NRT; Clinical Outcomes Group, Inc. to determine amount and type of NRT.

Signature of Medical Staff:

Print name ___________________ Date ________ Phone ____________________________

CONFIDENTIAL: For Internal Use Only
This survey examines nurses’ and physicians’ perceptions and experiences regarding the smoking cessation counseling training and implementation of the acquired methods in clinical practice.

Please respond according to your own experiences. Please read the instructions before completing each section of the questionnaire.

All responses will be kept confidential – there will be NO attempt to link responses back to you or the clinic where you work. The survey requires approximately 10 minutes to complete.

### Training Specific Evaluation: After receiving this training, how do you rate your skills regarding the following:

<table>
<thead>
<tr>
<th></th>
<th>Highly Effective</th>
<th>Adequate</th>
<th>Weak</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

1. Counseling patients on the risks of second hand smoke (SHS) and third hand smoke (THS).

2. Counseling patients on how to protect their children from SHS and THS.

3. Motivating pregnant patients and parents to reduce their child’s SHS exposure while acknowledging the barriers facing smokers as they try to quit.

### Training Specific Evaluation: After receiving this training, how do you rate your confidence regarding the following:

<table>
<thead>
<tr>
<th></th>
<th>High</th>
<th>Adequate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

4. Educating patients on the use of nicotine replace therapy (NRT).

5. Applying evidence-based smoking cessation counseling techniques to smoking parents.

6. Implementing the process at Geisinger Health System for referral to Clinical Outcomes Group, Inc. (COGI) for smoking cessation counseling.

### Clinical practice: How often do you encounter the following:

7. Patient’s friends or family members smoke and their children encountered no health problems, so the patient sees no reason to stop smoking.
   - □ Always
   - □ Often
   - □ Sometimes
   - □ Never

8. Patient or parent is stressed (due to multiple caregivers, marital problems, financial problems, etc.) and finds it difficult to quit smoking.
   - □ Always
   - □ Often
   - □ Sometimes
   - □ Never
9. Patient feels smoking cessation is only necessary during pregnancy or when child is symptomatic.

- Always
- Often
- Sometimes
- Never

10. Patient believes that nicotine replacement therapies (NRTs) are ineffective.

- Always
- Often
- Sometimes
- Never

11. Patient can not afford nicotine replacement therapies (NRTs) or cessation counseling.

- Always
- Often
- Sometimes
- Never

**NURSE/PROVIDER ISSUES:** In general, how often do the following nurse/provider interactions occur at your clinic?

12. Nurses and providers use a team approach to address smoking cessation

- Always
- Often
- Sometimes
- Never

13. Providers reinforce the information provided by a nurse.

- Always
- Often
- Sometimes
- Never

14. Please identify other things about smoking cessation assessment and counseling that might be important but were not included in the program?
15. Please tell us a little about yourself. **This information will be used only to describe those participated in this survey.**
   
a. what is your discipline?
   
   □ Physician
   □ Nurse
   □ Other _______________

b. What is your primary clinical area?
   
   □ Prenatal care prenatal
   □ OB
   □ Childbirth unit
   □ Pediatrics & well child care
   □ Pediatrics specialty care
   □ Other _______________

**Thank you for participating in this survey!**
Parental Smoking Cessation Study BPA and Flowsheet

Parental Smoking Cessation BPA upon entering an encounter

Parental Smoking Cessation Flowsheet (will fire 3 questions)
Selecting “Yes” on the 1st question in the Exposure section will open up to two additional questions.

Selecting Yes under the Caregiver section will open up 2 additional questions.
Selecting “Yes” on the 3rd question in the Caregiver section will open up 5 additional selections.

Selecting “No” on the 3rd question in the Caregiver section will open up to 1 additional selection.
To find the flowsheet history, after entering your encounter go to the activity and click “flowsheets”.

The menu box will automatically appear, the flowsheet can either be selected by scrolling on the menu bar or click “cancel” and under “select flowsheet to view” ID your flowsheet.
Parental Smoking Cessation Study BPA and Flowsheet

This opens the flowsheet report. This report will show the questions from the flowsheet, history of the dates and the answers that were recorded.
May 2011

<table>
<thead>
<tr>
<th># referrals received</th>
<th>55</th>
</tr>
</thead>
<tbody>
<tr>
<td># COGI was able to contact*</td>
<td>36 (65%)</td>
</tr>
<tr>
<td># who enrolled in at least one session</td>
<td>35 (97%)</td>
</tr>
<tr>
<td># who declined to participate in counseling</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

*some referrals are still in the contact-process. COGI standard contact-process includes 3 phone calls and a letter to referrals.

Cumulative 2011

<table>
<thead>
<tr>
<th># referrals received</th>
<th>234</th>
</tr>
</thead>
<tbody>
<tr>
<td># COGI was able to contact</td>
<td>138 (59%)</td>
</tr>
<tr>
<td># who enrolled in at least one session</td>
<td>131 (95%)</td>
</tr>
<tr>
<td># who declined to participate in counseling</td>
<td>7 (5%)</td>
</tr>
<tr>
<td># who report being quit at 4th counseling session</td>
<td>21 (15%)</td>
</tr>
<tr>
<td># contact for 30 day follow-up*</td>
<td>3</td>
</tr>
<tr>
<td>% able to demonstrate 30 day point prevalence quit rate at follow up*</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>% reported SF home at 30 day follow-up*</td>
<td>2 (67%)</td>
</tr>
</tbody>
</table>

*30 day follow-up count begins at the last counseling session or client contact

The referrals are steadily coming in, and that is wonderful. More people are referring family members for services as well. Clinic staffs are encouraged to offer the opportunity of cessation services to both their patient and their family members, keeping in mind that each person is a separate referral and therefore each person must sign the referral for him/herself. We can discuss and develop a simple takeaway for patients interested in cessation services for family members who do not accompany them to the clinic, so that these family members can call COGI directly for services.
Appendix A: Recruitment and Outcomes
Section 1: Recruitment and Follow-up with Pediatricians

Ten pediatricians, four from the treatment practice and six from the control practice, participated originally in this study. Baseline data on these pediatricians is presented here.

First, we asked whether the pediatrician’s role involves addressing tobacco use among children/teens. Notably, 50% reported that it was often required, whereas the other 50% reported that it was always a necessity. In this highly motivated sample of physicians, 80% reported feeling comfortable at baseline in discussing tobacco use with patients. However, only half believed that their patients would be honest with them if asked about tobacco use.

Interestingly, there was a bimodal distribution on an item assessing whether pediatricians believed they could prevent cigarette smoking. Half of the physicians believed they could have little prevention effect, whereas the other half believed they could have a lot of impact on prevention. When it comes to smoking cessation, the pediatricians were even less encouraged: Eighty percent of them believed they could have little effect on teen smoking cessation, and only 20% thought they could have a lot of impact on helping adolescents quit. These data are in line with other research suggesting that pediatricians generally feel discouraged about the utility of their role in tobacco reduction (Frankowski & Secker-Walter, 1989).

We also asked the pediatricians about their current practices in following the Agency for Health Care Policy and Research (AHCPR) Smoking Cessation Clinical Practice Guideline guidelines (Fiore, Bailey, Cohen, et al., 1997). According to their reports, 70% of the pediatricians often asked about their patients’ tobacco use and 90% advised against smoking often or always. However, only 20% reported sometimes helping to arrange for a teen to quit. None of the group of pediatricians reported scheduling a follow-up visit to see how a patient was doing with quitting. In addition, none reported prescribing smoking cessation medication for their patients.

Other items assessed barriers that pediatricians might encounter that could interfere with their ability to discuss tobacco use with their patients. Twenty percent reported that they were not sure what to say. More frequently, there were concerns about the parent: 40% indicated that they were unsure about approaching the topic with a parent present. Half of the pediatricians reported that limited time was a concern, and 20% simply believed that their efforts to address the topic would not influence the child’s smoking.

Regarding conversations with parents, only 10% of the doctors reported that they felt it was always part of the pediatrician’s role to discuss tobacco use among parents. Twenty percent thought it was never appropriate, 40% thought it was rarely appropriate, and 30% thought it was sometimes part of the pediatrician’s role.

It should be noted that the above data concerning physician behavior and attitudes should be considered suggestive only. The small sample size limits the possibility of generalizing to the larger population of physicians. Nonetheless, it does give us information about the particular pediatricians enrolled in this study.
Section 2: Recruitment and Follow-up with Parents

Our original proposal called for 120 parents to be recruited into each arm of the study, or 60 in the treatment condition and 60 controls. Given the number of patients seen annually, the estimated parental smoking rate, and estimated percent of the parents with age-eligible offspring, we expected that 462 eligible cases would present within 6 months.

As it turned out, we screened far more parents ($N = 1176$) for the study than anticipated. As Table 1 indicates, only 5.62% of the parents screened were eligible, because of language barriers, lack of an age-eligible child, and/or non-smoking status. Of the 63 eligible parents approached about the study, only one declined participation, suggesting that parents are receptive to clinical research on tobacco in primary care settings.

Of the 62 parents recruited, however, only 41 (66.1%) completed the one-month follow-up (see Table 2). Eleven parents (18% of those recruited) did not return our phone calls. About 10% of the parents in the study could not be reached for follow up, because their given phone number was inaccurate or disconnected. Two more did not provide contact information at pre-test, and another two parents declined to complete the second evaluation.

| Table 1 | Recruitment at Baseline |
|---|---|---|
| Criterion | $n$ | % |
| Total Approached ($N = 1176$) | | |
| Not eligible | 1112 | 94.56 |
| Eligible | 63 | 5.36 |
| Declined | 1 | 0.09 |
| Participated | 62 | 5.27 |

| Table 2 | Recruitment at Follow-Up |
|---|---|---|
| Follow-up Issue | $n$ | % |
| Total Participants ($N = 62$) | | |
| Posttest completion | 41 | 66.13 |
| Disconnected/invalid number | 6 | 9.68 |
| No contact information | 2 | 3.23 |
| Declined participation | 2 | 3.23 |
| Did not return follow-up call | 11 | 17.74 |
| Total Attrition | 21 | 33.87 |
Section 3: Characteristics of the Parent Sample

Data on the characteristics of the parents who enrolled in the study are presented in Table 3. As can be seen, 92% of the sample was female, with an average age of 36 years. African Americans comprised 39% of the sample, 48% were Caucasian, and 11% were of other ethnicities. Only 27% were married; of the rest, 47% were never married, 12% were divorced, 2% widowed, and 12% separated. Educational level was generally low, with 61% of the sample having a high school education or less. Annual income was similarly depressed; 47% of the parents made only $10,000 to $19,000 a year.

Turning to smoking practices, 95% of those recruited to the study reported using tobacco. Of the remaining participants, 5% smoked more than a pack per day (ppd), 32% smoked a ppd, 47% smoked about ½ a ppd, and about 8% smoked less. It should be noted that African Americans were a large portion of our sample and they typically smoke fewer cigarettes per day relative to Caucasians (Trinidad et al., 2009). Notably, 75% of our parents were in the Contemplation Stage of Change at the beginning of the study, whereas 26% were in Precontemplation (that is, not considering quitting). Approximately 29% of the smokers had managed to quit for at least a week in the past.

Regarding their attitudes at baseline toward physician intervention, most of these smoking parents believed it was very important for pediatricians to discuss tobacco use with children and teens (87%). However, they were not hopeful that such discussions could actually decrease the odds of children smoking: Only 27% reported that pediatrician intervention could prevent smoking “a lot.” They were similarly doubtful about pediatricians’ ability to help children quit smoking. Only 37% believed that pediatricians could help youth who smoke to stop. Parents were even less likely to believe that pediatricians or their own doctor could assist their own quit attempt.

We also asked parents about their personal feelings if they were asked about their own tobacco use by a physician. Only 14% of our smoking parents reported that they would be “very” or “somewhat upset” if their child’s pediatrician discussed their own tobacco use. In contrast, 42% of the sample reported that they would not care, and 42% reported that they would be “somewhat” or “very relieved” to be asked about their smoking. Parents were even more receptive when asked about their reaction to their personal physician’s inquiry about smoking.

Finally, we asked parents about the importance of pediatricians discussing tobacco use with parents. Over half (55%) reported that they considered this to be “very important.” Another 31% viewed a discussion about tobacco as “somewhat important.” Only 13% regarded a pediatrician/parent discussion about smoking as “somewhat” or “very unimportant.”
Table 3  
Participant Parents’ Baseline Characteristics  

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>56</td>
<td>91.8%</td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>8.2%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>30</td>
<td>49.2%</td>
</tr>
<tr>
<td>Black</td>
<td>24</td>
<td>39.3%</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>11.5%</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>16</td>
<td>27.6%</td>
</tr>
<tr>
<td>Divorced</td>
<td>7</td>
<td>12.1%</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>Separated</td>
<td>7</td>
<td>12.1%</td>
</tr>
<tr>
<td>Never married</td>
<td>27</td>
<td>46.6%</td>
</tr>
<tr>
<td>Highest education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary or middle school</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>Some high school</td>
<td>10</td>
<td>16.9%</td>
</tr>
<tr>
<td>High school or GED</td>
<td>25</td>
<td>42.4%</td>
</tr>
<tr>
<td>Some college or technical school</td>
<td>18</td>
<td>30.5%</td>
</tr>
<tr>
<td>Graduated from college</td>
<td>5</td>
<td>8.5%</td>
</tr>
<tr>
<td>Annual income</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>$10,000 to $19,000</td>
<td>29</td>
<td>52.7%</td>
</tr>
<tr>
<td>$20,000 to $29,000</td>
<td>10</td>
<td>18.2%</td>
</tr>
<tr>
<td>$30,000 to $39,000</td>
<td>9</td>
<td>16.4%</td>
</tr>
<tr>
<td>$40,000 to $49,000</td>
<td>3</td>
<td>5.5%</td>
</tr>
<tr>
<td>$70,000 to $79,000</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td>$80,000 or more</td>
<td>3</td>
<td>5.5%</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoked &gt; 100 cigarette in lifetime</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58</td>
<td>95.1%</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>4.9%</td>
</tr>
<tr>
<td>Smoked in the last 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>56</td>
<td>91.8%</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>8.2%</td>
</tr>
<tr>
<td>How many cigarettes usually smoke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>5</td>
<td>8.3%</td>
</tr>
<tr>
<td>About one cigarette per week</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>About one cigarette per day</td>
<td>4</td>
<td>6.7%</td>
</tr>
<tr>
<td>About 10 cigarettes per day</td>
<td>28</td>
<td>46.7%</td>
</tr>
<tr>
<td>About a pack a day</td>
<td>19</td>
<td>31.7%</td>
</tr>
<tr>
<td>More than a pack a day</td>
<td>3</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

(Table continued on following page.)
<table>
<thead>
<tr>
<th>Variable</th>
<th>$n$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking of quitting next month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30</td>
<td>50.0%</td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>50.0%</td>
</tr>
<tr>
<td>Thinking of quitting next 6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>45</td>
<td>75.0%</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>25.0%</td>
</tr>
<tr>
<td>Stopped smoking at least 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25</td>
<td>49.0%</td>
</tr>
<tr>
<td>No</td>
<td>26</td>
<td>51.0%</td>
</tr>
<tr>
<td>Stopped smoking at least a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>28.6%</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>71.4%</td>
</tr>
<tr>
<td>Stopped smoking at least a month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>23.5%</td>
</tr>
<tr>
<td>No</td>
<td>39</td>
<td>76.5%</td>
</tr>
<tr>
<td>Stages of change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precontemplation</td>
<td>14</td>
<td>26.2%</td>
</tr>
<tr>
<td>Contemplation</td>
<td>40</td>
<td>74.1%</td>
</tr>
<tr>
<td><strong>Pediatrician Communications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Importance of pediatrician discuss tobacco use with children/teens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very important</td>
<td>54</td>
<td>87.1%</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>6</td>
<td>9.7%</td>
</tr>
<tr>
<td>Not very important</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>Not at all important</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>How much pediatricians prevent smoking in children and teens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>6.6%</td>
</tr>
<tr>
<td>A little</td>
<td>20</td>
<td>32.8%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>20</td>
<td>32.8%</td>
</tr>
<tr>
<td>A lot</td>
<td>4</td>
<td>27.9%</td>
</tr>
<tr>
<td>How much pediatricians can help children and adolescents quit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A little</td>
<td>21</td>
<td>33.9%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>18</td>
<td>29.0%</td>
</tr>
<tr>
<td>A lot</td>
<td>23</td>
<td>37.1%</td>
</tr>
<tr>
<td>How much pediatricians can prevent smoking in parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>9</td>
<td>14.8%</td>
</tr>
<tr>
<td>A little</td>
<td>26</td>
<td>42.6%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>18</td>
<td>29.5%</td>
</tr>
<tr>
<td>A lot</td>
<td>8</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

(Table continued on following page.)
### Pediatrician Communications

**How much pediatricians can help parents quit smoking**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5</td>
<td>8.1%</td>
</tr>
<tr>
<td>A little</td>
<td>24</td>
<td>38.7%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>22</td>
<td>35.5%</td>
</tr>
<tr>
<td>A lot</td>
<td>11</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

**Feelings if pediatrician discussed your tobacco use**

<table>
<thead>
<tr>
<th>Feeling</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very annoyed</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>Somewhat annoyed</td>
<td>8</td>
<td>13.1%</td>
</tr>
<tr>
<td>I wouldn't care</td>
<td>26</td>
<td>42.6%</td>
</tr>
<tr>
<td>Somewhat relieved</td>
<td>13</td>
<td>21.3%</td>
</tr>
<tr>
<td>Very relieved</td>
<td>13</td>
<td>21.3%</td>
</tr>
</tbody>
</table>

**Feelings if own doctor talked about your tobacco use**

<table>
<thead>
<tr>
<th>Feeling</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very annoyed</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>Somewhat annoyed</td>
<td>3</td>
<td>4.9%</td>
</tr>
<tr>
<td>I wouldn't care</td>
<td>26</td>
<td>42.6%</td>
</tr>
<tr>
<td>Somewhat relieved</td>
<td>14</td>
<td>23.0%</td>
</tr>
<tr>
<td>Very relieved</td>
<td>17</td>
<td>27.9%</td>
</tr>
</tbody>
</table>

**Importance of pediatricians discussing with parents about smoking**

<table>
<thead>
<tr>
<th>Importance</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very important</td>
<td>34</td>
<td>55.7%</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>19</td>
<td>31.1%</td>
</tr>
<tr>
<td>Not very important</td>
<td>7</td>
<td>11.5%</td>
</tr>
<tr>
<td>Not at all important</td>
<td>1</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

*Note: N = 62.*

### Section 4: Changes in Pediatricians’ Beliefs over Time

Due to the short-term involvement of the control practice, follow-up data on only the four physicians in the treatment condition were available. Thus, the analyses lacked the power needed to identify statistically significant changes over time. Instead, these findings are being reported as descriptive data on this group of pediatricians.

The perceived prevalence of smoking simply measures the proportion of the population that adolescents believe smoke. The higher the teens’ perceived prevalence of smoking, the more likely they are to take up tobacco. We were interested in the degree to which pediatricians might also show this bias toward overestimating tobacco use. In fact, we found that the physicians did overestimate the prevalence of smoking among high school students at pretest (27%) and at posttest (30%) despite receiving information on the correct rate of use (i.e., 20%). Further, the physicians overestimated tobacco use among parents at pretest (41%), although their posttest estimate (25%) was much closer to the actual average (21%). It appears that more powerful messages are needed to
ensure that pediatricians will not inadvertently assume that smoking among both teens and parents is more common than it is.

Other analyses focused on pediatricians’ perceptions that they can help prevent child and adolescent smoking. Despite our small sample size, the results revealed a marginally significant increase in the perception that they could be effective in preventing tobacco use, \(paired t (3) = 3.0, p = .058\).

Other variables generally showed change in a positive direction, although a shift over time could not be detected statistically, given our reduced power.

**Section 5: Changes in Parents’ Beliefs & Knowledge over Time**

**Parental Attitudes toward Smoking among Children and Teens**
We asked parents about their attitudes toward smoking among children and teens in two separate questions. Both were rated on 4-point Likert scales, with high scores indicating more disapproval of underage smoking.

Analysis revealed no changes over time in both variables. Inspection of the pretest data (see Table 4) suggested the reason for this lack of change: At pretest, all parents except one reported that they strongly disapproved of their child smoking. Parents’ opinions about teens’ smoking were not as extreme, but almost all still reported disapproval at pretest (\(M = 2.80, SD = .51\)). Thus, the scores were so extreme at pretest that a ceiling effect prevented any statistical change over time.

**Table 4**

*Changes in Attitudes toward Youth Smoking*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Test ((n = 41))</th>
<th>Post-Test ((n = 41))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval of children smoking</td>
<td>2.98 (0.15)</td>
<td>2.98 (0.15)</td>
</tr>
<tr>
<td>Approval of teens smoking</td>
<td>2.80 (0.51)</td>
<td>2.90 (0.30)</td>
</tr>
</tbody>
</table>

We should note that these data on parental attitudes toward teen smoking are at odds with data produced by teens in other research (Robinson et al., 2012, manuscript in preparation). This study, using a longitudinal sample of approximately 7,000 teens, showed that by the time Caucasian adolescents reach the middle of high school, *they believe* their parents do not care if they smoke. It should be noted, however, that the current study was largely composed of people of color. Previous research has shown that African American parents, in particular, are more likely to view smoking as unacceptable among both children and teens (Robinson, Jackson, & Hum, 2012). Thus, the degree of disapproval of child/adolescent smoking that we observed in the current study may partly be a reflection of normative anti-tobacco beliefs among parents of color.
Parental Knowledge about the Effects of Smoking
Two standard questions about the dangerousness of smoking were asked. First, we asked whether it is safe for children or teens to smoke only for a year or two, as long as they quit. Second, we asked whether smoking causes serious illness in children and teens while they are still young. Both items called for ratings on 4-point Likert scales, with higher scores indicating stronger agreement.

Once again, both variables were quite skewed toward agreement (see Table 5). Thus, even at pretest, the majority of parents were well aware of the dangers smoking poses to children and teens. Not surprisingly, given this restricted range, there were no significant changes on both variables.

Table 5  
Changes in Knowledge on Youth Smoking Dangers

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Test</th>
<th>Post-Test</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe for children or teens to smoke a year or two</td>
<td>40</td>
<td>2.90 (0.30)</td>
<td>2.85 (0.36)</td>
<td>1.00</td>
</tr>
<tr>
<td>Smoking causes serious illness in children and teens</td>
<td>41</td>
<td>2.54 (0.59)</td>
<td>2.56 (0.74)</td>
<td>-0.19</td>
</tr>
</tbody>
</table>

Parents’ Estimates of the Perceived Prevalence of Smoking
We asked parents to estimate the prevalence of smoking among parents in ten families. Similar questions were asked about the prevalence of smoking among both middle school students and teens. Previous research (Robinson & Klesges, 1997) has shown that adolescents who believe that smoking is quite common are at greater risk for tobacco use. As such, we wondered whether it would be helpful to give parents accurate information about smoking prevalence among teens and children. The question about parents’ estimate of the prevalence of smoking among other parents was used on an exploratory basis.

We should note that our physician intervention focused on tobacco control and only briefly referred to information about smoking prevalence among children, adolescents, or parents. However, our handout for parents did report that about 20% of adolescents and 8% of children smoke. It did not address the prevalence of parental tobacco use.

The results of our questions about prevalence were interesting. At baseline, parents believed that 61.8% of parents smoke around their children, a value that did not change significantly over time (paired t (38) = 0.00, p = 1.00). This is a strong overestimate of the prevalence of parental smoking.

Further, at baseline parents believed that 42.5% of middle school youth used tobacco. This estimate is a gross overestimate of smoking in middle school. Despite our providing correct information in the parent brochure on smoking among middle school children, we observed no changes over time in this estimate (paired t (39) = -0.82, p = .41).
Parents estimated at baseline that 61.6% of high school students used tobacco, a figure that is also an overestimate. Once again, no significant changes in perceived prevalence occurred over the course of the study.

In summary, these smoking parents greatly overestimated smoking frequency. It appears that a stronger message than that offered in this study is necessary in order to change these perceptions.

**Section 6: Changes in Parents’ Behavior over Time**

The central purpose of the project was to get parents to increase their efforts at tobacco control. This point was emphasized by the pediatricians delivering the intervention to parents, and it was also covered in the brochure designed for parents.

We measured potential changes in tobacco control in a number of different ways. One item asked parents how difficult it would be to keep their tobacco products away from their offspring. Parents responded on a Likert scale ranging from “extremely difficult” (0) to “very easy” (3). Thus, higher scores indicated that parents believed it would be easy to control their children’s access to tobacco. Our analyses showed a significant improvement over time, paired t (39) = 3.56, p = .001. At pretest, these smoking parents reported that it was relatively difficult to keep tobacco away from their children (M = 1.85, SD = 1.15); at posttest, they were more likely to report that this was somewhat to very easy (M = 2.38, SD = .93).

Parents were asked how many methods they used to restrict their tobacco from their children. At pretest, they reported using on average only 2.6 of 8 possible ways of restricting tobacco. At posttest, they used an average of 3.6 ways of limiting tobacco, a statistically significant improvement, paired t (38) = 2.47, p = .018.

What techniques did the parents learn to use for controlling tobacco? Results (see Table 6) indicated that at posttest, parents were significantly more likely to count the cigarettes in their packs than they were at pretest. Similarly, they were more likely to count the packs they had than at pretest. Parents were also significantly more likely to keep their tobacco at work and to keep their tobacco with them, rather than leaving it where children could get it.
Table 6
Changes in the Proportion of Participants that Acknowledged Using Several Tobacco Control Techniques

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>Pre</th>
<th>Post</th>
<th>Cochran's Q</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counting cigarettes in pack</td>
<td>37</td>
<td>27%</td>
<td>49%</td>
<td>4.571</td>
<td>.033</td>
</tr>
<tr>
<td>Counted the number of packs</td>
<td>36</td>
<td>22%</td>
<td>44%</td>
<td>4.571</td>
<td>.033</td>
</tr>
<tr>
<td>Watched the amount of smokeless</td>
<td>16</td>
<td>31%</td>
<td>19%</td>
<td>0.667</td>
<td>.414</td>
</tr>
<tr>
<td>Hidden tobacco</td>
<td>37</td>
<td>30%</td>
<td>35%</td>
<td>0.400</td>
<td>.527</td>
</tr>
<tr>
<td>Locked up tobacco</td>
<td>36</td>
<td>28%</td>
<td>31%</td>
<td>0.143</td>
<td>.705</td>
</tr>
<tr>
<td>Kept tobacco with you</td>
<td>39</td>
<td>67%</td>
<td>87%</td>
<td>4.000</td>
<td>.046</td>
</tr>
<tr>
<td>Kept tobacco at work</td>
<td>37</td>
<td>16%</td>
<td>35%</td>
<td>4.455</td>
<td>.035</td>
</tr>
<tr>
<td>Warned child not to take tobacco</td>
<td>37</td>
<td>68%</td>
<td>73%</td>
<td>0.333</td>
<td>.564</td>
</tr>
</tbody>
</table>

Surprisingly, our parents also reported increased restriction of smoking for adults in their homes. This variable was measured on a 3-point Likert scale ranging from “no smoking is allowed anywhere in my home” (0) to “smoking is allowed anywhere in my home” (2). Thus, smaller scores indicated more tobacco control at home. At pretest, parents reported a strong tendency to control smoking in their homes ($M = .80$, $SD = .69$). However, at posttest, their efforts toward tobacco control for adults were even greater ($M = .63$, $SD = .09$), paired $t (39) = 2.48$, $p = .018$.

Notably, a similar question regarding rules against smoking at home for children showed no significant change over time. However, parents almost uniformly reported that they did not allow their children to smoke at home at baseline ($M = .18$, $SD = .50$). Thus, a floor effect made improvements virtually impossible.

Section 7: Second-hand Smoke Exposure

To measure children and teens’ exposure to second-hand smoke, we asked specific questions about how often in the past week their children were exposed to smoke at home or in a car. Overall (combining both answers), we found a significant decrease from pretest to posttest in the number of days offspring were exposed to smoke in both places (paired $t (38) = 2.06$, $p = .05$).

When we explored the car and home settings separately, we found that parents reduced their child’s exposure significantly only in their car (paired $t (38) = 2.15$, $p = .04$). In the home, exposure did not change over time (paired $t (38) = 1.18$, $p = .24$). However, we should note that few parents admitted to home exposure at pretest ($M = 1.28$, $SD = 1.52$), a situation that produced a floor effect.

Section 8: Parents’ Perceptions of Pediatricians

Previous research has shown that physicians often believe that parents will resent being counseled about tobacco use and that attempting such a conversation may alienate parents (Frankowski,
Weaver, & Secker-Walker, 1993). Thus, we asked these smoking parents how they would feel if their pediatrician addressed their tobacco use with them. Their responses were measured on a five-point Likert scale, ranging from “very annoyed” (0) to “very relieved” (4). Thus, high scores were associated with greater acceptance of pediatricians’ interventions. Even at pretest, these parents were relatively positive about physician communication about smoking ($M = 2.46, SD = 1.05$). However, they became even more positive over the course of the intervention (posttest $M = 2.88, SD = .90$), paired $t (40) = 2.97, p = .005$. These data suggest that pediatricians should not fear that addressing tobacco use will alienate their patients’ parents. In fact, addressing tobacco use is associated with positive feelings on the parents’ part.

We also wondered about parents’ perceptions of the efficacy of pediatricians as interventionists. After the intervention, parents were more likely to believe that pediatricians can prevent smoking in children and teens, paired $t (39) = 2.06, p = .046$.

**Section 9: Parents’ Knowledge of Cessation Strategies**

Although the central purpose of our intervention was not to have parents quit smoking, we suspected that a number of parents would ask about smoking cessation. Analyses showed that these smoking parents were more likely to report they had received pamphlets about quitting (Cochran’s $Q = 6.23, p = .013$), tended to report they were helped to identify a quit date (Cochran’s $Q = 3.00, p = .08$), and were provided with a follow up appointment (Cochran’s $Q = 4.00, p = .046$). Overall, parents were much more likely to report that they had talked with a pediatrician about their smoking after the intervention than before (Cochran’s $Q = 20.00, p < .001$).

**Section 10: Pediatricians’ Evaluation of the Intervention**

Program evaluation forms were completed only by the four pediatricians in the treatment condition. After they finished the study, we asked a series of questions designed to determine how feasible the training and intervention were. Most questions were assessed on four-point Likert scales. The results are presented below. As can be seen, the pediatricians were quite positive about the overall program, the training, and likelihood that they would continue to use the information in their practices.

| Table 7 |
| Program Evaluation by Pediatricians |

| Did the content of the training program seem relevant? | Highly relevant | 75% |
| Somewhat relevant | 25% |
| Somewhat irrelevant | 0% |
| Highly irrelevant | 0% |

<p>| How would you rate the program in terms of content? | Excellent | 75% |
| Good | 25% |
| Needs improvement | 0% |
| Poor | 0% |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you rate the program in terms of format?</td>
<td>Excellent</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Needs improvement</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>0%</td>
</tr>
<tr>
<td>How well did the training instructor communicate?</td>
<td>Quite well</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Fairly well</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Not particularly well</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Not well at all</td>
<td>0%</td>
</tr>
<tr>
<td>How comfortable did the training instructor make you feel?</td>
<td>Quite comfortable</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Fairly comfortable</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Not particularly comfortable</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Not comfortable at all</td>
<td>0%</td>
</tr>
<tr>
<td>How prepared did you feel to deliver the planned intervention after the training program?</td>
<td>Well prepared</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Fairly prepared</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Somewhat prepared</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Not at all prepared</td>
<td>0%</td>
</tr>
<tr>
<td>Would you recommend this program to your colleagues?</td>
<td>Yes, highly</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Yes, somewhat</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0%</td>
</tr>
<tr>
<td>How difficult was it to implement this intervention with parents?</td>
<td>Not at all difficult</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Not particularly difficult</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Fairly difficult</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Quite difficult</td>
<td>0%</td>
</tr>
<tr>
<td>How much did participating in this study disrupt your usual activities at your practice?</td>
<td>Not at all disrupted</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Not particularly disrupted</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Fairly disrupted</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Quite disrupted</td>
<td>0%</td>
</tr>
<tr>
<td>What proportion of parents reacted in the following ways to the intervention?</td>
<td>Positively</td>
<td>87.5%</td>
</tr>
<tr>
<td></td>
<td>Neutrally</td>
<td>16.7%</td>
</tr>
<tr>
<td></td>
<td>Negatively</td>
<td>0%</td>
</tr>
<tr>
<td>Were there any negative parental reactions to the intervention or research procedures?</td>
<td>Yes</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>100%</td>
</tr>
<tr>
<td>Over time, did giving the intervention become…</td>
<td>Easier</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>More difficult</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Stayed the same</td>
<td>50%</td>
</tr>
<tr>
<td>Question</td>
<td>Category</td>
<td>Before the program</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>How helpful were the pocket reference cards when giving the intervention?</td>
<td>Quite helpful</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Fairly helpful</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Not particularly helpful</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Not at all helpful</td>
<td>0%</td>
</tr>
<tr>
<td>How helpful were the brochures?</td>
<td>Quite helpful</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Fairly helpful</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Not particularly helpful</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Not at all helpful</td>
<td>0%</td>
</tr>
<tr>
<td>Did we train you adequately to give the intervention?</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0%</td>
</tr>
<tr>
<td>Should we have done a longer training program?</td>
<td>Yes</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>75%</td>
</tr>
<tr>
<td>Should we have done more than one training program?</td>
<td>Yes</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>75%</td>
</tr>
<tr>
<td>How many sessions would you have been willing to attend?</td>
<td>2 sessions</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>1 session</td>
<td>75%</td>
</tr>
<tr>
<td>How likely is it that you will use motivational interviewing for discussing other health topics with parents?</td>
<td>Highly likely</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Somewhat likely</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Somewhat unlikely</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Highly unlikely</td>
<td>0%</td>
</tr>
<tr>
<td>How likely is it that you will use motivational interviewing for discussing other health topics with patients?</td>
<td>Highly likely</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Somewhat likely</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Somewhat unlikely</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Highly unlikely</td>
<td>0%</td>
</tr>
<tr>
<td>How likely is it that you will continue to address tobacco issues with your patients after participating in this study?</td>
<td>Highly likely</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Somewhat likely</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Somewhat unlikely</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Highly unlikely</td>
<td>0%</td>
</tr>
<tr>
<td>How would you rate your understanding of adolescent smoking?</td>
<td>Before the program</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>After the program</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Question</td>
<td>Before the program</td>
<td>After the program</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>How would you rate your understanding of motivational interviewing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>high</td>
<td>0%</td>
<td>25%</td>
</tr>
<tr>
<td>medium</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>low</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>How would you rate your overall ability to provide a tobacco control intervention?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>high</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>medium</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>low</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>How would you rate your willingness to provide a tobacco control intervention?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>high</td>
<td>25%</td>
<td>100%</td>
</tr>
<tr>
<td>medium</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>low</td>
<td>50%</td>
<td>0%</td>
</tr>
</tbody>
</table>
PROJECT PACT:
Parents Actively Controlling Tobacco

“Pediatricians and parents working together to keep children tobacco free.”

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Tennessee Chapter

THE UNIVERSITY OF MEMPHIS
CENTER FOR HEALTH PROMOTION AND EVALUATION

THE UNIVERSITY of TENNESSEE UT
Pediatricians are a respected source of information for parents, and research has shown that even parents who smoke do not want their children to smoke. However, up to 60% of teens who smoke get cigarettes from family members. Research suggests that parents are largely unaware that their children are likely to get cigarettes at home. An important step in preventing smoking onset is preventing children’s ability to get tobacco, especially at home.

The purpose of this study is to teach pediatricians to encourage parents who smoke to keep their tobacco products out of their children’s reach. This is the first research project designed to evaluate the benefits of teaching parents to keep their tobacco away from children.

Two medical practices are enrolled in this project: the intervention practice and the control practice. The control practice will continue as usual. The intervention practice will have a five minute conversation with all parents who smoke about keeping their tobacco out of reach. These parents will get a follow-up phone call a month later. Measures of parents and pediatricians will be conducted in both practices. Outcomes will be evaluated by the research team at The University of Memphis.
STUDY STAFF

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Project PACT is funded by the American Academy of Pediatrics (AAP) Friends of Children Fund and sponsored by the Tennessee chapter of the AAP.
OVERVIEW OF STUDY PROCEDURES

1. **First Steps:** Each practice identifies a study liaison to:
   1. screen participants for eligibility
   2. consent participants
   3. administer surveys
   4. retrieve sealed packets
   5. inform pediatrician when participant should receive the intervention

2. **Pediatrician Training:** University team provides training in the intervention and conducts baseline surveys with pediatricians.

3. **Data Collection & Pediatrician Intervention** with parents begin.

4. University team will occasionally visit the practice to make sure the intervention is running smoothly and to pick up completed surveys from the liaison.

5. **Parent Follow-ups:** One month after Pediatrician Intervention: University team will survey parents by phone.

6. Study ends.

7. **Physician Follow-up:** University team will give pediatricians a follow-up survey and program evaluation form.
COLLECTING DATA

1. Parent and/or caregiver checks in.

2. Liaison asks all parents with non-critical cases to fill out the Eligibility Form.

3. Liaison checks the Eligibility Form.
   - If parent is not eligible:
     1. Thank
     2. Tell them they are not eligible
     3. Note on the Eligibility Form that parent was not eligible.
     4. File form in lock box in hanging file titled: “non-eligible”
   - If parent is eligible, continue

4. Liaison tells eligible parents about the study. See the Script for Consenting.
   - If parent declines
     1. Thank
     2. Fill out Liaison part of the Script for Consenting. Staple to Eligibility Form.
     3. File Script for Consenting and Eligibility Form in lock box in hanging file titled: “eligible but declined”
   - If parent consents
     1. Have them sign Parental Consent Form
     2. Liaison signs as witness
     3. File Eligibility Form, Consent Form, and Script for Consenting in the parent’s survey envelope.
     4. Ask the parent to write the first name and age of the Target Child on the survey.

5. Liaison: Have parent fill out the Survey thinking about themselves and the identified target child. Remind parent to seal Consent Form and Survey in unmarked envelope & return the envelope to liaison.

6. Liaison: Remind parent that the University Team will call in a month to follow-up. Verify phone number.

7. Liaison:
   1. Tells physician a participant has been enrolled
   2. Gives pediatrician a Tip Sheet as a guide for the intervention, and also a Study Brochure to give to the participant.

8. Pediatrician delivers intervention.

9. Liaison calls University Team to collect data when needed.
Researchers funded by the American Academy of Pediatrics are doing a study of parent-pediatrician communication. We want to see if you’re eligible for the study. Being in the study would not affect your child’s medical care, and your pediatrician will not see your answers. This study is for parents who smoke only, but you will not be asked to quit. If you’re in the study, you’ll fill out a questionnaire and may have a brief talk with your pediatrician about how to make it less likely that your child will smoke. Filling out this form and being in the study are voluntary. We do believe the information you give will help us design better health care for children.

Please circle the number that best describes you:

1. During the past month, have you used any tobacco (for example, cigarettes, cigars, smokeless tobacco, etc)?
   1               2
   No              Yes

2. If yes to the above, which product did you use?
   1  2  3  4  5  6  7  8
   Cigarettes   Cigars   Cigarillos   Smokeless Tobacco   Pipes   Bidis   Kreteks   Other (small, thin hand-rolled cigarettes imported to the United States)

3. Is the child you brought into the pediatrician’s office today here for a non-critical visit?
   1               2
   No              Yes

4. Do you have a child between the ages of 9-15 (doesn’t have to be the child you brought in today)?
   1               2
   No              Yes

FOR OFFICE USE:

1               2
Not Eligible   Eligible
SCRIPT FOR CONSENTING PARENTS

NOTE: Liaison keeps the Eligibility Forms for the University Team. Liaison also keeps Scripts for Consenting when parents decline participation. This allows us to calculate how many parents were eligible and of those eligible, how many chose to participate.

SCRIPT for consenting parents:
We are working with the Tennessee American Academy of Pediatrics to conduct research on how doctors’ communication affects health practices. Parents in the study complete a short survey about their beliefs about tobacco.

You will not be asked to quit smoking, & your doctor will not know your answers! Please take a look at the Parent Consent Form...

Are you interested in participating? YES NO

Do you have any questions about the consent forms?

Parent signed their consent form? YES NO

Witness signed consent forms? YES NO

If declined:

Why are you not interested in the study, if you don’t mind my asking? (ask parent about all answers)

_____ not enough time
_____ concerned about privacy
_____ afraid I’ll be pressured not to smoke
_____ I’m too busy right now.
_____ I can’t focus on this right now.
_____ Other reason (What? ________________________________)

Next Steps:
1. Give parents the package, containing
   1. a blank consent form
   2. the survey
   3. an unmarked envelope to seal the consent and questionnaire in.

2. Determine Target Child and write below and ask parent to write child’s first name and birthday on 1st pg of survey. Parent will need to think of child while completing the survey.

Identify target child (First name, birthday): ________________________

If they have more than one child between these ages, ask parent to identify the child whose birthday is closest to today’s date.

3. Tell parent to give the sealed materials to you when finished.

4. Remind parent that Research Staff will call in a month!
Parent Tobacco Access Control Intervention  
Physician Training Program

1. Welcome: Joe Weinberg, M.D., Leslie Robinson, Ph.D., Ashley Hum, M.S., Laurie Burke, M.S. (5 minutes).

2. Baseline survey administered (10 minutes).

3. Presentation (15 minutes):
   A. **Description of study:** This study helps parents find ways of keeping their tobacco products out of reach for children.
   
   B. **Why is this study important?**
      1. Prevalence of smoking among parents & children
      2. Children frequently get tobacco from their parents
      3. Physicians are effective in reducing smoking.
      4. Novelty of this study: Increasing parental control of tobacco products.

   C. **Overview of physician intervention:**
      1. Motivational interviewing (MI).
         A. **Strategies used in MI:** ask permission; use open ended questions, reflective listening, non-confrontational; allow client to generate strategies; discuss barriers and ways to overcome barriers; summary statements.
            - Handout on MI Strategies & Techniques: Rationales and Examples (see “Research Articles” section).¹
         
         B. **Watch videotape:** examples of non-MI interaction and MI interaction.

   2. Steps in intervention:
      A. Could we talk about ways to keep your child from smoking?
      B. How would you feel if your child smoked?
      C. How much information do you have about the dangers of smoking for teens?
      D. Note that children commonly get cigarettes at home.²
      F. How could your child try to get cigarettes at home?
      G. How do you try to keep your tobacco away from your child? .
         
         **Example:** If a parent doesn’t seem interested in trying to control tobacco, don’t push them. Instead, explore their views. This approach decreases the parent’s resistance by avoiding argumentation.

   ¹
   ²
H. Great! What else could you do?
I. Are there any things that might make it hard to follow through with these plans?
J. Summarize & provide parent with pamphlet.
K. Thank parent and praise.

IV. **Watch role play** of intervention performed by research team (5 minutes).

V. **Physician role play** (20 minutes): 3 scripts
   
   A. Role play intervention with non-resistant parent.
   
   B. Role play intervention with resistant parent.
   
   C. Role play parent who needs help generating how to control child’s tobacco.

VI. Questions and wrap up (5 minutes).

**References**


Non-Resistant Parent Interaction

I. Ask parent for permission to discuss tobacco control.

<table>
<thead>
<tr>
<th>DR:</th>
<th>Do you mind if we spend a few minutes talking about ways to keep your child from smoking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>I guess.</td>
</tr>
</tbody>
</table>

II. Discuss some of the risks of smoking for children.

<table>
<thead>
<tr>
<th>DR:</th>
<th>First, how would you feel if your child smoked?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENT:</td>
<td>Not ok. It would really make me mad.</td>
</tr>
<tr>
<td>DR.</td>
<td>Most parents feel that way, even if they smoke. How much information do you have about the effects of smoking on teens?</td>
</tr>
<tr>
<td>Parent:</td>
<td>I know it’s bad for them.</td>
</tr>
</tbody>
</table>
| DR. | True. It actually interferes with lung growth, so that children who smoke never reach their full lung capacity. 
Now this may surprise you, but nearly 60% of children get their tobacco at home, from family members who smoke. |
III. Discuss ways parent is keeping tobacco from child. Ask parent for other ideas for tobacco control.

<table>
<thead>
<tr>
<th>DR.</th>
<th>How could _______ try to get cigarettes at home?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>I don’t know—I don’t leave my cigarettes around.</td>
</tr>
<tr>
<td>DR:</td>
<td>Good! How else could you keep cigarettes away from _______?</td>
</tr>
<tr>
<td>Parent:</td>
<td>I could count the number of cigarettes left in my pack so I would know if he’s taken any.</td>
</tr>
<tr>
<td>DR:</td>
<td>Okay, so you could keep track of how many cigarettes you have. These are really great strategies!</td>
</tr>
</tbody>
</table>

IV. Discuss potential barriers.

<table>
<thead>
<tr>
<th>DR.</th>
<th>Are there any things that might make it hard to follow through on these ideas?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>Well, his dad smokes, and I’m not sure he would help with this. But I could talk to him about why it’s important.</td>
</tr>
<tr>
<td>DR:</td>
<td>Sure. What other things might make it difficult?</td>
</tr>
<tr>
<td>Parent:</td>
<td>Well, it’s kind of a hassle having to count the number I have left in the pack.</td>
</tr>
<tr>
<td>DR:</td>
<td>Yeah, I can imagine that counting cigarettes takes some extra discipline. What could you do to make it easier?</td>
</tr>
<tr>
<td>Parent:</td>
<td>Well, I guess just making it a habit, so it’s part of my routine.</td>
</tr>
</tbody>
</table>
V. Sum up and thank them.

<table>
<thead>
<tr>
<th>DR:</th>
<th>Sure. To help you make it part of your routine, I’m going to write down the ideas we discussed. The brochure I’m writing on tells you a bit about why this is important.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>Thanks. Is this for me to keep?</td>
</tr>
<tr>
<td>DR:</td>
<td>Sure. And thanks for talking with me. I appreciate your time.</td>
</tr>
</tbody>
</table>
“Needs More Information” Parent Interaction

I. Ask parent for permission to discuss tobacco control behaviors

<table>
<thead>
<tr>
<th>DR:</th>
<th>Do you mind if we spend a few minutes talking about ways to keep your child from smoking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>I guess.</td>
</tr>
</tbody>
</table>

II. Discuss some of the risks of smoking for children.

<table>
<thead>
<tr>
<th>DR:</th>
<th>First, how would you feel if your child smoked?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENT:</td>
<td>I don’t know.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DR.</th>
<th>It sounds like you haven’t really thought about this before. I can tell you, though, that most parents don’t want their children to smoke. How much information do you have about the effects of smoking on teens?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>I guess it’s bad for them.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DR.</th>
<th>True. It actually interferes with lung growth, so that children who smoke never reach their full lung capacity. Now this may surprise you, but nearly 60% of children get their tobacco at home, from family members who smoke.</th>
</tr>
</thead>
</table>
III. Discuss ways parent is controlling keeping tobacco from child. Ask parent for other ideas for tobacco control.

<table>
<thead>
<tr>
<th>DR.</th>
<th>How could _______ try to get cigarettes at home?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>I don't know—</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DR:</th>
<th>I have heard a couple ideas from parents, Would you like to hear them?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>OK.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DR:</th>
<th>Well, some parents find that their children get their half-smoked cigarettes. So they empty their ashtrays carefully.</th>
</tr>
</thead>
</table>

**Other ways parents keep cigarettes controlled:**

- Count the number of cigarettes in your pack and the number of packs you have to keep track if any go missing
- Keep track of the amount of smokeless tobacco in your container and how many containers you have
- Hide your tobacco products from your child
- Keep your tobacco locked up
- Keep your tobacco with you
- Keep your tobacco at work
- Warn your child not to take your tobacco

<table>
<thead>
<tr>
<th>DR:</th>
<th>What could you do to make sure your child doesn’t get your tobacco?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>Well, I could keep it locked up.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DR:</th>
<th>Exactly.</th>
</tr>
</thead>
</table>
IV. Discuss potential barriers.

<table>
<thead>
<tr>
<th><strong>DR.</strong></th>
<th>Are there any things that might make it hard to follow through on these ideas?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>Well, his dad smokes, and I’m not sure he would help with this. But I could talk to him about why it’s important.</td>
</tr>
<tr>
<td><strong>DR:</strong></td>
<td>Sure. What other things might make it difficult?</td>
</tr>
<tr>
<td>Parent:</td>
<td>Well, it’s kind of a hassle having to keep up with the packs.</td>
</tr>
<tr>
<td><strong>DR:</strong></td>
<td>Yeah, I can imagine that it takes some extra discipline. What could you do to make it easier?</td>
</tr>
<tr>
<td>Parent:</td>
<td>Well, I guess just making it a habit, so it becomes part of my routine.”</td>
</tr>
</tbody>
</table>

V. Sum up and thank them.

| **DR:** | Sure. To help you make it part of your routine, I’m going to write down the ideas we discussed. The brochure I’m writing on tells you a bit about why this is important |
| Parent: | Thanks. Is this for me to keep? |
| **DR:** | Sure. And thanks for talking with me. I appreciate your time. |
Resistant Parent Interaction

I. Ask parent for permission to discuss tobacco control behaviors

<table>
<thead>
<tr>
<th><strong>DR:</strong></th>
<th>Do you mind if we spend a few minutes talking about ways to keep your child from smoking?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>I guess.</td>
</tr>
</tbody>
</table>

II. Discuss some of the risks of smoking for children.

<table>
<thead>
<tr>
<th><strong>DR:</strong></th>
<th>First, how would you feel if your child smoked?</th>
</tr>
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<tbody>
<tr>
<td>Parent:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DR:</strong></th>
<th>It sounds like whether ______ smokes isn’t very important to you right now. Do you mind if I give you some information about the effects of smoking on teens?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>No, I really don’t want to hear it.</td>
</tr>
</tbody>
</table>

III. Exit gracefully.

<table>
<thead>
<tr>
<th><strong>DR:</strong></th>
<th>I understand. Well, if you ever find you want to keep ____ from smoking, please feel free to contact us here. We can give you some ideas that have worked for other parents. Second, if you find that you or _____ later want to quit smoking, I’d be glad to give you all the help I can.</th>
</tr>
</thead>
</table>

STOP!
IV. Alternative Direction for the Conversation:

<table>
<thead>
<tr>
<th>DR:</th>
<th>Well, let me ask you this: What are some ways you control ______ access to other things you don’t want him/her to get into... like alcohol or guns?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent:</td>
<td>I keep them locked up.</td>
</tr>
<tr>
<td>DR:</td>
<td>OK. So you keep potentially dangerous things locked up. What do you think about locking up your tobacco?</td>
</tr>
<tr>
<td>Parent:</td>
<td>I just don’t care.</td>
</tr>
<tr>
<td>DR:</td>
<td>Okay, well, if you ever want more information on keeping tobacco out of ______’s reach, please feel free to contact us here. We can give you some ideas that have worked for other parents.</td>
</tr>
</tbody>
</table>

I. Sum up.

| DR: | Here’s a pamphlet with some information about different strategies for keeping your child away from tobacco. It also lists some inexpensive places where you can get help quitting smoking. |

VII. Thank parent for their participation and praise them for their effort.

| DR: | I appreciate you talking with me about this today! |

Remember, resistant parents are not open to change, and arguing with them isn’t productive. Simply tell them you will have information if they want it in the future, so that you keep the door open for future discussions on tobacco use.
References


Study Information
Project PACT was funded by the American Academy of Pediatrics (AAP) Friends of Children Fund and sponsored by the Tennessee chapter of the AAP. This study was conducted by Joseph Weinberg, M.D., and the Center for Health Promotion and Evaluation (Leslie Robinson, Ph.D. and Ashley Hurn, M.S.).

“Pediatricians and parents working together to keep children tobacco free.”

If you have questions about Project PACT, please contact us:

Joseph Weinberg, M.D.
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Leslie A. Robinson, Ph.D.
(901) 678-1667
Lrobinson@memphis.edu

Ashley Hurn, M.S.
(901) 678-2060
ahurn@memphis.edu

“Pediatricians and parents working together to keep children tobacco free.”
Why is keeping your tobacco away from your child important?

Many children and teens get their tobacco from family members, without the family's knowledge. A survey of young smokers found that up to 60% of teens get their cigarettes from a family member. Almost 25% of high school students and 8% of middle school students use tobacco. They become addicted very quickly, sometimes within two days of smoking.

Children experience both immediate and long-term damage from smoking. Even young smokers experience stunted lung growth and impaired lung function, the beginnings of atherosclerosis, and the development of risk factors for chronic obstructive pulmonary disease, cancer, and cardiovascular disease.

Fortunately, 71% of children who smoke try to quit each year, but the odds of their success are low. About 92% of young people who quit start smoking again within a year.

Purpose of the study

This study is designed to help pediatricians encourage parents to keep their tobacco products away from their children. By having pediatricians and parents work together, we hope to keep more Tennessee children tobacco-free.

How to keep your tobacco away from your child

There are many ways that parents can secure their tobacco products:

- Count the number of cigarettes in your pack and the number of packs you have
- Keep track of the amount of smokeless tobacco in your container and how many containers you have
- Keep your tobacco locked up
- Keep your tobacco with you
- Keep your tobacco at work
- Warn your child not to take your tobacco
- Do not leave half-smoked cigarettes around

How can you keep your child from getting your tobacco?

- _________________
- _________________
- _________________
- _________________
- _________________
- _________________
- _________________
- _________________

Resources for parents and youth who want to quit smoking

Quitline:
For support in quitting, including free quit coaching, a free quit plan, free educational materials, and referrals to local resources, call 1-800-QUIT-TODAY (1-800-784-8669); TTY 1-800-332-8615

Online Resources:
http://www.cdc.gov/tobacco/quit_smoking/how_to_quit/index.htm
http://www.asap.org/richmondcenter/resourcesForFamily.html#quityouth
http://www.tobaccofreekids.org/

Community Resources
- The Psychological Services Center
  The University of Memphis
  (901) 678-2147
  http://www.memphis.edu/psychology/psc/index.php
  Ask for Leslie Robinson, Ph.D., for information on the Smoking Clinic.
- Center for Health Promotion and Evaluation
  The University of Memphis
  (901) 670-2060
- The Church Health Center
  http://www.churchhealthcenter.org/
  (901) 272-7170
- American Lung Association
  901-276-1731

We would like to thank all of the parents and pediatricians participating in this project!
Appendix D: All Consent Forms
This research is being conducted by the Tennessee chapter of the American Academy of Pediatrics. The purpose of this study is to see how physician communication might affect patient health practices, such as tobacco use.

Participation in this study requires that you currently are a practicing pediatrician. Participants at one pediatrician group will be trained by our Health Educator in a method of discussing tobacco with parents that has proven to be effective in previous research. The training will take approximately one to one and a half hours. Afterwards, you will initiate a short discussion of children’s access to tobacco with caregivers who are tobacco users. The aim of this discussion is to help parents make wise decisions about preventing their children’s access to tobacco products at home. Unfortunately, many children learn to smoke using their parent’s cigarettes.

Participants at the other group will not be asked to deliver this intervention and will not undergo any training. However, we will offer written material and training to those interested after the study is complete.

Both sets of pediatricians will be asked to complete questionnaires both at the beginning of the study and at its end. The questionnaires ask about tobacco use, attitudes toward discussions with parents, and beliefs in physicians’ ability to reduce smoking, among other issues. Your answers will be confidential to the fullest extent of the law. The information that you provide in the questionnaires will not be released to anyone outside the scope of the study. If the results from this research are published, your names will never be used and there will be no way for anyone to identify you.

From both practices, we will ask you to nominate someone to serve as study liaison. We will train this person to recruit your patients into the trial. Caregivers will fill out surveys while waiting to see you. These will be sealed and kept private for the research team. Some pediatricians will then lead caregivers in a short discussion about controlling tobacco; other pediatricians will not initiate this discussion. Caregivers will complete surveys again one month later in a call from our research offices.

From time to time during the study, the Health Educator may observe your sessions with participating caregivers, with the consent of those caregivers. This procedure will allow us to observe how well the conversations about tobacco control are going.

Your participation in this study is voluntary. You may skip questions on the questionnaires or stop filling them out entirely. You can withdraw at any time from the study with no penalties. If you have any questions about this program, you could contact the Principal Investigator(s) of the study, Dr. Leslie Robinson at 901-678-1667 or Dr. Joseph Weinberg at 901-755-6180. In addition, you could contact the Chair of the University of Memphis Institutional Review Board at 678-3074.

I have read this consent form and I agree to participate in this research project. I will be given a copy of this form for my own records.

__________________________________________  __________________________
Pediatrician’s Signature                  Date

__________________________________________  __________________________
Witness' Signature                      Date

Please Print Name


CAREGIVER CONSENT FORM
The University of Memphis

This study is being conducted by the Tennessee chapter of the American Academy of Pediatrics. Its purpose is to see how physician-caregiver talks might affect children and tobacco. You will not be asked to quit smoking during this study.

To be part of this study, you must be a tobacco user. Second, the child that you brought to the doctor’s office today must be here for a non-critical visit. Third, you must have a child between 9 and 15 years old (although it doesn’t have to be the child you brought in today).

You will be asked to fill out a short survey about your beliefs about tobacco. It asks questions about tobacco use, your thoughts about children smoking, your home rules about smoking, alcohol use, and other related questions. Your survey will never be seen by the doctor. A month later, we will call you to ask you some of the same questions. The survey only takes about 10 minutes to finish, and you can do it here in the office while you wait.

Today, some parents and/ or caregivers in this study will discuss children and tobacco use with the doctor. Other parents and/ or caregivers will not be asked to have this discussion. However, you should feel free to ask the doctor any questions you are interested in.

Your surveys will be kept confidential to the full extent of the law. In fact, you will seal the one you fill out today in an envelope. It will then be given to the researchers. We will not share them with the doctor’s office. Your name will never be associated with this study. In addition, your child’s medical record will not be viewed for the purpose of this study.

It is up to you whether you participate in this research. We believe it will help doctors learn about parents and tobacco. Even if you start the survey, you can skip any question or quit without any penalties.

If you have any questions, you could contact the heads of this study, Dr. Leslie Robinson at 901-678-1667 and Dr. Joseph Weinberg at 901-755-6180. In addition, you could contact the Chair of the University of Memphis Institutional Review Board at 678-3074.

If you agree to be in the research, please sign below:

I have read this consent form and I agree to participate in this research project. I will be given a copy of this form for my own records.

________________________________________________________________________

Parent's and/ or Caregiver’s Signature Date Witness' Signature Date

I can be contacted next month the following ways:

Home phone number with area code: ___________________________ Cell phone with area code: ___________________________

Work phone with area code (answer only if it is okay to call you at work!!): ____________________________________________

Email address: ___________________________ Address: ___________________________________________

________________________________________________________________________

Parent's Signature Date Witness' Signature Date

Please Print Name

We look forward to talking with you next month! Our graduate students, Ashley or Laurie, will give you a call. Many thanks for your participation!
CAREGIVER CONSENT FORM FOR OBSERVATION
The University of Memphis

Thank you for participating in the study conducted by the Tennessee chapter of the American Academy of Pediatrics. You are helping us learn how to help parents and/ or caregivers keep tobacco from children.

Today, your child’s doctor will discuss children and tobacco use with you. To understand what messages are helpful, one of our staff members would like to be present as an observer only during that discussion. She is a doctoral student working on her degree in clinical psychology at The University of Memphis. She has been trained in research procedures and will keep all information about you and your child confidential to the fullest extent of the law.

Our student’s job is to observe how well communication works. You do not have to allow her to be present. In fact, you can ask her to leave at any time without penalty. It is up to you completely.

If you have any questions, you could contact the heads of this study, Dr. Leslie Robinson at 901-678-1667 and Dr. Joseph Weinberg at 901-755-6180. In addition, you could contact the Chair of the University of Memphis Institutional Review Board at 678-3074.

If you agree to be in the research, please sign below:

I have read this consent form and I agree to allow the student observer to be present in my meeting with the physician. I will be given a copy of this form for my own records.

__________________________  ___________________________  ___________________________
Parent’s and/or Caregiver’s Signature  Date  Witness’ Signature  Date
Appendix E: All Surveys
Participant #: ___________________

Parent Survey 1
Directions: Please check the one answer for each question that is most true for you.

Please note: Your child’s doctor will NOT see your answers. No one at the doctor’s office will see your answers. The University of Memphis researchers will be the only ones to see your survey, and they will protect your privacy to the fullest extent of the law.

Your answers will help us understand how parents feel about tobacco use among kids, doctors’ roles in counseling youth and parents, and what actions parents take to prevent their kids from smoking. We do not know the answers to these questions, and there are no right or wrong answers. Your information will help us understand parents’ opinions. Thank you for your help!

OPINIONS ABOUT YOUTH SMOKING

1. How much do you approve of children smoking?
   ____ Strongly approve
   ____ Somewhat approve
   ____ Somewhat disapprove
   ____ Strongly disapprove

2. How much do you approve of teens smoking?
   ____ Strongly approve
   ____ Somewhat approve
   ____ Somewhat disapprove
   ____ Strongly disapprove

3. Is it safe for children or teens to smoke for only a year or two, as long as they quit after that?
   ____ Definitely not
   ____ Probably not
   ____ Probably yes
   ____ Definitely yes

4. Does smoking tobacco cause serious illness in children and teens while they are still young?
   ____ Definitely not
   ____ Probably not
   ____ Probably yes
   ____ Definitely yes
5. Out of 10 middle school students, how many use tobacco on average? (Circle the best number)
   0 1 2 3 4 5 6 7 8 9 10

6. Out of 10 high school students, how many use tobacco on average? (Circle the best number)
   0 1 2 3 4 5 6 7 8 9 10

7. Out of 10 families, how many parents use tobacco around their children? (Circle the best number)
   0 1 2 3 4 5 6 7 8 9 10

8. How important is it that pediatricians discuss tobacco use with children and teens?
   ____ Very important
   ____ Somewhat important
   ____ Not very important
   ____ Not at all important

9. How much do you think pediatricians can prevent smoking in children and adolescents?
   ____ None
   ____ A little
   ____ Somewhat
   ____ A lot

10. How much do you think pediatricians can help children and adolescents to quit smoking?
    ____ None
    ____ A little
    ____ Somewhat
    ____ A lot

11. How much do you think pediatricians can prevent smoking in parents?
    ____ None
    ____ A little
    ____ Somewhat
    ____ A lot

12. How much do you think pediatricians can help parents to quit smoking?
    ____ None
    ____ A little
    ____ Somewhat
    ____ A lot
13. How would you feel if your child’s pediatrician talked with you about your tobacco use?
   _____ Very annoyed
   _____ Somewhat annoyed
   _____ I wouldn’t care
   _____ Somewhat relieved
   _____ Very relieved

14. How would you feel if your own doctor talked with you about your tobacco use?
   _____ Very annoyed
   _____ Somewhat annoyed
   _____ I wouldn’t care
   _____ Somewhat relieved
   _____ Very relieved

15. How important is it that pediatricians discuss tobacco use with parents?
   _____ Very important
   _____ Somewhat important
   _____ Not very important
   _____ Not at all important

16. Has a doctor ever talked to you about smoking around your child?
   _____ Yes
   _____ No

17. During the past year, has a doctor asked if you used tobacco?
   _____ Yes
   _____ No

18. During the past year, has a doctor advised you to stop using tobacco?
   _____ Yes
   _____ No

19. During the past year, has a doctor tried to help you quit tobacco?
   _____ Yes
   _____ No
20. What did your doctor do to help you quit tobacco use? *(Mark all that apply)*:

____  My doctor didn’t try to help me quit.
____  Gave me pamphlets about quitting.
____  Gave me the number to a telephone quit line.
____  Gave me a website about quitting.
____  Helped me find the best date to quit.
____  Arranged a follow-up visit to check on how quitting was going.
____  Referred me to a professional to help me quit.
____  Other *(Please tell us what: ______________________________________________________)*

21. During the past year, which of the following health care workers talked with you about tobacco use? *(Mark all that apply)*

____  Nurse
____  Dentist
____  Pediatrician
____  My family doctor
____  Another health care worker *(What kind? __________________________________________)*

22. Has a doctor ever talked to you about controlling your child’s access to tobacco?

____  Yes
____  No

23. Has a doctor ever talked to your child about smoking?

____  Yes
____  No

24. Do you know if your child has ever tried to take tobacco from you?

____  Yes, s/he has tried to take it.
____  No, s/he has not tried to take it.
____  I don’t know.
25. How likely is it that controlling your own tobacco could prevent your kids from using tobacco?

_____ Very unlikely
_____ Somewhat unlikely
_____ Somewhat likely
_____ Very likely

26. How difficult would it be to put your tobacco where children and teens could not possibly get it?

_____ Extremely difficult
_____ Somewhat difficult
_____ Somewhat easy
_____ Very easy

27. Have you tried to control your child’s access to tobacco in any of the following ways? Please check “yes” to all that you’ve tried:

Yes  No
   ____ counted your cigarettes in a pack
   ____ counted the number of packs you have
   ____ watched the amount of smokeless in your container
   ____ hidden your tobacco products
   ____ locked up your tobacco products
   ____ kept your tobacco with you
   ____ kept your tobacco at work
   ____ warned your child not to take your tobacco

28. How often have you tried to control your child’s access to tobacco in your home or car?

_____ Never
_____ Rarely
_____ Sometimes
_____ Often
_____ Always
29. How many times have you talked with your child about the dangers of tobacco?
   _____ Never
   _____ A few times
   _____ Quite a few times
   _____ Many times

30. Which statement best describes the rules about smoking inside your home FOR ADULTS?
   _____ Smoking is not allowed anywhere inside my home.
   _____ Smoking is allowed in some places or at some times.
   _____ Smoking is allowed anywhere in my home.

31. Which statement best describes the rules about smoking inside your home FOR CHILDREN/TEENS?
   _____ Smoking is not allowed anywhere inside my home.
   _____ Smoking is allowed in some places or at some times.
   _____ Smoking is allowed anywhere in my home.

32. How likely is it that you will restrict your child’s access to your tobacco during the next year?
   _____ Very unlikely
   _____ Somewhat unlikely
   _____ Somewhat likely
   _____ Very likely

33. How difficult do you think it would be to restrict your child’s access to tobacco during the next year?
   _____ Very difficult
   _____ Somewhat difficult
   _____ Somewhat easy
   _____ Very easy

34. Teens sometimes pester their parents for tobacco. How many times have you given your teen tobacco?
   _____ Never
   _____ A few times
   _____ Quite a few times
   _____ Many times
35. During the past 7 days, on how many days did someone smoke in the same room with your child in your home?
   _____ 0 days
   _____ 1 or 2 days
   _____ 3 or 4 days
   _____ 5 or 6 days
   _____ 7 days

36. During the past 7 days, on how many days did someone smoke while riding in a car with your child?
   _____ 0 days
   _____ 1 or 2 days
   _____ 3 or 4 days
   _____ 5 or 6 days
   _____ 7 days

37. How do you feel about the law that stops smoking inside of hospitals?
   _____ Strongly support it
   _____ Somewhat support it
   _____ Somewhat against it
   _____ Strongly against it

38. How do you feel about the law that stops smoking at the workplace?
   _____ Strongly support it
   _____ Somewhat support it
   _____ Somewhat against it
   _____ Strongly against it

39. How do you feel about the law that stops smoking at restaurant or bars?
   _____ Strongly support it
   _____ Somewhat support it
   _____ Somewhat against it
   _____ Strongly against it
40. How would you feel about a law that would raise taxes on tobacco products?
   _____ Strongly support it
   _____ Somewhat support it
   _____ Somewhat against it
   _____ Strongly against it

41. How would you feel about a law that would severely fine companies that sell tobacco to minors?
   _____ Strongly support it
   _____ Somewhat support it
   _____ Somewhat against it
   _____ Strongly against it

**TOBACCO USE**

42. Please check all the adults who live with you and whether they smoke.

   **Check HERE if they live with you:**
   _____ spouse/significant other
   _____ mother/mother-in-law
   _____ father/ father-in-law
   _____ brother
   _____ sister
   _____ adult child / step-child
   _____ other adult

   **Check HERE if they smoke:**
   _____
   _____
   _____
   _____
   _____
   _____

43. Please list the ages of all children or step-children who live with you and tell us whether they use tobacco.

   **Age of Child**  **Does the child smoke? (Answer yes or no)**
   _____
   _____
   _____
   _____
   _____
   _____
   _____
In general, would you say your health is...

- Excellent
- Very good
- Good
- Fair
- Poor

Have you smoked at least 100 cigarettes in your entire life?  
**NOTE: 5 packs = 100 cigarettes**

- Yes
- No

Have you smoked cigarettes in the last 30 days?

- Yes
- No

How many cigarettes do you usually smoke?  
(Pick the one best answer.)

- None
- About one cigarette per month
- About one cigarette per week
- About one cigarette per day
- About 10 cigarettes per day
- About a pack a day
- More than a pack a day

Which kinds of smoked tobacco do you use?  
(Please check all that apply.)

- Regular cigarettes
- Menthol cigarettes
- Cigars
- Cigarillos
- Pipes
- Bidis
- Kreteks (clove cigarettes)
- None
49. Which kind of smokeless tobacco do you use? *(Please check all that apply.)*
   _____ Chewing tobacco
   _____ Snuff
   _____ Snus
   _____ None

50. How often do you use smokeless tobacco?
   _____ Every day
   _____ Some days
   _____ Never

51. How soon after you wake up do you use tobacco?
   _____ Within 5 minutes
   _____ 6 to 30 minutes
   _____ 31 to 60 minutes
   _____ After 60 minutes

52. Which time when you use tobacco would you hate most to give up?
   _____ The first one in the morning
   _____ Any other

53. Are you seriously thinking about quitting tobacco during the next month?
   _____ Yes
   _____ No

54. Are you seriously thinking about quitting tobacco during the next six months?
   _____ Yes
   _____ No

55. During your lifetime, how many times have you tried to quit tobacco? __________ times

56. During the past year, have you successfully stopped using tobacco on purpose for…
   a) At least 24 hours? Yes No
   b) At least a week? __ __
   c) At least a month? __ __
Your Child

Please answer these questions about the child you brought today, if that child is between ages 9 to 15. If not, please choose a child that is between 9 to 15 years old and whose birthday is closest to today.

Please put the first name of the child you choose above: ____________________
(Note: We ask for the first name only so that we can remind you which child you choose later when we call you.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your child ever used tobacco?</td>
<td>Yes, No, I don't know.</td>
</tr>
<tr>
<td>Has your child ever been told by a doctor that s/he has a chronic illness, such as asthma, diabetes, or cancer?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>In general, would you say your child’s health is:</td>
<td>Excellent, Very good, Fair, Poor, Very poor</td>
</tr>
<tr>
<td>Has your child ever asked you to change your smoking behavior?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>

Demographic Information

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old are you?</td>
<td>years old</td>
</tr>
<tr>
<td>What is your gender?</td>
<td>Male, Female</td>
</tr>
<tr>
<td>Are you Hispanic (Latino)?</td>
<td>No, Yes</td>
</tr>
</tbody>
</table>
64. Which one or more of the following is your race/ethnicity? (Please check all that apply)
   _____ American Indian or Alaska Native
   _____ Asian
   _____ Black or African American
   _____ Native Hawaiian or Pacific Islander
   _____ White
   _____ Other

65. Which best describes your annual household income from all sources?
   _____ $10,000 to $19,999
   _____ $20,000 to $29,999
   _____ $30,000 to $39,999
   _____ $40,000 to $49,999
   _____ $50,000 to $59,999
   _____ $60,000 to $69,999
   _____ $70,000 to $79,999
   _____ $80,000 or more

66. Which one best describes your marital status?
   _____ Married
   _____ Divorced
   _____ Widowed
   _____ Separated
   _____ Never Married

67. What is the highest grade or year of school you completed?
   _____ Elementary or Middle School (up to 8th grade)
   _____ Some high school (grades 9 to 11)
   _____ Graduated from high school or GED
   _____ Some college or technical school
   _____ Graduated from college
   _____ Postgraduate degree (M.D., Ph.D., etc.)

MANY THANKS FOR YOUR HELP!
## Parent Survey 2

**Directions:** Please check the one answer for each question that is most true for you.

Please note: Your child’s doctor will NOT see your answers. No one at the doctor’s office will see your answers. The University of Memphis researchers will be the only ones to see your survey, and they will protect your privacy to the fullest extent of the law.

Your answers will help us understand how parents feel about tobacco use among kids, doctors’ roles in counseling youth and parents, and what actions parents take to prevent their kids from smoking. We do not know the answers to these questions, and there are no right or wrong answers. Your information will help us understand parents’ opinions. Thank you for your help!

### OPINIONS ABOUT YOUTH SMOKING

1. How much do you approve of **children** smoking?
   - [ ] Strongly approve
   - [ ] Somewhat approve
   - [ ] Somewhat disapprove
   - [ ] Strongly disapprove

2. How much do you approve of **teens** smoking?
   - [ ] Strongly approve
   - [ ] Somewhat approve
   - [ ] Somewhat disapprove
   - [ ] Strongly disapprove

3. Is it safe for **children** or **teens** to smoke for only a year or two, as long as they quit after that?
   - [ ] Definitely not
   - [ ] Probably not
   - [ ] Probably yes
   - [ ] Definitely yes

4. Does smoking tobacco cause serious illness in **children and teens while they are still young**?
   - [ ] Definitely not
   - [ ] Probably not
   - [ ] Probably yes
   - [ ] Definitely yes
5. Out of 10 middle school students, how many use tobacco on average? (*Circle the best number*)
   0 1 2 3 4 5 6 7 8 9 10

6. Out of 10 high school students, how many use tobacco on average? (*Circle the best number*)
   0 1 2 3 4 5 6 7 8 9 10

7. Out of 10 families, how many parents use tobacco around their children? (*Circle the best number*)
   0 1 2 3 4 5 6 7 8 9 10

---

**HEALTH PROVIDER COMMUNICATIONS**

8. How important is it that pediatricians discuss tobacco use with children and teens?
   
   ____ Very important
   ____ Somewhat important
   ____ Not very important
   ____ Not at all important

9. How much do you think pediatricians can prevent smoking in children and adolescents?
   
   ____ None
   ____ A little
   ____ Somewhat
   ____ A lot

10. How much do you think pediatricians can help children and adolescents to quit smoking?
    
    ____ None
    ____ A little
    ____ Somewhat
    ____ A lot

11. How much do you think pediatricians can prevent smoking in parents?
    
    ____ None
    ____ A little
    ____ Somewhat
    ____ A lot

12. How much do you think pediatricians can help parents to quit smoking?
    
    ____ None
    ____ A little
    ____ Somewhat
    ____ A lot
13. How would you feel if your child's pediatrician talked with you about your tobacco use?
   _____ Very annoyed
   _____ Somewhat annoyed
   _____ I wouldn't care
   _____ Somewhat relieved
   _____ Very relieved

14. How would you feel if your own doctor talked with you about your tobacco use?
   _____ Very annoyed
   _____ Somewhat annoyed
   _____ I wouldn't care
   _____ Somewhat relieved
   _____ Very relieved

15. How important is it that pediatricians discuss tobacco use with parents?
   _____ Very important
   _____ Somewhat important
   _____ Not very important
   _____ Not at all important

16. Has a doctor ever talked to you about smoking around your child?
    _____ Yes
    _____ No

17. During the past year, has a doctor asked if you used tobacco?
    _____ Yes
    _____ No

18. During the past year, has a doctor advised you to stop using tobacco?
    _____ Yes
    _____ No

19. During the past year, has a doctor tried to help you quit tobacco?
    _____ Yes
    _____ No
20. What did your doctor do to help you quit tobacco use? *(Mark all that apply)*:

- [ ] My doctor didn’t try to help me quit.
- [ ] Gave me pamphlets about quitting.
- [ ] Gave me the number to a telephone quit line.
- [ ] Gave me a website about quitting.
- [ ] Helped me find the best date to quit.
- [ ] Arranged a follow-up visit to check on how quitting was going.
- [ ] Referred me to a professional to help me quit.
- [ ] Other *(Please tell us what: ________________________________________________)*

21. During the past year, which of the following health care workers talked with you about tobacco use? *(Mark all that apply)*

- [ ] Nurse
- [ ] Dentist
- [ ] Pediatrician
- [ ] My family doctor
- [ ] Another health care worker *(What kind? ________________________________________________)*

22. Has a doctor ever talked to you about controlling your child’s access to tobacco?

- [ ] Yes
- [ ] No

23. Has a doctor ever talked to your child about smoking?

- [ ] Yes
- [ ] No

24. Do you know if your child has ever tried to take tobacco from you?

- [ ] Yes, s/he has tried to take it.
- [ ] No, s/he has not tried to take it.
- [ ] I don’t know.
25. How likely is it that controlling your own tobacco could prevent your kids from using tobacco?
   ____ Very unlikely
   ____ Somewhat unlikely
   ____ Somewhat likely
   ____ Very likely

26. How difficult would it be to put your tobacco where children and teens could not possibly get it?
   ____ Extremely difficult
   ____ Somewhat difficult
   ____ Somewhat easy
   ____ Very easy

27. Have you tried to control your child’s access to tobacco in any of the following ways?
   *Please check “yes” to all that you’ve tried:*
   
   Yes  ____ No
   ____  ____ counted your cigarettes in a pack
   ____  ____ counted the number of packs you have
   ____  ____ watched the amount of smokeless in your container
   ____  ____ hidden your tobacco products
   ____  ____ locked your tobacco products
   ____  ____ kept your tobacco with you
   ____  ____ kept your tobacco at work
   ____  ____ warned your child not to take your tobacco

28. How often have you tried to control your child’s access to tobacco in your home or car?
   ____ Never
   ____ Rarely
   ____ Sometimes
   ____ Often
   ____ Always
29. How many times have you talked with your child about the dangers of tobacco?
   ____ Never
   ____ A few times
   ____ Quite a few times
   ____ Many times

30. Which statement best describes the rules about smoking inside your home FOR ADULTS?
   ____ Smoking is not allowed anywhere inside my home.
   ____ Smoking is allowed in some places or at some times.
   ____ Smoking is allowed anywhere in my home.

31. Which statement best describes the rules about smoking inside your home FOR CHILDREN/ TEENS?
   ____ Smoking is not allowed anywhere inside my home.
   ____ Smoking is allowed in some places or at some times.
   ____ Smoking is allowed anywhere in my home.

32. How likely is that you will restrict your child's access to your tobacco during the next year?
   ____ Very unlikely
   ____ Somewhat unlikely
   ____ Somewhat likely
   ____ Very likely

33. How difficult do you think it would be to restrict child's access to tobacco during the next year?
   ____ Very difficult
   ____ Somewhat difficult
   ____ Somewhat easy
   ____ Very easy

34. Teens sometimes pester their parents for tobacco. How many times have you given your teen tobacco?
   ____ Never
   ____ A few times
   ____ Quite a few times
   ____ Many times
35. During the past 7 days, on how many days did someone smoke in the same room with your child in your home?
   _____  0 days
   _____  1 or 2 days
   _____  3 or 4 days
   _____  5 or 6 days
   _____  7 days

36. During the past 7 days, on how many days did someone smoke while riding in a car with your child?
   _____  0 days
   _____  1 or 2 days
   _____  3 or 4 days
   _____  5 or 6 days
   _____  7 days

37. How do you feel about the law that stops smoking inside of hospitals?
   _____ Strongly support it
   _____ Somewhat support it
   _____ Somewhat against it
   _____ Strongly against it

38. How do you feel about the law that stops smoking at the workplace?
   _____ Strongly support it
   _____ Somewhat support it
   _____ Somewhat against it
   _____ Strongly against it

39. How do you feel about the law that stops smoking at restaurant or bars?
   _____ Strongly support it
   _____ Somewhat support it
   _____ Somewhat against it
   _____ Strongly against it
40. How would you feel about a law that would raise taxes on tobacco products?
   ______ Strongly support it
   ______ Somewhat support it
   ______ Somewhat against it
   ______ Strongly against it

41. How would you feel about a law that would severely fine companies that sell tobacco to minors?
   ______ Strongly support it
   ______ Somewhat support it
   ______ Somewhat against it
   ______ Strongly against it

42. Please check all the adults who live with you and whether they smoke.

   **Check HERE if they live with you:**
   ______ spouse/significant other
   ______ mother/mother-in-law
   ______ father/ father-in-law
   ______ brother
   ______ sister
   ______ adult child / step-child
   ______ other adult

   **Check HERE if they smoke:**
   ______

43. Please list the ages of all children or step-children who live with you and tell us whether they use tobacco.

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Does the child smoke? (Answer yes or no)</th>
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TOBACCO USE
44. In general, would you say your health is...
   _____ Excellent
   _____ Very good
   _____ Good
   _____ Fair
   _____ Poor

45. Have you smoked at least 100 cigarettes in your entire life?   \textit{NOTE: 5 packs = 100 cigarettes}
   _____ Yes
   _____ No

46. Have you smoked cigarettes in the last 30 days?
   _____ Yes
   _____ No

47. How many cigarettes do you usually smoke?   (\textit{Pick the one best answer.})
   _____ None
   _____ About one cigarette per month
   _____ About one cigarette per week
   _____ About one cigarette per day
   _____ About 10 cigarettes per day
   _____ About a pack a day
   _____ More than a pack a day

48. Which kinds of \textit{smoked tobacco} do you use? (\textit{Please check all that apply.})
   _____ Regular cigarettes
   _____ Menthol cigarettes
   _____ Cigars
   _____ Cigarillos
   _____ Pipes
   _____ Bidis
   _____ Kretteks (clove cigarettes)
   _____ None
49. Which kind of smokeless tobacco do you use? (Please check all that apply.)
   _____ Chewing tobacco
   _____ Snuff
   _____ Snus
   _____ None

50. How often do you use smokeless tobacco?
   _____ Every day
   _____ Some days
   _____ Never

51. How soon after you wake up do you use tobacco?
   _____ Within 5 minutes
   _____ 6 to 30 minutes
   _____ 31 to 60 minutes
   _____ After 60 minutes

52. Which time when you use tobacco would you hate most to give up?
   _____ The first one in the morning
   _____ Any other

53. Are you seriously thinking about quitting tobacco during the next month?
   _____ Yes
   _____ No

54. Are you seriously thinking about quitting tobacco during the next six months?
   _____ Yes
   _____ No

55. During your lifetime, how many times have you tried to quit tobacco? __________ times

56. During the past year, have you successfully stopped using tobacco on purpose for…
   a) At least 24 hours?    Yes  No
   b) At least a week?  ________
   c) At least a month?     ________

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57. Has your child ever used tobacco?
   ____ Yes
   ____ No
   ____ I don't know.

58. Has your child ever been told by a doctor that s/he has a chronic illness, such as asthma, diabetes, or cancer?
   ____ Yes
   ____ No

59. In general, would you say your child's health is:
   ____ Excellent
   ____ Very good
   ____ Fair
   ____ Poor
   ____ Very poor

60. Has your child ever asked you to change your smoking behavior?
   ____ Yes
   ____ No

61. How old are you?
   ____ years old

62. What is your gender?
   ____ Male
   ____ Female

63. Are you Hispanic (Latino)?
   ____ No
   ____ Yes
64. Which one or more of the following is your race/ethnicity? (Please check all that apply)
   _____ American Indian or Alaska Native
   _____ Asian
   _____ Black or African American
   _____ Native Hawaiian or Pacific Islander
   _____ White
   _____ Other

65. Which best describes your annual household income from all sources?
   _____ $10,000 to $19,999
   _____ $20,000 to $29,999
   _____ $30,000 to $39,999
   _____ $40,000 to $49,999
   _____ $50,000 to $59,999
   _____ $60,000 to $69,999
   _____ $70,000 to $79,999
   _____ $80,000 or more

66. Which one best describes your marital status?
   _____ Married
   _____ Divorced
   _____ Widowed
   _____ Separated
   _____ Never Married

67. What is the highest grade or year of school you completed?
   _____ Elementary or Middle School (up to 8th grade)
   _____ Some high school (grades 9 to 11)
   _____ Graduated from high school or GED
   _____ Some college or technical school
   _____ Graduated from college
   _____ Postgraduate degree (M.D., Ph.D., etc.)

MANY THANKS FOR YOUR HELP!
Pediatrician Survey 1

Please choose the one best answer, unless instructed otherwise. Your responses will not be revealed to anyone in your practice, and your confidentiality will be protected to the fullest extent of the law.

Your answers are important—they will help us learn how pediatricians perceive the importance of tobacco use among children and parents and the barriers that interfere with communication around smoking.

HEALTH PROVIDER COMMUNICATIONS

Please answer the following questions about your PEDIATRIC patients...

1. Do you feel that it is part of a pediatrician’s role to address tobacco use among children/teens?
   ____ Never
   ____ Rarely
   ____ Sometimes
   ____ Often
   ____ Always

2. How comfortable do you feel discussing tobacco use with your patients?
   ____ Very uncomfortable
   ____ Somewhat uncomfortable
   ____ Somewhat comfortable
   ____ Very comfortable

3. Do you believe that children who smoke will tell you if you ask about tobacco use?
   ____ Never
   ____ Rarely
   ____ Sometimes
   ____ Often
   ____ Always

4. How much do you think pediatricians can influence smoking cessation in children and adolescents?
   ____ None
   ____ A little
   ____ A lot
   ____ A great deal
5. How much do you think pediatricians can influence smoking prevention in children and adolescents?
   _____ None
   _____ A little
   _____ A lot
   _____ A great deal

6. How likely is it that restricting children's access to tobacco could prevent them from starting to use tobacco?
   _____ Highly unlikely
   _____ Somewhat unlikely
   _____ Somewhat likely
   _____ Highly likely

7. How often do you ask patients about their tobacco use?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

8. How often do you advise patients not to use tobacco?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

9. How often have you assisted patients with quitting tobacco?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always
10. Which of the following have been a barrier for you in discussing tobacco use with patients? (Check all that apply!)

_____ Time is short.

_____ I’m not sure what to say.

_____ I’m unsure about discussing it with a parent present.

_____ I really don’t think it will influence the child’s smoking.

_____ Kids get argumentative with me.

_____ Other reason (Please write here: ________________________________)

11. Have you used any of the following methods to help your patients to quit smoking?

<table>
<thead>
<tr>
<th>Used</th>
<th>Have not used</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____</td>
<td>_____</td>
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</tr>
</tbody>
</table>
| _____ | _____ | Other (Please tell us what: ________________________________)

Please answer the following questions about the PARENTS of your patients...

12. Do you feel that it is part of a pediatrician’s role to address tobacco use among parents?

_____ Never

_____ Rarely

_____ Sometimes

_____ Often

_____ Always
13. How comfortable do you feel discussing tobacco use with parents?
   _____ Very uncomfortable
   _____ Somewhat uncomfortable
   _____ Somewhat comfortable
   _____ Very comfortable

14. Do you believe that parents who smoke will tell you if you ask about tobacco use?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

15. How much do you think pediatricians can influence smoking cessation in parents?
   _____ None
   _____ A little
   _____ A lot
   _____ A great deal

16. How much do you think pediatricians can influence smoking prevention in parents?
   _____ None
   _____ A little
   _____ A lot
   _____ A great deal

17. How often do you ask parents about their tobacco use?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always
18. How often do you advise parents not to use tobacco?
   ____ Never
   ____ Rarely
   ____ Sometimes
   ____ Often
   ____ Always

19. How often have you assisted parents with quitting tobacco?
   ____ Never
   ____ Rarely
   ____ Sometimes
   ____ Often
   ____ Always

20. Which of the following have been a barrier for you in discussing tobacco use with parents? (Check all that apply!)
   ____ Time is short.
   ____ I’m not sure what to say.
   ____ I don’t think discussing smoking with a nonsmoking parent is appropriate.
   ____ I really don’t think I can influence a smoking parent to quit.
   ____ I think the parent would be offended.
   ____ Other reason (Please write here: __________________________________________)

21. Have you used any of the following methods to help your parents to quit smoking?
    Used       Have not used
    ____       ____    Gave them pamphlets about quitting.
    ____       ____    Gave them the number to a telephone quit line.
    ____       ____    Gave them a website about quitting.
    ____       ____    Helped them find the best date to quit.
    ____       ____    Arranged a follow-up visit to check on how quitting was going.
    ____       ____    Referred them to a professional to help them quit.
    ____       ____    Prescribed them medication to help them quit.
    ____       ____    Other (Please tell us what: _________________________________)
22. How often do you discuss tobacco control (i.e., restricting children’s access to tobacco) with parents?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

PERCEPTIONS OF TOBACCO USE

For the following questions, please give us your best guess, even if you’re not sure.

23. What proportion of high school students smoke at least once a week?
   _____ %  (You may answer from 0% to 100%)

24. What proportion of high school students who smoke a few cigarettes go on to smoke as adults?
   _____ %  (You may answer from 0% to 100%)

25. What proportion of teens who smoke try to quit tobacco in a year?
   _____ %  (You may answer from 0% to 100%)

26. What proportion of teens who quit successfully stay quit for 2 years?
   _____ %  (You may answer from 0% to 100%)

27. What proportion of parents smoke?
   _____ %  (You may answer from 0% to 100%)

28. What proportion of teens get their cigarettes from their parents?
   _____ %  (You may answer from 0% to 100%)

29. Is it safe for children or teens to smoke for only a year or two, as long as they quit after that?
   _____ Definitely not
   _____ Probably not
   _____ Probably yes
   _____ Definitely yes
30. Does smoking tobacco cause serious illness in children and teens while they are still young?
   - Definitely not
   - Probably not
   - Probably yes
   - Definitely yes

31. Have you smoked at least 100 cigarettes in your entire life?  
    *NOTE: 5 packs = 100 cigarettes*
   - Yes
   - No

32. Have you smoked cigarettes in the last 30 days?
   - Yes
   - No

33. How many cigarettes do you usually smoke?  
    *Pick the one best answer.*
   - None
   - About one cigarette per month
   - About one cigarette per week
   - About one cigarette per day
   - About 10 cigarettes per day
   - About a pack a day
   - More than a pack a day

34. Which kinds of smoked tobacco do you use?  
    *Please check all that apply.*
   - Regular cigarettes
   - Menthol cigarettes
   - Cigars
   - Cigarillos
   - Pipes
   - Bidis
   - Kretex (clove cigarettes)
   - None
35. Which kind of smokeless tobacco do you use? (Please check all that apply.)
   _____ Chewing tobacco
   _____ Snuff
   _____ Snus
   _____ None

36. How often do you use smokeless tobacco?
   _____ Every day
   _____ Some days
   _____ Never

TOBACCO USE CESSATION

37. Are you seriously thinking about quitting tobacco during the next month?
   _____ Yes
   _____ No

38. Are you seriously thinking about quitting tobacco during the next six months?
   _____ Yes
   _____ No

39. During your lifetime, how many times have you tried to quit tobacco? ________ times

40. During the past year, have you successfully stopped using tobacco on purpose for...
   a) At least 24 hours?    Yes    No
   b) At least a week?    Yes    No
   c) At least a month?   Yes    No

DEMOGRAPHIC

41. How old are you?
   _____ years old

42. What is your gender?
   _____ Male
   _____ Female

43. Are you Hispanic (Latino)?
   _____ Yes
   _____ No
44. Which one or more of the following is your race/ethnicity? *(Please check all that apply)*

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ Native Hawaiian or Pacific Islander

_____ White

_____ Other

*Many thanks for your help!*
Pediatric Survey 2

Please choose the one best answer, unless instructed otherwise. Your responses will not be revealed to anyone in your practice, and your confidentiality will be protected to the fullest extent of the law.

Your answers are important—they will help us learn how pediatricians perceive the importance of tobacco use among children and parents and the barriers that interfere with communication around smoking.

Please answer the following questions about your Pediatric patients...

1. Do you feel that it is part of a pediatrician’s role to address tobacco use among children/teens?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

2. How comfortable do you feel discussing tobacco use with your patients?
   _____ Very uncomfortable
   _____ Somewhat uncomfortable
   _____ Somewhat comfortable
   _____ Very comfortable

3. Do you believe that children who smoke will tell you if you ask about tobacco use?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

4. How much do you think pediatricians can influence smoking cessation in children and adolescents?
   _____ None
   _____ A little
   _____ A lot
   _____ A great deal
5. How much do you think pediatricians can influence smoking prevention in children and adolescents?
   _____ None
   _____ A little
   _____ A lot
   _____ A great deal

6. How likely is that restricting children’s access to tobacco could prevent them from starting to use tobacco?
   _____ Highly unlikely
   _____ Somewhat unlikely
   _____ Somewhat likely
   _____ Highly likely

7. How often do you ask patients about their tobacco use?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

8. How often do you advise patients not to use tobacco?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

9. How often have you assisted patients with quitting tobacco?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always
10. Which of the following have been a barrier for you in discussing tobacco use with patients? (Check all that apply!)

____ Time is short.

____ I’m not sure what to say.

____ I’m unsure about discussing it with a parent present.

____ I really don’t think it will influence the child’s smoking.

____ Kids get argumentative with me.

____ Other reason (Please write here: _________________________________)

11. Have you used any of the following methods to help your patients to quit smoking?

<table>
<thead>
<tr>
<th>Used</th>
<th>Have not used</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____</td>
<td>_____ Gave them pamphlets about quitting.</td>
</tr>
<tr>
<td>_____</td>
<td>_____ Gave them the number to a telephone quit line.</td>
</tr>
<tr>
<td>_____</td>
<td>_____ Gave them a website about quitting.</td>
</tr>
<tr>
<td>_____</td>
<td>_____ Helped them find the best date to quit.</td>
</tr>
<tr>
<td>_____</td>
<td>_____ Arranged a follow-up visit to check on how quitting was going.</td>
</tr>
<tr>
<td>_____</td>
<td>_____ Referred them to a professional to help them quit.</td>
</tr>
<tr>
<td>_____</td>
<td>_____ Prescribed them medication to help them quit.</td>
</tr>
<tr>
<td>_____</td>
<td>_____ Other (Please tell us what: _________________________________)</td>
</tr>
</tbody>
</table>

Please answer the following questions about the PARENTS of your patients...

12. Do you feel that it is part of a pediatrician’s role to address tobacco use among parents?

____ Never

____ Rarely

____ Sometimes

____ Often

____ Always
13. How comfortable do you feel discussing tobacco use with parents?
   _____ Very uncomfortable
   _____ Somewhat uncomfortable
   _____ Somewhat comfortable
   _____ Very comfortable

14. Do you believe that parents who smoke will tell you if you ask about tobacco use?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

15. How much do you think pediatricians can influence smoking cessation in parents?
   _____ None
   _____ A little
   _____ A lot
   _____ A great deal

16. How much do you think pediatricians can influence smoking prevention in parents?
   _____ None
   _____ A little
   _____ A lot
   _____ A great deal

17. How often do you ask parents about their tobacco use?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always
18. How often do you advise parents not to use tobacco?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

19. How often have you assisted parents with quitting tobacco?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

20. Which of the following have been a barrier for you in discussing tobacco use with parents?
    (Check all that apply!)
    _____ Time is short.
    _____ I'm not sure what to say.
    _____ I don't think discussing smoking with a nonsmoking parent is appropriate.
    _____ I really don't think I can influence a smoking parent to quit.
    _____ I think the parent would be offended.
    _____ Other reason (Please write here: ____________________________________________)

21. Have you used any of the following methods to help your parents to quit smoking?
    Used       Have not used
    _____ _____ Gave them pamphlets about quitting.
    _____ _____ Gave them the number to a telephone quit line.
    _____ _____ Gave them a website about quitting.
    _____ _____ Helped them find the best date to quit.
    _____ _____ Arranged a follow-up visit to check on how quitting was going.
    _____ _____ Referred them to a professional to help them quit.
    _____ _____ Prescribed them medication to help them quit.
    _____ _____ Other (Please tell us what: _________________________________)
22. How often do you discuss tobacco control (i.e., restricting children’s access to tobacco) with parents?
   _____ Never
   _____ Rarely
   _____ Sometimes
   _____ Often
   _____ Always

23. How often did you use the tobacco control intervention when you had parents who were eligible for it?
   _____ None of the time
   _____ Some of the time
   _____ Most of the time
   _____ All of the time

24. How comfortable did you feel using the tobacco control intervention?
   _____ Very comfortable
   _____ Somewhat comfortable
   _____ Somewhat uncomfortable
   _____ Very uncomfortable

25. How likely do you think it is that the intervention had an effect on parents' tobacco control?
   _____ Very unlikely
   _____ Somewhat unlikely
   _____ Somewhat likely
   _____ Very likely

26. How likely do you think it is that parents who control their tobacco reduce their children’s odds of smoking?
   _____ Very unlikely
   _____ Somewhat unlikely
   _____ Somewhat likely
   _____ Very likely
27. How likely is it that you will still be implementing this intervention one year from now?
   _____  Very unlikely
   _____  Somewhat unlikely
   _____  Somewhat likely
   _____  Very likely

28. How likely is it that you will still be implementing this intervention five years from now?
   _____  Very unlikely
   _____  Somewhat unlikely
   _____  Somewhat likely
   _____  Very likely

29. Which of the following were barriers for you in using this intervention?
    (Check all that apply!)
   _____  Time was too short for discussions with parents.
   _____  The intervention was too short.
   _____  I wasn’t sure what to say.
   _____  I really didn’t think I could influence a smoking parent to quit.
   _____  I thought the parent was offended.
   _____  The parents seemed to tune me out.
   _____  I don’t think the parents changed their tobacco control procedures after I talked with them.
   _____  I don’t think the parents were an important source of their children’s tobacco.
   _____  Other reason (Please write here: ____________________________________________)

PERCEPTIONS OF TOBACCO USE

For the following questions, please give us your best guess, even if you’re not sure.

30. What proportion of high school students smoke at least once a week?
    _____ %  (You may answer from 0% to 100%)

31. What proportion of high school students who smoke a few cigarettes go on to smoke as adults?
    _____ %  (You may answer from 0% to 100%)

32. What proportion of teens who smoke try to quit tobacco in a year?
    _____ %  (You may answer from 0% to 100%)
33. What proportion of teens who quit successfully stay quit for 2 years? 
   _____%  (You may answer from 0% to 100%)

34. What proportion of parents smoke? 
   _____%  (You may answer from 0% to 100%)

35. What proportion of teens get their cigarettes from their parents? 
   _____%  (You may answer from 0% to 100%)

36. Is it safe for children or teens to smoke for only a year or two, as long as they quit after that? 
   _____ Definitely not 
   _____ Probably not 
   _____ Probably yes 
   _____ Definitely yes

37. Does smoking tobacco cause serious illness in children and teens while they are still young? 
   _____ Definitely not 
   _____ Probably not 
   _____ Probably yes 
   _____ Definitely yes

38. Have you smoked cigarettes in the last 30 days? 
   _____ Yes 
   _____ No

39. How many cigarettes do you usually smoke? (Pick the one best answer.) 
   _____ None 
   _____ About one cigarette per month 
   _____ About one cigarette per week 
   _____ About one cigarette per day 
   _____ About 10 cigarettes per day 
   _____ About a pack a day 
   _____ More than a pack a day
40. Which kinds of smoked tobacco do you use? (Please check all that apply)
   _____ Regular cigarettes
   _____ Menthol cigarettes
   _____ Cigars
   _____ Cigarillos
   _____ Pipes
   _____ Bidis
   _____ Kreteks (clove cigarettes
   _____ None

41. Which kind of smokeless tobacco do you use? (Please check all that apply)
   _____ Chewing tobacco
   _____ Snuff
   _____ Snus
   _____ None

42. How often do you use smokeless tobacco?
   _____ Every day
   _____ Some days
   _____ Never

TOBACCO USE CESSATION

43. Are you seriously thinking about quitting tobacco during the next month?
   _____ Yes
   _____ No

44. Are you seriously thinking about quitting tobacco during the next six months?
   _____ Yes
   _____ No

45. During your lifetime, how many times have you tried to quit tobacco? __________ times

46. During the past year, have you successfully stopped using tobacco on purpose for…

   a) At least 24 hours?     Yes  No
   b) At least a week?       Yes  No
   c) At least a month?      Yes  No

Many thanks for your help!
PROJECT PACT

1. Can we talk about ways to keep your child from smoking?
2. How would you feel if your child smoked?
3. What do you know about the effects of smoking on children? [*Interferes with lung growth, etc.*]
4. Up to 59% of children get tobacco from home.
5. How do you think your child could try to get tobacco at home?
6. How do you try to keep your child from getting your tobacco? [*Probe.*]
7. What are some other things you could do? [*Probe.*]
8. What might make it hard?
9. What could you do for yourself to make it easier?
10. To help you, I’m going to write down the ideas that we discussed.
11. Thanks for talking with me.
Appendix G: Project PACT Physician Training
SLIDE PRESENTATION
by
Leslie A. Robinson, Ph.D.
Project PACT: Parents Actively Controlling Tobacco

JOSPEH WEINBERG, M.D.
LESLIE ROBINSON, PH.D.
ASHLEY HUM, M.S.
LAURIE BURKE, M.S.
Introductions

Joseph Weinberg, M.D.
  o PI
  o Associate Professor of Pediatrics, UT

Leslie Robinson, Ph.D.
  o Associate Professor, Clinical Psychology
  o Specialist in children’s tobacco use

Ashley Hum, M.S.
  o Doctoral candidate in clinical psychology
  o Specialist in physicians’ impact on smoking

Laurie Burke, M.S.
  o Doctoral candidate in clinical psychology
  o Specialist in loss and grief
PROJECT PACT

- Consent forms for pediatricians
- Questionnaire
- Rationale for the study
- Review of procedures
- Intervention
- Role plays
- Questions and wrap up
Before we start.....
Please complete a short questionnaire!
PROJECT PACT: Why is it important?

- Up to 60% of adolescents who smoke get their cigarettes from family members.

- One way to reduce smoking among children is to reduce their access to tobacco products.

- **Study aim:** To encourage parents to keep their tobacco products from their children.
Prevalence of Smoking

• Among adults: 21%

• Among high school students: 20%

• Among middle school students: 6%
Trying to Quit is Common in Teens

• 68% of teens try to quit in a year\textsuperscript{1}

• 8% of teens actually stay quit for 1 year\textsuperscript{1}

• Given how hard it is to quit, we want to reduce the number of kids who start smoking.

• To reduce smoking, we need to make tobacco harder to get.
Where Do Teens Get Tobacco?

- 19% of daily teen smokers get their cigarettes from their parents \(^1\)

- 42% of teen smokers’ parents give them cigarettes \(^2\)

- Up to 60% of teen smokers steal cigarettes from their parents \(^2,3\)
Physician Advice about Smoking

• *High reach*: 83% of adults and 90% of children see a health care professional each year¹

• Physician advice does reduce smoking.
  - reduces environmental tobacco smoke (ETS) exposure in children²
  - reduces parental smoking³
  - increases quitting among adolescents⁴,⁵

• Further, parents who smoke support pediatricians’ efforts to reduce smoking among children and are open to discussions about tobacco⁶
How to Produce Change: Motivational Interviewing (MI)

- Is a counseling technique.

- Assumes motivation to change must lie within the patient—cannot be imposed.

- **Goal**: To strengthen the patient’s commitment to change.
Research on the Effectiveness of MI$^1$

MI outperforms traditional advice giving in 80% of studies. $^1$

MI has successfully changed:
- body mass index
- cholesterol
- alcohol and drug use
- cigarette smoking
- systolic blood pressure
- adherence to asthma and diabetes medication regimens
- HIV risk behavior

MI can be effective in brief encounters, but booster contact may improve outcomes.
Main principles of MI

- Express empathy

- Support self-sufficiency
  - increase patient’s belief that s/he can change

- Keep the discussion positive
  - avoid direct confrontations, orders, and argumentation

- Develop discrepancy (the directive part)
  - Is patient behaving in a way that is not congruent with their reported values?
Motivational Interviewing Techniques

- Ask permission to address smoking
- Use open-ended questions
- Listen
- Be non-confrontational
- Allow client to come up with strategies
- Discuss barriers and ways to overcome barriers
- Summarize their plan
Videotapes

- Without MI
- With MI

- *See handout on MI in your packets.*
Present Study

Purpose of study:
- To teach pediatricians to use MI to encourage parents who smoke to keep their tobacco out of their children’s reach.

Design is simple:
- 2 practices: 1 intervention practice
  1 control practice
- Questionnaires for pediatricians & parents who smoke.
  - Baseline and follow-up
- Results will be evaluated by the University research team.
Basic Procedure at Your Practice

- Liaison will screen & consent parents.

- Liaison will administer & collect parent surveys.

- Liaison will tell you when a parent has been enrolled in study & give you a study brochure.

- You will administer the intervention & give parent brochure.

Note: See brochure and tip sheet.
MI Intervention Steps

1. Ask parent for permission.

   “Can we talk about ways to keep your child from smoking?”

2. Ask parent how they would feel if their child smoked.

   “First, how would you feel if your child smoked?”
3. What do the parents know?

“How much information do you have about the effects of smoking on children?”

- Reduced lung growth
- Increased cough
- Reduced exercise tolerance
- Development of risk factors for cardiovascular disease, COPD, and cancer
4. Children get tobacco at home.

“This may surprise you, but up to 60% of children get tobacco from home.”

5. Ask parent about how their child could get tobacco from home.

“How could your child try to get tobacco at home?”
6. Ask how parent tries to keep tobacco away.

“How do you try to keep your tobacco away from your child?”

• Summarize
• Avoid being confrontational.

7. Other ways to restrict tobacco?

“What are some other things you could do?”

• Recap what parent has already done & new ideas.
• Write ideas for restricting tobacco in brochure.
8. What might make it difficult to follow through with plans to restrict tobacco?

“What might make it hard to do?”

9. How could they make following-through easier?

“What could you do to make this easier?”
10. Summarize discussion & give parent pamphlet.

“To help you, I’m going to write down the ideas that we discussed.”

11. Thank parent and praise.

“I think this is a really great start. Thanks for talking with me.”
Get Ready for Role Play

• Dr. Robinson and staff model role play with
  o cooperative parent
  o less cooperative parent.

• Have brochure, pen, and tip sheet ready.
Role Plays

• Role play intervention with non-resistant parent.
• Role play intervention with resistant parent.
• Role play parent who needs help generating ideas.
Your Binder

- Overview of the research
- Research team
- Scripts
- Research on relevant topics
General Information

• At what age do children start to smoke?

• How is smoking different for African American children vs. Caucasians?

• What motivates young girls to smoke?

• How can you prevent a child from smoking?

• How can you help a teen who is smoking to quit?
Questions?

Thanks!!!
PROJECT PACT: OBSERVATION CHECKLIST

Note: Check if each step was completed by the pediatrician, exact wording or order is not necessary.

1. Can we talk about ways to keep your child from smoking?
   _____ Yes   _____ No

2. How would you feel if your child smoked?
   _____ Yes   _____ No

3. What do you know about the effects of smoking on children? [Interferes with lung growth, etc]
   _____ Yes   _____ No

4. Up to 59% of children get tobacco from home.
   _____ Yes   _____ No

5. How do you think your child could try to get tobacco at home?
   _____ Yes   _____ No

6. How do you try to keep your child from getting your tobacco?
   _____ Yes   _____ No

7. What are some other things you could do?
   _____ Yes   _____ No

8. What might make it hard?
   _____ Yes   _____ No

9. What could you do for yourself to make it easier?
10. To help you, I'm going to write down the ideas that we discussed.

_____ Yes  _____ No

11. Thanks for talking with me.

_____ Yes  _____ No

**ADDITIONAL OBSERVATIONS:**

12. Was the pediatrician empathetic during the intervention?

_____ Yes  _____ No

13. Was the pediatrician warm with the parent?

_____ Yes  _____ No

14. Did the pediatrician reflect the parents' responses throughout the intervention?

_____ Yes  _____ No

15. Was the pediatrician flexible with the intervention based on the parent's responses?

_____ Yes  _____ No
Note: Please think about the initial Saturday training session when you answer this section of questions.

1. Did the content of the training program seem relevant to your practice?
   _____ Highly relevant
   _____ Somewhat relevant
   _____ Somewhat irrelevant
   _____ Highly irrelevant

2. How would you rate the program in terms of content?
   _____ Excellent
   _____ Good
   _____ Needs improvement
   _____ Poor

3. How would you rate the program in terms of format (slides, talk, role-playing)?
   _____ Excellent
   _____ Good
   _____ Needs improvement
   _____ Poor

4. How well did the training instructor communicate?
   _____ Not at all well
   _____ Not particularly well
   _____ Fairly well
   _____ Quite well

5. How comfortable did the training instructor make you feel?
   _____ Not at all comfortable
   _____ Not particularly comfortable
   _____ Fairly comfortable
   _____ Quite comfortable
6. How prepared did you feel to deliver the planned intervention after the training program?
   _____ Not at all prepared
   _____ Somewhat prepared
   _____ Fairly prepared
   _____ Well prepared

7. How would you rate your understanding of adolescent smoking?
   a) Before attending the program           b) After attending the program
      _____ Low                     _____ Low
      _____ Medium                 _____ Medium
      _____ High                   _____ High

8. How would you rate your understanding of motivational interviewing?
   a) Before attending the program           b) After attending the program
      _____ Low                     _____ Low
      _____ Medium                 _____ Medium
      _____ High                   _____ High

9. How would you rate your overall ability to provide a tobacco control intervention?
   a) Before attending this program           b) After attending this program
      _____ Low                     _____ Low
      _____ Medium                 _____ Medium
      _____ High                   _____ High

10. How would you rate your willingness to provide a tobacco control intervention?
    a) Before attending this program           b) After attending this program
       _____ Low                     _____ Low
       _____ Medium                 _____ Medium
       _____ High                   _____ High

11. Would you recommend this training program to your colleagues?
    _____ Yes, highly
    _____ Yes, somewhat
    _____ No
12. Any other suggestions or comments about the training program?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

FEASIBILITY OF INTERVENTION

Note: Please think about the time period when you were giving the intervention and how feasible the procedures were for your practice.

13. How difficult was it to implement this intervention with parents?
   _____ Not at all difficult
   _____ Not particularly difficult
   _____ Fairly difficult
   _____ Quite difficult

14. How much did participating in this study disrupt your usual activities at your practice?
   _____ Not at all disrupted
   _____ Not particularly disrupted
   _____ Fairly disrupted
   _____ Quite disrupted

15. What proportion of parents reacted the following ways to the intervention…
   Positively _____%    Negatively _____%    Neutral _____%

16. Were there any negative parental reactions to the intervention or research procedures?
   _____ No
   _____ Yes

17. If so, please describe:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

18. Over time, did giving the intervention become…..
19. How helpful were the pocket reference cards when giving the intervention?
   _____ Not at all helpful
   _____ Not particularly helpful
   _____ Fairly helpful
   _____ Quite helpful

20. How helpful were the brochures?
   _____ Not at all helpful
   _____ Not particularly helpful
   _____ Fairly helpful
   _____ Quite helpful

21. Did we train you adequately to give the intervention?
   _____ No
   _____ Yes

22. Should we have done a longer training program?
   _____ No
   _____ Yes

23. How long would you have been willing to stay to get trained? ________________

24. Should we have done more than 1 training session?
   _____ No
   _____ Yes

25. How many sessions would you have been willing to attend? ________________
26. How likely is that you will use motivational interviewing strategies for discussing other topics (e.g., nutrition) with parents?
   _____ Highly unlikely
   _____ Somewhat unlikely
   _____ Somewhat likely
   _____ Highly likely

27. How likely is that you will use motivational interviewing strategies for discussing other topics (e.g., weight loss) with patients?
   _____ Highly unlikely
   _____ Somewhat unlikely
   _____ Somewhat likely
   _____ Highly likely

28. How likely is it that you will continue to address tobacco issues with your patients after participating in this study?
   _____ Highly unlikely
   _____ Somewhat unlikely
   _____ Somewhat likely
   _____ Highly likely

29. If you plan to continue to use some part of the intervention, what part?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Thank you for taking part in this study! We will enter and analyze the data throughout the summer. As soon as we have results, we would be delighted to present our findings to you!