



State of Arkansas  
2009-2010

# Evaluation and Analysis of Statewide Cessation Resources

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Susan Brandzel, MPH  
Program Manager  
Arkansas Training and Outreach Contract

Gillian Schauer  
Manager, Training and Outreach Unit  
Clinical and Behavioral Sciences Department

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Susan Brandzel, MPH, Program Manager, Arkansas Training and Outreach Contract

Afomeia Tesfai, Associate Program Manager, Training and Outreach Unit, Clinical and Behavioral Sciences

Lisa Mahoney, MPH, Sr. Data Analyst, Clinical and Behavioral Sciences

Tamara Altman, PhD, Associate Director of Evaluation, Clinical and Behavioral Sciences

Gillian Schauer, Manager, Training and Outreach Unit, Clinical and Behavioral Sciences

Susan Zbikowski, PhD, Vice President, Clinical and Behavioral Sciences

Tim McAfee, MD, MPH Senior Vice President and Medical Officer, Clinical and Behavioral Sciences

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For additional copies of this report, please contact:

Susan Brandzel, MPH  
Free & Clear, Inc.  
999 Third Avenue  
Suite 2100  
Seattle, WA 98104  
Telephone: 206-876-2332/206-407-8894  
Fax: 206-876-2101  
Email: [susan.brandzel@freeclear.com](mailto:susan.brandzel@freeclear.com)

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## **Purpose**

The purpose of this report is to document the findings of a survey conducted amongst Arkansas Department of Health Tobacco Prevention and Cessation Program (ADH TPCP) affiliates who provide health education services on behalf of the ADH. The survey was conducted to assess the current tobacco cessation activity and the capacity level of these individuals in order to determine how they factor in to future plans to expand tobacco cessation training and outreach for health care providers in Arkansas.

This report fulfills the requirements of Deliverable 3 of Task 2, set in the 2009-2010 contracts between Free & Clear, Inc. (F&C) and the Arkansas Department of Health (ADH) Tobacco Prevention and Cessation Program (TPCP).

## Introduction

The Arkansas Department of Health's (ADH) Tobacco Prevention and Cessation Program (TPCP) is in the process of expanding and systematizing tobacco cessation training and outreach that occurs with health care providers throughout the state. As an initial step to this process, the ADH TPCP contracted with Free & Clear (F&C) for a number of quantitative and qualitative evaluation tasks to assess the current level of tobacco cessation work. As part of these evaluation tasks, F&C designed and implemented a survey to assess work occurring among ADH-affiliated field staff charged with carrying out tobacco cessation, either as part of their job description or as the recipients of a grants provided by the TPCP for tobacco control.

An online survey tool was sent to 344 ADH-affiliated health educators or individuals with health education responsibilities to assess the following areas: 1) description of work responsibilities and use of field time, 2) knowledge of evidence-based tobacco cessation concepts, 3) confidence in skills required for conducting tobacco cessation training and outreach and, 4) frequency of and ability to conduct tobacco cessation training or outreach activities with healthcare providers or systems. Of the 344 individuals who were eligible to complete the survey, 221 fully completed and submitted it, resulting in a 64% response rate.

The survey data were reviewed, cleaned and ultimately analyzed, resulting in the subsequent report and conclusions.

## Methods

### Survey Design

Free & Clear designed the survey tool with the goal of assessing both the knowledge and confidence of ADH-affiliated health education staff charged with conducting tobacco control work, as well as assessing the frequency and content of their current tobacco control activities. The survey was designed using concepts from an instrument previously designed and implemented in Washington State for the same purpose. The ADH TPCP provided input to assist F&C in appropriately tailoring the tool to meet the needs of Arkansas' specific health education population.

Based on feedback from the ADH TPCP, the survey tool was designed to reach the following specific health educator and/or outreach populations that work with or through the ADH TPCP:

- Rural Health Educators / Rural Health Specialists
- Community Health Promotion Specialists (CHPS)
- Community Health Nurse Specialists (CHNS)
- TPCP Grantees
- Office of Alcohol and Drug Abuse Programs (OADAP) Grantees
- University of Arkansas at Pine Bluff (UAPB) Grantees
- Nurses at Local Health Units

The first set of questions, (1 through 14; see **Attachment A**), were designed to gather information from all respondents, regardless of their professional role. These questions gathered basic work descriptives, assessed current use of field time, and assessed the respondents' level of knowledge and confidence related to tobacco cessation and control. Question 14 asked respondents to identify the primary area or setting for their work and directed them accordingly to a customized section to identify the frequency of activities conducted at work. Customized sections were tailored to reach respondents working primarily in either: 1) schools or daycares, 2) a local health unit, 3) a clinic and/or hospital healthcare setting (outside of a local health unit), or 4) in the community (outside of schools and daycares).

### Survey Administration

Once the survey content was finalized and approved by ADH TPCP, it was programmed into DatStat, an online survey system. The final online survey link was distributed by the ADH via email to 344 potential respondents on Monday, April 26<sup>th</sup>, 2010. The email contained a detailed survey cover letter with instructions for survey completion and information about confidentiality.

F&C tracked response rates once the survey was opened and established a final survey completion date of May 19<sup>th</sup>, 2010, with approval from AHD TPCP. At the end of the day on May 19<sup>th</sup>, 2010, 221 of 344 potential respondents had completed the survey, resulting in a response rate of 64%. Forty-four partial surveys were completed, but were not included in the analyses as responses could have belonged to respondents who also completed an entire survey at a subsequent time.

### Survey Analysis

Once survey data collection closed, F&C initiated data review and cleaning. Survey questions that included an “other” category to capture unanticipated response categories were reviewed for redundancy with already existing categories and, when appropriate, were recoded accordingly. Using SAS Version 9.2, F&C staff output survey response frequencies and bi-variate analyses (cross tabulations) of select data in order to obtain the best understanding and value from the survey data.

During the analysis process, four errors in survey set-up and implementation were discovered. They are noted as follows with an explanation and a brief discussion of any implications:

1. The question placed between Questions 8 and 9 on the programmed online survey was un-numbered. This error had no impact on the data obtained and was accounted for in the analysis so as to ensure the correct matching of question numbers with data output.
2. There was no Question 13 on the programmed online survey. Again, this error had no impact on the data obtained and was accounted for in the analysis so as to ensure the correct matching of question numbers and data output.
3. In the survey version approved by ADH TPCP and F&C, Question 21 included a response category that asked relevant respondents how often they refer patients who use tobacco to resources other than the Arkansas Tobacco Quitline (Question 21g). This response option was erroneously omitted during the set-up of the online survey and thus no data was received for it. The survey version in **Attachment A** of this report was modified to reflect this omission.
4. The first response category for Question 28 of the survey was misprogrammed as “>25%” instead of the intended category label “<25%”. Given that it is not known how respondents interpreted this response category (literally or as it was intended), the responses to this actual category have been excluded from the analysis.
5. Also, because the surveys were anonymous and data were deidentified, there is a small possibility that an individual could have completed the survey more than once. Although there is little motivation for such an event to occur, it should be taken into account in the conclusions drawn from survey results.

Complete survey data are reported in the following Results section and include both the original frequencies for each survey question as well as a number of cross-tabulations from selected survey questions that are thought to provide additional meaning and depth to the interpretation of these data.

## Results

### Frequency Results

The frequency results for this survey are reported in the same order that the survey was administered.

**Note 1:** Response totals may add up to slightly great than 100% due to rounding.

**Note 2:** Although there is strong representation from each group included, ADH nurses were over-represented in the population asked to complete the survey. Thus, in summary statistics, the results may be biased by this disproportionate representation.

### SECTION A: IDENTIFICATION AND DESCRIPTION

#### 1. What is your current professional role for the state of Arkansas?

CURRENT PROFESSIONAL ROLE	n	%*
Health Educator or Rural Health Specialist	4	2%
Hometown Health Improvement Coordinator	5	2%
Community Health Nurse Specialist (CHNS)	13	6%
Community Health Promotion Specialist (CHPS)	6	3%
OADAP Grantee	18	8%
TPCP Grantee	29	13%
UAPB Grantee	9	4%
Other Nurse employed by ADH (RN, LPN, RNP, APN)	115	52%
Other	22	10%
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

\* Percentage out of total survey population, not percentage of respondents out of those invited to respond to the survey in each professional group.

ADH nurses outnumbered all other groups represented among survey respondents. However, all groups were well represented proportionately to how many were invited to complete the survey.

**2. How many years have you worked in your current role?**

<b>YEARS IN CURRENT ROLE</b>	<b>n</b>	<b>%</b>
Less than 6 months	5	2%
6 months to 1 year	20	9%
>1 - 3 years	46	21%
>3 – 5 years	39	18%
>5 years	111	50%
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

Half of the respondents reported at least five years of experience in their current role, indicating that an experienced population responded to this survey.

**3. Where is the majority of your work time spent?**

<b>Type of Area</b>	<b>n</b>	<b>%</b>
Large city (pop. 50,000+)	46	21%
Small city (pop. 10,000 – 49,999)	71	32%
Town (only basic services and population between 1,000 – 9,999)	97	44%
Isolated rural area (no hospital and population under 1,000)	7	3%
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

Survey respondents work in a variety of urban and rural areas. The majority of respondents reported working in towns (44%) or small cities (32%).

**4. What public health issues are you required to address as part of your work plan/ job description?\***

<b>HEALTH ISSUES</b>	<b>n</b>	<b>%</b>
Diabetes	74	33%
Cardiovascular Disease	76	34%
Weight/Nutrition/Obesity/Physical Activity	152	<b>69%</b>
Other Chronic Disease	9	4%
HIV/AIDS/STDs	141	<b>64%</b>
Other Infectious Diseases	106	48%
Teen Pregnancy	132	<b>60%</b>
Vaccination	131	<b>59%</b>
Injury Prevention	45	20%
Oral Health Care	67	30%
Infant Mortality	54	24%
Breast and Cervical Cancer Prevention	129	<b>58%</b>
Substance Abuse/Mental Health Prevention	93	42%
Disaster Preparedness	78	35%
Tobacco Cessation and Prevention	197	<b>89%</b>
Other**	17	8%

\* Percentages add up to >100 since respondents were asked to mark all categories that apply

\*\* "Other" responses included: *abuse, violence, health education, family planning, other cancers, WIC, Hometown Health coalition, community health, vision, hearing, scoliosis and school drop outs*

Results from question 4 indicate that the top six most common issues addressed by ADH tobacco partners who responded to this survey are: Tobacco Cessation and Prevention (89%), Weight/Nutrition/Obesity/Physical Activity (69%), HIV/AIDS/STDs (64%), Teen Pregnancy (60%), Vaccination (59%), and Breast and Cervical Cancer Prevention (58%).

**5. In your current job/work plan (2009-2010), do you conduct tobacco prevention and/or cessation work?**

<b>Response</b>	<b>n</b>	<b>%</b>
No	23	10%
Yes	198	90%
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

Ninety percent of respondents reported that some aspect of tobacco control is part of their current job or work responsibilities.

**5a. How would you feel about adding tobacco prevention and cessation work to your current job/work plan?** (Administered only to respondents who answered “no” to item 5, n=23)

<b>FEELINGS ABOUT ADDING TOBACCO CONTROL TO WORK</b>	<b>n</b>	<b>%</b>
Negative (1-3)	5	22%
Neutral (4-6)	12	<b>52%</b>
Positive (7-10)	6	26%
<b>TOTAL</b>	<b>23</b>	<b>100%</b>

As denoted above, question 5a was administered only to respondents who indicated that they did not currently have tobacco prevention and cessation in their work plan / job. Results from responses to question 5a depict a unimodal response pattern and indicate that the majority of survey respondents (52%) were neutral when asked about adding tobacco prevention and cessation to their current job / work plan.

**6. How many years of work experience do you have in positions that address tobacco prevention and/or cessation?**

<b>YEARS OF WORK IN POSITIONS WITH TOBACCO CONTROL</b>	<b>n</b>	<b>%</b>
Less than 6 months	5	3%
6 months to 1 year	15	8%
>1 - 3 years	43	22%
>3 – 5 years	35	18%
>5 years	100	<b>51%</b>
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

Just over half of survey respondents reported having over five years of tobacco control work experience. An additional 18% report having over three years of tobacco control experience. These experience rates show that a significant majority of respondents have a very strong background in conducting tobacco control work.

**7. Approximately how much of your current work time do you dedicate to all tobacco prevention and control activities (prevention, policy, cessation, youth, secondhand smoke, etc)?**

<b>TIME FOR ALL TOBACCO CONTROL</b>	<b>n</b>	<b>%</b>
None	8	4%
1-25%	142	<b>64%</b>
26-50%	34	15%
51-75%	15	7%
76-100%	22	10%
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

Although the response to question 4 shows that 89% of survey respondents address tobacco in their work, and responses to questions 6 indicate that this is a highly experienced cohort in tobacco control, the amount of time that the majority (68%) of respondents dedicate to tobacco control is less than or equal to 25% of their work time.

8. *Of your total current work time for all tobacco prevention and control activities, how much do you dedicate just to tobacco cessation activities (e.g., direct patient services, educating healthcare providers about treatment resources like the Quitline, teaching healthcare providers to identify and treat tobacco addiction in patients, making sure that hospitals and clinics have systems to help patients who use tobacco to quit)?*

<b>TIME FOR CESSATION ONLY</b>	<b>n</b>	<b>%</b>
None	33	15%
1-25%	176	<b>71%</b>
26-50%	20	9%
51-75%	7	3%
76-100%	5	2%
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

Responses to this question show that survey respondents devote a relatively small proportion of their overall time spent on tobacco control specifically to work on tobacco cessation. Eighty-six percent of survey respondents report spending 25% or less of their tobacco-related work time on cessation.

**9. Please rate your current knowledge in the following key elements of tobacco cessation:**

<b>ELEMENTS OF TOBACCO CESSATION</b>	Not Knowledgeable % (n)	Somewhat Knowledgeable % (n)	Moderately Knowledgeable % (n)	Highly Knowledgeable % (n)
Tobacco use or substance abuse addiction	2% (5)	26% (57)	<b>46%</b> (102)	26% (57)
Client-centered counseling or Motivational Interviewing	19% (43)	33% (73)	<b>37%</b> (82)	10% (23)
Brief Interventions (5As, 4As, or 2As&R)	<b>41%</b> (90)	27% (60)	27% (60)	5% (11)
AR State Tobacco Quitline	5% (11)	14% (30)	38% (84)	<b>43%</b> (96)
Quitline Fax Referral Program	6% (13)	16% (36)	36% (80)	<b>42%</b> (92)
The Public Health Service Guidelines (e.g. Making tobacco use a vital sign, etc.)	29% (64)	<b>35%</b> (77)	29% (64)	7% (16)
Tobacco-Free policies (at clinics, schools, hospitals...)	4% (8)	20% (44)	<b>42%</b> (92)	35% (77)

The knowledge levels of survey respondents in the different areas of tobacco control varied. The highest response rates in each knowledge area are highlighted in the table above, and in many cases, do not vary dramatically from proximal category response rates. Overall, the knowledge level of survey respondents is highest in the Quitline and the Fax Referral Program. Lowest knowledge rates are in Brief Interventions and Public Health Service Guidelines.

**10. If you needed to learn more in any of these areas, what would help you to improve your knowledge?**

<b>TYPE OF TRAINING PREFERRED</b>	Yes % (n)	No % (n)
Online Written Information	33% (72)	67% (149)
Online Training	31% (69)	69% (152)
Remote Learning Such as Webinars	26% (57)	74% (164)
Classroom Training	<b>41%</b> (91)	59% (130)
One-on-One In-Person Training	6% (14)	<b>94%</b> (207)

Survey respondents most prefer learning more about tobacco through classroom training. Their least preferred method of improving their tobacco knowledge is through one-on-one in-person training.

**11. How willing are you to learn how to implement tobacco cessation training and outreach programs in order to help teach healthcare providers in clinics and hospitals how to treat tobacco use?**

<b>WILLINGNESS TO LEARN TOBACCO CONTROL TRAINING AND OUTREACH</b>	<b>n</b>	<b>%</b>
Not Willing (1-3)	16	7%
Neutral (4-6)	81	37%
Willing (7-10)	124	<b>56%</b>
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

The majority of respondents (56%) report a willingness to learn how to implement tobacco cessation training/outreach programs to help healthcare providers.

**12. How confident are you in your ability to:**

<b>CONFIDENCE IN CONDUCTING TRAINING AND OUTREACH</b>	Not Confident % (n)	Somewhat Confident % (n)	Moderately Confident % (n)	Highly Confident % (n)
Present or Speak in Public?	16% (36)	24% (52)	<b>33%</b> (72)	28% (61)
Create appropriate communications for target audiences?	17% (37)	<b>33%</b> (72)	31% (69)	19% (43)
Engage and enlist community-based individuals to work on a project with you??	16% (36)	29% (65)	<b>33%</b> (72)	22% (48)
Gain access to (make appointments and interact with) physicians?	17% (37)	31% (68)	<b>36%</b> (78)	19% (38)
Gain access to (make appointments and interact with) non physician healthcare providers in clinics or hospitals?	11% (25)	34% (74)	<b>36%</b> (80)	19% (42)
Identify and create partnerships with key decision makers?	19% (41)	27% (60)	<b>36%</b> (79)	19% (41)
Implement and deliver trainings to healthcare providers (in any setting)?	23% (51)	27% (60)	<b>35%</b> (78)	14% (32)
Prepare other community members to deliver trainings (e.g. a champion nurse)?	26% (57)	29% (64)	<b>32%</b> (71)	13% (29)
Locate tobacco cessation data on prevalence, use and other information that you need?	16% (36)	31% (68)	<b>35%</b> (78)	18% (39)
Locate current research/studies related to tobacco prevention and control topics on which you are working?	16% (36)	<b>34%</b> (76)	33% (72)	17% (37)
Read and understand data and studies?	9% (19)	30% (67)	<b>41%</b> (90)	20% (45)
Use technology (e.g. PowerPoint, Excel, etc.) to conduct and track field work?	19% (43)	29% (63)	<b>35%</b> (77)	17% (38)

The confidence levels of survey respondents in specific training and outreach areas related to tobacco cessation fall into the intermediate range, with the majority or responses falling into the “moderately confident” category.

*-Note that there was no question 13, as described in the methods section.*

**14. How would you describe the majority of the work that you do in tobacco prevention and cessation?** (choose only one response from the following that best describes the majority of your work)

<b>CURRENT TOBACCO WORK DESCRIPTION</b>	<b>n</b>	<b>%</b>
I work primarily with schools/daycares (e.g., CHPS, CHNS).	37	17%
I work in a local health unit.	125	<b>57%</b>
I work in clinic and/or hospital healthcare setting. *	8	4%
I work with the community outside schools and daycares (e.g., grantee).*	51	23%
<b>TOTAL</b>	<b>221</b>	<b>100%</b>

*\*NOTE: As described in the Methods Section, these two groups were administered the same "Activities" questions on the survey.*

As described above, the majority of survey respondents were local health unit nurses. Question 14 was used to segment various professional types so as to learn more about the specific activities that each specific professional group conducts.

**15. How many times in the last full year have you conducted a presentation or training for teachers, daycare providers or school nurses that was related to a tobacco cessation topic such as intervening with kids or parents about tobacco use or using the Quitline?**

<b>FREQUENCY OF TOBACCO CESSATION TRAINING OR PRESENTATION</b>	<b>n</b>	<b>%</b>
none	9	24%
1-2	10	<b>27%</b>
3-5	11	<b>30%</b>
6-10	4	11%
>10	3	8%
<b>TOTAL</b>	<b>37</b>	<b>100%</b>

*NOTE: Question administered only to respondents who work primarily with schools/daycares.*

These results indicate that over three quarters of respondents who work primarily with schools or daycares conducted five or fewer tobacco cessation trainings for teachers, daycare providers or school nurses in the past year. Over half of the sample reported conducting two or fewer trainings per year.

**16. How many times in the last full year did you conduct a presentation or training for teachers, daycare providers or school nurses that was related to other tobacco topics (e.g., tobacco-free policy, prevention, secondhand smoke education, etc.) ?**

<b>GENERAL TOBACCO CONTROL PRESENTATION/TRAINING FREQUENCY IN LAST FULL YEAR</b>	<b>n</b>	<b>%</b>
none	8	22%
1-2	10	<b>27%</b>
3-5	12	<b>32%</b>
6-10	3	8%
>10	4	11%
<b>TOTAL</b>	<b>37</b>	<b>100%</b>

*NOTE: Question administered only to respondents who work primarily with schools/daycares.*

The response pattern to this item mirrors that of the previous item, showing that survey respondents who work primarily with schools or daycares conducted five or fewer presentation or trainings for teachers, daycare providers or school nurses on tobacco-related topics other than cessation. Again, about half of the sample report conducting two or fewer trainings a year.

**17. How frequently do you include a message about tobacco prevention or cessation when you are training on other topics (e.g., obesity, other substance use, physical activity, etc.)?**

<b>FREQUENCY OF TOBACCO CONTROL MESSAGING IN OTHER TRAINING</b>	<b>n</b>	<b>%</b>
Never	2	5%
Rarely	1	3%
Sometimes	6	16%
Often	13	<b>35%</b>
Always	15	<b>41%</b>
<b>TOTAL</b>	<b>37</b>	<b>100%</b>

*NOTE: Question administered only to respondents who work primarily with schools/daycares.*

Seventy-six percent of respondents who work primarily with schools or daycares indicated that they often or always include messages about tobacco control when conducting a training on other topics.

**18. How many of your regular contacts at the schools or daycares where you have provided trainings are authorized to make changes happen within the organization related to tobacco prevention and control policy, treatment, etc.?**

<b>NUMBER OF REGULAR CONTACTS AUTHORIZED TO MAKE CHANGES REGARDING TOBACCO CONTROL</b>	<b>n</b>	<b>%</b>
None	5	14%
Some	21	<b>57%</b>
Many	10	27%
All	1	3%
<b>TOTAL</b>	<b>37</b>	<b>100%</b>

*NOTE: Question administered only to respondents who work primarily with schools/daycares.*

The response pattern to this question shows that the majority of respondents working in schools and daycares felt that *some* of their regular contacts were authorized to make changes happen in the organization related to tobacco control policy.

**19. How many times in the last full year have you conducted a presentation or training for other healthcare providers within your organization that was related to a tobacco cessation topic such as intervening with patients about tobacco use or referring patients to the Quitline for treatment?**

<b>FREQUENCY OF HEALTHCARE PROVIDER TOBACCO-CESSATION PRESENTATION/TRAINING IN LAST FULL YEAR</b>	<b>n</b>	<b>%</b>
None	108	<b>81%</b>
1-2	16	12%
3-5	5	4%
6-10	2	2%
>10	2	2%
<b>TOTAL</b>	<b>133</b>	<b>100%</b>

*NOTE: Question administered only to respondents who work primarily with local health unit clinics and/or hospital healthcare settings.*

The majority (81%) of respondents who work in a local health unit clinic or hospital report that they have not conducted a tobacco cessation related presentation or training for other providers in their organization.

**20. How often do you or other providers on your clinical team:**

<b>FREQUENCY OF TOBACCO CESSATION ACTIVITIES</b>	<b>Never/ Rarely % (n)</b>	<b>Sometimes % (n)</b>	<b>Often/ Always % (n)</b>
Ask patients about their smoking status?	6% (8)	4% (5)	<b>90%</b> (120)
Identify smoking patients' reasons for smoking or quitting, or discuss prior quit attempts (i.e., assess pros/cons, barriers)?	9% (12)	31% (41)	<b>60%</b> (80)
Advise or recommend that patients quit smoking	5% (7)	12% (16)	<b>83%</b> (110)
Determine if smoking patients are interested in quitting (i.e., assessing motivation)?	6% (8)	14% (19)	<b>80%</b> (106)
Help patients to quit smoking (i.e., distributing self-help materials, providing brief counseling, offering medications, referring to treatment programs, etc.)?	12% (16)	23% (30)	<b>65%</b> (87)
Refer patients who use tobacco to the Arkansas Tobacco Quitline?	8% (10)	20% (26)	<b>73%</b> (97)
Offer to schedule a follow-up visit or phone call to discuss quitting with smoking patients?	<b>54%</b> (72)	27% (36)	19% (25)
Combine discussions about tobacco use with discussions about other co-morbid conditions that may be related?	20% (27)	<b>41%</b> (55)	38% (51)

*NOTE: Question administered only to respondents who work primarily with local health unit clinics and/or hospital healthcare settings.*

While responses to question 19 indicate that respondents from local health units are not conducting many trainings with their peers, responses to question 20 indicate that they have a high frequency of cessation related activity with their patients. In all categories other than two (scheduling follow-up and combining tobacco discussions with discussions of co-morbid conditions), the majority (>50%) of respondents from local health units reported often or always conducting the listed tobacco cessation activities.

**21. Please rate the degree to which you agree with the following statements:**

<b>STATEMENTS ABOUT TOBACCO</b>	<b>Disagree % (n)</b>	<b>Somewhat Disagree % (n)</b>	<b>Somewhat Agree % (n)</b>	<b>Agree % (n)</b>
There is not enough time to counsel tobacco users.	15% (20)	17% (22)	<b>52%</b> (69)	17% (22)
There are more important health issues than tobacco cessation.	<b>38%</b> (50)	36% (48)	23% (30)	4% (5)
Tobacco cessation intervention is not my part of my job.	<b>68%</b> (90)	21% (28)	7% (9)	5% (6)
Most of my patients who use tobacco are not interested in quitting.	12% (16)	28% (37)	<b>45%</b> (60)	15% (20)
Treating tobacco users is not a covered or billable service.	<b>38%</b> (50)	26% (35)	15% (20)	21% (28)
Most tobacco cessation treatments are not effective.	35% (46)	<b>38%</b> (50)	24% (32)	4% (5)

*NOTE: Question administered only to respondents who work primarily with local health unit clinics and/or hospital healthcare settings.*

Respondents from local health units reported that a shortage of time and a perceived lack of patient interest in quitting are the two greatest barriers they face in addressing tobacco treatment. Respondents vary in their responses as to how tobacco ranks in importance compared to other health issues, whether they believe effective tobacco treatment exists and whether they think tobacco treatment is a billable service. Eighty-nine percent of these survey respondents disagree or somewhat disagree that tobacco cessation is not part of their job.

**22. How many times in the last full year have you conducted a presentation or training for any healthcare providers (outside of a local health unit) that was related to tobacco cessation topics (e.g. referring patients to the Quitline for treatment, providing treatment interventions, etc)?**

<b>FREQUENCY OF HEALTHCARE PROVIDER TOBACCO- CESSATION PRESENTATION/TRAINING IN LAST FULL YEAR</b>	<b>n</b>	<b>%</b>
None	25	<b>49%</b>
1-2	10	20%
3-5	5	10%
6-10	7	14%
>10	4	8%
<b>TOTAL</b>	<b>51</b>	<b>100%</b>

*NOTE: Administered only to survey respondents who work primarily with the clinics or hospitals OR with the community outside schools and daycares.*

Nearly half of respondents who work primarily with the community reported that they had not conducted tobacco cessation trainings or presentations with health care providers in the past year. An additional 20% reported conducting only 1-2 trainings in the past year.

**21. What is the typical length of the tobacco cessation trainings you conduct?**

<b>LENGTH OF TRAINING/PRESENTATIONS</b>	<b>n</b>	<b>%</b>
< 15 minutes	2	8%
15-30 minutes	13	<b>50%</b>
>30 minutes	11	42%
<b>TOTAL</b>	<b>26</b>	<b>100%</b>

*NOTE: Administered only to survey respondents who work with the community outside schools and daycares and who indicated that they have done a presentation or training in the last full year.*

Of those respondents working with the community who reported that they had conducted any training in the past year, half of them indicated that the tobacco cessation trainings that they conduct last between 15 and 30 minutes. Another large proportion of these respondents (42%) indicated that their trainings last greater than 30 minutes.

**24. How often do you provide education on the following tobacco cessation topics within your trainings?**

<b>TOBACCO CESSATION ACTIVITIES</b>	<b>Never % (n)</b>	<b>In about a quarter of all trainings % (n)</b>	<b>In about half of all trainings % (n)</b>	<b>In about three quarters of all trainings % (n)</b>	<b>In all of trainings % (n)</b>
a. Brief Interventions Training	11% (3)	<b>31% (8)</b>	19% (5)	23% (6)	15% (4)
b. Quitline Education	0 (0%)	8% (2)	8% (2)	8% (2)	<b>77% (20)</b>
c. Fax Referral Education	8% (2)	24% (6)	0 (0%)	12% (3)	<b>56% (14)</b>
d. Information on how to make tobacco use a vital sign.	<b>27% (7)</b>	23% (6)	12% (3)	15% (4)	23% (6)

*NOTE: Administered only to survey respondents who work with the community outside schools and daycares and who indicated that they have done a presentation or training in the last full year.*

Of those respondents working with the community who reported that they had conducted any training in the past year, the majority (77%) report including education about the Quitline in all of their trainings. A smaller percent (56%) report including education about fax referrals in all of their trainings. Respondents report covering Brief Interventions and Tobacco Use as a Vital Sign (e.g., systems change) less frequently.

**25. Who are the typical attendees at the tobacco cessation presentations or trainings that you conduct? Please check all that apply.**

<b>TYPES OF ATTENDEES AT TRAININGS AND PRESENTATIONS</b>	<b>n</b>	<b>%</b>
Physician	6	23%
Non-school-based nurse or medical assistant	5	19%
School-based nursing staff	6	23%
Dentist	5	19%
Dental Hygienist	4	15%
Respiratory Therapist	4	15%
Pharmacist	3	11%
Administrative clinic/hospital staff (billing, reception, etc.)	8	<b>31%</b>
Social Worker	10	<b>38%</b>
Health Educator	14	<b>54%</b>
Behavioral Health/Substance Abuse Counselor	7	27%
Other*	13	50%

*NOTE: Administered only to survey respondents who work with the community outside schools and daycares and who indicated that they have done a presentation or training in the last full year.*

\*"Other" attendees cited include: clients, general public, parents, community members and leaders, factory owners, business owners, teachers and students.

Of those respondents working with the community who reported that they had conducted any training in the past year, the three most common training attendees reported were Health Educators (54%), Social Workers (38%), and Administrative staff (31%). Respondents also reported conducting trainings with "Other" non-specified individuals on 13 occasions. These types of individuals included clients, the general public, parents, community members and leaders, factory or business owners, and teachers or students.

**26. What proportion of the providers or stakeholders whom you are training/working with is authorized to make changes to their organizations (e.g., policies, procedures, systems)?**

<b>PROPORTION OF STAKEHOLDERS AUTHORIZED TO MAKE CHANGES</b>	<b>n</b>	<b>%</b>
Not training or working with any providers or stakeholders	9	18%
None	4	8%
Some of them	26	<b>51%</b>
Many of them	7	14%
Don't Know	5	10%

*NOTE: Administered only to survey respondents who work with the community outside schools and daycares.*

Half of the respondents working primarily with the community indicated that *some* of the providers or stakeholders they routinely work with are authorized to make organizational or policy-related changes. Another 14% reported that many of their stakeholder partners are authorized to make policy/procedural changes to their organizations.

**27. What percent of the clinics/hospitals and organizations in your service region, county or community can you currently access (easily see or make an appointment to see)?**

<b>PERCENT OF ACCESSIBLE CLINICS/HOSPITALS</b>	<b>n</b>	<b>%</b>
< 25%	n/a*	n/a*
26-50%	9	18%
51-75%	22	<b>43%</b>
76-100%	3	6%

*NOTE: Administered only to survey respondents who work with the community outside schools and daycares.*

\*See note in Methods section about this category having been misadministered.

Respondents working primarily with the community reported that they have a moderate level of access to clinics and/or hospitals in their region, with the majority (43%) indicating that they can access between 51 and 75% of the clinics and hospitals in their area. Only six percent of respondents reported having access to greater than 75% of clinics or hospitals in their service region.

**28. In what percent of the clinics and/or hospitals in your service region, county or community have you identified committed champions? \* Champion = a provider who advocates for tobacco cessation and has the ability to make changes within his/her organization.**

<b>PERCENT OF CLINICS/HOSPITALS WITH A CHAMPION</b>	<b>n</b>	<b>%</b>
Not working with clinics or hospitals	17	<b>33%</b>
0-25%	17	33%
26-50%	12	24%
51-75%	3	6%
76-100%	2	4%
<b>TOTAL</b>	<b>51</b>	<b>100%</b>

*NOTE: Administered only to survey respondents who work with the community outside schools and daycares.*

Of these respondents, 57% report having a champion in less than 50% of the clinics or hospitals in their service region. Only 10% report having a champion in greater than 50% of the clinics or hospitals in their service region. Thirty-three percent report that they are not working at all with clinics or hospitals.

## Bi-variate Results

In addition to the frequencies reported in the previous section, selected survey data were analyzed using cross tabulation. Due to the small sample size, statistical significance of findings was not investigated. However, this report features a number of cross tabulation tables that contribute critical information to the development and implementation of a systematic tobacco cessation training and outreach program.

### 1. Current professional role by whether they are required to address tobacco prevention and/or cessation in that role (Y/N): (Question 1 by Question 5)

<b>Professional Role</b>	No %/(n)*	Yes %/(n)
Health Educator or Rural Health Specialist	0% (0)	100% (4)
Hometown Health Improvement Coordinator	0% (0)	100% (5)
Community Health Nurse Specialist (CHNS)	0% (0)	100% (13)
Community Health Promotion Specialist (CHPS)	0% (0)	100% (6)
OADAP Grantee	11% (2)	89% (16)
TPCP Grantee	0% (0)	100% (29)
UAPB Grantee	0% (0)	100% (9)
Other Nurse employed by ADH (RN, LPN, RNP, or APN)	14% (16)	86% (99)
Other	27% (6)	73% (16)
<b>TOTAL</b>	<b>11% (24)</b>	<b>89% (197)</b>

A very high percentage of survey respondents reported that they are required to address tobacco prevention and/or cessation in their role. Of eight of the specified professional roles responding to this survey, 100% of survey respondents from six of them are required to address some aspect of tobacco control as part of their work.

## 2. Professional role by mean confidence level in tobacco cessation training and outreach:

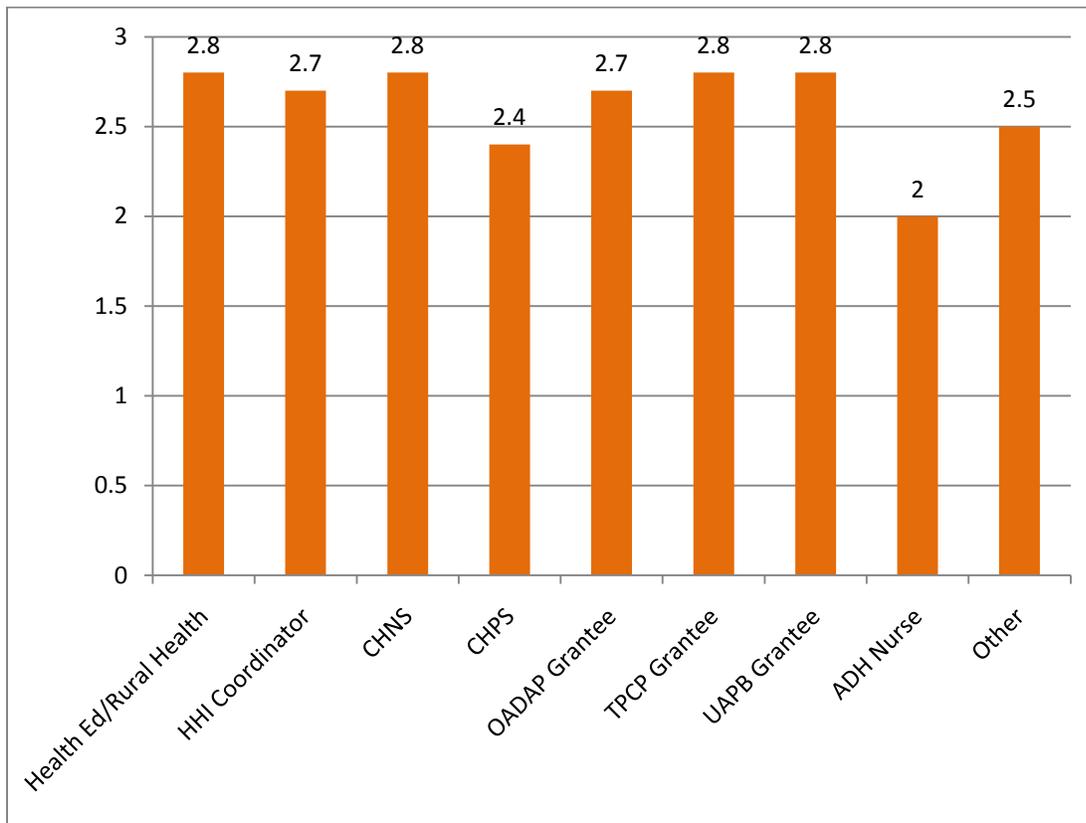
(Question 1 by Question 12)

Confidence ratings: 1 = Not Confident, 2 = Somewhat Confident, 3 = Moderately Confident, 4 = Highly Confident, 5 = Extremely Confident

	Health Ed/ Rural Health	HHI Coord.	CHNS	CHPS	OADAP Grantee	TPCP Grantee	UAPB Grantee	ADH Nurse	Other
a. Present or speak in public?	<b>3.3</b>	3.2	<b>3.3</b>	2.8	<b>3.3</b>	<b>3.3</b>	3.2	2.3	2.8
b. Create appropriate communication pieces for target audiences?	<b>3.6</b>	3.0	3.3	3.3	3.2	3.2	3.1	2.1	2.6
c. Engage and enlist community-based individuals to work on a project with you?	<b>3.3</b>	3.0	<b>3.3</b>	2.6	3.0	<b>3.3</b>	3.2	2.1	2.9
d. Gain access to physicians?	2.6	2.2	<b>2.9</b>	2.0	2.6	2.7	<b>2.9</b>	2.4	2.7
e. Gain access to non physician healthcare providers in clinics or hospitals?	3.0	2.4	<b>3.2</b>	2.3	2.8	2.9	2.9	2.4	2.9
f. Identify and create partnerships with key decision makers?	3.0	<b>3.4</b>	3.2	2.3	3.1	3.2	3.3	2.1	2.6
g. Implement and deliver trainings to healthcare providers (in any setting)?	2.8	2.6	<b>3.3</b>	2.3	2.9	2.5	2.8	2.2	2.3
h. Prepare other community members to deliver trainings. [e.g. a champion nurse]?	2.8	2.8	<b>3.0</b>	2.5	2.6	2.7	2.9	2.0	2.3
i. Locate tobacco cessation data on prevalence, use and other information that you need?	2.8	3.0	3.0	3.0	3.0	<b>3.1</b>	3.0	2.1	2.8
j. Locate current research/studies related to tobacco prevention and control topics on which you are working?	2.8	<b>3.2</b>	2.7	3.0	3.1	3.0	2.8	2.1	2.7
k. Read and understand data and studies?	3.0	3.0	2.7	2.8	2.9	3.1	<b>3.3</b>	2.5	2.8
l. Use technology (e.g., PowerPoint, Excel, etc.) to conduct and track regular field work?	<b>3.5</b>	2.8	2.8	2.7	3.1	3.0	2.9	2.2	2.5

This table displays the mean confidence level in each area of training and outreach by professional role. For each area of training and outreach (horizontal row), the professional group(s) with the highest confidence level is bolded. There is a relatively small range of confidence levels, both within each tobacco cessation area and by professional role. The mean overall training and outreach confidence levels by profession role are as displayed in **Figure 1** below:

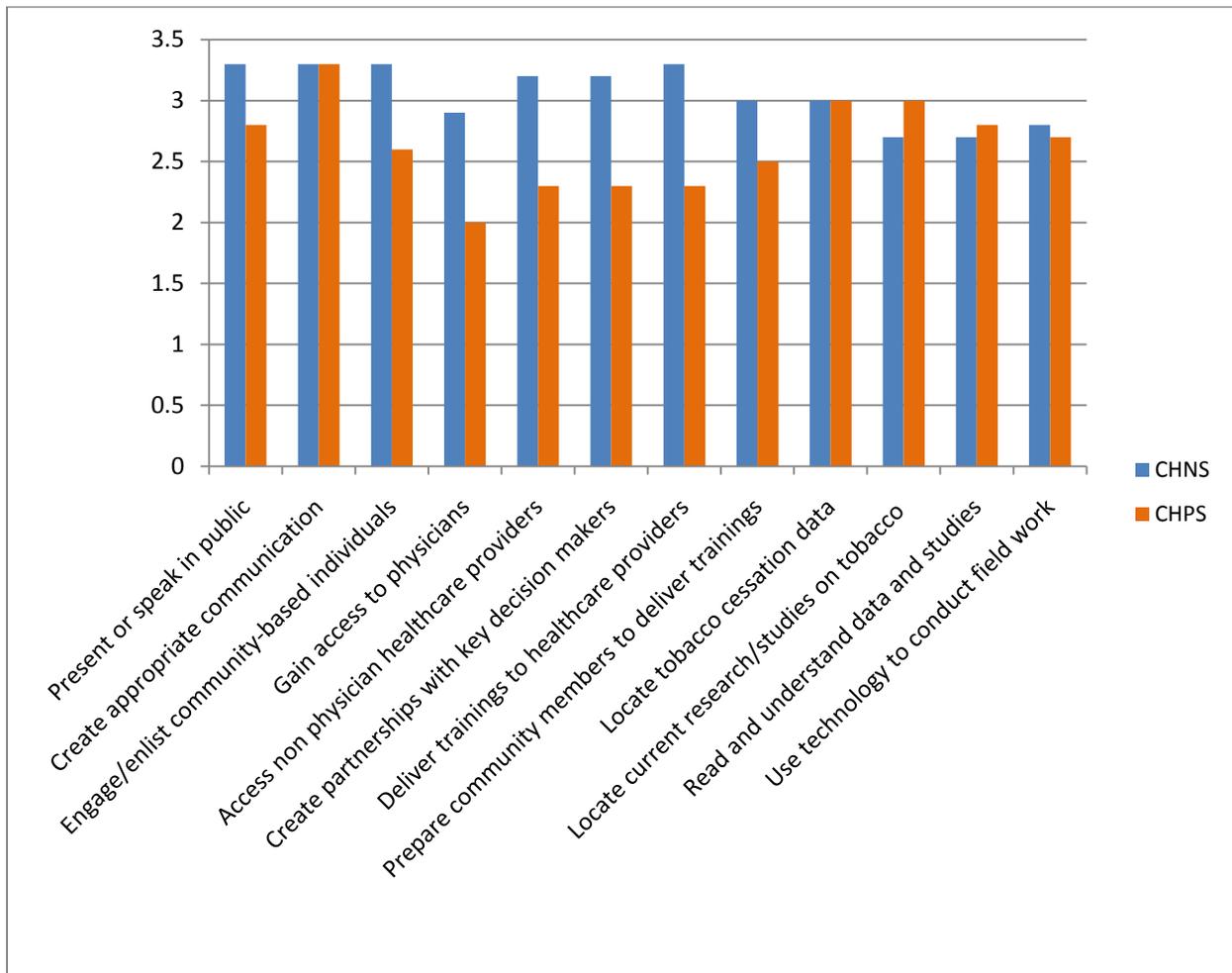
**Figure 1: Mean Training and Outreach Confidence Level by Professional Role**



Although the ADH nurses stand out as having a notably lower mean confidence level in training and outreach than the other groups, all groups' responses translate into a mean confidence level of "somewhat confident" or "moderately confident".

Given that the CHPS and CHNS are two of the professional roles that are clearly charged with doing training and outreach, their confidence levels in the different areas of tobacco cessation have been highlighted in **Figure 2** below.

**Figure 2. CHPS and CHNS Training and Outreach Confidence Levels**



The greatest discrepancies in training and outreach confidence levels between CHPS and CHNS are in the areas of gaining access to physicians, gaining access to non-physicians, identifying and creating partnerships with key decision makers and implementing and delivering training to health care providers. In all of these areas, the confidence level of the CHNS was notably higher than that of the CHPS. It should be noted, however, that the sample size for both CHPS and CHNS was extremely small, making a true comparison challenging. However, the total sample is limited to the total number of individuals employed by ADH in each of these professional groups.

**3. Professional role by years of tobacco cessation experience (Question 1 by Question 6)**

	< 6 months (n)	6 months to 1 year (n)	>1 to 3 years (n)	>3 to 5 years (n)	>5 years (n)
Health Edu. or Rural Health Spec.	1	1	0	0	2
HHI Coordinator	0	0	1	0	5
CHNS	0	0	0	6	7
CHPS	0	0	0	1	5
OADAP Grantee	1	1	4	4	7
TPCP Grantee	0	6	9	5	9
UAPB Grantee	1	2	2	1	3
Other Nurse employed by ADH	2	3	24	13	54
Other	1	2	2	5	9
<b>TOTAL</b>	<b>7</b>	<b>15</b>	<b>42</b>	<b>35</b>	<b>101</b>

The responses to this item highlight the fact that survey respondents have, for the most part, a number of individuals with greater than five years of experience in tobacco cessation. The Health Education or Rural Health Specialist respondents are the only group without individuals with greater than one year of tobacco cessation experience. Again, because this group contains so few individuals, a comparison with the other groups has limitations.

#### 4. Professional role by mean knowledge of areas of tobacco cessation

(Question 1 by Question 9)

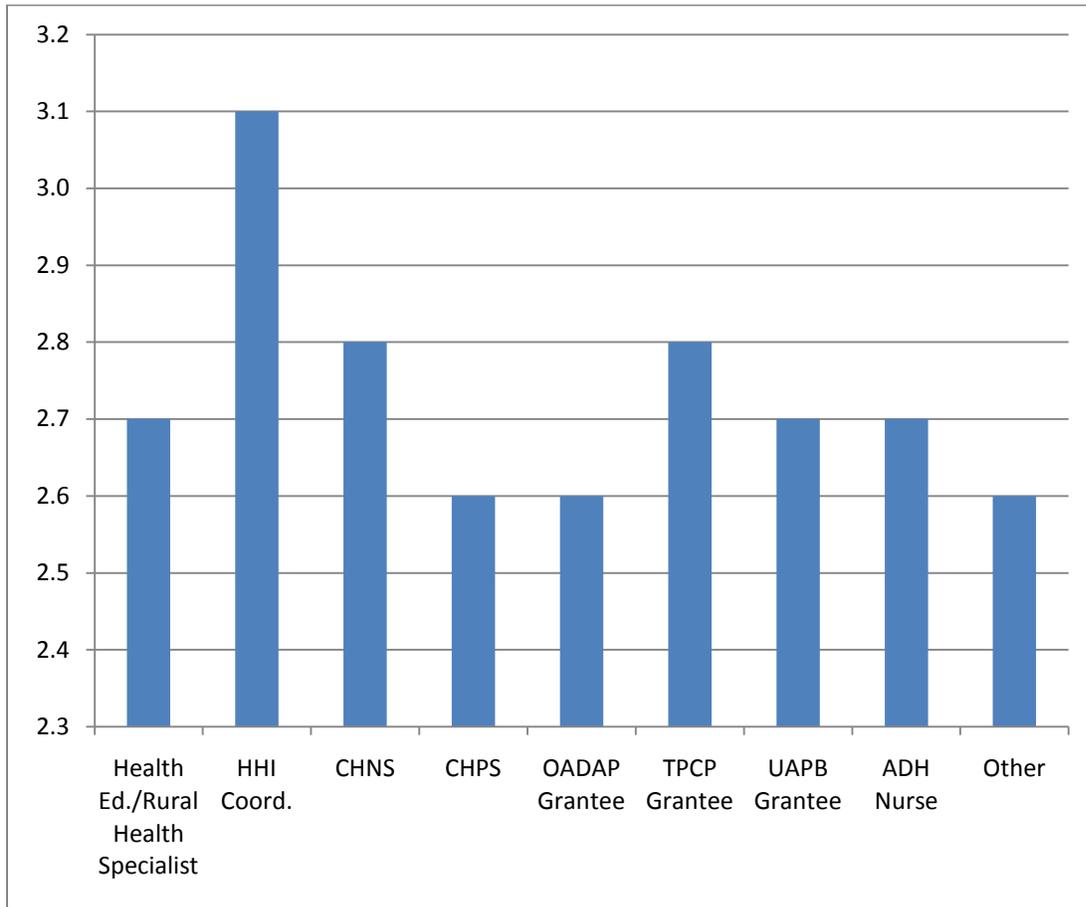
Knowledge ratings: 1 = not knowledgeable, 2 = somewhat knowledgeable, 3 = moderately knowledgeable, 4 = highly knowledgeable

	Health Ed/ Rural Health	HHI Coord	CHNS	CHPS	OADAP Grantee	TPCP Grantee	UAPB Grantee	ADH Nurse	Other
a. Tobacco Use or Substance Abuse	2.5	3.4	3.2	2.8	<b>3.7</b>	3.3	2.9	2.7	2.9
b. Client centered counseling or Motivational Interviewing	1.8	2.2	1.9	2.3	2.5	2.0	2.0	<b>2.6</b>	2.1
c. Brief Interventions (5As and 2As&R)	1.8	<b>2.2</b>	1.9	1.5	<b>2.2</b>	1.9	2.1	1.9	<b>2.2</b>
d. Arkansas State Tobacco Quitline	3.5	<b>3.6</b>	3.5	3.3	2.7	3.5	3.3	3.2	3.0
e. Quitline Fax Referral Program	3.5	<b>3.6</b>	3.5	3.5	2.3	3.4	3.1	3.1	2.9
f. The Public Health Service Guidelines	2.3	<b>2.8</b>	2.0	1.5	1.9	2.3	2.3	2.1	2.1
g. Tobacco-free policies	3.3	<b>3.8</b>	3.5	3.3	3.0	3.2	3.0	3.0	3.0

The highest level of mean knowledge within each area of tobacco cessation work (horizontal rows) is highlighted in each row in the table above. Although no major variation exists within any of the areas, it should be noted that the Hometown Health Initiative respondents rated their knowledge highest among the different professional groups in five of the seven areas of cessation. It is also of note that the highest overall mean knowledge responses exist for the Quitline, the Fax Referral Program, and Tobacco Free Policies (responses >3.5).

The mean knowledge of each professional group is displayed in **Figure 4** below. The values in this figure are the mean confidence level over all of the different areas of tobacco cessation for each professional role.

**Figure 4: Mean Overall Knowledge of Tobacco Control by Professional Role**



The interpretation and implications of the results displayed in this section are furnished in the subsequent Conclusions and Recommendations section of this report.

## Conclusions and Recommendations

This survey furnished a helpful view into how tobacco control is currently being conducted among ADH-affiliated health education staff, the frequency with which it is being conducted, and the audience being reached by current activities. It yielded the knowledge and confidence levels of survey respondents within different areas of tobacco cessation, training and outreach. And it revealed a better understanding of where barriers to tobacco control may exist.

Conclusions and recommendations resulting from the survey data can be viewed in four distinct, though related areas: 1) description of work responsibilities and use of field time, 2) knowledge of evidence-based tobacco cessation concepts, 3) confidence in skills required for conducting tobacco cessation training and outreach and, 4) frequency of tobacco cessation training or outreach activities with health care providers and/or systems.

### I. Description of work responsibilities and use of field time

#### *a. The role of tobacco control within respondents' jobs*

**Almost all survey respondents are charged with tobacco control responsibilities.** Within the scope of the work they conduct, ninety percent of survey respondents reported conducting tobacco prevention or cessation as part of their job. Of all the health areas that respondents reported addressing as part of their work, tobacco is the highest ranking issue in terms of the number of respondents who are required to address it. Of the small percentage of respondents who do not currently address tobacco in their work (n=23), 78% are either neutral or willing to integrate tobacco prevention or cessation into their responsibilities. No information is available as to why the five individuals were negative about adding tobacco prevention and cessation to their jobs.

#### *b. Tobacco prevention versus tobacco control*

Although a very high percentage of survey respondents reported doing tobacco control work, it is important to draw the spotlight to the type of work they do. Question 8 of the survey furnished critical information that showed that **a relatively small percentage of survey respondent time is actually being spent on tobacco cessation.** Eighty-six percent of respondents indicated that 25% or less of the tobacco work they do is devoted to cessation. Only 5% of respondents reported that >49% of the tobacco cessation work that they do is on cessation.

The patterns described above are indicative of a disproportionate amount of attention being paid to tobacco prevention rather than cessation. Although preventing youth and adults from initiating tobacco use is highly important, the ADH is encouraged to advocate for the complimentary inclusion of cessation as an essential part of tobacco control. Therefore, F&C recommends that the ADH TPCP identify staff and affiliates who can devote more of their time to cessation in the various domains (e.g. schools, daycares, clinics/hospitals/other health care facilities) in order to reduce the health burden of current tobacco use.

#### *c. Tobacco cessation interventions*

When working directly with patients, **survey respondents who reported working in a health care setting reported a very high level of attention paid to tobacco cessation among patients.** Of the 133 healthcare providers responding to this section of the report, 90% said that they ask patients about their tobacco use status often or always. Eighty percent often or always assess whether a tobacco-using

patient is willing to quit. Eighty-three percent of these respondents often or always advise patients to quit. And 73% often or always refer tobacco-using patients to the Quitline. These numbers indicate that brief interventions, or at least parts of them, are taking place often among ADH-affiliated health care providers.

When survey respondents who work in a health care setting were asked why they don't intervene with every tobacco using patient, they indicated the three top reasons as (as calculated by an "agree" response to Question 21 of the survey):

1. "Treating tobacco users is not a covered or billable service"
2. "There is not enough time to counsel tobacco users"
3. "Most of my patients who use tobacco are not interested in quitting" .

If combining the "somewhat agree" responses with the "agree responses", the same three reasons take precedence, but in a different order and in different proportion:

1. "There is not enough time to counsel tobacco users"
2. "Most of my patients who use tobacco are not interested in quitting"
3. "Treating tobacco users is not a covered or billable service" .

As a result of these responses, it would be worthwhile for the ADH to help train its affiliates working in this area to maximize the efficiency of the tobacco cessation interventions they do (in order to make intervening as minimally burdensome as possible), or to identify whether they can engage other staff who may not have previously been considered for the conduct of tobacco control work. Additionally, given that conducting tobacco cessation interventions is a reimbursable service, the ADH may consider refreshing its affiliates who do direct tobacco cessation interventions as to how they can maximize the frequency and amount of related reimbursement. Assuming that the survey respondents are assessing a patients' readiness to quit accurately, there is no additional recommendation that can be made to increase a patient's willingness to quit. Nonetheless, refresher trainings as to how to best make these assessments are warranted for everyone who has contact with patients about their tobacco use.

#### *d. Tobacco cessation training and outreach*

**Respondents who work in community-based settings reported a wide variety of attendees to their trainings.** This is a positive finding given that tobacco cessation is known to be most successful when reinforced through a multitude of channels and when different levels and areas of health care can support cessation interventions .

#### *e. Tobacco control training frequency*

This survey yielded data about the frequency with which tobacco control training and outreach is taking place. Questions 15 and 16 identified how often survey respondents who primarily do work in schools and daycare conducted tobacco-related training. Unlike the prevention-focused pattern identified above, **these school and daycare-based survey respondents are conducting tobacco cessation trainings with about the same frequency as tobacco prevention trainings.** The majority of respondents in this area are doing between one and five trainings in each of these areas per year. Among those who focus their work on health care settings, fewer trainings are taking place about tobacco with health care staff. Only 8% of these respondents reported doing three or more tobacco control trainings with health care professionals in the past year. The highest proportion of tobacco cessation trainings among survey respondents is among those who do tobacco control work in the community. Thirty two percent of this group (n=16) reported doing three or more tobacco cessation trainings with healthcare providers in the

community in the past year.

The percentage of survey respondents who had done any training about tobacco control in the past year was highly variable by the type of work they do within their job. Among those whose work primarily focuses on schools and daycares, 76% have done at least one training with teachers or day care workers. Among health care-based respondents, only 20% have done one or more trainings in the past year. And among those who work primarily in the community, 52% have conducted a training in the past year. It is understandable that these numbers are varied based on the other types of work that these individuals are required to do. However, given the number of respondents who are charged with doing tobacco control work, and given how relatively few are doing training work with great regularity, it would be worthwhile for the ADH TPCP to explore whether those who are charged primarily with training responsibilities are maximizing the frequency with which they are conducting trainings and the reach of such trainings to individuals who can contribute to tobacco cessation activity.

*f. Tobacco Control Content*

**The Quitline and Fax Referral are topics getting the most attention in the training and outreach that respondents are doing.** As stated above, all four areas of tobacco cessation listed in this survey, Quitline, Fax referral, Brief Intervention and Tobacco Use as a Vital Sign are considered the most essential to maximizing quit rates. Therefore, the ADH should consider following up with groups represented in this survey as to how they can increase the frequency with which they are covering Brief Intervention and Tobacco as a Vital Sign. As shown in the 4<sup>th</sup> crosstab in the analysis section of this report, the knowledge levels of these two areas of tobacco cessation were much lower than those in the Quitline and fax referrals, another indicator that additional training to increase knowledge levels may be of use.

## II. Knowledge of evidence-based tobacco cessation concepts

**The respondents to this survey possess a range of knowledge about the various aspects of tobacco cessation within the different topics.** They possess the most confidence about the Quitline and Fax Referrals to the Quitline and the least knowledge about Brief Interventions, Public Service Guidelines and Motivational Interviewing. By role, the Hometown Health Initiative survey respondents reported the highest level of cumulative knowledge about tobacco cessation. Where appropriate, the ADH TPCP should consider means by which to boost skill levels in these areas for all professional roles charged with conducting tobacco cessation interventions, training and outreach.

## III. Confidence in skills required for conducting tobacco cessation training and outreach

One of the reasons that this survey was conducted was to determine how confident current ADHTPCP-affiliated staff are in conducting tobacco cessation training and outreach work. Obviously, the ADH TPCP seeks to have a highly knowledgeable *and* confident staff in order to maximize the impact of the tobacco cessation work it conducts.

**In general, the confidence levels measured in this survey show that there is a across-the-board need for additional training with ADH affiliates who are conducting tobacco control work in order to increase their confidence in the areas of tobacco control training and outreach. It is therefore**

recommended that the ADH develop strategies for improving the staff confidence levels in tobacco training and outreach as well as the knowledge level of the tobacco control issues outlined previously in this report.

#### **IV. Frequency of tobacco cessation training or outreach activities with health care providers and/or systems**

One of the goals for this survey was to assess current tobacco cessation training and outreach activities currently underway. Additionally, since additional training for health care professionals is planned for the future, the survey assessed how survey respondents would prefer to receive additional training for themselves.

**Given the knowledge and confidence levels reported above, it is clear that survey respondents need and want more training in tobacco cessation.** In Question 10 of the survey, they indicated that classroom- based training is their preferred method of learning new information, with online written information and online training being their second and third preferred method of training respectively. When planning future training programs, the ADH TPCP should take this preference into account and ideally develop a multifaceted training program, accessible in both classroom and online formats.

The survey also assessed the access that respondents with training and outreach responsibilities have to health care professionals and systems in order to conduct their work. Of those survey respondents whose work focuses on schools and daycare, only 30% indicated that many or all of their contacts for their work are authorized within their organization to make system changes regarding tobacco cessation. Of those who work in community-based settings, 65% report that many or all of their stakeholders/contacts are authorized to make policy changes within their organizations. Although this latter group is accessing a higher proportion of stakeholders who may be able to authorize systems change to improve tobacco cessation within their organization, the pattern shown by the responses to these two questions indicates that the ADH and its affiliates engaged in this survey should revisit the targets for their outreach and training and seek to reach a higher proportion of individuals with systems change authority.

Community-based respondents also reported on the level of access they have to health care facilities in their region as well as the proportion of these facilities in which there is a tobacco cessation champion who can help maximize the impact of training and outreach. Only 6% of respondents indicated that they have access to between 76% and 100% of the health care facilities in their area. And only 10% of respondents indicated that they have a champion in 50% of the facilities where they do work. The data clearly indicate that the ADH TPCP would significantly improve the systemic impact of its tobacco cessation training and outreach programs by working to increase the number of health care facilities to which they have access and develop meaningful/sustained relationships with many more champions within health care organizations in order to make systematic tobacco cessation for successful.

In summary, this survey yielded highly meaningful information that shows:

1. There are many ADH affiliates who report conducting tobacco prevention or cessation activity but very few who are able to exclusively devote their time to it.
2. Knowledge and confidence levels regarding the varied aspects of tobacco cessation and training skills are generally moderate and could be improved through classroom and online training.
3. Despite reporting moderate levels of knowledge and confidence, survey respondents reported conducting few trainings with healthcare providers in any setting (schools, local health units or clinics/hospitals) and had not identified a majority of champions in positions of influence within an organization.
4. ADH affiliates working in a clinical setting either within or outside the ADH Local Health Units represented by this survey see time restrictions and lack of reimbursement as the key barriers to furnishing comprehensive tobacco interventions to patients.
5. There is extensive, yet-to-be-accessed territory, including the enlistment of more champions, change-makers, health care providers and systems-based strategies to be targeted for increased awareness and implementation of systematic tobacco cessation.

The plans that the ADH TPCP has to create a statewide training and outreach program using well-trained, devoted staff to conduct regular and systems based strategy will address these very findings from this survey and elevate tobacco cessation to where it needs to be in order to maximize impact on the prevention of related chronic diseases and improve the general well-being of Arkansans through lowering tobacco use rates.