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Helping Smokers Quit: New Partners and New Strategies from the University of California, San Francisco Smoking Cessation Leadership Center

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ABSTRACT

The Smoking Cessation Leadership Center (SCLC) was established in 2003 to increase the rate of smoking cessation attempts and the likelihood those efforts would succeed. Although smoking remains the number one cause of preventable death and disability, clinicians underperform in smoking cessation. Furthermore, many clinical organizations, governmental agencies, and advocacy groups put little effort into smoking cessation. Initially targeted at increasing the efforts of primary care physicians, SCLC efforts expanded to include many other medical and non-physician disciplines, ultimately engaging 21 separate specialties. Most clinicians and their organizations are daunted by efforts required to become cessation experts. A compromise solution, *Ask, Advise, Refer* (to telephone quitlines), was crafted. SCLC also stimulated smoking cessation projects in governmental, not-for-profit, and industry groups, including the Veterans Administration, the Health Resources Services Administration, Los Angeles County, and the Joint Commission. SCLC helped CVS pharmacies to stop selling tobacco products and other pharmacies to increase smoking cessation efforts, provided multiple educational offerings, and distributed $6.4 million in industry-supported smoking cessation grants to 55 organizations plus $4 million in direct SCLC grants. Nevertheless, smoking still causes 540,000 annual deaths in the US. SCLC's work in the field of behavioral health is described in a companion article.

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Clinical specialties; organizational partnerships; public health; smoking cessation; vulnerable populations

Background

Long recognized as the major preventable cause of death and disability in the United States (US) and worldwide (McGinnis and Foege 2015), tobacco use has been decreasing in the US since the 1964 Report of the Surgeon General (US Department of Health and Human Services 2014). As shown in Figure 1 (National Center for Health Statistics 2017; Jamal et al. 2016), adult cigarette smoking prevalence in the US now stands at a modern low of 15%. Furthermore, from 1995 on, the number of cigarettes smoked by those who did not quit decreased from more than 20 to the current level of about 14 per day (Figure 2) (National Center for Health Statistics 2017; Jamal et al. 2016; Schroeder 2012). Thus, not only was there a major decline in the proportion of people who smoke, but even those who continued to smoke consumed fewer cigarettes.

The impressive decline in smoking prevalence resulted from a set of tobacco control policies that reduced both the numbers of new smokers as well as continuing smokers. These policies include: raising tobacco taxes; enacting state and local clean indoor air laws; developing counter-marketing programs featuring messages highlighting the nefarious tactics of the tobacco industry; educating the public about the harm caused by smoking, especially to those exposed to secondhand smoke; and providing smoking cessation services, including counseling, medications, and access to toll-free telephone quitlines.

Despite these impressive gains, smoking still remains the number one cause of premature deaths in the United States. More than 40 million adults continue to smoke, half of whom will die prematurely. Smoking causes 540,000 deaths a year (Carter et al. 2015), and the earlier smokers quit, the bigger the benefit. Even at age 60, a smoker who quits gains an extra four years of life (Jha et al. 2013).

The fastest way to reduce population smoking levels is to accelerate the rate at which smokers stop (Maciosek et al. 2006). Quitting is a two-step function. First, the smoker must decide to stop. Second, that attempt—or subsequent ones—must succeed. But cessation is a struggle. The average person who quits does so after many unsuccessful attempts—estimated from 10 to as many as 30. The likelihood of a successful unaided quit attempt is

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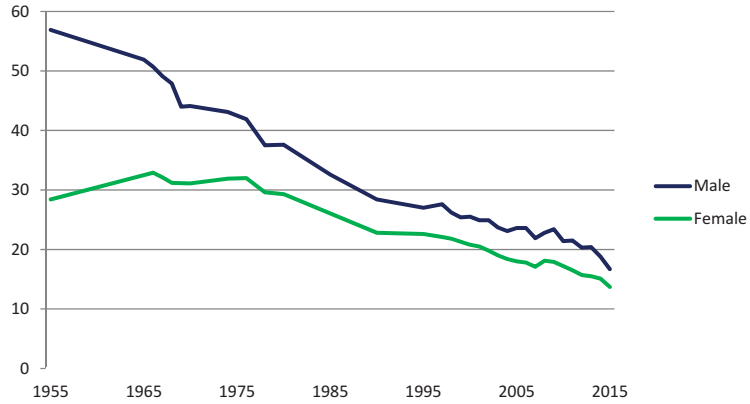

Figure 1. Current smoking prevalence among US adults (aged ≥18 years) by sex, 1955–2015.

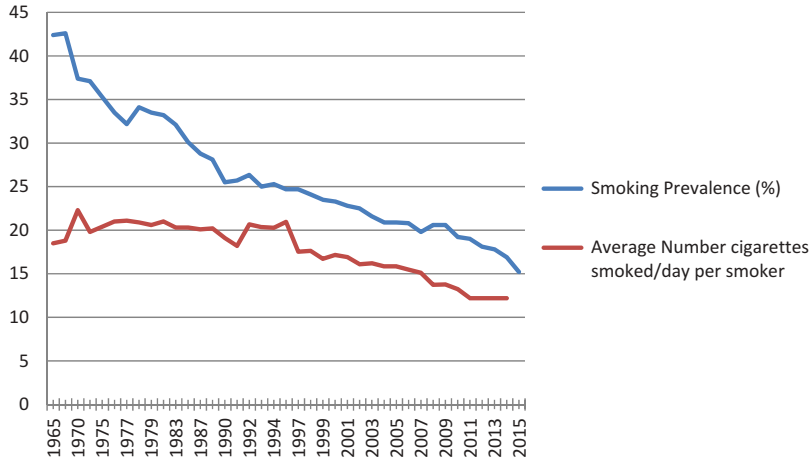

Figure 2. Smoking prevalence and average number of cigarettes smoked per day per current smoker, 1965–2015.

only about 4–7%. With counseling and smoking cessation medications, those odds increase to as high as 20% or so in real world settings, and even higher in reported clinical trials (Tobacco Use and Dependence Guideline Panel 2008). Many clinicians are discouraged by these low success rates, although they do not differ from the results of treatments for conditions such as many cancers. Yet even the simple advice from clinicians to quit raises the odds of quitting, with the increase being as high as two-fold for physicians and somewhat less, but still substantial, for other clinicians.

Surprisingly, given the huge toll smoking exerts on health and the impressive benefits that occur with quitting, most clinicians do not place a high priority on helping smokers quit. For example, in a 2003 survey of seven health professional groups, although almost all clinicians reported asking about smoking, the percent referring to smoking cessation programs ranged from a high of 46.7% for primary care physicians to a low of 23.6% for dentists. The proportion arranging follow-up visits was even lower, ranging from 1% to 23% among the clinician groups (Tong et al. 2010). Similar results were found in a 2007 survey of physicians. Only 13% of physicians referred smokers to cessation services and only 17% arranged for smoking cessation follow-up (Association of American Medical Colleges 2007). It is not known whether there have been any recent changes in rates of smoking cessation interventions.

The creation of the Smoking Cessation Leadership Center at UCSF

The combination of the known lethality of smoking and the relative recalcitrance of clinicians to help smokers quit prompted the Robert Wood Johnson Foundation (RWJF) to establish the Smoking Cessation Leadership Center (SCLC) at the University of California, San Francisco, when the lead author (Schroeder) left his position as RWJF President and CEO at the end of the year 2002. The smoking cessation theme made programmatic sense since, during his tenure at RWJF, the foundation was active in tobacco control. Indeed, RWJF's tobacco control programs were identified as one of American philanthropy's 12 high impact programs of

the twentieth century (Fleishman 2007). The decision to focus on smoking cessation, rather than initiation of tobacco use, reflected the reality that two effective organizations—the American Legacy Foundation (now Truth Initiative) and the Campaign for Tobacco-Free Kids)—had strong programs on preventing youth smoking initiation. The SCLC grant was for $10 million to extend over five years; it contained $4 million to be used for re-granting to national organizations, presumably clinical associations that would stimulate smoking cessation efforts. Although there are multiple forms of tobacco, SCLC focused on cigarettes as by far the most harmful and widely used tobacco product (Fiore, Schroeder, and Baker 2014).

As initially conceived, the SCLC would concentrate on educating and motivating professional organizations —mainly those representing primary care clinicians, especially physicians—to stimulate their members to do better in helping smokers quit. It would achieve this by persuading organizational leadership of the worthiness of that effort, and then providing tools to enable clinicians to serve as more effective smoking cessation activists. But over time the approach to clinicians changed, the list of clinicians who could serve as smoking cessation advocates expanded, and the sphere of organizations with the potential to create opportunities for better smoking cessation enlarged. Furthermore, because SCLC was able to attract more resources and modify its grant-making approach, the life of the Center surpassed the original expectation that it would only survive for five years. Ultimately, the SCLC pursued five major strategies. The first four addressed general issues regarding smoking cessation. The fifth, "Engaging behavioral health professionals in smoking cessation: Challenging old myths and traditions," is the topic of a companion article (Schroeder et al. 2017).

Strategy 1: Make it easier for clinicians to help patients stop smoking

There are many reasons why clinicians do not counsel patients about stopping smoking or help them once they've decided to quit. They include being too busy, lacking smoking cessation expertise, lacking fiscal incentives, perceived unavailability of treatments and/or insurance coverage, the discouraging reality that most smokers cannot or will not quit, the stigma attached to smoking, a respect for privacy and the "right to smoke," the fear that a negative message might scare away patients, and the circumstance that the clinician himself is a smoker (common for behavioral health clinicians, but not others) (Schroeder 2005).

Given these obstacles, the initial strategy involved persuading primary care clinicians to adopt the model practice embodied in the US Clinical Practice Guideline, *Treating Tobacco Use and Dependence* (Tobacco Use and Dependence Guideline Panel 2000), which recommends that clinicians use the "Five As" with their patients who smoked: "Ask (about tobacco use), Advise (to quit), Assess (willingness to make a quit attempt), Assist (in quit attempts), and Arrange" (follow-up). Under the original plan, SCLC would persuade relevant professional societies to educate their members about the "Five As," and then provide support to embed these Guideline components into routine clinical practice. But none of the professional organizations had heard of the Guideline, and when informed of its components, they protested that their members were simply too busy to spend the 20 minutes or so required to perform the "5As." Therefore, the SCLC formulated a simpler approach. At its first organizational meeting, held in San Francisco in September 2003 and involving the American Dental Hygienists' Association (ADHA), an alternative plan emerged. Instead of five As, the number was reduced to three: Ask, Advise, Refer (to a toll-free telephone quitline, which offers free cessation services in every state and has proven effectiveness).

The resultant relationship with the ADHA was the inaugural SCLC partnership, and it led to two phrases that have since become mainstream in tobacco control: *Ask, Advise, Refer*, and *Take 30 Seconds to Save a Life*. Easier referral to quitlines was facilitated in 2004 with the establishment of a national routing number (1-800-QUITNOW), housed at the National Cancer Institute of the National Institutes of Health. Because there was no budget to market the availability of this service, the SCLC took the lead by designing a wallet-size plastic card (Figure 3) that it made available at cost to anyone interested in stimulating quitline referrals (Saucedo and Schroeder 2010). In some instances, organizations modified the card and imprinted their own logo. Over 5 million cards have been distributed.

Strategy 2:Expand the network of practitioners helping people to stop smoking

Over time, SCLC formed partnerships with 21 separate clinical organizations. The sequence of engagement typically began with a phone call or in-person meeting with organizational leadership—either senior administrative staff or members with a demonstrated interest in tobacco control—explaining the goal of SCLC and exploring whether the organization wished to become more involved in smoking cessation. Unlike many foundation-sponsored programs, the request did not prescribe a specific formula for organizational engagement. Rather,

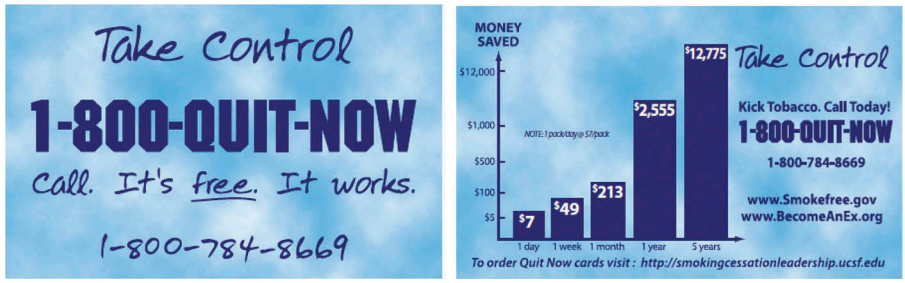

Figure 3. National quitline card.

SCLC tried to tailor programs that met organizational needs and capabilities. Sometimes an alliance was quickly forged, sometimes the "courtship" was prolonged and, in some instances, it proved impossible to come to an arrangement. In most cases, SCLC provided initial grants, often for assembling an organizational planning committee that set goals, proposed ways to achieve those goals, and assigned responsibility for execution.

Initially, SCLC anticipated awarding a relatively small number of grants, ranging from $100,000 to $250,000. It became apparent, however, that the more enthusiastic organizations felt about partnering, the less funds they required to participate. By contrast, some prominent and large national organizations stipulated a very high price—such as $1 million—for engagement. Often, those funds would be earmarked to develop a separate curriculum, even though the comprehensive *Rx for Change* curriculum was available for free as a well-tested and frequently updated resource (UCSF 2014. *Rx for Change*, as described in a following section, is a comprehensive tobacco control curriculum that focuses on smoking cessation and is available free of charge for all to use. Consequently, SCLC limited its support to organizations appearing to have a genuine interest in smoking cessation, and which usually had identified smoking cessation champions within their midst. This strategy expanded the types of clinicians beyond the primary care fields originally envisioned.

For most organizations, SCLC provided infrastructure grants of about $25,000 to begin the process. Sample activities included: creating regional smoking cessation experts who could stimulate state and local activity (American Association of Family Physicians/AAFP and ADHA); conducting pilot studies of *Ask, Advise, Refer* in hospital emergency rooms (American College of Emergency Physicians), as well as in pre-operative surgery suites (American Society of Anesthesiologists/ASA) (Warner 2009); providing educational content via society newsletters, webinars, articles in professional journals, and sessions at annual and regional meetings (all partners, to various extent); creating their own version of the *blue card* (AAFP, ASA, and ADHA); adopting a national policy urging members to either become smoking cessation experts themselves or refer all pre-operative smokers to a quitline (ASA); and creating permanent infrastructure mechanisms to ensure that tobacco control would remain an organizational priority (most partners). Notably absent from these partnerships were organizations representing clinical subspecialties facing the greatest burden from smoking: those dealing with cancer, lung disease, and heart disease. These "downstream" specialties were so involved with treating the consequences of smoking that they did not see it as their role to engage vigorously in smoking cessation activities. However, after a decades-long courtship, in 2015 the American College of Cardiology formally affiliated with the SCLC and established a task force on smoking cessation, with the goal of devising strategies that would motivate and educate members.

Strategy 3: Stimulating governmental and not-for-profit agencies to become more invested in smoking cessation

Governmental agencies provide opportunities to promote smoking cessation. In 2003, leaders of the Department of Veteran's Affairs (VA) central health office asked SCLC to organize a national conference to help the VA drive down the historically high smoking rates of veterans treated at VA health facilities. In September 2004, a meeting organized by SCLC was held in San Francisco that assembled 90 national experts in smoking cessation, including national and local VA officials. The published proceedings were widely disseminated across all VA facilities and a set of recommendations was created that included increasing the priority of smoking cessation, better integration of smoking cessation activities into chronic disease and mental health treatment settings, more research into smoking cessation activities, and better marketing of telephone quitlines (Isaacs, Schroeder, and Simon 2005). A follow-up application process allowing VA facilities to receive free quitline posters and cards resulted in 100 of the 158 VA institutions installing quitline promotional materials in patient waiting rooms and clinics.

Another federal agency with great potential to reach smokers is the Health Resources Services Administration (HRSA), which administers almost 10,000 clinical sites serving 24 million people. Since most HRSA clinic patients come from low-income settings that have higher rates of smoking, this provides an opportunity to reach many smokers. But although SCLC was able to present some lectures on smoking cessation topics at HRSA-sponsored national and regional meetings, and to participate in some webinars, the engagement was relatively minimal, despite many attempts at deeper engagement. However, as described in the companion article, lower-income populations were reached through involvement with other organizations, especially those serving persons with behavioral health conditions (Schroeder et al. 2017) Regional governmental partnerships arose on an ad-hoc basis. One of the strongest resulted when Los Angeles (LA) County Health Commissioner Jonathan Fielding, MD, invited SCLC to help administer a county-wide program: *LA Quits*. SCLC initially donated its services, and then was supported by CDC subcontracts from LA County. SCLC services between 2011 and 2014 included webinars plus in-service training at over 75 community mental health and substance abuse treatment centers to integrate cessation services and become tobacco-free campuses. Results included an almost two-fold increase in calls from county residents to the state telephone quitline and a decrease in adult smoking prevalence from 15% in 2011 to 12% by 2014. SCLC staff also participated in place-based smoking cessation efforts in Chicago and the states of Oregon and Washington.

SCLC also engaged in a variety of not-for-profit agencies. Five examples are provided:

- *The Joint Commission*. In 2011, after pilot testing in 24 hospitals and undergoing a period of public comment, the Joint Commission followed the recommendations of an advisory panel that included the SCLC director to create a new tobacco cessation performance measure set for hospitalized patients to replace a previous set that had proved meaningless because hospitals were "gaming it" by reporting performance scores at 100%. The new set had four components: (1) document tobacco use status on admission; (2) deliver cessation counseling and medications during hospital stay; (3) arrange for counseling and medication post-discharge; and (4) check smoking status one month post-discharge. These components were designed by a technical advisory panel appointed by the Joint Commission; SCLC was represented on that panel (Fiore, Goplerud, and Schroeder 2012). The tobacco cessation measure set was one of 14 from which hospitals had to select four for reporting purposes. Subsequently, the Joint Commission suspended component 4, responding to criticisms that it was unduly burdensome and lacked an evidence base. To date, 754 acute care hospitals and 503 inpatient psychiatric facilities have chosen to use the tobacco measure set, with most representing the governmental sector (VA and Department of Defense). Anecdotally, two reasons why more hospitals did not choose the tobacco measure set were greater familiarity with alternative choices and the concern that the tobacco measures were more labor-intensive. In 2016, the Centers for Medicare and Medicaid Services ruled that psychiatric hospitals would be required to implement and report the first three components of the Joint Commission tobacco measure set or risk financial penalties.
- *The Association of Tobacco Treatment Use Disorders (ATTUD)*. In 2011, SCLC accepted a request from ATTUD to maintain a listserv for its over 600 members. This service connects interdisciplinary smoking cessation specialists, providing opportunities to disseminate educational material, as well as serving as a vehicle for interchange among members.
- Beginning in 2004, *Kaiser Permanente Northern California (KPNC)* engaged SCLC in a number of educational offerings, including two webinars with its providers, the endorsement of Kaiser's tobacco control strategy, and ad hoc consultation regarding specific medication issues, as well as approaches to patients with behavioral health conditions. KPNC was able to lower its already impressive adult smoking rate from 13.9% in 2002 to 8.1% in 2017. (Although it is likely that SCLC played a role in that outcome, its impact was probably relatively minor).
- *The American Legacy Foundation*, now known as Truth Initiative, co-hosted a series of webinars addressing various smoking cessation topics.
- *The Gay and Lesbian American Medical Association*. SCLC provided technical assistance to a lesbian, gay, bisexual, and transgender (LGBT)-oriented smoking cessation curriculum for clinicians, worked with its Healthlink network, and accredited a virtual conference.

Strategy 4: Forging smoking cessation partnerships with pharmaceutical companies

The tobacco control movement has traditionally avoided corporate partners. In part, this is a legacy of the tobacco industry's role as the vector in the smoking epidemic, which created a general suspicion of other industry motives. Nevertheless, SCLC felt it was strategic to engage with corporate partners whose ostensible business is to

promote health, notably Pfizer and CVS Health. The Pfizer relationship evolved from invitations to join the Pfizer speaker circuit, a mechanism whereby academic experts receive funds to lecture on their subject of expertise, often using educational materials supplied by a pharmaceutical company that produces a relevant product. Based on the desire to avoid perceived conflicts of interest that might compromise its role as a broker among organizations that could foster smoking cessation efforts, SCLC declined this role. In 2012, however, a senior Pfizer officer catalyzed discussions between SCLC and Pfizer's Independent Grants for Learning and Change program about a possible unique partnership that would delegate administration of a Pfizer-supported smoking cessation grants program to SCLC. The incentive for Pfizer was that increased smoking cessation would stimulate sales of its products—varenicline (Chantix®), and nicotine gum and inhalers. For the SCLC, the incentive was to enlist more health professional groups into smoking cessation efforts. SCLC's strategy to avoid appearances of conflict of interest was three-fold. First, it refused payment for the effort, offering its services gratis because the project was so aligned with its core mission. Second, SCLC sought to make the relationship transparent, both in the conduct of the grants program and by publishing the results (Jensen et al. 2017). Third, paying for cessation medications was not an allowable budgetary expense for the grants. The program proved satisfactory to both Pfizer and SCLC. There was such interest in applying for a grant (201 letters of intent versus the 50 or so expected) that Pfizer raised its funding pool from $2 million to $4.6 million. A total of 40 organizations received grants ranging from $50,000 to $200,000. In addition to the expected grantees representing hospitals and medical groups, there were novel recipients: pharmacists in the Giant Eagle supermarket chain in four Mid-Atlantic states; anesthesiology residency programs; retail clinics; substance abuse treatment programs in Texas; and parolees from Colorado prisons. Based on this experience, in 2015 Pfizer authorized a second round of funding for a similar effort that yielded 154 applications, resulting in 15 grants totaling $2 million.

Pharmacists have long been on record as opposing the sale of cigarettes in pharmacies, because promoting smoking stands in direct conflict with the pro-health mission of the pharmacy profession (Hudmon et al. 2006). Several studies over the past four decades documented that while independent pharmacies tend not to sell tobacco products, all chain pharmacies do (Eule et al. 2004; Schroeder and Showstack 1978). CVS Health, in order to strengthen its position as a pro-health organization, reached out to SCLC through its chief medical officer, Troyen Brennan, MD. He requested advice concerning how to end sales of tobacco products in the CVS chain of pharmacy retail outlets. That ban was announced in early 2014, and the rationale for the decision was published in *JAMA* with joint CVS and SCLC authorship (Brennan and Schroeder 2014). SCLC also worked with other chains containing pharmacy outlets, including Safeway and two large regional chains—Giant Eagle and Ralphs—to help pharmacists become stronger smoking cessation advocates.

Lessons learned while employing the smoking cessation strategies

No single formula exists for engaging relevant clinical organizations in smoking cessation activities. A crucial element for many partnerships involved identifying existing champions, either in the organizational membership or in the executive leadership (ideally both). Particularly helpful were the late Peggy Walsh in dental hygiene, David Warner in anesthesiology, Steve Bernstein in emergency medicine, and the three pharmacists—Karen Hudmon, Robin Corelli, and Lisa Kroon—who developed *Rx for Change*. Other important ingredients were the existence of a strong science base on the harm from using combustible tobacco and the associated secondhand smoke exposure, as well as evidence that smoking cessation interventions can improve the chances of quitting; flexibility concerning terms of engagement; patience; and willingness to be a background partner rather than a dominant one.

Although one might assume that working with governmental, non-governmental but not-for-profit, and corporate entities entail vastly different negotiating styles and reporting relationships, that was not the case. In all instances, establishing and maintaining a partnership required identifying mutual interests, establishing trust, clarifying roles, and maintaining credibility. In all sectors, a challenge was the frequent turnover of staff, with the consequent need to review the rationale for the activity and to establish trust with the new staff contacts. Budgetary cuts and changes in leadership were particularly common in state governments.

Major accomplishments of SCLC in 2003–2017 (excluding behavioral health)

SCLC has engaged in many activities and worked with multiple partners. Although there has been no formal evaluation of its work, this section presents highlights.

- *Contributing to decreased smoking prevalence*. Since the inception of the SCLC, three key indicators have trended favorably. Overall, adult smoking prevalence

declined, with the 2015 figure at a modern low of 15% (Figure 1), and those who continue to smoke consume fewer daily cigarettes (Figure 2). Finally, the proportion of smokers able to quit more than tripled during the past two decades (Mendez et al. 2016). It is likely that many factors contributed to this progress. Obvious components include increased tobacco taxation, both nationally in 2009 and at the state level, clean indoor air laws, and counter-marketing campaigns. Other factors specifically focused on cessation are new medications such as varenicline, the use of alternative nicotine delivery devices such as electronic cigarettes, expanded health insurance enrollment and mandating coverage of cessation services under the 2010 Affordable Care Act, and the fact that clinicians, especially in behavioral health specialties, have become more aggressive in urging their patients to quit smoking. It is likely that SCLC contributed to these trends.

- *Expanding the types of clinicians invested in smoking cessation*. At its inception, SCLC assumed that promoting smoking cessation would concentrate on primary care clinicians, especially physicians. But the reality is that smokers encounter many different types of clinicians, and each encounter presents a new opportunity to encourage and assist smokers to quit. To that end, SCLC has helped to create new smoking cessation actors across a wide variety of clinical disciplines, often enabled by existing champions within those specialties.
- *Devising and marketing* Ask, Advise, Refer *as an acceptable strategy for busy clinicians to refer smokers to toll-free telephone quitlines*. SCLC developed this approach when confronted with the reality that, because of perceived time constraints, most clinical organizations were reluctant to exhort their members to become full-fledged smoking cessation experts. But, recognizing the need to address smoking, they were comfortable with the strategy of referral. To facilitate those referrals, SCLC also developed the referral "blue card" (Figure 3) and made it available at cost.
- *Helping CVS stop selling tobacco products*. Although this seemed a counterintuitive business move, forfeiting about $2 billion in annual sales, it was consistent with CVS' desire to position itself as a pro-health corporation. SCLC was privileged to be a small part of the execution of the tobacco-free policy, and also to help other pharmacy outlets do better at providing smoking cessation services.
- *Distributing more than $10 million in smoking cessation grants to organizations throughout the country*. Initially with RWJF funds of $4 million, and later with $6.4 of Pfizer funds, SCLC identified and supported multiple smoking cessation efforts at the national and state levels. Hopefully, these grants will leave lasting legacies in the form of enhanced voices of organizational champions, persistence of system changes such as electronic health record referral systems to quitlines, and educational exposures that will endure long after grants end.
- *Developing curricula, webinars, and tool kits to educate and accredit clinicians. Rx for Change* is a comprehensive tobacco control curriculum created in 1999 by three faculty members of the UCSF School of Pharmacy, who generously made *Rx* available to all without charge. SCLC marketed this resource through its website, as well as supported tailored variants for use in psychiatry, for peer counselors of mental health populations, for cardiology, and for respiratory care, among others. In addition, between 2007 and 2017, SCLC provided 70 free webinars. SCLC maintains an active listserv with 1229 subscribers, plus Twitter and Facebook accounts.
- *Publishing articles in the scientific literature*. Between 2003 and 2017, SCLC published 55 tobacco-related papers in the medical literature—including nine in the *New England Journal of Medicine* and seven in the *Journal of the American Medical Association* (the medical journals with the two highest impact factors)—plus three op-eds in metropolitan newspapers, including the *Washington Post*. These scientific articles then stimulate coverage in the lay press, on radio, and in television spots. In addition to motivating and educating clinicians, by keeping cigarette smoking in the public eye they help to combat the view that the battle against smoking has been won and it is now time to move on to other issues.

Discussion

During its 14 years, the SCLC has learned many lessons. A key one is that opportunities arise that were not part of the original strategic map. In SCLC's case, it envisioned a relatively narrow playing field, limited to specific clinical organizations. But its scope enlarged over time to include governmental agencies, advocacy organizations, the prison system, the homeless, pharmacies, retail clinics, and the retail pharmacy industry. The overall goal—increasing the frequency of quit attempts and the odds of those attempts succeeding—never wavered, but as SCLC became entrenched in the field and developed

its own reputation, unanticipated opportunities arose. This expansion of SCLC activities would not have been possible without sustained funding, as well as permission from the funders to avoid getting locked into an inflexible strategic plan. SCLC's efforts in behavioral health, a field that encompasses so many persons who smoke, is described in a companion article (Schroeder et al. 2017). Since almost 40 million persons still smoke cigarettes, there is much more to do. Immediate tasks for the SCLC include securing resources to enable it to plan for the future, and focusing on those vulnerable populations that have higher rates of smoking.

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