Using a Patient Focused Approach to Aid in Smoking Cessation

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Introduction

Tobacco use is the leading preventable cause of disease, disability, and death in the U.S. and according to the Centers for Disease Control and Prevention (CDC), cigarette smoking results in about 1 in every 5 (premature) deaths in the U.S.[1] Additional for every one person who dies from smoking, about 20 more suffer from at least one serious tobacco-related illness.[2]

There is no debate about the adverse effects smoking has on health, however the true challenge is how the problem is dealt with from a primary care perspective. As Primary care physicians we are on the front lines, and have the opportunity to help patients quit smoking. Key question is, can a PCP balance the workload of a busy clinic, and execute effective behavior modifying measures to help a patient quit smoking?

Helpers is one type of patient-centered approach used to help patients quit. It is an online brief tobacco cessation intervention training (approx 4 hours duration) open to all, and it is designed to teach an individual communication and motivational skills to identify why people smoke, the barriers to quitting, and to provide useful tools/resources to help them quit. The trained individual becomes a health coach, a source of support, an ally.

Methods

Completed Helpers on-line brief tobacco intervention training. Study population: Convenience sample of 23 patients, 9 female, and 14 male from Dr. Yaqub's practice. Most were above the age of 40 and had a 20 + pack year smoking history. Patients selected were those who had a chronic smoking history greater than 5 years of one pack per year. In addition to nicotine dependence, patients needed to have other chronic medical issues, such as depression, diabetes, and hypertension. That would ensure the clinic visit was not solely about quitting smoking.

Each clinic visit focused on the other chronic medical issues. Then after each clinic visit where other topics of health were discussed, 5 to 7 minutes was set aside at the end of the visit to focus on smoking cesstion.

Table 1. Patient Demographics

	Male	Female
Gender	60% (n=14)	40% (n=9)
Age	Mean 51, (range 36 to 66)	Mean 53, (range 28 to 76)
Years smoking	Mean 30, (range 15 to 50)	Mean 30, (range 5 to 46)

Table 2. Results

	Male	Female
Visits w/ provider	Mean 3, (range 1 to 5)	Mean 2, (range 1 to 4)
Accepted cessation medications (chantix/nicotine patches/Bupropion)	42% (n = 6)	44% (n = 4)
Referral to quitline	28% (n = 4)	22% (n = 2)
Reduced smoking by > ½ pack	14% (n = 2)	33% (n = 3)
Willing to quit (no change in # cigs)	28% (n = 4)	11% (n = 1)
Not willing to quit	35% (n = 5)	22% (n =2)
Lost to f/u	21% (n = 3)	33% (n = 3)

Results

- 10 individuals were willing to quit, and use cessation medications such as Bupropion, Chantix, nicotine patch and gum. Of these 10, 6 were referred to the Quit line.
- 5 individuals made dramatic improvements in reducing smoking use, defined as more than a 0.5 pack a day decrease.
- 7 individuals were not willing to quit, the majority of these people had a mental health issue that proved to be an obstacle
- 6 people were lost to follow up.

Patients with mental health issues such as depression, illegal drug use, and anxiety tended to be most resistant when discussing smoking, in comparison to those individuals who did not have any mental health issues. Most patients otherwise were open and willing to talk about the topic.

Conclusions

Limitations:

- small sample size
- limited study time, the approach of Helpers is based on the patient, and the level of comfort and willingness to quit. A longer timeframe of 3 to 5 years would be more helpful in assessing the effectiveness of patient centered approach.
- limitation of clinic time, only 5 to 7 minutes. Would success rate increase with more time spent on the issue?
- mental health issues (depression, anxiety, drug addiction) were major obstacles for those wanting to quit smoking.
- Due to time I focused on cessation medications more than the quit line when offering patients tools to help quitting

The overall approach was helpful though in terms of reminding me as the PCP to discuss smoking at each visit. It is very easy to lose track of smoking in the setting of the other chronic medical issues. In this study chronic medical issues were addressed, in addition to smoking. Some of the chronic medical issues however proved to be an obstacle in discussing smoking.

For the patients who suffered from a mental health disorder, quitting smoking was not a priority. Quitting heroin or addressing depression was the priority. Most patients were using smoking as an outlet from the depression or illegal drug use. Patients who suffered from anxiety used smoking as a calming tool. For these patients the underlying mental health issues needed to be addressed before the issue of quitting smoking could be focused on. I was not as aggressive with this group because they tended to be the most resistant when discussing smoking, in comparison to those individuals who did not have any mental health issues.

Despite the limitations, the patient centered approach showed moderate effectiveness, 21% of patients decreased smoking use, and another 41% were willing to quit. The amount of time invested from the PCP perspective was minimal, 5 to 7 minutes. Topic does require further study, with a greater sample size and longer study time duration for better assessment. Patient centered approach has been shown to be effective in helping patients quit smoking.[3]

Behavior change is difficult, but the right ingredients are present. The key aspects are continuity of care, and patient - physician relationship, which is the vehicle that enables a patient centered approach to be effective.

References

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