Patient Perspectives on Tobacco Use Treatment in Primary Care*

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Background

- Adherence to clinical practice guidelines for treating tobacco use can improve patient care and quit rates, yet treatment is
  - Not consistently offered by providers
  - Underutilized by patients
- Thus, interventions are needed to improve tobacco use treatment delivery and acceptance
- What might patient voices add?

Methods

Patient Recruitment
- Eligibility: English speakers age ≥18
  - Attended 1 of 3 UNC Physicians Network practices
  - Smoking or quit in past 6 months
- Recruitment: Flyers in waiting and exam rooms & letter from physicians
  - Incentive: $50 gift card

Focus Groups
- Conducted by 3 researchers at locations near practices
- Interview guide topics:
  - Participant tobacco use and quit attempts
  - Interactions with providers about tobacco use
  - Opinions about outcomes
  - Opinions about interventions during office visits (Figure 1)

Analysis
- Audio tapes transcribed and imported into ATLAS.ti 6.2
- Inductive coding techniques to identify theme

Participant Demographics

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<th>33 focus group participants</th>
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<tr>
<td>Average age</td>
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<tr>
<td>Female</td>
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Percentage responding “yes” to question item:

- Cigarette Use:
  - Smoke every day (16 cpd; range 4-40): 73%
  - Smoke some days (6 cpd; range 2-10): 6%
  - Recently quit smoking: 21%
  - Have medical insurance: 100%
  - Serious quit attempt during past year: 67%
  - Doctor offered guidance for quitting: 79%

Results: Four Main Themes

1) Experience of cigarette smoking in today’s culture

- Inconvenience: “You can’t just go stand outside of a building and smoke anymore, so we’re always sneaking around and figuring… where can I go to smoke?” (PCP3)
- Shame: “No one else I work with smokes so I’m always the stinky person.” (PCP2)
- Isolation: “Society has placed such a stigma on it…” (PCP2)
- Risks: “It’s either gain weight or be in the wooden coffin… it’s terrible” (PCP3)
- Enjoyment: “Honestly… I very much so purely love smoking.” (PCP2)

2) Medical encounter

- Expectations: “Smoking… should be addressed every time a person comes in… [like] blood pressure.” (PCP1)
- Trust: “The only person… is [my] doctor because he trusts me. I’m not going to let somebody help me get rid of my addiction that takes up 2 hours a day that I’ve been doing for over 30 years that I don’t trust.” (PCP1)
- Respect: “[Don’t] shake a finger at me… or tell me all of the terrible things that are going to happen…” (PCP2)
- Positive messaging: “Just say the word, we have plenty of things to help you [and] let me know; this is what works.” (PCP3)
- Targeted messaging: “I told my doctor… I am doing these with these studies because of [point pain]; she [said] ‘I absolutely can’t take you off them… as a smoker your risk of a heart attack is 34% more.’” (PCP2)

3) High value actions for practices & communities

- More dialogue: “I don’t want to check “yes or no”. I want you to ask me my true need & to give me something to help it… then follow up.” (PCP1)
- Use addiction model: “It’s just like drug addiction… has to be a part of the disease model & [doctors] they have to accept it as such.” (PCP1)
- Point of care nicotine replacement therapy: “What does this patch do? What can I do on this patch? How is this going to affect me?” (PCP1)
  - “Give something on the way out… it gives me a choice & smokers have so little choice… if it cut that craving then & there, you’re going to call that doctor back.” (PCP2)
- Carbon monoxide monitoring: “It’s something that’s giving you positive feedback… you met that goal… I’m proud of you.” (PCP2)
- Comprehensive infrastructure needs: “I think every physician should have somebody like a tobacco cessation counselor… & have [them] call me.” (PCP1)

4) Patient-centered outcomes

- Patient behavior change
  - Decreased use of tobacco (cutting back, not necessarily quitting)
  - Use of support (quitlines, group, family/friends)
- Quality of life and wellness
  - Increased energy levels, with ability to be more active
  - Reduced sense of isolation and stagnation
  - Increased available time with freedom in not having to accommodate tobacco use
- Sense of pride in setting example for others or pride showing others that they can reach goals

Discussion

- Effectiveness of most patient suggestions supported in literature
- Other suggestions warrant further study
- Few tobacco use treatment studies engaged patients before design
- Patient advice for providers:
  - Show understanding of isolation felt by those who smoke
  - Provide attractive & positively-framed materials in waiting area
  - Address smoking at every visit
- Acknowledge and assist patients from an addiction model
- Several factors may limit generalizability
- All participants had insurance, were predominately female, and may have had higher motivation
- Regional smoking rate lower than national average

Figure 1 Clinical flow chart prompted participants to address all aspects of typical visit

Conclusions

- Patient voice needed early in intervention planning process
- Patients want honest, consistent, and pro-active discussion/action from providers
- Patient suggestions & outcome measures can inform effectiveness studies & quality-improvement initiatives such as those funded by PCORI
- Minimal burden on practices to implement many suggested interventions

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