BEHAVIORAL ASPECTS OF SMOKING CESSATION FOR PRIMARY CARE

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DO I HAVE ANYTHING TO DISCLOSE?

NO.

LEARNING OBJECTIVES

1. IDENTIFY AVAILABLE APPROACHES TO THE FACILITATION OF SMOKING CESSATION.
2. IDENTIFY THE BEHAVIORAL CHANGE THEORIES THAT MAY RELATE TO EFFORTS TO STOP SMOKING.
3. DISCUSS THE IMPLEMENTATION OF SMOKING CESSATION EFFORTS IN A PRIMARY CARE SETTING.
4. DISCUSS A MODEL OF INTERDISCIPLINARY COLLABORATION IN SMOKING CESSATION EFFORTS.

ARE THERE ANIMAL STUDIES?

A WELL KNOWN PREMISE

TOBACCO USE AND OTHER BEHAVIORAL ISSUES CONTRIBUTE TO MORE CHRONIC HEALTH PROBLEMS, AND HIGHER HEALTH CARE COSTS.

THE INNOVATOR'S PRESCRIPTION (2009)

BEHAVIORAL CHALLENGES WERE SEEN AS A MAJOR DRIVER OF INCREASED HEALTH CARE COSTS.

TOBACCO USE, POOR DIETARY HABITS, AND LACK OF PHYSICAL ACTIVITY ACCOUNT FOR 34.7% OF MORBIDITY IN THE UNITED STATES.

(MOKDAD, MARKS, STROUP, & GERBERDING; 2004)

QUICK FACTS

- ABOUT 1.3 MILLION PEOPLE QUIT SMOKING PER YEAR. (CDC)
- WITH AN EFFECTIVE PROGRAM, 20-40% ARE ABLE TO QUIT AND STAY OFF AT ONE YEAR. (CDC)
- THOSE WHO QUIT SMOKING MAKE ABOUT 30 ATTEMPTS BEFORE THEY SUCCEED.
- IT IS 3 TIMES MORE DIFFICULT TO QUIT SMOKING IF THE PERSON IS A DAILY AS OPPOSED TO AN OCCASIONAL SMOKER.
- ABOUT 80% OF SMOKERS VISIT A PRIMARY CARE PROVIDER.*

  * COMMENT…

SURGEON GENERAL'S REPORT (HHS, 2014)

1. SMOKING IS THE LEADING CAUSE OF PREMATURE DISEASE AND DEATH IN THE UNITED STATES.
2. 25.2% OF ADULTS IN THE U.S. USE SOME FORM OF TOBACCO PRODUCT.
3. 18% OF U.S. ADULTS CONTINUE TO SMOKE.
4. 2.0% OF THESE ADULTS SMOKE CIGARS.
5. 2.6% OF THESE ADULTS USE SOME FORM OF SMOKELESS TOBACCO.

PRIMARY CARE?

- 68.8% OF SMOKERS WANT TO QUIT. (CDC, 2011)
- THOSE IN THE AGE GROUPS YOUNGER THAN 65 YEARS OLD HAVE THE HIGHEST RATE OF WANTING TO QUIT = 70.2%. (CDC, 2011)
- IN PRIMARY CARE, TOBACCO USE SCREENING OCCUR AT ABOUT 62.7% OF VISITS. (BUT, ONLY 20.9% OF PATIENTS REPORTED RECEIVING TOBACCO CESSATION "COUNSELING.") (JAMAL, DUBE, MALARCHER, SHAW, & ENGSTROM; 2012)

CULTURE AND DIVERSITY CONSIDERATIONS

- TOBACCO USE IS GREATEST AMONG MEN, YOUNGER ADULTS, THOSE WITH LESS EDUCATION, LOWER INCOME, AND LGB. (AGAKU, ET AL., 2014)
- HISPANIC PATIENTS, PATIENTS IN THE 25-44 YEAR OLD AGE GROUP, AND THOSE WITHOUT HEALTH INSURANCE THAT COVERED TOBACCO CESSATION TREATMENT WERE LESS LIKELY TO RECEIVE COUNSELING FOR THESE ISSUES COMPARED TO MATCHED COHORTS. (JAMAL, ET AL., 2012)
- 75.6% OF BLACK ADULTS AND 61% OF HISPANIC ADULTS REPORTED AN INTEREST IN STOPPING SMOKING, COMPARED TO 69.1% OF WHITE ADULTS, AND 62.5% OF “OTHER” RACES. (CDC, 2011)
- LOWER PERCENTAGE OF BLACK ADULTS REPORTED STOPPING FOR $\geq$ 6 MONTHS.

AGAIN, PRIMARY CARE?

- PRIMARY CARE PROVIDERS ARE POSITIONED TO DELIVER THIS CARE.
  - THE PRIMARY CARE POPULATION IS DIVERSE, MEDICALLY, CULTURALLY, SOCIOECONOMICALLY.
  - SMALL AMOUNTS OF ATTENTION FROM THE PROVIDER (AUGMENTED WITH SELF-HELP AND/OR PHARMACOLOGIC AGENTS) CAN LEAD TO BETTER RESULTS THAN PATIENTS WHO TRY TO STOP ON THEIR OWN: 10% QUIT RATE VERSUS 3-5% QUIT RATE.
  - 31-90 MINUTES WITH PATIENTS, INTERVENING WITH PATIENTS AROUND THE ISSUE OF SMOKING CESSATION COULD INCREASE THE ABSTINENCE RATE FROM 21.5 TO 31.4% (FIORE ET AL., 2000)
- WHAT IS “IN THE WAY?” INCONSISTENCY OF INTERVENTION RELATED TO A) LACK OF AVAILABILITY OF PHYSICIAN TIME, AND B) LACK OF NECESSARY TRAINING.

ROBERT (PART 1)

ROBERT IS A 49 YEAR-OLD MALE WHO PRESENTS FOR REGULAR FOLLOW-UP IN YOUR OFFICE. HE HAS A HISTORY OF HYPERTENSION, HYPERLIPIDEMIA, EXERCISE-INDUCED BRONCHOSPASM, CHRONIC CONSTIPATION, AND ALLERGY TO BEE STINGS. HE ALSO PRESENTS AS POSITIVE FOR DEPRESSION AND ANXIETY THAT APPEAR WORSE WHEN HE IS UNDER HEAVY STRESS LOADS.

MEDICATIONS INCLUDE: VERAPAMIL, 240 MG QD; ATORVASTATIN, 20 MG QD; ALBUTEROL, 2 MG PO TID; POLYETHYLENE GLYCOL 3350; AND AVAILABILITY OF AN EPIPEN WITH HIM AT ALL TIMES. HE TAKES IBUPROFEN FOR OCCASIONAL COMPLAINTS OF PAIN. FORMERLY, HE TOOK SERTALINE, 100 MG QD FOR SYMPTOMS OF DEPRESSION, BUT HAS NOT USED IT FOR SEVERAL YEARS AT THIS POINT.

ROBERT

WEIGHT – 189 LBS. HEIGHT – 69 INCHES BMI – 27.9

VITAL SIGNS AT THIS VISIT:

BLOOD PRESSURE	135/88
HEART RATE	98
RESPIRATIONS	18
TEMPERATURE	98.6 F.
PULSE OX	91%

A META-ANALYSIS OF BRIEF TOBACCO INTERVENTIONS FOR USE IN INTEGRATED PRIMARY CARE

AUTHORS: WRAY, & FUNDERBURK, ET AL. (2018)

JOURNAL: *NICOTINE & TOBACCO RESEARCH*

- THERE IS LIMITED EVIDENCE-BASED GUIDANCE REGARDING TREATMENTS FOR TOBACCO USE DISORDER THAT FITS THE BRIEF FORMAT FOUND IN INTEGRATED PRIMARY CARE.
- META-ANALYSIS LOOKED AT 36 STUDIES, INCLUDING 12,975 PARTICIPANTS.
- PATIENTS IN INTERVENTION GROUPS EXHIBITED GREATER ODDS OF SMOKING CESSATION COMPARED TO THOSE IN COMPARISON GROUPS. ($OR=1.78$, $P<.001$)

META-ANALYSIS (CONTINUED)

- CITED THAT PROVIDERS COMPLAINED OF
  - LACK OF KNOWLEDGE AND TRAINING REGARDING NON-PHARMACOLOGIC INTERVENTION STRATEGIES FOR SMOKING CESSATION.
  - LACK OF TIME IN APPOINTMENTS TO BE ABLE TO SPEND TIME ON THIS ISSUE.
  - DISCOURAGEMENT WITH PAST FAILURES WITH PATIENTS WHO FAILED TO QUIT.
- DATA ANALYSIS LOOKED AT VARIABLES INCLUDING
  - TYPE OF INTERVENTION APPROACH (5 A'S, CBT, MOTIVATIONAL INTERVIEWING, STAGE-BASED INTERVENTION, HEALTH EDUCATION, AND SIMPLE ADVICE GIVING.
  - TYPE OF PROVIDER.
  - TYPE OF FORMAT: GROUP VS. INDIVIDUAL, # APPOINTMENTS, TOTAL TIME IN MINUTES.

META-ANALYSIS (CONTINUED)

- PARTICIPANT CHARACTERISTICS
  - AVE. AGE = 42.76 YEARS OLD
  - 52.7% MALE
  - AVE. CIGARETTES PER DAY – 17.88
- STUDY CHARACTERISTICS
  - 53% BIOVERIFICATION REQUIRED
  - 83% HAD LONGITUDINAL ASSESSMENT, $\geq$ 6 MONTHS
  - 58% STUDIED EFFICACY OF NON-PHARMACOLOGIC INTERVENTIONS
  - 42% STUDIED ANY INTERVENTION
  - 37% RECRUITED FROM PRIMARY CARE SETTINGS

META-ANALYSIS (CONTINUED)

- INTERVENTION CHARACTERISTICS
  - AVERAGE LENGTH IN APPOINTMENTS = 2.64
  - AVERAGE LENGTH IN TIME (MINUTES) = 113.67 – 540
  - 2/3 OF THE INTERVENTIONS WERE DELIVERED BY A "HEALTH PROFESSIONAL" (PHYSICIAN, NURSE, DENTIST)
- RESULTS
  - GENDER WAS NOT FOUND TO BE A SIGNIFICANT MODERATOR OF CESSATION OUTCOMES.
  - USE OF BIOVERIFICATION DID NOT RELATE TO THE RATE OF SUCCESSFUL CESSATION.
  - FOLLOW-UP INTERVAL DID NOT ALTER TREATMENT OUTCOME EFFECTS.
  - THE TYPE OF INTERVENTION DONE WAS NOT ASSOCIATED WITH THE OUTCOME RATES.

BOTTOM LINE

1. THE LARGER THE NUMBER OF CIGARETTES SMOKED PER DAY, THE LESS LIKELY THE PATIENT WAS TO ACHIEVE ABSTINENCE.
2. THE TYPE OF INTERVENTION WAS NOT ASSOCIATED WITH SUCCESSFUL OUTCOME.
   A. PROVIDERS COULD, HOWEVER, INCLUDE "BEHAVIORAL HEALTH PROVIDERS."
   B. THE LITERATURE, HOWEVER, DOES NOT OFTEN IDENTIFY SUCH PROVIDERS FOR THIS ACTIVITY. (THEY ARE USUALLY LOOKED AT FOR PROVIDING OTHER SERVICES.)
   C. THE PRIMARY CARE SETTING DID NOT HAVE DIFFERENT OUTCOMES FROM NON-PRIMARY CARE SETTINGS.
3. ACKNOWLEDGED THAT "BHP'S" HAD VARIABLE TYPES OF TRAINING, WHICH MIGHT BE ACCEPTABLE SINCE NO PARTICULAR APPROACH WAS SUPERIOR.

BOTTOM LINE (REALLY!!)

HEALTH CARE PROVIDERS MAY BE ABLE TO EFFECTIVELY DELIVER BRIEF INTERVENTIONS FOR SMOKING CESSATION, AUGMENTED WITH THE INCLUSION OF BEHAVIORAL HEALTH PROVIDERS FOR MORE INVOLVED CASES, OR CASES REQUIRING LONGER INVOLVEMENT.

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THERE ARE SEVERAL BEHAVIORAL CHANGE MODELS THAT CAN/HAVE BEEN EMPLOYED IN EFFORTS WITH SMOKING CESSATION, WEIGHT LOSS, EXERCISE CONSISTENCY, AND OTHER BEHAVIORALLY DRIVEN PROBLEM AREAS.

BEHAVIORAL CHANGE MODELS (BCM'S)

A. THE HEALTH BELIEF MODEL (HBM)
   a. ACKNOWLEDGES THE DESIRE TO AVOID ILLNESS.
   b. FOCUSES ON BELIEFS THAT A SPECIFIC HEALTH ACTION WILL PREVENT OR CURE ILLNESS.
B. CONSTRUCTS INCLUDE NOTIONS OF
   a. PERCEIVED SUSCEPTIBILITY, PERCEIVED SEVERITY, PERCEIVED BENEFITS, PERCEIVED BARRIERS, CUES TO ACTION (SOMETHING THAT GETS THE PERSON'S ATTENTION), AND SELF-EFFICACY.
C. LIMITATIONS CENTER AROUND THE FACT THAT THE MODEL IS MORE DESCRIPTIVE THAN EXPLANATORY, AND DOESN'T SUGGEST STRATEGIES FOR CHANGE.

BCM'S

A. THE THEORY OF PLANNED BEHAVIOR (TPB)
   a. KEY CONSTRUCT: THE PRESENCE OF BEHAVIORAL INTENT
   b. SUCCESS DEPENDS ON MOTIVATION (INTENTION) AND ABILITY (BEHAVIORAL CONTROL).
   c. ADDITIONAL CONSTRUCTS INCLUDE: ATTITUDES, BEHAVIORAL INTENTION, SUBJECTIVE NORMS, SOCIAL NORMS, PERCEIVED POWER, AND PERCEIVED BEHAVIORAL CONTROL.

B. LIMITATIONS INCLUDE ASSUMPTIONS THAT THE INDIVIDUAL HAS ACQUIRED THE OPPORTUNITIES AND RESOURCES TO BE SUCCESSFUL AT CHANGE. IT DOES NOT ACCOUNT FOR OTHER VARIABLES THAT AFFECT BEHAVIORAL INTENTION AND MOTIVATION. (FEAR, THREAT, MOOD, PAST EXPERIENCE, ETC.)

BCM'S

A. DIFFUSION OF INNOVATION THEORY (DOI)
   a. THE CENTRAL CONSTRUCT IS THAT PEOPLE ADOPT SOMETHING (PRODUCT, IDEA, ETC.) AS IT "DIFFUSES" THROUGH THE POPULATION OR SOCIAL SYSTEM. PEOPLE ARE SEEN TO DO THIS DIFFERENTLY, HOWEVER, BASED ON SETS OF PERSONAL CHARACTERISTICS. FIVE GROUPS ARE RECOGNIZED:
      1) INNOVATORS—THE FIRST ONES TO TRY THE INNOVATION
      2) EARLY ADOPTERS—OPINION LEADERS, WHO ADOPT RELATIVELY QUICKLY
      3) EARLY MAJORITY—NOT THE LEADERS, BUT THOSE WHO ADOPT NEW IDEAS FASTER THAN AVERAGE
      4) LATE MAJORITY—THOSE SKEPTICAL OF CHANGE, BUT COME AROUND AFTER "IT SEEMS TO WORK"
      5) LAGGARDS—THOSE BOUND BY TRADITION; USUALLY VERY CONSERVATIVE

BCM'S

B. STAGES OF ADOPTION: AWARENESS OF NEED→ DECISION TO ADOPT/REJECT→ INITIAL USE→ CONTINUED USE

C. FACTORS INFLUENCING ADOPTION

  a. RELATIVE ADVANTAGE
  b. COMPATIBILITY
  c. COMPLEXITY
  d. TRIABILITY
  e. OBSERVABILITY

D. LIMITATIONS OF THIS MODEL ARE THAT IT DOES NOT FOSTER A PARTICIPATORY APPROACH; AND, IT WORKS BETTER WITH ADOPTION OF BEHAVIORS AS OPPOSED TO CESSATION OF BEHAVIORS.

BCM'S

A. SOCIAL COGNITIVE THEORY (SCT)/BEGAN AS SOCIAL LEARNING THEORY (SLT)
   a. CONSTRUCTS: RECIPROCAL DETERMINISM, BEHAVIORAL CAPABILITY, OBSERVATIONAL LEARNING, REINFORCEMENTS, EXPECTATIONS, SELF-EFFICACY
   b. LIMITATIONS: THEORY TENDS TO ASSUME THAT CHANGE WILL HAPPEN SOMEWHAT AUTOMATICALLY.

B. SOCIAL NORMS THEORY
   a. ATTEMPTS TO UNDERSTAND THE ENVIRONMENT AND INTERPERSONAL INFLUENCES IN ORDER TO CHANGE BEHAVIOR (OFTEN TARGETS COLLEGE STUDENTS, AND YOUNGER)
   b. CONSTRUCTS INCLUDE: PERCEIVED NORMS, ACTUAL NORMS, AND MISPERCEPTION
   c. TESTS MESSAGES AND EVALUATES ITS EFFECTIVENESS (OFTEN USED IN MEDIA)

BCM'S

C. LIMITATIONS OF THE MODEL INCLUDE USE OF POOR SOURCES OF DATA, POOR DATA COLLECTION METHODS, POOR DELIVERY OF THE MESSAGE.

THESE VARIOUS BEHAVIORAL CHANGE MODELS HAVE BEEN USED WITH PROBLEMS SUCH AS SMOKING CESSATION WITH VARYING RESULTS. THE COMPLEXITY AND LIMITATIONS OF THESE MODELS MAY CONTRIBUTE TO SIGNIFICANT VARIATIONS IN PROVIDER TRAINING AND HENCE, APPROACHES TO SMOKING CESSATION AND OTHER BEHAVIORAL PROBLEMS CAN BE CORRELATELY VARIED.

ROBERT (PART 2)

TODAY, ROBERT'S PHQ-2 IS NEGATIVE. REGARDING ANXIETY, HOWEVER, HE INDICATES THAT HE IS DOING A GREAT DEAL OF WORRYING ABOUT WORK AND FINANCES. HE ADMITS TO HAVING 2 DRINKS OF ALCOHOL PER DAY (BEER). HE STATES THAT HE USES NO STREET DRUGS, AND HAS NOT DONE SO SINCE HE WAS A TEENAGER, WHEN HE DOES ADMIT TO HAVING USED MARIJUANA ON A WEEKLY BASIS. ROBERT STARTING SMOKING CIGARETTES WHEN HE WAS 14 YEARS OF AGE. HE STATES THAT HE CONTINUES TO SMOKE CIGARETTES, 2 PACKS PER DAY, FOR 35 YEARS (70 PACK YEARS).

ROBERT (PART 2)

- IN DESCRIBING HIS CURRENT SITUATION, HE TELLS YOU THAT HE IS DEALING WITH THE STRESS OF SIGNIFICANT CHANGES AT HIS PLACE OF WORK, WITH A BUY OUT, OR POSSIBLE MERGER IN THE NEAR FUTURE. IF THE BUSINESS IS SOLD, HE FEELS THAT HE WILL MOST LIKELY LOSE HIS JOB. IF A MERGER TAKES PLACE, HE IS NOT SURE IF HE WILL KEEP HIS JOB OR NOT. HE FURTHER STATES THAT HE IS NOT SMOKING MORE DURING ALL OF THIS, BUT HE IS CHAIN-SMOKING AT TIMES, WHICH HE HAS NEVER DONE BEFORE. HE DOES EXPRESS SOME CONCERNS ABOUT THE LATTER REPORT.

THE TRANSTHEORETICAL MODEL (TTM)

- THE ELEMENTS OF CHANGE:
  - READINESS TO CHANGE
  - BARRIERS TO CHANGE
  - EXPECTATION OF RELAPSE
- THIS MODEL ACKNOWLEDGES THAT NO ONE APPROACH TO CHANGE WORKS FOR EVERYONE.
- MAINTAINING CHANGE REQUIRES MEANS TO STAY MOTIVATED.
- READINESS TO CHANGE IS RELATED TO SEVERAL STAGES THAT IDENTIFY WHERE THE INDIVIDUAL IS IN RELATION TO MAKING A CHANGE EFFORT.

TTM

1. PRECONTEMPLATION: NO CHANGE IS BEING CONSIDERED (WITHIN THE NEXT 6 MONTHS).
   - IN THIS STAGE, PEOPLE MAY FEEL RESIGNED TO THEIR CURRENT STATE, AND FEEL THAT THEY HAVE NO CONTROL OVER THE BEHAVIOR.
   - IN THIS STAGE, JUST ACKNOWLEDGING THE ISSUE MAY BE ALL THAT IS DONE. THE CLINICIAN MAY GIVE INFORMATION ABOUT HOW/WHERE/WHEN TO ASK FOR HELP AT A LATER TIME.
2. CONTEMPLATION: CHANGE IS BEING CONSIDERED (WITHIN THE NEXT 6 MONTHS).
   - MORE AWARENESS IS EVIDENT ABOUT THE PROS AND CONS OF MAKING A CHANGE, EVEN THOUGH INDIVIDUALS MAY STILL BE SOMEWHAT AMBIVALENT.

TTM

2. CONTEMPLATION (CONTINUED)
   - THIS STAGE INVITES MORE DISCUSSION (EX. MOTIVATIONAL INTERVIEWING) ABOUT HOW CHANGE CAN BE MADE.
3. PREPARATION: THERE IS THE MOTIVATION TO TAKE ACTION TO CHANGE (WITHIN THE NEXT 30 DAYS). SOMETIMES THIS STAGE IS CALLED "DETERMINATION."
   - GATHER INFORMATION ABOUT WAYS TO APPROACH THE CHANGE.
   - BEGIN TO MAKE SMALL CHANGES THAT MOVE TOWARD THE ULTIMATE GOAL. (FOR EXAMPLE, WITH SMOKING CESSATION, THE PERSON MIGHT CHANGE BRANDS OF CIGARETTES, OR SMOKE FEWER CIGARETTES PER DAY.)

TTM

4. ACTION: CHANGE HAS TAKEN PLACE (WITHIN THE LAST 30 DAYS).
   - DIRECT ACTION AIMED AT CHANGE MAY INVOLVE MODIFYING THE PROBLEM BEHAVIOR, OR REPLACING THE BEHAVIOR WITH A HEALTHIER CHOICE.
   - REINFORCEMENT AND SUPPORT FOR CHANGE BECOME ESSENTIAL FOR HELPING THE CHANGE TO BE MAINTAINED.
5. MAINTENANCE: CHANGE HAS BEEN MAINTAINED FOR MORE THAN 6 MONTHS.
   - PEOPLE WORK TO AVOID/PREVENT RELAPSE.
   - IT IS IMPORTANT TO ACKNOWLEDGE THAT RELAPSE IS COMMON, AND IS PART OF THE PROCESS OF CHANGE.

TTM

6. TERMINATION (OLD TERM): THERE IS NO DESIRE TO RETURN TO THE OLD BEHAVIOR, AND THE PERSON IS CERTAIN THAT THEY WILL NOT RELAPSE.
   - THIS STAGE IS OFTEN NEVER REACHED, HENCE INDIVIDUALS REMAIN IN THE MAINTENANCE STAGE.

VERSUS

6. RELAPSE (NEW TERM): THIS IS A COMMON OCCURRENCE THAT IS SEEN AS PART OF THE PROCESS.
   - DO NOT LET RELAPSE UNDERMINE SELF-CONFIDENCE.
   - LOOK FOR WHAT TRIGGERED THE RELAPSE.
   - RESTART THE PROCESS AT PREPARATION, ACTION, OR MAINTENANCE STAGES.

TTM

TEN PROCESSES OF CHANGE:

1. CONSCIOUSNESS RAISING—INCREASING AWARENESS ABOUT HEALTHY BEHAVIOR
2. DRAMATIC RELIEF—EMOTIONAL AROUSAL ABOUT THE HEALTH BEHAVIOR; + OR - .
3. SELF-REEVALUATION—SELF REAPPRAISAL TO GIVE VALUE TO THE HEALTHY BEHAVIOR
4. ENVIRONMENTAL REEVALUATION—SOCIAL REAPPRAISAL RE: B'S EFFECTS ON OTHERS
5. SOCIAL LIBERATION—FINDING ENVIRONMENTAL REINFORCEMENT FOR HEALTHY B
6. SELF-LIBERATION—COMMITMENT TO CHANGE OF B WITH BELIEF THAT IT IS POSSIBLE
7. HELPING RELATIONSHIPS—FINDING SUPPORTIVE RELATIONSHIPS THAT REWARD CHANGE
8. COUNTER-CONDITIONING—SUBSTITUTING HEALTHY B'S AND THOUGHTS FOR UNHEALTHY
9. REINFORCEMENT MANAGEMENT—REWARDING HEALTHY AND PUNISHING UNHEALTHY
10. STIMULUS CONTROL—PROVIDE CUES FOR HEALTHY B; REMOVE CUES FOR UNHEALTHY

TTM

LIMITATIONS OF THE TRANSTHEORETICAL MODEL:

1. IGNORES SOCIAL CONTEXT IN WHICH CHANGE OCCURS, SUCH AS SES AND INCOME.
2. LINES BETWEEN THE STAGES ARE ARBITRARY.
3. NO CLEAR DATA ON HOW LONG SOMEONE NEEDS TO BE IN A GIVEN STAGE.
4. ASSUMES THAT PEOPLE MAKE LOGICAL, COHERENT DECISIONS ABOUT CHANGE.

ROBERT (PART 3)

IN TERMS OF QUITTING HIS SMOKING HABIT, ROBERT STATES THAT HE HAS TRIED TO STOP SMOKING, USING VARIOUS APPROACHES, "ABOUT 15 TIMES." CURRENTLY, HE IS NOT THINKING ABOUT STOPPING BECAUSE HE FEELS THAT SMOKING HELPS HIM TO RELAX IN THE MIDST OF HIS CURRENT STRESS-RELATED PROBLEMS.

- **WHAT WOULD YOU SAY TO ROBERT ABOUT HIS SMOKING AT THIS POINT?**

- **IS THERE ANYTHING THAT YOU MIGHT DO FOR HIM, SINCE HE IS NOT THINKING ABOUT STOPPING?**

5 A'S BEHAVIOR CHANGE MODEL

APPLICATION OF THE MODEL TO SMOKING CESSATION IN PRIMARY CARE:

- **ASSESS** (BELIEFS, BEHAVIOR, KNOWLEDGE)
- **ADVISE** (PROVIDE SPECIFIC INFORMATION ABOUT RISKS AND BENEFITS OF CHANGE)
- **AGREE** (SET GOALS IN A COLLABORATION WITH THE PATIENT)
- **ASSIST** (IDENTIFY BARRIERS, SELECT STRATEGIES, PROBLEM-SOLVE, BOLSTER SOCIAL SUPPORT)
- **ARRANGE** (SPECIFY PLANS FOR FOLLOW-UP AND PREVENTION)

ASSESS

ASK ABOUT SMOKING CESSATION AT EVERY VISIT.

ESTABLISH PATTERNS OF USE.

ESTABLISH ANTECEDENTS TO USE.

TAKE A HISTORY OF CESSATION ATTEMPTS.

CONSIDER THE PATIENT'S STRESS LEVELS.

NOTE ANY COMPLICATING FACTORS THAT MIGHT UNDERMINE CESSATION.

ADVISE

PROVIDE INFORMATION ABOUT THE ADVANTAGES OF SMOKING CESSATION.

PROVIDE INFORMATION ABOUT THE MODES OF SMOKING CESSATION.

EXPLAIN THE PROCESS THAT YOU WILL UNDERTAKE WITH THE PATIENT.

DETERMINE THE PATIENT'S WILLINGNESS (READINESS) TO BEGIN THE EFFORT.

AGREE

SELECT THE APPROACH THAT WILL FIT THE PARTICULAR PATIENT.

PROVIDE REINFORCEMENT FOR THE PATIENT'S MOTIVATION TO ATTEMPT THE CESSATION EFFORT.

ASSIST

MAKE A **SMOKING CESSATION PLAN** AND PUT IT IN WRITING.

HAVE THE PATIENT SET A QUIT DATE.

DISCUSS ENVIRONMENTAL CHANGES THAT NEED TO BE ADDRESSED BEFORE QUITTING.

CONSIDER HOW LIFE WILL BE LIVED DIFFERENTLY AFTER THE PATIENT QUITS.

INSTITUTE NICOTINE FADING, AVERSIVE TOBACCO USE, AND BRAND SWITCHING IN THE LAST DAYS BEFORE THE QUIT DATE.

WHEN PATIENTS REACH QUIT DATE, PROVIDE NICOTINE REPLACEMENTS.

ASSIST 2

MEET WITH THE PATIENT ON OR SHORTLY AFTER THE QUIT DATE.

BE PREPARED FOR WITHDRAWAL SYMPTOMS, NEGATIVE AFFECT, AND/OR CRAVINGS.

COUNSEL ON THE "OTHER A'S": **A**VOID, **A**LTER, USE **A**LTERNATIVES, STAY **A**CTIVE.

EMPLOY COGNITIVE STRATEGIES, INCLUDING RELAXATION TECHNIQUES.

HAVE A **RELAPSE PREVENTION PLAN**.

ARRANGE

SET UP APPOINTMENTS TO SUPPORT THE CESSATION EFFORT:

APPT. 1—PREPARING FOR THE QUIT ATTEMPT

APPT. 2—ON OR SHORTLY AFTER THE QUIT DATE

APPT. 3—APPROXIMATELY ONE WEEK AFTER THE QUIT DATE

APPT. 4—APPROXIMATELY ONE MONTH AFTER THE QUIT DATE

YOU MAY CONSIDER MORE APPOINTMENTS WITH YOU OR A MEMBER OF YOUR STAFF. NOTE THAT THE NUMBER OF CONTACTS IS POSITIVELY ASSOCIATED WITH QUITTING. **MOST LAPSES OCCUR WITH 5 TO 10 DAYS AFTER QUITTING. 90% OF LAPSES LEAD TO A RELAPSE.**

BEHAVIORAL EMBELLISHMENT OF EXISTING PLANS

1. VARIOUS BEHAVIORAL APPROACHES CAN ADDRESS ENVIRONMENTAL CONTINGENCIES, COGNITIVE BEHAVIOR, STRESS MANAGEMENT EFFECTIVENESS, AND THE BUILDING OF NEW ASSOCIATIONS WITH NON-SMOKING.
2. UNDERSTANDING THE PATIENT'S PSYCHOLOGICAL TRAITS AND STATES CAN ENHANCE THE PROVIDER'S UNDERSTANDING OF THE VULNERABILITIES THAT THE PATIENT BRINGS TO THE CESSATION EFFORT.
3. CONSIDERATION OF WHAT THE PATIENT HAS LEARNED OR BELIEVES ABOUT SMOKING BEHAVIOR HELPS TO EXPLAIN BEHAVIOR AND ODDS FOR CHANGE.

ROBERT (PART 4)

IT HAS BEEN ONE MONTH SINCE ROBERT'S LAST VISIT WITH YOU. IN TODAY'S VISIT, HIS CHIEF COMPLAINT IS THAT HE HAS EXPERIENCED MORE STRESS AT WORK. HE HAS LEARNED THAT THERE WILL BE A MERGER. NOW HE KNOWS THAT HE MIGHT HAVE A JOB, BUT RECOGNIZES THAT HE ALSO MIGHT NOT HAVE A JOB.

A PHQ-9 IS 15, SUGGESTING MODERATELY SEVERE DEPRESSION. A GAD-7 IS 13, WHICH SUGGESTS MODERATE, GENERALIZED ANXIETY, BUT SYMPTOMS WHICH ARE NEARING "SEVERE." ROBERT ADMITS TO FEELING DEPRESSED AND ANXIOUS, BUT STATES THAT HE UNDERSTANDS HOW STRESS LEVELS MAY BE MAKING THESE THINGS WORSE. HIS SYMPTOMS HAVE BEEN WORSE SINCE HE LEARNED OF THE MERGER ABOUT 10 DAYS AGO.

ROBERT (PART 4)

HE IS EATING LESS, AND IS SLEEPING POORLY. HE IS HAVING PROBLEMS CONCENTRATING. NOTHING IS AS INTERESTING OR PLEASURABLE TO HIM AS IT WAS BEFORE HE LEARNED OF THE UPCOMING CHANGES AT WORK. HIS BIGGEST COMPLAINT, HOWEVER, IS THAT HE HAS STARTED SMOKING MORE. HIS CHAIN-SMOKING HAS CONTINUED, AND HE IS NOW SMOKING 2½ -3 PACKS OF CIGARETTES PER DAY. THE REASON FOR HIS COMING IN TODAY IS BOTH FOR HIS FEELINGS OF ANXIETY AND DEPRESSION, AND FOR FEELING THE NEED TO DO SOMETHING ABOUT HIS SMOKING.

ROBERT

- IN TERMS OF READINESS TO CHANGE, WHAT STAGE DO YOU THINK ROBERT IS IN?
    - WHY?
- WHAT QUESTIONS MIGHT YOU ASK ROBERT AT THIS POINT?
- AS THINGS PROGRESS, WHAT WOULD NEXT STEPS BE FOR ROBERT?
- WOULD YOU PRIORITIZE SMOKING CESSATION OVER ATTENTION TO ROBERT'S MENTAL STATUS?

THE PRIMARY CARE ENVIRONMENT

PRIMARY CARE SETTINGS ARE FREQUENTLY WHERE PATIENT'S CAN ADDRESS SMOKING CESSATION AND OTHER BEHAVIORALLY LADEN HEALTH PROBLEMS.

PROVIDERS CAN BENEFIT FROM INCREASING KNOWLEDGE AND SKILL IN HOW TO DEAL MORE CONSISTENTLY AND EFFECTIVELY WITH THE PERSON READY TO CHANGE.

PROVIDERS MAY BENEFIT FROM KNOWING WHAT RESOURCES ARE AVAILABLE IN THE COMMUNITY AND ON-LINE.

THE PRIMARY CARE ENVIRONMENT

PRIMARY CARE LENDS ITSELF TO THE USE OF TEAM APPROACHES INCLUDING PHYSICIANS, NURSE PRACTITIONERS, NURSING AND OFFICE STAFF, AND "BEHAVIORAL HEALTH" PROVIDERS.

GENERAL HEALTH AND WELLNESS EFFORTS MAY ENHANCE SMOKING CESSATION EFFORTS.

FOR MORE INVOLVED CASES, BEHAVIORAL MEDICINE CONSULTATION MAY BE A GOOD FIRST MOVE.