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ScienceDirect
Research in Social and Administrative Pharmacy 10 (2014) 369–377
RESEARCH IN SOCIAL & ADMINISTRATIVE PHARMACY

Original Research

Focusing on the five A's: A comparison of homeless and housed patients' access to and use of pharmacist-provided smoking cessation treatment

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Abstract

Introduction: The prevalence of smoking remains high among the medically underserved and could be related to disparities in access to and use of smoking cessation treatments.
Methods: This study implemented and tracked providers' use of the 5 A's intervention for tobacco use (Ask, Assess, Advise, Assist, Arrange) with homeless ($n = 260$) and housed ($n = 226$) adults attending a free medical clinic, including referrals to and use of an on-site pharmacist-led smoking cessation service.
Results: Among patients whose tobacco use was Asked about and Assessed (97%), homeless (vs. housed) patients were more likely to smoke (59% vs. 39%; $P = 0.008$). Among current smokers, there were no homeless-housed disparities in receipt of Advice to quit smoking (84% vs. 78%; $P = 0.22$) or Arrangement of treatment (36% vs. 31%; $P = 0.46$). Overall, among patients for whom treatment was Arranged, homeless patients were less likely than housed patients to attend the smoking cessation program (25% vs. 48%; $P = 0.04$). However, among those that attended any treatment (i.e., were Assisted to quit), homeless and housed patients attended similar numbers of sessions and used pharmacotherapy at similar rates.
Conclusions: Providers may reduce homeless-housed disparities in smoking by offering special Assist(ance) to homeless smokers that reduces barriers to initially accessing treatment services.

Keywords: Smoking cessation; Free clinic; Homeless; Pharmacist services; Medically underserved

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http://dx.doi.org/10.1016/j.sapharm.2013.05.011

Introduction

The prevalence of smoking in medically underserved communities remains high, particularly among the homeless. Rates of cigarette smoking among homeless adults are between 58 and 75%,[1–4] which is three to four times higher than the general population[1] and twice as high as those who live at or below the federal poverty level (30.6%).[5,6] Rates of smoking-induced death and disease among the homeless are also disproportionately high,[7] in part due to high-risk smoking behaviors such as sharing cigarettes, remaking cigarettes from discarded butts, and smoking discarded cigarette butts,[8,9] but also due to inadequate access to health care.[3] Effective smoking cessation services for the medically underserved, and particularly for the homeless, are needed to reduce the tobacco-related health disparity between homeless and housed adults.[10]

High rates of smoking among homeless adults do not appear to be related to differences in the effectiveness or acceptability of current interventions. Like their housed peers, approximately one third of homeless smokers report current readiness to quit smoking,[2,11] and more than half of homeless smokers are planning to make a quit attempt within 6 months.[12] Among those contemplating quitting smoking, homeless smokers are willing to use pharmacological and behavioral interventions,[12] and a small number of clinical trials suggest that established pharmacological and behavioral treatments such as nicotine replacement therapies (NRTs) in combination with Motivational Interviewing[13,14] may improve quit rates to levels comparable with other hard-to-reach groups such as homeless persons and inner-city dwelling African Americans.[13,15]

Instead, factors maintaining smoking disparities among homeless adults may be related to access to and use of established interventions.[16] Homeless persons may experience unique barriers related to transportation, clinic location, hours, environment and/or correlates of common comorbidities in the population (e.g., substance use, mental illness).[4,11] Such barriers could limit the impact of treatments that reduce smoking rates in other groups.

On the provider side, safety-net providers (i.e., providers of preventive care to the under- or uninsured) describe barriers to offering smoking cessation interventions including lack of time, perceived lack of patient readiness to change, inadequate provider and patient resources, and inadequate clinical skills.[17]

The Clinical Practice Guideline for Treating Tobacco Use and Dependence recommends that all providers implement the 5 A's intervention to reduce smoking, including Asking all patients about smoking at every visit, Advising all tobacco users to quit, Assessing smokers' willingness to try to quit, Assisting smokers to quit with treatment or referrals, and Arranging follow-up visits for those attempting to quit.[18] These recommendations are specifically intended to reduce provider bias and barriers that propagate population disparities in tobacco treatment. Nonetheless, the extent to which providers use the 5 A's when treating homeless and housed patients is unclear. Indeed, naturalistic studies of homeless persons' use of community smoking cessation services have not been reported, yet such data could provide crucial systems-level information needed to reduce homeless-housed disparities in smoking.[19]

The aim of this study is to describe provider use of the 5 A's and subsequent patient utilization of a pharmacist-led smoking cessation program within a free primary care clinic for the medically underserved. Specifically, this report describes the frequency with which clinic providers Asked about tobacco use, Assessed patients' willingness to quit, Advised tobacco users to quit, and provided Assist(ance) with quitting and Arrange (ment) of follow-up services for smoking cessation for homeless and housed patients attending the clinic.

Methods

Data were collected between April–December 2010. Provider use of and patient response to the 5 A's (see also Procedure section, below), including patient self-reported and biochemically confirmed smoking status was tracked. Study procedures were approved by the University of Pittsburgh Medical Center's Total Quality Committee as a quality improvement project, and secondary data analyses were approved by RAND's Human Subjects Protections Committee. Participants in the smoking cessation program received free behavioral treatment and free pharmacotherapy; no other incentives were provided.

Clinic and population

The general medical clinic (in which clients were Asked, Assessed, and Advised to quit smoking) which also includes the smoking cessation clinic (in which patients received Assistance and