Smoking Cessation Efforts in One New York City HIV Clinic

Mary Ann Zwiebel, RN, ACRN, CTTS
Valery Hughes, FNP

Key words: *HIV infection, nursing, smoking cessation*

In recent years, the medical management of HIV infection has become well-delineated, with established regularly updated standards of care that increasingly include health maintenance and promotion (Panel on Antiretroviral Guidelines for Adults and Adolescents, 2008). The management of HIV infection has progressed to the point that many experts consider it a chronic disease (Burkhalter, Springer, Chhabra, Ostroff, & Rapkin, 2005; Gritz, Vidrine, & Fingeret, 2007; Mamary, Bahrs, & Martinez, 2002; Niaura et al., 2000; Sackoff, Hanna, Pfeiffer, & Torian, 2006). The perception of HIV management has changed as people living with HIV infection (PLWH) live longer and their lives are less constrained by illness or illness-related activities. HIV should not be an acute terminal illness but rather a chronic, manageable disease, especially in well-resourced epicenters such as New York City, where HIV care and medications are readily available.

Health maintenance and promotion issues such as diet and exercise may have once had secondary importance or even been considered unimportant components of HIV care. But now they have become increasingly relevant, even a priority, to an HIV-infected person's immediate and long-term health status.

Since 1997, mortality in PLWH from non-HIV-related disease has risen to approximately 25%. The causes of these deaths include non-HIV-related cancers, heart disease, and non-HIV-related bacterial infections (Benard et al., 2007; Niaura et al., 2000; Sackoff et al., 2006). Tobacco smoking is a modifiable risk common to all of these diseases. Tobacco use by PLWH is estimated to be approximately 40% to 70% (Benard et al., 2006), and several studies have reported that the occurrence of non-HIV-related cancers, chronic lung disease, and heart disease is greater in smokers with HIV infection than in nonsmokers with HIV infection (Burkhalter et al., 2005; Crothers et al., 2005; Cummins, Trotter, Moussa, & Turham, 2005).

Extensive literature has addressed the diverse complexities that influence a person's ability to stop smoking. Change theories (Burkhalter et al., 2005), issues of self-efficacy (Gritz et al., 2007), and pharmacologic interventions (Covey et al., 2008; Kozlowski et al., 2007), for example, highlight the challenges faced by people who are trying to make a positive health change.

Owning and Addressing the Problem: Changing Practice

Recognizing the issues previously described prompted the authors to explore techniques for

Mary Ann Zwiebel, RN, ACRN, CTTS, is senior staff nurse, New York Presbyterian Hospital, Center for Special Studies, New York. Valery Hughes, FNP, is a research nurse practitioner, Cornell Clinical Trials Unit, Weill-Cornell Medical College, New York.

The authors report no real or perceived vested interests that relate to this article (including relationships with pharmaceutical companies, biomedical device manufacturers, grantors, or other entities whose products or services are related to topics covered in this manuscript) that could be construed as a conflict of interest.

JOURNAL OF THE ASSOCIATION OF NURSES IN AIDS CARE, Vol. 21, No. 1, January–February 2010, 11-15
doi:10.1016/j.jana.2009.10.001

smoking cessation that their staff could initiate. Their 20-year-old urban comprehensive HIV care program currently serves 2,300 people with HIV disease at two sites. One is a traditional hospital-based clinic and the other is located in a building that also houses a community-based AIDS service organization.

To get started, one member of the nursing staff attended a symposium on smoking cessation sponsored by the state health department in the fall of 2005. A liaison was established with the Manhattan Tobacco Cessation Program (MTCP) as a result of her networking at the symposium. The MTCP staff helped the authors implement a smoking cessation program, which was launched in October 2006.

MCTP uses a four-step framework: (a) *ask* if a patient uses tobacco products, (b) *advise* the patient that stopping tobacco use is an important part of an individual health plan, (c) *assess* the patient's readiness for change, and (d) *assist* with a referral or pharmacotherapy support. This effort increases the identification of smokers and provides links to effective treatment.

Clinical Assessment

The authors reviewed the charts of 1,564 patients seen over a 2-month period, from October to December 2006, to determine the prevalence of tobacco use in their patient population. Tobacco use was documented in only 37.5% of charts reviewed; of the charts with documentation of tobacco use, smoking prevalence was 43%. This result verified that the recommendation of the U.S. Department of Health and Human Services to discuss tobacco use with patients (Smoking cessation overview, 2009) was being followed inconsistently in the clinic.

The next focus was to make sure that each patient's tobacco use was assessed consistently as the first step in smoking cessation (Niaura et al., 2000). The importance of asking the question goes beyond its assessment purpose: A health care provider who asks about tobacco use conveys the message that smoking is an important health issue of personal relevance for that individual. Evidence shows that not only are physicians' smoking cessation interventions effective (Niaura et al., 2000) but that repetition is a key to success (Mamary et al., 2002).

Taking Clinical Action

The authors decided that the responsibility for smoking cessation in their clinic would be multidisciplinary. Because patients were weighed at all visits, the authors specified this as the designated time to ask about tobacco use. Patients might be weighed by a nurse, a nursing attendant, or a physician. Details regarding tobacco use (method of use, volume of use, previous attempts to quit, and the patient's interest in quitting) were recorded on a tracking sheet that followed the patient throughout the clinic visit. Putting this issue on the tracking sheet reminded providers to ask about tobacco use and ensured that the information would be available to every clinician who saw the patient. It also made it easier to collect prevalence and follow-up data, which would ultimately be documented in the electronic medical record.

After being identified as a tobacco user, the patient was scheduled for further assessment and counseling by a registered nurse who was specially trained in tobacco cessation counseling. This counseling session could occur in tandem with a regularly scheduled visit or as an additional stand-alone visit. The assessment included the Fagerstrom Test for Nicotine Dependence (Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991). Tobacco use patterns (e.g., when the patient smokes the first cigarette of the day) were explored, as well as behaviors typically carried out in concert with smoking (e.g., talking on the telephone, watching television, or driving). Strategies for quitting were reviewed. with a critical focus on what may have been tried in the past and what worked. Tactics such as distractions and use of medications were evaluated. After triggers had been identified, suggestions for changing triggered behaviors were made. For example, if after eating dinner a patient always sits in the same chair and watches the same television show while smoking a cigarette, the nurse may either suggest sitting in a different chair or not watching television to break the behavior pattern associated with smoking after dinner. Another example would be substituting one behavior for another: Instead of smoking a cigarette, for instance, the patient might be encouraged to go for a walk, chew sugarless gum, or brush his or her teeth.