

# The Clinician's Role in Intervening with High Risk Families to Reduce Secondhand Smoke Exposure

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## Background

In 1996, the National Research Council released a report, *Environmental Tobacco Smoke: Measuring Exposures And Assessing Health Effects*. It documented the health effects of secondhand smoke on children. According to the report:

- Respiratory symptoms, such as wheezing, coughing, and sputum production, are increased in children of smoking parents. These symptoms are more common in children of smokers than children of nonsmokers.
  - Respiratory infections manifested as pneumonia and bronchitis are significantly increased in infants of smoking parents.
  - Some studies have reported that infants of smoking parents are hospitalized for respiratory infections more frequently than children of nonsmokers.
  - Among children aged under 1 year, studies are remarkably consistent in showing an increased risk of respiratory infections among children living in homes where parents smoke.
- Since children's exposure to secondhand smoke (SHS) is associated with increased respiratory problems, the NRC report concludes that it is prudent to eliminate ETS exposure from the environments of small children.

According to the 2006 Surgeon General's Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, children are more heavily exposed to secondhand smoke than adults. Almost one in four children aged 3 -11 years old lives with at least one smoker. Low income children and African American children are disproportionately exposed to SHS. Rates of asthma are higher in this population as well putting them at even greater mortality risk. Results from a large-scale study of children with asthma from urban communities indicate that 39% of families had a caretaker who smoked and 59% of families reported at least one smoker in the home (Kattan et al., 1997). Similarly, Huss et al. (1994) found that 56% of urban minority families with a child with asthma included a smoker.

## AMA Secondhand Smoke Initiative

The American Medical Association (AMA), with cooperative agreements from the Environmental Protection Agency, is implementing an initiative to increase physician counseling on secondhand smoke to reduce children's exposure. Even low levels of exposure have a negative health effect, especially on children. Despite the fact that secondhand smoke exacerbates or results in disease, physicians do not regularly address it in office visits. Inner city medical practices are especially challenged to find the time and resources to counsel parents and families. The AMA initiative focuses on providing physicians and other health care providers with the tools they need to overcome practice-based barriers and offer families advice on how to protect their children and themselves from secondhand smoke exposure. The program is divided into two areas: demonstration sites and physician training. The Office of Continuing Professional Development at the University of Wisconsin is working with the AMA on implementation and evaluation.

## Project Goals and Objectives

### Goals

- ▶ Increase physician knowledge, awareness and practice on the health impact of secondhand smoke exposure
- ▶ Establish systems to assist physicians in educating patients on the health impact of secondhand smoke exposure especially to children with asthma and how to reduce family (adults, children) exposure, especially through smoking cessation.

### Objectives

- ▶ Educate physicians and staff in practices on the health impacts of secondhand smoke.
- ▶ Develop educational tools and materials that will support physicians and their practice settings.
- ▶ Develop CME training for physicians on secondhand smoke and counseling parents .

## Physician Training

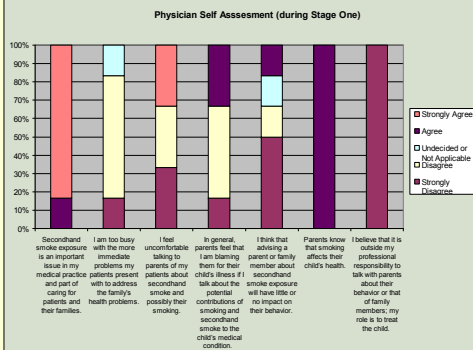
### Performance Improvement CME

Performance Improvement (PI) CME is a structure three stage process where physicians:

- Assess their current practice based on performance measures/best practice guidelines
- Apply those performance standards to their practice over time
- Reassess and evaluate progress

This physician training does not isolate the physician from his practice like traditional CME, but involves integrating changes within the practice and involving the clinic staff. The AMA is pilot testing the first PI CME on secondhand smoke with five unique clinicians: 2 family physicians, 3 pediatricians. Their practices represent urban, rural, private and corporate practices.

## PI CME Physician Self-Assessment



## Live and Online CME

Traditional CME has been presented in a didactic format The AMA developed a two hour and one hour CME. One hundred and fifty physicians and other clinical staff have attended live CME trainings or grand rounds presented in Kentucky, Illinois, South Dakota and Minnesota. In addition, Medscape worked with the AMA to develop an online CME. More than 3500 physicians and nurses have received certification for viewing this one hour program. This free offering can be viewed at <http://cme.medscape.com/viewarticle/577642>

## Demonstration Sites

The AMA is working with 3 demonstration sites in the Midwest that serve children and families that are un-insured or under-insured. These areas also have higher rates of childhood asthma than the national average as well as high rates of adult smoking.

- ▶ Mile Square Health Center – Chicago's west side; patient population predominately African American
- ▶ Erie Family Health Center – Chicago's north west side; patient population predominately Hispanic
- ▶ Institute for Family Medicine – St. Louis; mixed patient population; low income

Staff and physicians receive ongoing training and support. This includes basic information on secondhand smoke health risks, available resources and motivational interviewing techniques. Education is provided to patients and their families through environmental cues in reception areas, exam rooms and restrooms.

Utilizing tools from Cease: Clinical Effort Against Secondhand Smoke Exposure, ([www.ceasetobacco.org](http://www.ceasetobacco.org)), staff ask parents about their child's exposure to the SHS and offer the appropriate intervention.

### Program Principles

**Step 1: Assess secondhand smoke exposure/smoking status**  
Ask about secondhand smoke exposure – how often and by whom – add to patient's chart

**Step 2: Advise parents to quit smoking and/or establish a smokefree home/car policy**

- Utilize motivational interviewing
- Show parent video/provide parent education materials
- Display posters/leaflets in exam/waiting rooms and restrooms

**Step 3: Assist those who want to quit smoking and/or establish smokefree home/car policy**

### Systems strategies

- Ensuring that leadership is committed
- Screening - parents' smoking status, and smokefree home/car rules
- Tracking individual's and practice's progress over time
- Organizing information obtained in the screening process
- Systematically cueing clinicians to address parental tobacco control and explaining how to do it
- Establishing a prompting system to follow up with parent
- Organizing, maintaining, and distributing parent education materials

## Physicians Need to Talk About Smokefree Cars/Homes

TOBACCO SCREENING (survey of parents) Winickoff et al, Pediatrics 2003

	Family Practitioner	Pediatrician
Asked if anyone in household smokes	48	52.1
Asked if smoking is allowed in the house	28.7	38.2
Asked if smoking is allowed in the car	15.3	25.5

Authors' Conclusion: Opportunities exist to improve tobacco control activities in primary care settings that serve children.

## Parent Knowledge VS Behavior

Regardless of smoking status, majority of parents know SHS is harmful, yet their actions do not reflect that knowledge. Strategies include: fans; fragrance sprays; open windows; different room. Halterman et al. Journal of Asthma, 2007

## Parents Want and Expect Help

Majority of parents would accept medications to help them quit—only 7% get it (Winickoff et al 2005)

Majority of parents want to be enrolled in a telephone quitline—only 1% get enrolled (Winickoff et al 2005)

Majority of parents would be more satisfied with visit if child's doctor addressed their smoking (Cluss 2002; Frankowski 1993; Groner 1998; Klein 1995)

## Conclusion

Children of low economic status have higher rates of exposure to secondhand smoke and suffer more from the negative health outcomes. Today's busy clinicians cite lack of time, lack of available resources, patient indifference/hostility and lack of efficacy as barriers to counseling parents about secondhand smoke exposure and smoking cessation. Recent studies on physician behavior and public beliefs and a review of tools available offer a much different picture. They provide clear guidelines on talking to families about secondhand smoke and smoking cessation.

The AMA Secondhand Smoke Initiative has demonstrated that physicians and other health care providers have the willingness to improve clinical practice and that when provided with training and support materials and tools can adapt even a busy practice to provide education, brief intervention and specific referrals to resources in the community. A full evaluation will be completed in 2010.

## Acknowledgements

The AMA would like to thank the following for lending their assistance and expertise to the project:

Jonathan Winickoff, MD, MPH • Jay Shannon, MD • Eliseo Perez-Stable, MD • Jonathan Klein, MD, MPH • Bethany Hipple, MPH • Richard Yoast, Ph.D. • Sherri White

The AMA project is funded by cooperative agreements with the Environmental Protection Agency: XA-83059002/XA-XA-83309301