Chapter 13
Using Integrated Care for Addressing Tobacco Use Among Latino Populations

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Prevalence and Patterns of Tobacco Use

Tobacco use, mainly in the form of cigarette smoking, is the principal health hazard in the United States (US; CDC, 2004), and epidemiological data indicate that 12.1 % of Latino adults smoke cigarettes (CDC, 2014). Although overall smoking prevalence among Latinos is lower compared with some other racial/ethnic groups [19.4 % for non-Latino whites, 18.3 % African Americans, 26.1 % American Indian/ Alaska Natives; (CDC, 2014)], smoking is linked to the two leading causes of death among this population [i.e., heart disease and cancer; (American Cancer Society, 2012; CDC, 2015)]. As such, there is a pressing need to effectively intervene on smoking among U.S. Latinos in order to decrease the burden of tobacco-related health consequences in the U.S.

Latino smokers share many of the same characteristics as the general population of smokers. For example, like the general population of smokers, Latino smokers are more likely to be single, younger, male, and have other smokers in the home (Cooper, Rodríguez de Ybarra, Charter, & Blow, 2011; Cox, Feng, Cañar, Ford, & Tercyak, 2005; Kaplan et al., 2014; Rodríguez-Esquivel, Cooper, Blow, & Resor, 2009; Wilkinson et al., 2005). In contrast, common socioeconomic correlates of smoking among the general population (e.g., education, income, employment status) have not been consistently related to smoking among Latinos (Abraído-Lanza, Chao, & Flórez, 2005; Kaplan et al., 2014; Lorenzo-Blanco & Cortina, 2013a; Reitzel et al., 2009).

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Smoking rates among Latinos differ by nativity (whether the person was born in the US or another country), country of origin, and gender. The smoking prevalence rate is 17.7 % for US-born Latinos and 10.3 % for Foreign-born (CDC, 2015). The prevalence of smoking is higher among U.S. Latinos of Puerto Rican and Cuban descent (21.6 % and 18.2 % respectively), followed by those of Mexican (13.0 %) and Central/South American descent (9.2 %). Also, within Latinos, substantially more men than women smoke (17.7 % vs. 8.9 %, respectively), and that pattern is similar in all sub-ethnic groups (American Cancer Society, 2012; CDC, 2015; Kaplan et al., 2014).

The smoking patterns of Latinos smokers also differ from other racial/ethnic groups of smokers and across Latinos subgroups. A considerable number of Latino adult smokers report that they are social/occasional (known in the literature as intermittent or non-daily) and/or light smokers; that is, they smoke cigarettes only some days rather than on a daily basis, and tend to smoke fewer cigarettes on the days they smoke (i.e. about 10 cigarettes per day) compared to the general population of smokers (Cupertino et al., 2011; Fagan, Shavers, Lawrence, Gibson, & Ponder, 2007; Moolchan et al., 2007; Perez-Stable et al., 2001; Trinidad et al., 2009; Trinidad, Perez-Stable, White, Emery, & Messer, 2011; Zhu, Pulvers, Zhuang, & Baezconde-Garbanati, 2007). This pattern of non-daily and light smoking has been reported by nearly all age groups, gender, and backgrounds, although it is more common among younger adults and persons of Mexican and Central American origin. An exception to this is Cuban daily smokers, whose smoking intensity is the highest among sub-ethnic groups (e.g. about half men and 1/3 of females consume >20 cigarettes per day; Kaplan et al., 2014). Latinos also wait longer after waking to smoke their first cigarette of the day (Benowitz, Bernert, Caraballo, Holiday, & Wang, 2009; Daza et al., 2006; Trinidad et al., 2011). However, it is important to note that there is no safe amount of smoking. Both intermittent and light smoking are still associated with negative health outcomes (e.g. chronic diseases) when compared with former or never-smokers (Bjartveit & Tverdal, 2005).

Although cigarettes are still the most prevalent tobacco product, experimentation with a variety of non-cigarette tobacco products (e.g. cigars, little cigars, hookah, smokeless tobacco, e-cigarettes) is widespread, partially due to misperceptions of safety. Latinos generally acknowledge the adverse health effects of tobacco use; however, some gaps in knowledge have been identified including uncertainty about how different tobacco products vary with respect to health risks (Foraker, Patten, Lopez, Croghan, & Thomas, 2005; Richter, Pederson, & O'Hegarty, 2006). In recent surveys, Latino youth report high rates of smokeless tobacco and hookah use compared to teens of other race/ethnicities (Lauterstein et al., 2014; Wilkinson et al., 2015). Except for cigars, ever use of most non-cigarette tobacco products is lowest among foreign-born Latino young adults aged 18–34, and similarly high among US-born Latino, Non-Latino Blacks, and Non-Latino Whites (Lariscy et al., 2013). These patterns are similar for both men and women. Current use of other tobacco products is very low among foreign-born Latino women and there is no difference between US-born Latino and Whites (Lariscy et al., 2013). Among men, current use of other tobacco products do not significantly differ by race/ethnicity or nativity. In addition, some perceived benefits of smoking identified by Latinos include: stress and anxiety relief, pleasure, help to make friends, improved ability to

focus, and weight loss. These perceived benefits have been found to differ by gender, age, and education level (Constantine et al., 2009). Even though there is a general warning that no tobacco product is safe, more research is needed regarding the health effects of all tobacco products in order to better inform the population and provide guidance to health care professionals (Kozlowski & Edwards, 2005; Noonan & Kulbok, 2009).

Culturally relevant factors that correlate with smoking include acculturation and experience of discrimination. Acculturation refers to a process of multiple behavioral and ideological changes experienced by individuals as a result of contact between one or more cultures (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). Acculturation toward mainstream U.S. culture (as indicated by more years lived in the U.S., greater proportion of life lived in the U.S., English language preference or proficiency, etc.) is related to higher smoking prevalence among Latina women, but unrelated to prevalence among Latino men (Abraído-Lanza et al., 2005; Bethel & Schenker, 2005). Also, the experience of discrimination is a risk factor for smoking among Latinos (Lorenzo-Blanco & Cortina, 2013a, 2013b; Nguyen, Subramanian, Sorensen, Tsang, & Wright, 2012). Currently, scarce published research exists that examines how or why acculturation and discrimination might lead to increased smoking among Latinos, and the limited available research focuses on Latino youth. Generally, experience of discrimination is suspected to increase stress or negative emotions, which in turn increases the odds of smoking (Unger, Schwartz, Huh, Soto, & Baezconde-Garbanati, 2014) and greater acculturation is suspected to lead to higher odds of smoking both by increasing the experience of certain stressors (e.g. acculturative stress, discrimination, family conflict; Lorenzo-Blanco & Cortina, 2013b), but also by influencing the adoption of beliefs and attitudes that are more accepting of smoking (Bethel & Schenker, 2005).

Tobacco Cessation and Treatment-Related Characteristics

Compared to smoking prevalence and patterns, much less is known about what predicts success in quitting smoking among Latino smokers, but many factors relevant to White smokers and the general population of smokers are also relevant to Latino smokers. For example, older age, having a spouse/partner, partner support for quitting, the presence of children in the home (Brothers & Borrelli, 2011; Kaplan et al., 2014; Nevid & Javier, 1997), all increase odds of quitting, while stress (Businelle et al., 2010) and withdrawal from cigarettes (Castro, Kendzor et al., 2011) decrease odds of quitting among Latino smokers as they do among the general population of smokers.

Unlike the general population of smokers, success with quitting smoking does not seem to differ by gender (Bock, Niaura, Neighbors, Carmona-Barros, & Azam, 2005; Castro et al., 2009; Kaplan et al., 2014) and experiencing depressive symptoms does not appear to be associated with quitting among Latino (Castro, Costello, et al., 2011; Kiviniemi, Orom, & Giovino, 2011; Munoz, Marin, Posner, & Perez-Stable, 1997). Also, traditional indications of socioeconomic status (education, income,

employment) have not been consistently associated with quitting among Latinos in the U.S. (Businelle et al., 2010; Chiang & Borrelli, 2014; Kaplan et al., 2014).

As noted earlier, Latinos differ notably from the general population in behavioral smoking patterns, namely, daily versus non-daily smoking, cigarettes smoked per day, and the amount of time elapsed between waking and one's first cigarette of the day. These smoking patterns are widely used as behavioral markers of tobacco dependence (Heatherton, Kozlowski, Frecker, Rickert, & Robinson, 1989), but this practice may have limited utility for Latino smokers. Specifically, Latino's observed smoking patterns may suggest that they are less likely to be dependent on cigarettes, which would in turn lead to the assumption that they would be more successful at quitting. In fact, the quit rates of Latino smokers are lower or no different from non-Latino White smokers (CDC, 2002, 2011). There is a strong relationship between physical dependence and success at quitting smoking among non-Latino White smokers (Ferguson et al., 2003; Foulds et al., 2006; Rohsenow, Martin, Tidey, Monti, & Colby, 2013), but not among Latinos (Bock et al., 2005; Reitzel et al., 2009; Woodruff, Talavera, & Elder, 2002). This phenomenon among Latino smokers is not well-understood, but one possibility is that physiological aspects of dependence, may not be strong motivators for tobacco use among Latino smokers. This is consistent with the common occurrence of light and social/occasional smoking among Latino smokers. Nonphysiological aspects of dependence (e.g., social/environmental cues, cognitive factors such as outcome expectancies) may be more important motivators for smoking among Latinos (Castro et al., 2012, 2014; Foraker et al., 2005), but more research in this area is needed. Generally, indicators of physical dependence may not be useful prognostic indicators for Latino smokers trying to quit.

Acculturation toward mainstream U.S. culture may be related to greater likelihood of quitting (Bock et al., 2005) especially among men (Castro et al., 2009; Wetter et al., 2007). Lifetime experience of discrimination, particularly major discriminatory events, may reduce the probability of quitting among Mexican Americans (Kendzor et al., 2014). Research on how cultural variables influence cessation is limited and relatively new, but such knowledge can be used to identify and target at-risk groups.

Latinos experience notable disparities related to healthcare support for smoking cessation. In particular, Latinos consistently report extremely limited use of cessation aides compared to non-Latino Whites (Cupertino et al., 2011; Fu et al., 2005; Levinson, Perez-Stable, Espinoza, Flores, & Byers, 2004; Rodríguez-Esquivel et al., 2009; Trinidad et al., 2011). Socioeconomic condition likely plays some role in this disparity. For example, among Latino former smokers, use of prescriptions and over-the-counter medications for smoking cessation is more common among those with health insurance compared with those without insurance (Kaplan et al., 2014). Other studies have also demonstrated that socioeconomic factors may partly explain Latinos lesser use of cessation aids but these factors do not fully account for the disparity (Levinson et al., 2004; Thorndike, Biener, & Rigotti, 2002). Avoidance of medications and misconceptions about their use and effectiveness have also been reported (Foraker et al., 2005; Webb, Rodriguez-Esquivel, & Baker, 2010).

Latinos are also less likely compared to Whites to be asked whether or not they smoke and, if they do smoke, are less likely to receive advice to quit or be counseled about quitting during a healthcare encounter (CDC, 2011; Cokkinides, Halpern, Barbeau, Ward, & Thun, 2008; Houston, Scarinci, Person, & Greene, 2005; Levinson et al., 2004; Lopez-Quintero, Crum, & Neumark, 2006). This is particularly troubling because receiving physician advice (Kreuter, Chheda, & Bull, 2000; Whitlock, Orleans, Pender, & Allan, 2002) increases the probability of making a quit attempt and using cessation aids (Levinson et al., 2004). As these disparities in cessation support apply to actual encounters with healthcare professionals, they are clearly not an issue of lack of access to healthcare providers. Furthermore, the disparity in receiving advice to quit does not appear to be explained by the patients' English language proficiency (Lopez-Quintero et al., 2006).

Finally, there is a dearth of information regarding the efficacy of behavioral and pharmacological smoking cessation interventions among Latinos. Recent report found that, in contrast to the hundreds of smoking cessation intervention trials in existence (Fiore et al., 2008), fewer than 20 published studies directly target Latino smokers (Cox, Okuyemi, Choi, & Ahluwalia, 2011; Webb et al., 2010). The limited available evidence suggests that pharmacological and behavioral interventions for smoking cessation among Latinos are effective at the end of treatment, but their effects tend to wane beyond end of treatment (Webb et al., 2010). Additional research devoted to enhancing tobacco cessation interventions among Latinos is needed.

Assessment of Tobacco Use and Dependence

Screening for Tobacco Use

Health care practitioners are well-positioned to assess and intervene with patients that use tobacco. Depending on their particular work setting (e.g., primary care versus substance abuse treatments), one-third to three-fourths of practitioners' caseloads may be smokers (Fiore et al., 2008). Irrespective of a provider' specialty or treatment context, identifying tobacco users is the first step in treating tobacco use and dependence among patients in any health care setting. Given the high work demands experienced by some clinics coupled with lack of training for providers and staff, tobacco use assessments (TUAs) have historically seldom been included as a standard clinical practice and have often depended on the discretion of the practitioner. As a result, the documentation and delivery of tobacco cessation interventions has often been inconsistent and suboptimal. Fortunately, with the adoption of the Patient Protection and Affordable Care Act, there has been a dramatic increase in both the emphasis on and coverage for preventive care, including tobacco cessation (American Lung Association). Such changes are expected to positively impact the frequency and quality of TUAs and treatment in healthcare settings. Moreover, there are research-based recommendations for screening protocols that can

facilitate a clinic's adoption and implementation of structured TUAs and subsequent tobacco cessation support (Fiore et al., 2008; Warren et al., 2014). Healthcare settings are encouraged to treat "smoking as a vital sign" (McCullough, Fisher, Goldstein, Kramer, & Ripley-Moffitt, 2009) to be assessed systematically and in every patient encounter. As few as two questions integrated into a healthcare setting's electronic health records (EHR) system ("current smoker?" and "plans to quit?") dramatically increases both the number of smokers who are identified and those who receive cessation counseling (McCullough et al., 2009). In fact, even screenings comprised of just a few more questions can enable the identification of a large number of patients that use tobacco and promote referrals to specialized cessation programs without sacrificing significant additional time (Warren et al., 2014). An example of a short TUA is below.

For new patients, a *positive screen* results if a patient answers "every day" or "some days" to question 1, answers YES to either question 2 or 3, or responds that s/he has used tobacco during the last 30 days (question 4).

1. Do you currently smoke cigarettes every day, some days, or not at all?
2. Do you currently use any other tobacco products such as cigars, pipes, chewing tobacco, e-cigarettes, snuff, snus, bidis, etc?
3. Are you currently using any medication or nicotine replacement therapy (like gum, patches) to try to quit tobacco?
4. About how long ago did you last smoke a cigarette, even a puff or used other tobacco products?
5. Are you interested in stopping tobacco use or speaking with a team member (e.g. nurse, counselor, tobacco cessation specialist) about it?

When considering TUAs with Latino patients, it will be important to be mindful of the common practice of intermittent and light smoking among this population. This pattern of smoking may not be perceived as sufficiently frequent for the patient to identify him/herself as a tobacco user. Indeed, as many as 25 % of light and intermittent smokers under-report the amount they smoke (Perez-Stable, Marin, Marin, & Katz, 1990). Deliberate deception should not be assumed; patient reports are likely well-intended even when inaccurate. Questions like those above, which focus on the frequency of smoking behavior and that do not impose a label such as "smoker" or "nonsmoker" may be more helpful.

Tobacco Dependence and Withdrawal

Substance *dependence* refers to when a person cannot control the impulse to use a drug, such as tobacco, even in the face of negative consequences, and there are changes in the brain's natural inhibition and reward centers (National Institute of Drug Abuse). People with tobacco dependence may or may not also exhibit *physical dependence*. Physical dependence is characterized by either *tolerance* (need for increased amounts of a drug to achieve the desired effect or a diminished effect with

continued use of the same amount of the drug) or *withdrawal* (the characteristic set of symptoms that occur when use of a drug is stopped or continued use of the drug to avoid withdrawal symptoms). It is important to note that not all smokers are tobacco dependent, and that the degree to which tobacco dependence develops varies significantly across individuals. Although the diagnosis of tobacco dependence requires only two of 10 possible symptoms, only about half of regular smokers meet criteria for a *tobacco use disorder* according to the Diagnostic and Statistical Manual of Mental Disorders, fifth Edition (DSM-5; American Psychiatric Association, 2013; Breslau, Johnson, Hiripi, & Kessler, 2001), a widely used tool for assessing dependence and withdrawal.

Although documenting a *tobacco use disorder* (previosuly labeled as *nicotine use disorder*; DSM-IV-TR; American Psychiatric Association, 2000) or *tobacco withdrawal* may be required and useful for insurance-related purposes, examining all of the DSM-5 diagnostic criteria is not always feasible in a health care setting. In fact, its appropriateness for use in clinical settings as well as its validity to predict important outcomes (e.g. likelihood of quitting, response to treatment) has been questioned by experts in the field (Baker, Breslau, Covey, & Shiffman, 2012). Consequently, researchers have developed alternative instruments that better identify persons with tobacco dependence and that can be administered in shorter periods of time. The Fagerstrom Test for Nicotine Dependence (FTND; Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991) and the Heaviness of Smoking Index (HSI; Heatherton et al., 1989) are examples of such instruments. The FTND is a widely used instrument to measure tobacco dependence in both research and practice. Comprised of six items, it is a brief instrument that can be easily used in any health care setting. Ranges from 0 to 10, with higher scores indicative of higher dependence. Table 13.1 presents the items and scoring interpretation of the FTND.

Alternatively, the HSI consists of two items from the FTND: time to the first cigarette after waking up (TTFC; item 1) and number of cigarettes smoked per day (CPD; tem 4; Heatherton et al., 1989; Heatherton et al., 1991). When combined, these items comprise the HSI scale which ranges from 0 to 6 (Borland, Yong, O'Connor, Hyland, & Thompson, 2010). Higher scores indicate higher dependence. It is important to reiterate here that measures such as these, which assess physical dependence, have shown limited utility for predicting smoking treatment outcomes among Latino smokers (Bock et al., 2005; Brothers & Borrelli, 2011; Reitzel et al., 2009; Woodruff et al., 2002), and so we caution against using such measures for prognostic judgements among this population. However, such measures are still useful for documenting smoking behavior and physical dependence among Latinos, which is useful for treatment planning. Essentially, patients with low dependence (FTND=0–4) may benefit from brief interventions [see Brief Interventions section], while patients with moderate to high dependence (FTND=5–10) may require more intensive counseling and pharmacotherapy in order to increase their chances of quitting [see Intensive Interventions section].

Table 13.1 Fagerstrom test for nicotine dependence (FTND)/HSI

Item	Response options	Score
1. How soon after you wake up do you smoke your first cigarette?	(a) after 60 minutes	0
	(b) 31–60 minutes	1
	(c) 6–30 minutes	2
	(d) within 5 minutes consists of two items	3
2. Do you find it difficult to refrain from smoking where it is forbidden?	No	0
	Yes	1
3. Which cigarette would you hate most to give up?	(a) The first one in the morning	1
	(b) Any others	0
4. How many cigarettes per day do you smoke?	(a) 10 or less	0
	(b) 11–20	1
	(c) 21–30	2
	(d) 31 or more	3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	No	0
	Yes	1
6. Do you smoke even if you are so ill that you are in bed most of the day? (no/yes)	No	0
	Yes	1
Total Score (0–10)		

Source. Heatheron TF, Kozlowski LT, Frecker RC, Fagerstrom K (1991). The Fagerstrom Test for Nicotine Dependence: a Revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addiction; 86: 1119–1127

Note. Scoring: Sum up the scores of all items and interpret the total score as follows: 0–2 very low dependence; 3–4 low dependence; 5 moderate dependence; 6–7 high dependence; and 8–10 very high dependence

Comprehensive Assessment of Tobacco Use

Screening for tobacco use is a very important first step in intervening with tobacco users. However, once in treatment, helping smokers quit usually requires more extensive assessments, particularly among those highly dependent and/or with comorbid psychiatric conditions. Comprehensive TUAs involve getting to know the patient's tobacco use, smoking patterns, as well as reasons to smoke and reasons to quit. They guide the clinician to determine the most effective intervention that meets the patient's particular needs and to help formulate a treatment plan. TUAs can take the form of questionnaires that the patients complete by themselves or can be done by the practitioner in an interview format. They can take place in any treatment context, even if the focus of treatment is not smoking cessation. The time and resources available to administer the assessments and the complexity of the smoker's profile will help determine the length and breadth of the comprehensive TUA. Importantly, as with screening, a comprehensive TUA is an ongoing and dynamic process rather than a one-time clinical activity. As such, a comprehensive TUA should be completed throughout multiple visits and updated as the patient progresses in his/her quitting process.

In the comprehensive TUAs is important to ask questions about the patient's views regarding their history with tobacco, as well as their beliefs about, struggles

with, and aspirations for behavior change. The purpose of the comprehensive TUA is to go beyond simply eliciting answers to the set of questions, but to facilitate a discussion that motivates behavior change. Furthermore, because physical dependence might be less important as a motivator for smoking among Latinos, broader conversations about a Latino patient's lived experience with smoking may uncover other, more relevant motivators for smoking that can be targeted in treatment. Indeed, limited evidence suggests that a "multiple motives" approach to tobacco dependence that takes into account contextual and psychological motivators for smoking (Piper et al., 2004) may be more useful for predicting smoking outcomes among Latinos (Castro et al., 2012).

Biological Assessment. Carbon monoxide (CO) in the breath, and nicotine and its metabolite cotinine in saliva, urine, or blood, can be used to measure the extent of tobacco or nicotine use (APA, 2013). CO is one of the most deadly chemicals found in cigarette smoke. Burning cigars, cigarettes, and pipes all produce CO. CO takes the place of oxygen in the red blood cells, decreasing the actual amount of oxygen available causing strain on the heart and body, putting smokers at increased risk for having cardiovascular disease, especially heart attacks. Although CO is very deadly, it lasts in the body only a short time. Thus, its effect is reversible if the person stops smoking. The body can eliminate CO within 24 h but more likely within 2–3 days after a person quits smoking. The CO will go back down to the same level as that of someone who hast never smoked. CO meters measure expired CO from smoke exposure as either CO in parts per million (ppm) or percent carboxyhemoglobin (%COHb). Such devices provide immediate feedback on smoking level or confirmation of abstinence, and such feedback could serve as a motivator for the patient. A chart can help the patient to visualize CO effects (Table 13.2):

In sum, typical domains to be included in comprehensive TUAs are: (a) current tobacco use and intentions to quit, (b) past quit attempts (with particular attention to withdrawal symptoms), (c) social and contextual factors (that facilitate or hinder quitting), (d) medical history and biological assessment, (e) psychological assessment (e.g. psychiatric comorbidity, motivations to quit, self-efficacy, outcome expectancies). Examples of recommended measures and instruments to incorporate in a comprehensive TUA can be found in the *Smoking Initiative* of the Patient-Reported Outcome Measurement Information System (PROMIS; http://www.nihpromis.org/default.aspx). This initiative aims to develop, evaluate, and standardize item banks to assess smoking behavior and associated psychosocial constructs for both daily and nondaily smokers (Edelen et al., 2014; Shadel, Edelen, & Tucker, 2011). Some, although not all, of the recommended measures have been translated into Spanish and validated among Latinos.

Table 13.2 Meaning of CO levels

CO level	Meaning
0–8	Normal or very low (normal is 0–3 ppm)
8–12	Worry. Person is affecting their health
12–25	Cause for alarm. The person is harming themselves
25–40	Danger and hazard to health
Over 40	Severe danger—take immediate action (person can get lethargic)

Brief Interventions for Tobacco Cessation

The Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence*: *2008 Update* (PHS Guidelines; Fiore et al., 2008) provides clear recommendations regarding interventions for patients that are willing to make a quit attempt as well as for those that are not ready to make a quit attempt. The Guidelines are available in both English and Spanish and can be retrieved from http://www.ahrq. gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html. Brief interventions for tobacco cessation are characterized by a practical counseling encounter that lasts no more than 10 min. They are intended to be used by any health care provider in either outpatient or inpatient settings. Brief interventions for patients willing to make a quit attempt are best known as the 5A's (Ask-Advise-Assess-Assist-Arrange).

Interventions for Patients Willing to Make a Quit Attempt

ASK about tobacco use. Implement a clinic-wide system that ensures that every patient at every clinical encounter is queried about their tobacco use and that their smoking status is documented in their medical record. The main recommended identification system is simply to expand the Vital Signs to include tobacco use. Other alternatives include adding reminders to indicate tobacco use status through the EHR or "stickers" in the patient's charts.

Example: *Tobacco use* (*circle one*): *Current–Former–Never*

ADVISE the patient to quit. In a professional manner, offer the patient a strong advice to quit, emphasizing reasons to quit that are personally relevant to the patient and clearly emphasize the benefits of quitting. Beginning the conversation with assurance that providing this advice is standard practice for all tobacco users and that it is the professional responsibility of the provider may minimize the patient's perception of being judged or criticized. For example, "As your provider, it is my responsibility to let you know that stopping smoking (or using tobacco) is the best thing you can do for your own and your family's health and well-being. It will reduce your blood pressure, and reduce the asthma episodes in your child, and it will even allow you to save money. Cutting down is not enough. We are here to help you."

ASSESS willingness to make a quit attempt. Assess patient's willingness to make a quit attempt at the present time or the near future. For example, "How do you feel about trying to quit smoking within the next 2 weeks? Would you be willing to give it a try?"

If the patient is willing to make a quit attempt within the next 2 weeks, congratulate him/her for the decision and proceed to the next step, ASSIST.

If the patient is not willing to make a quit attempt within the next 2 weeks, evaluate their willingness to make the attempt within the next 30 days and assist accordingly.

If the patient is not willing to make a quit attempt in the near future, use a motivational approach and the 5R's model (discussed later) to increase the probability of a future quit attempt.

ASSIST in making a quit attempt. *For patients willing to make a quit attempt*, provide evidence-based intervention options to help them quit. Assistance includes provision or referral to counseling services as well as a prescription or recommendation to use medication. This step requires the provider to be knowledgeable in evidence-based interventions for smoking cessation as well as local smoking cessation resources. For example, if someone other than a physician is providing the 5 A's intervention, open communication must exist between the physician and the 5 A's provider regarding the feasibility of and physician's willingness to provide cessation aids that require a prescription. Providers should be familiar with the telephone Quitline services and be prepared to refer or connect patients with it [see Quitlines section]. In addition, there are numerous freely available self-help materials in English and Spanish that can be provided to the patient. Finally, local community organizations, clinics, and hospitals often have free or low cost smoking cessation counseling services available to community members. Beyond providing resources and referrals, there is much the provider can do immediately during the encounter to assist the patient with a quit attempt:

1. *Help the patient to prepare a quit plan*. Common steps to prepare for quitting include: (a) Setting a quit date, ideally, within 2 weeks; (b) Telling friends, family, and coworkers about intentions to quit and request their support. It may be particularly important to help the patient prepare for this if they have many other smokers in their social network; (c) Removing all tobacco-related products from the environment, including ashtrays, lighters, matches, and any other materials that promote smoking. If has not already been done, this is the time to make the home and car smoke-free. Prior to the quit day, the patient can practice changing their routine to disrupt their smoking pattern, and practice not smoking in places or situations where they frequently smoke. Patients should urge other smokers in the household to also quit or to not smoke in their presence; (d) Anticipating the challenges that will likely occur in the few weeks following the quit date, particularly nicotine withdrawal symptoms. The patient can make a list of these potential challenges and identify alternatives to deal with them; (e) Writing down the reasons why they are motivated to quit. Some people find useful to put that list in a visible place as a constant reminder; and (f) Determining if they want to start reducing the amount of cigarettes smoked per day in preparation for the quit day or if they will maintain their current smoking level and stop completely on the quit day. This preference varies by person, their previous experience quitting and their level of dependence. In general, lower socioeconomic status has been associated with gradual quitting.
2. *Provide practical counseling based on problem-solving/skills training*. Striving for complete abstinence is essential. Even one puff after quitting is discouraged. Capitalize on the patient's previous experience with quitting to identify what helped him/her to succeed and what factors provoked a relapse (e.g. increased

Table 13.3 Summary of the 5 A's model for treating tobacco use and dependence

Component	Description
ASK about tobacco use	For *every* patient at *every* visit, identify and document current and past tobacco use at the time that other vital signs are assessed
ADVISE to quit	In a clear, strong, and personalized manner, urge every tobacco user to quit (and encourage former smokers to stay quit)
ASSESS willingness to make a quit attempt	Inquire patient's interest in trying to quit
ASSIST in making a quit attempt	Aid the patient in quitting
ARRANGE follow-up	Ensure follow up contact

Main source: Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. (May 2008). Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service

physical activity and reducing coffee intake may have helped during previous quit attempts). The patient should plan to reduce stressful situations as much as possible and increase mood management and self-control skills [see Intensive Interventions].

3. *Recommend approved medications for cessation*, except when is contraindicated or with specific populations for which there is insufficient evidence of its effectiveness (Fiore et al., 2008). Approved medications are listed in a section below.

4. *Provide intra-treatment social support*; that is, providing general encouragement of the patient's quit attempt and be receptive to their questions.

ARRANGE a follow-up. Tobacco use is a chronic condition and should be treated as such. *For patients interested in making a quit attempt*, arrange for follow-up contacts, either in person or via telephone. Ideally, the follow-up contact should occur on the quit day or the day before. Other follow-ups should occur within a week after the quit day. During these follow-up contacts, discuss problems and challenges that have been encountered, and ways to address them. Assess medication use and any related issues. If patient is abstinent, congratulate them for their success! If they have smoked, congratulate them for the effort, revisit the challenges and strategies used and encourage a new attempt. *For patients unwilling to make a quit attempt* at a particular visit, continue addressing tobacco use/dependence and interest in quitting at the next clinic visit (Table 13.3).

Ask-Advice-Refer and Ask-Advice-Connect Models

In an effort to integrate brief interventions for tobacco cessation at the clinic level and after considering that often even the 5As approach is challenging to fully implement in a busy health care setting, briefer models started to emerge. The *Ask-Advise-Refer* (AAR) model is a health care-based smoking cessation initiative promoted nationally and recommended by several professional organizations (i.e. surgeons, dental hygienists; www.askadviserefer.org). Providers using this model ask their patients about their tobacco use, advise them to quit and then make a standard

recommendation providing the patient with a business/referral card to a state quit-line or another local cessation service. Certainly, implementation of the AAR has been a major step in the right direction and represents an improvement compared to outdated practices where assessment of tobacco use was not part of the clinical encounter. Unfortunately, the implementation of AAR has not been found to yield the expected results and only a small proportion of referred persons actually enroll in the recommended cessation program.

In an attempt to address clinic and patient-level barriers to effectively linking smokers to treatment, telephone care coordination programs and fax/email referral programs have been developed wherein quitlines receive patients' contact information from providers with the patient's permission, and the quitline proactively contacts the patient (Lichtenstein, Zhu, & Tedeschi, 2010). This eliminates the onus of initi-ating contact from the patient. One such program is the *Ask-Advise-Connect* (AAC) approach, which is designed to link smokers with quitline services through an auto-mated system within the clinic's EHR (Vidrine, Shete, Cao, et al., 2013). In the AAC model, connections to the quitline are made by medical assistants and licensed vocational nurses, distributing the workload among various providers. Personnel are trained to *ask* every patient about their smoking status at the time that vital signs are assessed, *advise* all smokers to quit, offer cessation *assistance* via the quitline, and *connect* to the quitline those willing to receive help. With the patient's permission, the quitline proactively calls the patient.

Research has been conducted in both private and safety-net health care systems comparing AAR and AAC approaches (Vidrine, Shete, Li, et al., 2013; Vidrine, Shete, Cao, et al., 2013). In both sectors, AAC has proven to significantly increase treatment enrollment when compared with AAR (a 13-fold and 30-fold increase for private and safety-net sectors, respectively). Of note, even when a high proportion of smokers declined to be connected to the quitline or were unreachable, the stream-lined and automated nature of the AAC approach dramatically enhanced the poten-tial for cessation treatment enrollment. In sum, research suggests that active connecting-to-quitline programs should be favored over passive referral approaches (Vidrine, Shete, Li, et al., 2013; Warren et al., 2014).

Quitlines. Quitlines are telephone-based tobacco cessation services that help tobacco users quit and that are available for free throughout the U.S. The main services include counseling and coaching by trained staff, mailing of self-help materials, and referral to local resources. The counseling offered can be reactive or active. Quitlines with a reactive counseling approach only respond to incoming calls; whereas proactive quitlines respond to incoming calls and also generate out-bound and follow-up calls to interested individuals. In addition, quitlines differ in their level of sophistication and resources; as such, they vary in the intensity of the counseling schedule (e.g. from 1 to 10 sessions), and time of operations (e.g. some are available 24 h a day, 7 days a week, and most holidays, while others operate only during typical business hours). Currently, the majority of quitlines offer web-based services, and some may also include provision of free nicotine replacement therapy (NRT) and training to healthcare providers. In addition, evidence-based internet smoking cessation interventions have been shown to produce good abstinence rates among Spanish speakers (Muñoz et al. 2009).

The North American Quitline Consortium (NAQC; http://www.naquitline.org/) is a nonprofit membership organization that seeks to promote evidence-based quitline services across diverse communities in North America. NAQC had set a goal for all quitline service providers in the U.S. to have the capacity for receiving referrals from EHRs by 2016. NAQC collects monthly data on call attempts to all quitlines in the U.S. and its territories and provinces. At present, NAQC does not collect quit rate data, but is planning to do it going forward. Notably, one of its goals is to "Increase the quality and cultural appropriateness of quitlines in North America". To achieve this goal, NAQC aims to deliver services to 6% of each priority populations, including Latinos. At present, some states (e.g., Texas, Washington) provide services in Spanish and services are available in at least 15 additional languages through a third party. For services in English, callers may contact 1-800-QUIT-NOW (1-800-784-8669), which is the national portal number that routes callers to their respective state quitline. For services in Spanish, persons should call 1-855-DEJELO-YA (1-855-335-3569) or access http://espanol.smokefree.gov

Research has shown that quitlines are highly effective in helping tobacco users quit (Fiore et al., 2008; Lichtenstein et al., 2010). They can double or even triple an individual's chances of successfully quitting smoking. Importantly, given that the vast majority of people and households have phone services (U.S. Bureau of the Census), quitlines are an intervention modality with extremely broad reach. Nevertheless, they can reach only 1–2% of smokers annually (Borland & Segan, 2006). In addition, few data is available regarding the reach, caller satisfaction, and effectiveness of the quitlines by diverse race/ethnic groups, including Latinos. While one study reported low reach among a Latino subgroup (Ortiz et al., 2008), another study reported that their state quitline services were as well received and effective for Latinos as they were for other race/ethnic groups (Maher et al., 2007). Moreover, the efficacy of clinical trials utilizing telephone-based smoking cessation counseling among Latinos (Correa-Fernández et al., submitted; Wetter et al., 2007) speaks about the potential of quitlines with this population.

Pharmacotherapy for Treating Tobacco Dependence

Current national guidelines for smoking cessation interventions recommend that all smokers be offered tobacco dependence treatment (TDT) that includes both behavioral counseling and pharmacotherapy (Fiore et al., 2008). The rationale for using pharmacotherapy in TDT is that nicotine, the main constituent in tobacco products, rapidly reaches and accumulates in the reward centers of the brain, promoting and maintaining the physical component of tobacco dependence. Thus, the main purpose of pharmacotherapy is to ease the withdrawal symptoms from nicotine. Currently, there are 7 medications approved by the Food and Drug Administration and that are considered first-line medications to treat tobacco use and dependence. Two of the approved medications are oral medicines and need a physician's prescription, and the others are NRT. Two of the NRT are available with prescription and three can be obtained over the counter (OTC). The OTC medications are the most commonly used pharmacotherapy for tobacco cessation (Table 13.4).

Table 13.4 Pharmacotherapy guidelines for tobacco use and dependence among adults

Medication	Dosage	Duration of treatment
Nicotine patch[a]	21 mg/24 hour[b]	8 week treatment (step-down)
	14 mg/24 hour	21 mg×4 weeks
	7 mg/24 hour	14 mg×2 weeks
		7 mg×2 weeks
Nicotine gum[a]	2 mg piece (less than 20 cpd)	1 piece every 1–2 h for 6 weeks (and up to 12 weeks)
	4 mg piece (more than 20 cpd)	
Nicotine lozenge[a]	2 mg piece (TTF[c] more than 30 min)	Approx. 9 lozenges daily in the first 6 weeks (and up to 12 weeks)
	4 mg piece (TTF less than 30 min)	
Nicotine inhaler	Dose = 1 puff or inhalation	Up to 6 month; taper dosage during last 3 months
	1 cartridge = 4 mg or 80 inhalations	
	6–16 cartridges a day	
Nicotine nasal spray	Dose = 1 mg (0.5 mg per nostril)	3–6 months
	1–2 doses per hour, increasing as needed	
	Minimum = 8 doses/day; Maximum = 40 doses per day	
Bupropion SR	150 mg every morning × 3 days; then	Begin 1–2 weeks before the quit date. For long term treatment, 150 mg daily for up to 6 months.
	150 mg twice daily × 7–12 weeks	
Varenicline	0.5 mg/daily × 3 days	Begin 1 week before the quit date. For long term treatment, up to 6 months.
	0.5 mg/twice daily × 4 days	
	1 mg twice daily × 3 months	

[a]OTC = over the counter
[b]Patients consuming less than 20 CPD can start with a lower dose patch
Main source: Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. (May 2008). Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service
[c]TTF = time to first cigarette/tobacco consumption

The type of pharmacotherapy will depend on whether the patient is ready to make a quit attempt or not, and considering potential contraindications. For example, nicotine patches works well for cessation treatment whereas nicotine gum and lozenges may be used for cessation and also to encourage tobacco reduction among those not ready to fully quit (Piper et al., 2014). Although the research documenting the efficacy of pharmacotherapy for TDT among Latinos is in its infancy, there is evidence for the use of the nicotine patch, and the acceptability of bupropion and varenicline (Cox et al., 2011; de Dios, Anderson, Stanton, Audet, & Stein, 2012).

Interventions for Patients Not Willing to Make a Quit Attempt

For patients not willing to make a quit attempt at the moment, a combination of brief motivational interventions and the 5R's model are recommended (Fiore et al., 2008).

Motivational Interviewing

Research has shown that when a patient is not ready to make a behavioral change, clinician's lectures and exhortations to modify their behavior are very unlikely to promote behavior change compared to when the patient voices his/her own concerns and reasons for a change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Motivational Interviewing (MI) is a goal-oriented, patient-centered counseling intervention that aims to strengthen personal motivation for and commitment to achieve a specific goal (Miller & Rollnick, 2013). With tobacco users, the overall objective of the MI approach is to explore tobacco user's beliefs, feelings, and values regarding tobacco use, identify any ambivalence about the use and elicit an intrinsic motivation for behavior change. By using MI, the clinician would pay particular attention to the *language of change*, which would be expressions of any desire, ability, reasons, and need to stop tobacco use, as well as verbalizations of commitment to quit and any actions or steps toward change. Although MI comprises several specialized techniques that may be more suitable to use within Intensive Interventions (see section below), its fundamental principles (e.g., collaboration, evocation, and autonomy) should be applied in any encounter with tobacco users not ready to quit. Of note, specific applications of MI in health care has been published (see Rollnick, Miller, & Butler, 2008). In their book, Rollnick and colleagues compare MI with a *guiding* communication style and suggest that health care providers use this approach (instead of the other extreme approaches of *directing* or *following*) when having conversations with the patient about behavior change. A guiding style makes a good balance of three communication skills: *asking*, *listening, and informing*. Thus, practitioners can engage in the MI spirit by asking the patient about their tobacco use and intentions to quit, listening nonjudgmentally to their reasons and barriers to quit, and informing them about the benefits of quitting and the resources available.

Research has generally supported the use of MI for smoking cessation, including single sessions, short sessions and those delivered by general practitioners and trained counselors (Lindson-Hawley, Thompson, & Begh, 2015). Although some of the research included in meta-analyses (studies that combine information from multiple intervention studies in order to estimate overall effect) have included Latinos in their sample, we are unaware of specific published research evaluating the efficacy of brief motivational interventions for Latino smokers not willing to quit.

The 5R's Model

The 5R's model provide the content areas that should be addressed within an MI framework. This model appears to increase future quit attempts (Carpenter, Hughes, Solomon, & Callas, 2004; Fiore et al., 2008). However, its particular usefulness among Latino populations have not been reported.

RELEVANCE. Providing information about tobacco use has the greatest impact when it is related to the patient's particular characteristics and situation. These include age, gender, his/her family (e.g., effects of smoking on children),

health issues (e.g., high blood pressure, dental problems), social issues (e.g., tobacco-free workplace policies), among others. Help the patient reflect on why quitting is personally relevant.

RISKS. Help the patient to identify potential negative consequences of tobacco use (U.S. Department of Health and Human Services, 2014), and suggest additional ones that seem relevant to the patient. For example, short term health risks include: shortness of breath, risk of respiratory infections, and exacerbation of asthma, impotence, fertility problems, bad smell, skin aging, and harm to pregnancy. Long term health risks include: several cancers (e.g., lung, oral cavity, larynx, pancreas, etc.), heart attacks and strokes, chronic obstructive pulmonary disease. Importantly, practitioners should also emphasize that smoking may negatively affect others in the household through second hand smoke (e.g. ear and respiratory infections in children, risk of lung cancer and heart disease in partners), and that smoking low tar/low nicotine cigarettes or other tobacco products still represent a risk.

REWARDS. Inquire about the patient's perceived benefits of stopping tobacco use, and suggest additional ones that seem relevant to the patient's situation. Rewards range from health improvements to other personal/social benefits including: improved sense of smell and taste, improved overall health and reduction of risk of chronic diseases, improved breath, improved smell of one's home/car, clothing will smell better, improved health of children and people in one's household, saving money, greater performance in physical activities, better appearance, feeling better about oneself (sense of success and control), and being a role model for one's children.

ROADBLOCKS. Explore perceived barriers and challenges for quitting tobacco, and provide strategies to cope with them. Typical barriers include: withdrawal symptoms; stress, anxiety, or depressed mood; tobacco is embedded in their routine/habit; gratification of tobacco use; other smokers in the environment; lack of support to quit; concurrent alcohol or other substance use; other psychological comorbidities; fear of failure; and lack of knowledge about effective treatment options.

REPETITION. Repeat the motivational messages to every patient that is not motivated or ready to quit, every time he/she attends the clinical setting (Table 13.5).

Table 13.5 The 5R's model for enhancing motivation to quit tobacco use

Component	Description
RELEVANCE	Providing information about tobacco use that is relevant for the patient.
RISKS	Help the patient to identify potential negative consequences of tobacco use, and provide additional information when needed.
REWARDS	Inquire the patient about perceived benefits of stopping tobacco use, and suggest additional ones that seem relevant to the patient's situation.
ROADBLOCKS	Explore perceived barriers and challenges for quitting tobacco, and provide strategies to cope with them.
REPETITION	Repeat the motivational messages to every patient that is not motivated or ready to quit, every time he/she attends the clinical setting.

Main source: Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. (May 2008). Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service

Intensive Interventions

Intensive interventions for TDT last more than 10 min in duration per clinical encounter and are characterized by greater depth and breadth in the assessment and counseling of tobacco use when compared with brief interventions. These are suitable for tobacco cessation clinics, substance abuse programs, psychology practices, and any other health care setting with trained personnel and time allocated for more intensive behavioral interventions. Intensive interventions are ideal for more complex patients, including individuals with higher tobacco dependence, and with comorbid physical or mental health conditions. These interventions include an extension of the 5A's model, with a particular focus on motivational interviewing techniques as well as cognitive behavioral treatment and problem solving/skills training approaches (Abrams et al., 2003; Rollnick et al., 2008). Importantly, a tobacco use treatment approach that combines pharmacotherapy/nicotine replacement with behavioral coping skills training outperforms the use of either treatment alone and this combined approach is recommended in the guidelines (Fiore et al., 2008). Further, although studies that specifically target Latino tobacco users are very few, the limited evidence suggests these treatment approaches are efficacious among Latinos (Webb et al., 2010).

Cultural Considerations

It has been consistently demonstrated that behavioral health interventions, including substance-use interventions, that are adapted for racial/ethnic minority populations tend to be more effective than non-adapted interventions. In fact, meta-analytic studies of culturally adapted interventions indicate that culturally adapted behavioral health interventions are approximately 20 % more effective than non-adapted interventions (Benish, Quintana, & Wampold, 2011; Smith, Rodríguez, & Bernal, 2011). Furthermore, it is widely regarded as an ethical responsibility for healthcare professionals to understand and consider factors associated with culture in order to effectively provide services (American Medical Association; American Psychological Association, 2002; National Association of Social Workers). As such, to incorporate cultural considerations into intensive interventions for TDT for Latinos is ethical and will increase the probabilities of positive outcomes.

Although still in its infancy, available evidence on cultural adaptations of TDT for Latinos seems promising (Wetter et al., 2007; Woodruff et al., 2002). Examples of elements that have been incorporated in the content and delivery of culturally adapted smoking cessation interventions for Latinos include: language appropriate content (e.g. for individuals with Limited English Proficiency (LEP) or attending to nuances in Spanish-terminology across subgroups), culturally specific images and stories (in written or audiovisual materials), and integration of common cultural values (e.g. *familismo* [family involvement], *personalismo* [positive personal relationship], *respeto* [respect]) (Cox et al., 2011; Webb et al., 2010). Nevertheless,

the usefulness of specific elements have not been directly tested. Hence, there is still a need to further examine the extent to which culturally relevant components are potential moderators of treatment effects on smoking abstinence and/or intermediate outcomes (e.g. motivation to quit, reduction of smoking rates, and quitting attempts). Additionally, given the different patterns of smoking behaviors among Latino ethnic subgroups and acculturation levels, researchers and practitioners should consider that effectiveness of cultural adaptations may differ by groups. For example, emphasis on traditional Latino values may be important for less acculturated persons but less relevant for more acculturated individuals.

Program Structure

The design of an intensive TDT program may vary depending on the resources available at a particular health care setting as well as the population being served. Specific aspects to consider include format (e.g., individual or group; in-person or telephone-based), total number of sessions, time allocated per session, length of the program and structure. For instance, programs can use individual (e.g., phone or face-to-face) or group format (or a combination of both), include 5–20 sessions, last from 10 min to 2 h (depending on format), and be conducted within 5 weeks to 6 months of duration. Many tobacco users may not be interested in committing to long programs, so shorter programs in between 6 and 10 sessions may be more appealing to a broader group of individuals. In terms of structure, it is typical for programs to go from weekly sessions to sessions every other week, and a final one that takes place a month after the penultimate one. Some programs are structured to have more sessions devoted to the preparation before the quit date, while others allocate more sessions after the quit day to help address withdrawal and prevent relapse. Whenever possible, the timing of the service should be relapse-sensitive, including one or more sessions before the quit date ("preparation phase"), one session on the quit day and one or more sessions after the quit date ("quitting phase"), another session a week after the first post-quit session, and additional sessions generally occurring at 2–3 weeks intervals thereafter ("maintenance").

Below we describe the core components of an intensive cessation program. These components can be incorporated in either group and individual formats, as well as both face-to-face and phone modalities. In-depth details on the procedures and treatment content are available in treatment handbooks such as those by Abrams et al., 2003 and Peterson, Vander Weg, & Jaen, 2010.

Therapeutic Approach

Motivational Interviewing. As previously discussed, MI is an approach especially suited for patients who are not willing or ready to change their tobacco use. The MI principles can be incorporated in any type of counseling encounter (e.g., brief intervention), but their specific techniques may be more feasible to use within intensive

interventions. Also, given that motivation for change can fluctuate during the quitting process, an MI approach can be incorporated at any time and can be easily integrated with other therapeutic approaches (Vidrine, Reitzel, Figueroa, et al., 2013). Among the several counseling strategies utilized in MI, the *rulers* is the most common. The "rulers" (Figure) inquire about how important is a behavior change for the person. For example, the clinician would ask the patient "*In a scale from 1 to 10, how important it is for you to quit smoking*?" After the patient select a number, and let's assume they chose a "6", the clinician would follow with "*Why did you select a "6" and not a "4"*?" By inquiring about why a patient didn't select a lower number, a clinician is encouraging the patient to talk about why stopping is important. After discussing the reasons to quit smoking, the clinician could follow with "*What would you need to go from "6" to an "8*"?" Asking about how the patient would get to a higher number will encourage the discussion about potential challenges and patient's needs. Similar procedures should follow to explore both confidence and readiness to quit (Figure). Additional details on MI-based strategies can be found elsewhere (Miller & Rollnick, 2013).

MI has been found to be effective in treating a variety of substance-use disorders. Among Latinos, it has shown to be efficacious for the reduction of problematic drinking (Clair et al., 2013). Also, when integrated with other approaches, MI has significantly increased continuous smoking abstinence in various underserved Latino populations (Borrelli, McQuaid, Novak, Hammond, & Becker, 2010; Clarke et al., 2013). Further implementation and testing of MI-based smoking cessation interventions among this population is warranted.

Rulers exercise utilized in Motivational Interviewing

Importance									
1	2	3	4	5	6	7	8	9	10
Not at all Important			Average Importance				Extremely Important		

Readiness									
1	2	3	4	5	6	7	8	9	10
Not at all Ready			Average Readiness				Extremely Ready		

Confidence									
1	2	3	4	5	6	7	8	9	10
Not at all Confident			Average Confidence				Extremely Confident		

Cognitive Behavioral/Social Learning model. The cognitive-behavioral/social learning model has proven to be an evidence-based approach to treat tobacco

dependence (Fiore et al., 2008) and has shown promise for Latino populations (Clarke et al., 2013; Webb Hooper & Kolar, 2015) This model conceptualizes smoking as a learned behavior that is acquired through classical and operant conditioning principles and cognitive processes (e.g. modeling other's behaviors, beliefs, self-control mechanisms, self-efficacy and outcome expectations). For instance, several cognitive, affective, and contextual cues can trigger the desire to smoke. Once the person smokes, they experience rewarding effects that reinforce smoking. Thus, the general rationale for treatment is that with behavioral skills training and practice, the smoker can unlearn the automatic sequence of events that leads to smoking and replace it with more adaptive patterns (Abrams et al., 2003). The learning of new skills involves actual practice both inside and outside of the counseling session. As such, homework in between sessions is encouraged as a way of helping the patient gaining insight regarding their tobacco use patterns and practice with quitting.

Below is a description of core components of cognitive behavioral interventions that have been recommended for TDT programs and have been positively related to smoking cessation (West, Walia, Hyder, Shahab, & Michie, 2010). Additional empirical support for the generalizability of current evidence-based practices for TDT among Latinos is warranted.

1. *Concept of dependence*. Social-cognitive model conceptualizes dependence on tobacco as motivated by mood management and learned automatic habits and patterns, as well as physical dependence. As such, the intervention should incorporate: (a) Discussion of the extent to which tobacco use is a way to cope with unpleasant feelings such as anger, frustration, depression, and anxiety; or when it is used to enhance an already positive experience (e.g., celebrations); (b) Identification of situations and behaviors that prompt the patient to smoke (i.e., triggers, urges), and; (c) The rationale and options for nicotine fading (e.g., changing brands, reducing number of cigarettes per day), and/or the use of pharmacotherapy. Information on approved medications should be offered. Nicotine fading addresses both pharmacological and psychological factors. The rationale is that, given that nicotine is physically addictive, gradually reducing its intake will reduce the intensity of withdrawal symptoms, making it less difficult to quit. Nicotine fading can serve as an alternative to pharmacological approaches for those interested in a nonpharmacological approach to quitting, or for whom medications are contraindicated. Importantly, patients need to be reminded that withdrawal symptoms may last for 2–3 weeks but that they are more intense during the first week, that urges/cravings only last minutes, and that cravings usually increase when exposed to triggers. Smokers often erroneously believe that urges to smoke will not cease until they succumb to smoke; thus they should be instructed of other ways to cope (see skills training).

2. *Conceptualization of quitting as a process*. Quitting is a long-term process that can be learned. For the majority of smokers it requires multiple quit attempts to finally achieve long-term abstinence. Ambivalence and mixed feelings about quitting are normal and the motivation to quit can wax and wane as smokers go through the quitting process and diverse life circumstances.

3. *Self-monitoring of smoking behavior*. A written record of cigarettes per day allows the patient to increase their awareness of their current smoking pattern. They are encouraged to keep a log of each cigarette smoked, time of the day, what they were doing, and their mood. This information will reveal factors that trigger smoking (e.g., situations, behaviors, thoughts, and feelings) which can be future high-risk situations for relapse. Considerations should be taken with smokers with low literacy as they may need assistance from a family/friend in completing a written log. Alternatively, the provider will work with the patient during the session to identify the patient's smoking pattern.

4. *Selection of a quit date*. Choosing a quit day gives the patient a specific day to work toward, and allows the patient to physically and mentally prepare to quit, as well as have time to acquire the skills needed to succeed. Typically, the target quit day is between 2 and 4 weeks from the treatment start date, but can be set before or after that timeframe depending on patient's readiness. Usually, quit days coincide with special occasions (e.g., holidays, birthdays, anniversaries) or particular days of the week when the patient is less stressed (e.g., after major work/school deadlines).

5. *Identification of steps to take in preparation for quitting*. Small behavioral changes that represent practice or preparation for quitting should be introduced prior to the quit day. Ideally, specific behavioral changes should come from the patient. However, typical examples that can be shared with them are: stop smoking in the car and/or inside the home, buy fewer quantities of cigarettes at a time, reduce the quantity of cigarettes smoked per day by eliminating the "least important cigarette of the day", change the smoking routine, eliminating cues from the environment, tell other people about the plans to quit, or write the reasons to quit and put in a visible place at home. The day before the quit day, it is important that the patient remove all cigarettes from their environments before going to bed, identify sources of support, and quit smoking upon awakening. Ideally, the patient should have an hour-by-hour plan for not smoking on the first day.

6. *Planning to manage triggers*. Setting short-term goals and planning in advance to manage triggers is key to success. Prior to goal setting and planning, it is important to differentiate *self-control* from *willpower*. Provider should discourage the common notion of willpower and introduce the concept of self-control. Willpower is "trying to exert absolute will over quitting without any particular plan or strategy", whereas self-control entails the "development of a systematic and strategic plan to manage trigger situations without smoking" (Abrams et al., 2003, p. 137). Self-control strategies fall under three main types. They are: (a) *avoid trigger situations*: for example, avoid being around other smokers near the time of usual smoking breaks, avoid common "smoke break" locations or hangouts, avoid social situations that include alcohol and/or the presence of other smokers; (b) *alter trigger situations*: for example, if the patient normally smokes while drinking their morning coffee, they might try drinking hot chocolate or juice instead, go for a walk during break time instead of smoking a cigarette, or practice positive self-talk such as "I don't need a cigarette in this

situation" when confronted with a stressful situation; (c) *use an alternative or substitute behavior instead of a cigarette*: for example, eating sugarless candy or chewing gum, cinnamon sticks, or a straw; also, eating a fruit, practicing breathing techniques, engaging in physical activity, drinking water, calling a friend, or painting can all help to keep one both physically and mentally distracted when an urge to smoke strikes. The practice of self-control strategies is key to treatment. Elicit from the patients their ideas on how to refrain from smoking in trigger situations. After quitting, discuss which strategies patients have found useful and which not, and remind them that they can fine-tune or change a strategy that has not worked. Remind the patient that managing triggers is a trial-and-error process for each person, but that *avoiding* triggers is the most effective coping strategy and should be used whenever possible. However, providers should be aware that sometimes the patient may discount the notion of avoiding cues/situations altogether because they believe they should expose themselves to the trigger and be able to not smoke ("willpower"); or they simply do not want to give up multiple pleasurable experiences at the same time (e.g. drinking coffee, consuming alcohol, socializing). Of note, although triggers related to negative emotions (e.g., stress boredom) and social situations (e.g., at parties, at a bar) appear to be equally important triggers for Latino and non-Latino white smokers, triggers that represent habitual or unpremeditated behaviors (e.g., smoking while driving, while on the phone, when drinking coffee) seem to be less salient to Latino smokers (Marin, Marin, Perez-Stable, Sabogal, & Otero-Sabogal, 1990). Importantly, stress related to acculturation processes and instances of discrimination may be particularly relevant for some Latinos.

7. *Self-efficacy*. High levels of self-efficacy is one of the best predictors of successful quitting in various populations (Businelle et al., 2010; Correa-Fernández et al., 2012). Self-efficacy can be increased by encouraging the patient to think about moments in their lives when they have been successful in making changes or accomplishing goals and how they did it. Reassure the patient that they can apply those abilities to quitting as well. It is expected that with the practice of new coping skills, patients will increase their self-efficacy for quitting. However, is important to note that, as with motivation, self-efficacy to quit may fluctuate at different stages of the quitting process and in different situations.

8. *Social support and social influences*. Initiate discussion about the role of social support for not smoking, and maximize support for quitting. Help the patient differentiate positive and negative social influences and support. For example, a positive social influence is someone who volunteers to talk over the phone or go for a walk when the patient is experiencing a craving to smoke. In contrast, a negative social influence could be someone who undermines the smoker's ability or determination to quit. Patients should identify what kinds of behaviors from others they find not supportive regarding quitting, and which ones they do find supportive. Then, help the patient to identify people who can be supportive and to practice asking for positive social support from others. Discourage the contact with other smokers and ask the patient how they will reduce or eliminate contact

to negative and non-supportive behaviors from others that interfere with their quitting efforts. For patients that live with other smokers or whose partner uses tobacco, quitting can be particularly challenging. Ideally, these individuals would quit together. Otherwise, the patient needs to practice assertiveness skills to be able to request instrumental support from these persons (e.g., not smoking in their presence or leaving tobacco-related paraphernalia visible or accessible).

The role of social support may be of particular importance with Latino smokers as the Latino cultural value of *familismo* may influence their quitting process in either direction. In particular, family conflict and low family cohesion have been associated with elevated smoking risk among Latinos (Lorenzo-Blanco & Cortina, 2013a, 2013b). On the one hand, high family support and cohesion can be a great motivator and support for quitting, but on the other hand, low levels of these can produce stress that triggers relapse. Anecdotally, it has been the experience of the first author that high family support and cohesion may also inhibit success, especially if family members are quitting together and one of them relapses. For example, in one instance family members quit together and when one person slipped to smoking, soon the other person lapsed even though they were doing well. The second person's reasons for returning to smoke included not wanting to succeed while the other person failed. In the patient own words: "We are together in this, and I feel bad being quit when he lapsed. We will try together again. (Correa-Fernández, Agosto, Sánchez, & Diaz-Toro, Unpublished manuscript).

9. *Skills training*. Techniques to manage negative mood, stress, and craving will be useful in the quitting process, particularly during the first weeks after the quit day. For example, advise patients to identify safe places and activities when they do not smoke. Also, engage daily in a relaxing and enjoyable activity for at least 45–60 min. It can be a hobby or an activity that can be done easily, that does not require a lot of mental energy, and has some value for the smoker (e.g. reading, exercising, dancing, playing with their children). Also, relaxation techniques, such as deep breathing, is a practice the can be used on a daily basis as well as in specific stressful situations. Coping imagery may be particularly useful to cope with urges or craving to smoke. For example, patients can imagine urges as a rollercoaster ride that rises and falls. Encourage patients to create their own metaphors and images and to practice letting the urge pass. Reductions in distress levels pre-to-postcognitive behavioral therapy have been linked with increased smoking abstinence among treatment-seeking Latinos (Webb Hooper & Kolar, 2015).

10. *Relapse prevention*. The ability to cope with high risk situations determines an individual's probability of maintaining abstinence. As such, discussion of how to cope with a lapse and avoid a relapse is highly warranted. First, help the patient understand that a lapse or slip (an instance of smoking after the quit date) is different from relapse (returning to smoking at levels similar to those before the quit date). Second, help the patient recognize that the typical response to an instance of smoking following the quit day is one of negative emotional reactions (e.g., sadness, guilt) and self-defeating attributions (e.g., considering oneself a failure or weak for slipping), which may result in

resumption of regular smoking. This normalization of slipping is not permission to slip, but an opportunity to view it as a mistake, rather than a failure. Now the objective is to prevent a lapse from becoming a relapse, by not smoking the next cigarette and by strengthening coping strategies. Introduce the relapse-prevention concept of identifying and coping with high-risk situations (i.e., a situation that can lead to resumption of smoking). Highlight that the major high risk situations for relapse are: (a) cravings; (b) negative mood; (c) social interactions with other smokers, and (d) positive mood, especially social situations involving alcohol use. However, patients should identify their own risk situation and for each situation, they should develop a full set of coping strategies (see *Plans to Manage Triggers*) to deal with the situation without smoking.

11. *Weight control*. A modest and usually temporary weight gain is common among people that quit smoking, and many smokers, especially women, relapse to smoking due to concerns about perceived or actual weight gain. Increasing physical activity, making healthy food choices, drinking a lot of water, snacking on fruits, vegetables, and low calorie foods will help control weight gain, and can be addressed as a lifestyle change.

12. *Rewards*. As a positive reinforcement, patients should be encouraged to plan rewards for a day of not smoking, as well as after a week, a month, or a year. An option is to calculate the amount of money saved for not smoking and choose a reward with similar value.

13. *Benefits of quitting*. For patients that become abstinent, exploring the benefits of quitting could serve as a motivator to continue without smoking. Examples include feeling proud of themselves, saving money, breathing more easily, increased taste and smell, etc. Benefits and reasons for quitting should be generated by the patient, but some examples that have been shown to be significantly more relevant to Latino smokers compared to non-Latino white smokers include: being criticized by family, burning clothes, damaging children's health, bad breath, family pressure, and being a good example to children (Pérez-Stable, Marín, & Posner, 1998).

14. *Lifestyle changes that support quitting*. For many smokers, quitting is a lifestyle change that can be enhanced and maintained by the simultaneous change in other areas. Common lifestyle changes recommended include: stress management, maintain a positive social support network, healthy diet, weight control, and physical activity. Most of these changes have been described above. Also, there has been some evidence that physical activity enhance smoking cessation and maintenance (Ussher, Taylor & Faulkner, 2014). Since exercise is usually incompatible with simultaneous smoking, it can serve as a substitute behavior. It may also be a good alternative to control weight gain, attenuate withdrawal symptoms, and decrease mood changes (such as anxiety and depression). For a vigorous exercise regimen the patient should consult a physician. Additionally, be aware of a panic reaction when patients think they are quitting for the rest of their lives. Encourage thinking of it as one day at a time, or an hour at a time. Offer information on resources for later support.

Innovative approaches that fully integrate MI and Cognitive-Behavioral models for smoking cessation has been documented (Vidrine, Reitzel, Figueroa, et al., 2013) and utilized among Latinos with positive results (Clarke et al., 2013; Correa-Fernández et al., submitted). Additionally, contemporary forms of cognitive-behavioral therapies, such as Acceptance and Commitment Therapy, has also shown promise for the treatment of tobacco dependence (Bricker, Mann, Marek, Liu, & Peterson, 2010; Gifford et al., 2011).

Provider and Clinic Changes in Integrated Health Care Settings

The occurrence of both medical and behavioral health problems is disproportionately higher among tobacco users compared to the general population, which puts them at further increased risk of mortality (Colton & Manderscheid, 2006). In particular, it is estimated that 44 % of the cigarettes smoked in the U.S. are consumed by people with a behavioral health disorders. As such, there is a call to designate smokers with behavioral health comorbidities as a specific tobacco use disparity group (Williams, Steinberg, Griffiths, & Cooperman, 2013). Fortunately, the benefits of quitting smoking encompass improvements in both physical and mental health status of the patient.

Programs that include quality interventions at both the provider- and clinic-level are more likely to increase the reach and effectiveness of TDT. As discussed, regular screening for tobacco use and the provision of cessation counseling and pharmacotherapy are evidence-based practices known to reduce tobacco use among Latino patients, including those with behavioral health disorders. Moreover, the adoption of clinic-level policies and interventions, such as tobacco-free workplace regulations and the provision of TDT to employees, are also effective in assisting patients quit (Anderson & Hughes, 2000). Importantly, these provider- and clinic-level approaches are likely to reduce patient-level barriers to care.

Below, we offer a number of recommendations for clinic-level and integrated approaches to successfully incorporate and support TDT. These recommendations are grounded in evidence-based practices as well as in our clinical experience with integrated care programs (Cahill & Lancaster, 2014; Correa-Fernández, et al., submitted; Fiore et al., 2008).

Environment

- *Develop and implement a tobacco-free workplace policy*. The objective of this policy is to support health initiatives by completely prohibiting the use of any form of tobacco on the worksite property. This regulation not only protects all individuals (including nonsmokers) from environmental tobacco smoke, but also helps former smokers maintain abstinence by eliminating smoking cues and

temptations in the environment. If possible, add to the policy cessation services for employees. Although this is not a standard component in all tobacco-free workplace policies, those policies that do include these services have positive impact on the reduction of tobacco use behaviors.

Support the implementation of a tobacco user identification system. The practitioner's intentions to systematically provide brief interventions for cessation must be supported by a clinic-wide system where the identification of every tobacco user can be documented. This can be accomplished my modifying the EHR or paper progress notes. Also, allowing time for tobacco-related education and training is another way of supporting this efforts.

Personnel

- *Provide training in TDT to all personnel.* All the personnel, including the administrative assistants or people making the appointments, should be trained in the basics TDT. This will promote shared values and a culture of change for tobacco use. Moreover, more specialized training for physicians and other health care providers is warranted. Research has shown that some of the barriers for assisting smokers to quit include providers' lack of knowledge and confidence in providing TDT. Conversely, there is evidence that having had cessation training is positively associated with performing some components of the 5A's and that intensive training programs for behavioral health professionals can increase the delivery of TDT as well as patient attempts to quit. Booster training sessions are often useful and can be done both in-person or through webinars. Also, peer-led audit and feedback increases the frequency of documenting cessation counseling and the appropriateness of NRT prescriptions (Kisuule, Necocheax, Howe, & Wright, 2010).
- *Designate a TDT coordinator* ("*tobacco champion*"). A tobacco champion would be a person trained in tobacco dependence and treatment that would take the lead in initiating and/or maintaining all initiatives related to tobacco-free workplace regulations as well as TDT. The person's responsibilities would vary depending on the treatment setting but could include following up with clinic's signage related to tobacco use, surveying providers and patients about their needs, ensuring the systematic identification of smokers, distributing NRT when available, and peer-leading trainings and booster sessions.

Use of an interdisciplinary team. The involvement of multiple health care professionals in TDT is effective and should be utilized. An approach could be to have a physician providing advice to quit in relation to the patient's health issues and offering pharmacotherapy, and having a behavioral specialist providing the counseling component (using recommended brief or intensive interventions). When available, other health professionals can be incorporated to provide additional education or support (e.g. nutritionist to address weight gain, health educator, and pharmacist).

Services

- Use a *patient-centered model of care* including logistics and practical aspects of the services. For instance:

  - Whenever possible, have an administrative assistant dedicated to the scheduling and logistic aspects of the TDT program. When that is not feasible, distribute the tasks among various professionals so no one is particularly burdened.
  - Show respect for the patient's time. Do not schedule more patients that clinicians are available to see at a given time point. Ideally, avoid the "first come, first serve" approach and instead schedule appointment for a specific time. Individuals that are not abstinent would likely be anxious if have to wait too long, especially if that alters their smoking routine, and this event may risk them leaving and missing the appointment.
  - Have the availability of making appointments by phone or internet, and allow for walk-in services when possible. If a patient stops by to inquire about cessation services, it is crucial to capitalize on that moment's motivation and at least offer a brief intervention.
  - Have flexible/extended hours of service, such as in the evening or weekends. For recent immigrants or Latinos of low SES, factors such as having multiple jobs, family obligations, and lack of transportation may be obstacles to attend sessions at normal business hours.
  - Maintain complete transparency about the program from the initial phone call or contact. Explain the services to the patient including how long it will take, which practitioners will see him/her and an overall structure of the program.
  - If smoking is allowed in the clinic premises, explain to patients exactly where they can or cannot smoke during the visit. If the clinic is tobacco-free, remind the patient.
  - Maximize privacy as much as possible. Tobacco use could be a source of a shame for some individuals, including less acculturated Latino women and persons from higher SES status or in the health fields.
  - Provide follow-up calls and reminders. Calls to confirm the appointment, and calls after a patient misses an appointment to check in on how they are doing and to reschedule are examples of intra-treatment support, which is recommended in the PHS guidelines (Fiore et al., 2008).

- Use a *patient-centered model of care in the content and structure* of the service. For instance:

  - Emphasize to patients from the beginning that they can and should keep coming to the visits, irrespective of their smoking status. Is not uncommon for Latino patients to withdraw from the program if they resume smoking due to shame and guilt of letting the provider down.
  - Implement a streamlined intake system, where information can be collected through questionnaires in the waiting room. Whenever possible, have help available for those who had difficulty reading/writing, have low literacy or LEP.

- Establish an EHR system and incorporate tobacco use modules and questions into it. This will facilitate communication among all health care providers.
- Be aware that Latino patients, particularly recent immigrants, less acculturated persons, or those with LEP can come to the visit accompanied with one or more relatives. Be prepared to incorporate them to any particular session at the request of the patient. However, use your clinical judgment to identify when is preferred to have individual sessions only with the patient and kindly communicate that to him/her.
- Provide an effective service at each visit. Enhance motivation and provide a service that is useful even if the patient does not return to the next visit.

Every health care setting has particular needs and resources, and the level and timing in which they can incorporate evidence-based practices varies. Nevertheless, these practices can be implemented in a gradual manner and evaluated for its effectiveness until a satisfactory integrated system is reached. Providing evidence-based practices through integrated care is a tremendous avenue for achieving tobacco use cessation in Latinos so its careful implementation should not be underestimated but pursued.

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