Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2020

Perceptions of Health Care Professionals Providing Smoking Cessation in Health Care Settings

Dr. Tenishia Tamika Edwards
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

 Part of the Medicine and Health Sciences Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Tenishia T. Edwards

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Precilla Belin, Committee Chairperson, Public Health Faculty
Dr. Patricia Risica, Committee Member, Public Health Faculty
Dr. Loretta Cain, University Reviewer, Public Health Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

Perceptions of Health Care Professionals Providing Smoking Cessation in Health Care Settings

by

Tenishia T. Edwards

MS, University of Phoenix, 2011

BA, Southern Connecticut State University, 2010

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Health

Walden University

August 2020

Abstract

Tobacco use affects many individuals in the United States and around the world, particularly those who have existing health disparities. Smoking cessation therapy is a process used by health care professionals (HCPs) to help aid in the reduction or elimination of tobacco use. HCPs providing this service in health care settings can reach patients directly while helping to decrease the mortality rate in those who use tobacco. The purpose of this phenomenological qualitative study was to identify HCPs' perceptions of patient barriers to adherence to smoking cessation services and what can be done to improve smoking cessation in health care settings. Convenience sampling was used to recruit a total of 15 HCPs at an urban healthcare facility in Hartford, Connecticut. Participating HCPs were interviewed in a private setting, where face-to-face semi-structured interviews took place. The theory of planned behavior was used to examine how HCPs perceive smoking cessation in their health care settings and how their perceptions and behaviors contribute to their patients' success with the intervention. The qualitative data analysis software NVivo was used to code themes that emerged from the interview questions. The findings revealed that most of the HCPs had an understanding as to why their patients continued to smoke tobacco despite the in-house resources provided to them. The study also revealed that HCPs' education and training on smoking cessation therapy directly impacted their delivery of cessation therapy. Results of this study may provide HCPs in different sectors of health care, the necessity information to develop effective smoking cessation programs in health care settings.

Perceptions of Health Care Professionals Providing Smoking Cessation in Health Care Settings

by

Tenishia T. Edwards

MS, University of Phoenix, 2011

BA, Southern Connecticut State University, 2010

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Health

Walden University

August 2020

Dedication

To my tribe – Aliyah Tiffany and Avon Abdalla, I did this for you. Thank you for having so much patience with me during my bad days. Thank you, Mom (Dr. Tonia Ann Walker), for those summers indoors spent reading books that stimulated my brain at a young age. Thank you, Dad, for teaching me resilience. It is because of my family that I persevered. One love.

Acknowledgements

I would like to recognize the health professionals who have dedicated their time to participate in this study. Your hard work has not gone unnoticed; you are appreciated. I would like to give a special thank-you to my committee for believing in my study and pushing me to keep going through this journey. Thank you, Dr. Precilla Belin, Dr. Patti Risica, and Loretta Cain, for the time you spent assisting me in perfecting my study and for your words of encouragement from the very beginning.

I would like to give a special thanks to my family and friends who have stuck by my side even when I was unbearable. Words cannot describe the appreciation I feel for the endless support I received during my doctoral journey and your prayers for me.

Last but not least, I want to thank the universe for showing me favor even when I felt that I was not worthy enough of my blessings. One love!

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Introduction

According to the Centers for Disease Control (CDC), approximately 40 million individuals are labeled as smokers (CDC, 2017). As of November 2016, the number of adult smokers in the United States represented 15.1% of the total population (Rigotti & Kalkhoran, 2017). Nearly 500,000 individuals die each year, costing the United States $170 billion annually to treat smoking-related illness in adults (CDC, 2017). Despite a significant decline in the number of smokers in the United States since 1964, there have been several diseases associated with the use of tobacco such as respiratory disease, lung cancer, and premature death (CDC, 2017; Van Schayck et al., 2017). These health disparities continue to be a global concern with more efforts needed to reduce disparities among identifiable populations; by 2030, it is predicted that tobacco will be responsible for 10% of global deaths or 8 million deaths per year (Van Schayck et al., 2017). Nonetheless, there has been a marked increase in public health efforts to reduce smoking in the United States.

Smoking cessation therapy is a process used by health care professionals (HCPs) to help patients reduce or discontinue smoking behavior. Literature indicates that smoking cessation significantly improves individual life expectancy, decreases morbidity, and reduces health care costs associated with smoking conditions (Ucar et al., 2014). It has been reported that more individuals in the United States are addicted to nicotine than any other drug, including heroin, cocaine, and alcohol (CDC, 2017). Individuals who are addicted to nicotine are at risk for tobacco-related health disparities (TRHDs) such as

respiratory disease and cancer. According to Subica and Douglas (2019), TRHDs have a disparate impact on those whom reside in disadvantage communities with limited access to health care. The smoking rates amongst those diagnosed with cancer are extremely high despite the advantages of reduced or discontinued use via smoking cessation therapy (Berg et al., 2013).

HCPs play an important role in patients' adherence to smoking cessation therapies based on how closely they work with patients as well as their intimate understanding of the challenges experienced by smokers (Li et al., 2014). HCPs include a mixed team of oncologists, residents, other doctors, and nurses (Moore, Rivera, Bravo-Soto, Olivares, & Lawrie, 2018). Not only have HCPs earned the trust of community members when it comes to tobacco control, they are also considered to be key stakeholders at the individual, community, and society levels (World Health Organization [WHO], 2005). These positive attributions can increase the life expectancies of individuals in vulnerable populations who are affected by the tobacco epidemic. Bains, Britton, Marsh, Jayes, and Murray (2014) contend that HCPs who work in hospital settings can provide smoking cessation therapies alongside behavioral counseling and pharmacotherapy to effectively support the population's needs.

Background of the Problem

During the latter half of the 20th century, there was an increase in tobacco-related deaths in both men and women (Thun et al., 2013). For as long as smoking cessation has been addressed in public health, researchers have conducted studies to examine the association between patient factors and medical professionals' delivery for cessation

services (Brown et al., 2015). HCPs can influence patients' perceptions of behaviors that influence their health and well-being such as smoking tobacco. Cancer patients expressed feeling uncertain about the risks associated with continued smoking behavior and the benefits of quitting tobacco (Wells et al., 2017). In a 2014 report, the U.S. Surgeon General reported that there was slow progress towards eliminating the cancer epidemic (U.S. Department of Health and Human Services, 2014).

Problem Statement

There has been a decline in the number of individuals in the United States. who smoke tobacco products (Jamal et al., 2015); however, smoking prevalence rates in individuals with cancer or other existing comorbidities are high (Cooley, Lundin, & Murray, 2009). With recent research reporting that smoking prevalence rates within the cancer population range from 45% to 75%, smoking prevalence rates continue to decrease amongst the general population (Cooley et al., 2009). Recent studies highlight the need for further research on continuous smoking behavior among cancer survivors due to the various forms of cancer that affect tobacco smokers such as cancer of the lung, larynx, esophagus, stomach, liver, pancreas, kidney, ureter, bladder, colorectum, and acute myeloid leukemia (Li, Lee, Chen, Jeng, & Chen, 2018). Approximately 250,000 cancer patients are being treated annually in hospital settings; however, there is little research examining smoking cessation therapy programs in these settings (Gallaway, Tai, & Rohan, 2018). In order to determine an effective intervention for this population, it is necessary to identify barriers to patients' participation in smoking cessation therapy with their HCPs.

Although there has been an increase in cancer survivors aged 18 years and older, there are no Healthy People 2020 recommendations targeting a decrease in smoking rates amongst cancer survivors (CDC, 2018; National Center for Health Statistics, 2018). The CDC has identified a goal for decreasing the number of smokers in the general population; that goal is to decrease the rate of smokers to no more than 12% (Cancer Survivors, 2018; CDC, 2018). Increasing health benefits and mortality rates amongst the targeted population can potentially decrease the number of individuals dying from diseases that are caused by smoking (CDC, 2018). According to the CDC (2018), cancer patients that smoke tobacco present to be a major public health concern. Recent research reports a reduction of smoking is correlated to a reduction of respiratory-related illness in individuals with underlying existing diseases.

In this study, I aimed to gain a better understanding of HCPs' perceived challenges to engaging with cancer patients regarding smoking cessation therapies. The U.S. Surgeon General's 1990 report reinforces the need for smoking cessation after a cancer diagnosis and the benefits of abstaining from tobacco use altogether. Recent research has supported the claim that more attention is needed on the delivery of smoking cessation to cancer survivors, indicating that many health care providers are underutilizing or neglecting smoking cessation therapy (*Stopping Tobacco Use*, n.d.).

Purpose Statement

The purpose of this qualitative phenomenological study was to identify HCPs' perceptions of patient barriers to adherence to smoking cessation services and what can be done to improve smoking cessation in health care settings. To address this gap,

qualitative analyses were conducted to assess cancer patients' adherence of smoking cessation therapy, allowing greater opportunities for professional health care workers to easily identify the barriers associated with smoking cessation services. Interviews and questionnaires were used to gain a better understanding of the effectiveness of smoking cessation through the lens of health care workers.

HCPs in Connecticut were used as the focus population in the study. The mortality rate of smokers in Connecticut with health disparities such as cancer is two to three times higher than non-smokers (Carter et al., 2015). According to a 2016 report from the Connecticut Department of Public Health (DPH) on the Tobacco Control Program (TCP), it is estimated that there are 434,000 (15.4%) smokers ages 18 years of age or older in the state (DPH, 2016). The rate of male smokers (17.5%) in the state is higher than that of the female smokers (13.5%; DPH, 2016).

Research Questions

The following three research questions were used to guide the research of this study:

RQ1: What are the perceptions of professional health care workers' level of preparedness regarding the delivery of smoking cessation based on training he/she received?

RQ2: What are the perceptions of professional health care workers regarding barriers to smoking cessation among cancer smokers?

RQ3: What changes in smoking cessation interventions or therapies do health care workers believe will improve success?

Theoretical Framework

In this study, the theoretical base used was the theory of planned behavior (TPB). Stemming from psychosocial and health communication literature, TPB postulates that positive attitudes, subjective norms, and perceived control on quitting is attributed to patients eliminating smoking behavior (Li et al., 2015). According to Li et al. (2015), decisional balance can be used as a core construct of the Transtheoretical Model (TTM); this model can be used to help individuals weigh the pros and the cons of continuous tobacco behavior.

Nature of the Study

This research study utilized a qualitative research approach consisting of interviews with professional health care workers. Qualitative research was utilized to determine the perceived barriers of cancer patients participating in smoking cessation treatment. Research has found that when using the qualitative approach for a research study, the true context of a problem is understood based on participants' responses to open-ended questions (Lewis, 2015).

Definitions

Cancer survivor: A person who is diagnosed with cancer from initial diagnosis until death, according to the National Coalition for Cancer Survivorship and the National Cancer Institute (as cited in Little et al., 2018). The term was first used by pediatrician Fitzhugh Mullan, who was diagnosed with cancer in 1975 (Marzorati, Riva, & Pravettoni, 2017).

Health care professionals (HCPs): Professionals in the health care sector who are the driving force of cancer care that focuses on patient well-being, health status and satisfaction (Moore et al., 2018).

Health disparities: Differences in health outcomes and health status (e.g., life expectancy, medical outcomes of acute and chronic illnesses), and health care use (differences in the quality or receipt of care; Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006).

Smoking cessation therapy: Interventions used to help an individual quit smoking. Such interventions may include counseling, behavior therapy, medicines, and nicotine-containing products such as nicotine patches, gum, lozenges, inhalers, and nasal sprays (National Cancer Institute, n.d.).

Assumptions, Limitations, Scope, and Delimitations

The assumption of this research was that the HCPs would provide responses to the questions that were true to the best of their knowledge. In this study, it was assumed that all participants would provide responses based on their experience in the health care setting. A key limitation of this research study was that cancer survivors' actual perceptions were not recorded because they were not the focal participants of the study. The responses of this research study represent HCPs' perceptions of patients' barriers to smoking cessation and the effectiveness of smoking cessation therapy for patients that have illnesses related to tobacco use.

To ensure that the results of the study were valid, I consulted with an expert panel to determine the reliability and validity of the interview protocol that was used (see

Appendix B for qualifications of panel members). The interview protocol was distributed amongst HCPs who were experts in the field through their direct work in the health care setting. The interview protocol was easy to read, and the questions were presented in language that was easily understood by the reader.

The key to ensuring reliability in a qualitative study is for the researcher to account for personal and research method biases that may influence the findings of the study (Noble & Smith, 2015). In this study, reliability was established via the consistency of analytical procedures. I collected the data and analyzed my findings using the qualitative data analysis software NVivo. I used NVivo to identify themes, which are discussed in Chapter 3.

Significance

Smoking is a major public health concern for many communities globally, with researchers analyzing the effectiveness of smoking cessation services being offered to community members. Many individuals have benefitted from smoking cessation services offered via a local health care professional; however, less is known about the effectiveness of smoking cessation therapy amongst individuals with cancer and/or other existing illness related to the use of tobacco. This research was needed to gain a better understanding of why patients continued to smoke after smoking cessation therapy. Researchers identified that there were additional risks to smoking and those extra risks could reduce treatment effectiveness and survival rates amongst patients who smoke tobacco (Li et al., 2018). It was projected by the National Cancer Institute (NCI) that 100,000 physicians help 10% of their patients stop smoking every year; based on this

projection, the number of smokers in the United States could decrease by 2 million each year ("Stopping Tobacco Use," n.d). This decrease is beneficial to the overall health of all populations by decreasing the morbidity and mortality rate in individuals who smoke.

Summary and Transition

In Chapter 1, I provided an overview of the tobacco epidemic that affects many populations and the significant role HCPs play in the delivery of smoking cessation therapy. Tobacco use has disparately impacted vulnerable populations and those with existing health disparities, possibly affecting the life expectancy of those living with illnesses such as cancer. The research questions of this study were used to examine HCPs' perceptions of patient barriers to smoking cessation and the effectiveness of smoking cessation therapy delivered by HCPs.

In Chapter 2, I review prior research that focused on HCPs' perception of smoking cessation in the health care setting. Chapter 3 includes a description of the methodology of the research topic and research questions.

Chapter 2: Literature Review

Introduction

The literature review is an examination of previous research studies related to smoking cessation and what can be done to improve cessation on a health care level with specific attention paid to individuals who are coping with existing health disparities. Current research on this public health epidemic investigated the barriers that HCPs may face in the delivery of cessation therapy and the importance of cessation services after diagnosis of an illness. The present research study focused on HCPs' perceptions and contributions to improve smoking cessation amongst cancer survivors and individuals with other exiting illnesses.

The literature search was conducted using ProQuest Dissertation and Theses full-text databases and Google Scholar. The databases were used to explore the effectiveness of smoking cessation therapies provided to cancer survivors by HCPs. The following search terms were used to retrieve results that highlight this topic: *smoking cessation and health care professionals, smoking cessation and cancer survivors,* and *health care professionals' perspectives and cessation.* Additional search terms included: *smoking cessation, health care professionals' perceptions, cancer survivors' perceptions, existing health disparities,* and *barriers.* The literature review contains the following sections: health care professionals' perceptions, the role of health care professionals, the role of health care organizations, and the importance of abstinence and smoking cessation programs.

Millions of lives are affected by tobacco use; however, little attention is focused on tobacco control and increasing awareness for those who need it (WHO, 2017). According to the WHO, the global tobacco epidemic is cited as an area that should be prioritized for monitoring in order to reduce tobacco use on a global level (WHO, 2017). The need to promote awareness and positive social change in individuals with existing health disparities has been proven in research. MPOWER measures were created via the WHO Framework Convention on Tobacco Control (FCTC) to inform individuals about ideal tobacco control practices (Levy, Yuan, Luo, & Mays, 2018). The six measures included (a) monitoring tobacco use and tobacco control measures; (c) protecting people from tobacco smoke; (c) offering help (e.g., treatments) to quit tobacco; (d) warning people about the dangers of tobacco; (e) enforcing bans on tobacco advertising, promotion and sponsorship; and (f) raising tobacco taxes (Levy et al., 2018). Increased health care worker participation in these targeted initiatives may translate into a decline in smoking-related illnesses, more education and awareness to vulnerable populations, and a decrease in mortality rates in cancer survivors.

Health Care Professionals' Perceptions

The purpose of this section is to examine how HCPs contribute to smoking cessation therapy on a health care level and their perception of barriers associated with the delivery of services. Prior research suggests that the most effective cessation practices are derived from an individual's provider, particularly a health professional trained across the health care spectrum who possesses the confidence and skills to deliver cessation treatments (Gichuki, Opiyo, Mugyenyi, & Namusisi, 2015; van Eerd et al., 2017). HCPs

who are trained on smoking cessation interventions can likely increase patient success in reducing tobacco use.

HCPs play an important role in patients' health and well-being. A cross-sectional study conducted by Gichuki et al. (2015) aimed to assess the knowledge, attitudes, and practices of HCPs as related to smoking cessation and recommended provisions to improve cessation success and quality of life particularly amongst individuals in high-risk demographic groups. In the cross-sectional analysis, Gichuki et al. (2015) delivered questionnaires to five sub-groups of HCPs (*n*=359): nurses, medical officers, dentists, clinical officers, and community oral health officers. The findings from Gichuki et al. (2015) showed that approximately 89% (*n*=302) of the participants had not been trained to deliver smoking cessation interventions; however, 96% (*n*=324) were open to training. Practice nurses (PNs) and general practitioners (GPs) were identified as individuals with whom patients can easily discuss their smoking behaviors and can refer patients to a higher level of service based on their role in preventative health care (van Rossem et al., 2015). Perceived barriers of HCPs to providing smoking cessation therapy included lack of sufficient training, lack of cessation specialist to perform duties, lack of knowledge on cessation, and lack of time due to prioritizing other health issues (Gichuki et al., 2015). Future research was recommended on the reporting and documentation of current smokers and how reporting and documentation can affect results.

HCPs report misperceptions regarding their role in smoking cessation, further suggesting that HCPs under certain specialists such as oncology are not adhering to the guidelines that promote awareness amongst high-risk demographic populations (Bains et

al., 2014). Qualitative studies conducted by Bains et al. (2014) and Twyman, Bonevski, Paul, and Bryant (2014) explored HCPs' views on smoking cessation and identified barriers in vulnerable groups. Bains et al. examined the scarcity of smoking cessation in community-based settings and the need for improvements from the perspective of HCPs. The aim of Twyman et al. was to identify common barriers for vulnerable groups and examine how addressing said barriers could improve the effectiveness of smoking cessation interventions. The authors of both studies identified a gap in the literature on the interaction between HCPs and high-risk demographic population members related to smoking cessation interventions. Bains et al. found that patients did see the importance of smoking cessation and viewed it as an encouraging factor to quit when it was offered by their provider. Bains et al. and Twyman et al. indicated that further research is needed on the barriers to receiving smoking cessation therapy, and it was determined to deserve top priority in order to improve smoking cessation in high-risk populations. Both research studies mentioned that lack of time, confidence, and knowledge of the delivery of smoking cessation therapies to high-risk demographic populations is a concern.

Van Eerd et al. (2017) and Wells et al. (2017) noted the similarities in organizational factors that influence the cessation services offered to patients. Because an addiction to smoking can be perceived to be not as serious as an addiction to other drugs, more attention is needed to make quitting tobacco a priority. According to van Eerd et al., smoking cessation was not considered a priority in some facilities and therefore wasn't always available or accessible. Wells et al. suggests that there is a distinction between philosophical and organizational structures, and oncology HCPs need more support to

deliver smoking cessations with confidence. Both studies suggest that HCPs can contribute to smoking cessation by having a clear understanding of their facility's guidelines and working towards minimizing the negative factors that affect the delivery of smoking cessation. The present study addressed the barriers that HCPs may face when communicating with individuals in high-risk demographic populations about smoking cessation therapies and the methods to address barriers adhering to smoking cessation in a health care setting.

Role of Health Care Professionals

HCPs have a level of influence on smoking cessation services offered to individuals in high-risk demographic groups. The role of HCPs is vital to the chronic field of smoking cessation (Hayes, Wolf, Labbe, & Murray, 2017). Hayes et al. (2017) and Morphett, Partridge, Gartner, Carter, & Hall (2015) addressed how HCPs influence an individual's smoking behavior. Included in the professional's role is the ability to provide support and motivational interviewing. Motivational interviewing is a key piece in smoking cessation services, allowing community members to receive an increase in their motivation to quit. According to Chiu et al. (2018), HCPs are valuable in disseminating information related to smoking cessation but have relatively low intentions of acting to help patients to quit. As mentioned previously, there is an identified need for stronger provider-patient relationship in health care settings. It can be implied here that through the strengthening of patient-provider relationships, consequences related to tobacco use of tobacco may be reduced significantly.

Role of Health Care Organizations

The settings where smoking cessation services are delivered can be an important factor related to the effectiveness of how HCPs deliver such services. Gallaway et al. (2018) and Papadakis et al. (2016) focused on how health care settings can influence smoking cessation practices provided in those settings. HCPs expressed difficulties delivering smoking cessation treatment in busy primary care settings. Gallaway et al. surveyed 6,400 U.S. hospitals to collect information regarding hospital demographics, organizational structure, service types and utilization, and other factors related to smoking cessation; Papadakis et al. used a large sample size for data collection but it was not as large as the sample used in Gallaway *et al*. The authors of both studies recommended linking cessation services between the patient, provider, and clinical settings to best support smoking cessation in patients and increase the likelihood of abstinence. Additional research would help HCPs understand the reasoning behind low provider performance in smoking cessation and abstinence promotion.

The Importance of Abstinence

Tobacco use has made a negative impact on the health care sector. There are many consequences linked to tobacco use, including but not limited to direct effects on an individual's health and the financial burden of tobacco use on the economy. Muthukrishnan and Warnakulasuriya (2018) and Petersen (2017) addressed the consequences of tobacco use and its effects on health from a global standpoint. Some of the not-so-obvious health effects of tobacco use are presented as chronic diseases and negative oral diseases. The International Agency for Research on Cancer observed that

tobacco and smokeless tobacco contributes to the increase in oral cancer, adult periodontal diseases, and congenital defects such as cleft lip in newborns of pregnant mothers who smoked during pregnancy (as cited in Petersen, 2017). Both studies suggest there is a need for more national tobacco programs to decrease tobacco usage in order to increase the quality of life of individuals residing in high-risk demographic populations.

Smoking Cessation Programs

Smoking cessation programs can be useful to HCPs when promoting and implementing anti-tobacco campaigns in communities. Evans et al. (2018) and Getachew et al. (2018) addressed communities' perceptions of anti-tobacco media campaigns and their influence on tobacco use. The "Truth" campaign was created by the Ad Council in 2000 and has played a major role in the initiative to reduce tobacco usage worldwide (Evans et al., 2018). Tobacco use remains at levels that are not acceptable despite the efforts of HCPs to provide community members with information on the negative outcomes of usage. Both studies imply that more research is needed to focus on alternative tobacco products (ATPs) when promoting abstinence. The present study provides more insight to HCPs on effective strategies related to cessation therapies.

Summary and Transition

In Chapter 2, I explained the role that HCPs play in smoking cessation for individuals with existing health disparities and potential recommendations to improve the success of cessation amongst this population. Smoking cessation has not received the attention that it deserved across all vulnerable groups. In Chapter 3, I outline the research methodology and design of the present study, data sources used to answer the research

questions, participants, instrumentation, recruitment process, providers' role, and ethical concerns.

Chapter 3: Research Methodology

The purpose of this qualitative phenomenological study was to identify professional health care workers' perceptions of barriers to adherence to smoking cessation services and what can be done to improve smoking cessation in health care settings. Researchers use qualitative research designs to gain a better understanding of beliefs, feelings, and personal experiences as they pertain to the phenomenon of interest (Berger, 2015). A goal of the present study is to provide recommendations and strategies that lower smoking rates amongst vulnerable populations, which are higher than the smoking rates of the general population (Berg et al. 2013). In Chapter 3, I present the study design, setting, methods, researcher's role, participants, and ethical concerns.

Research Design and Rationale

A phenomenological study design was used to explore HCPs' perceptions of barriers to implementing smoking cessation therapies to gain a deeper understanding of their experiences (O'Neill, McCaughan, Semple, & Ryan, 2018). Stemming from German mathematician Edmund Husserl (1859-1938) and others, phenomenology examines individual's personal lived experiences through interviews of five to 25 participants (Lewis, 2015). This design was chosen to not only provide more clarity on the effectiveness of smoking cessation from those who are living through the experience, but to also allow future researchers to have a broader understanding of the phenomenon (Qutoshi, 2018). The most successful phenomenological studies utilize interviews, observations, action research, discussion groups, focus group meetings, and document analysis to collect data (Qutoshi, 2018). In choosing a phenomenological approach, it is

understood that the focus is more so on the phenomenon rather than a sole focus on the reader, researcher, or participants (Lewis, 2015). According to McGarth, Palmgren, and Liljedahl (2019), what can be appreciated the most by conducting qualitative interviews for research is that it provides a voice to minorities and groups in society that cannot be heard anywhere else. It was important for me to portray the voices of the unheard in an accurate manner.

In this qualitative phenomenological research study, 15 HCPs were included to ensure data saturation. Research suggests that for completeness, a researcher can choose to recruit an amount that will reduce the chances of missed themes (Saunders et al., 2018). In-depth interviews were conducted between the researcher and each participating HCP in a private setting. HCPs were required to complete a written consent form which informed participants that they could withdraw their participation at any given time during the research study without consequence. With the HCP's consent, interviews were recorded using a Sony ICD recorder and later transcribed and analyzed based on the study's research questions. Participants who opted to receive a copy of the study results were emailed a copy of the study's results to the email address provided.

HCPs were interviewed using open-ended research questions. Open-ended questions provided an opportunity to gain better insight on the epidemic of tobacco use and HCPs' implementation of cessation therapies (see Krosnick, 2018). According to Moustakas (1994), there are two main questions that ground phenomenological studies: (a) what have you experienced in terms of the phenomenon?, and (b) what contexts or situations have typically influenced or affected your experiences of the phenomenon?

(Lewis, 2015). According to Lewis (2015), there are other open-ended questions that can be asked for more lucrative data; however, in this study, these questions connected the common phenomenon that HCPs are experiencing.

Research Questions

The following three research questions were used to guide the research of this study:

RQ1: What are the perceptions of professional health care workers level of preparedness regarding the delivery of smoking cessation based on training he/she received?

RQ2: What are the perceptions of professional health care workers regarding barriers to smoking cessation among cancer smokers?

RQ3: What changes in smoking cessation interventions or therapies do health care workers believe will improve success?

The Role of the Researcher

My role as a researcher was to make the participants feel comfortable throughout their participation in the research, and to conduct the research without any biases. It is important that a researcher provides a safe place for participants to answer questions freely. As a researcher, my role was to meet the participants where they were at their comfort level. Therefore, I conducted interviews in a private setting that was convenient to participants, reducing travel concerns to an outside location and accommodating participants' busy work schedules. Considering the comfort level of the researcher is also important. The researcher's role is to be knowledgeable of the topic and to deliver the

research questions with confidence. My questions were delivered with confidence and recorded using a Sony tape recorder and then transcribed later by listening to each interview and transcribing the audio file verbatim. I listened to each interview multiple times to ensure that I captured the essence of the responses to my questions. In my previous role as a health educator, I gained the confidence necessary to conduct interviews and to have a dialogue on smoking cessation with community members. Due to my knowledge of smoking cessation, I did not allow my personal opinions to bias the research. At the time of the interviews, I conducted myself in a professional manner and allowed each HCP time to answer the research questions to the best of their knowledge without any interruptions from me.

Before the research was conducted, I received permission to move forward in the data collection process from Walden University's Institutional Review Board (IRB); my IRB approval number from Walden University was 11-13-19-0519454. In addition to Walden University's approval to conduct research, I needed to receive permission from Hartford HealthCare to conduct research with their HCPs; my Hartford Hospital IRB number was HHC-2019-0221. Once approved, I received permission from Hartford Hospital to post my recruitment flyer in approved areas that would be visible to HCPs. The flyer was reviewed and approved by my chair, committee member, Hartford HealthCare IRB, and Walden IRB before it was posted.

It was my role as a researcher to collect enough data to ensure there was enough information that could be replicated for future research; in doing so, I ensured that the study was reliable and valid. According to Jordan (2018), data that meets the standards of

validity accurately reflect the phenomena, while data that meets the standards of reliability reflect the consistency of the research based on the instruments used. Lueng (2015) mentioned five approaches that could be used to enhance a researcher's reliability: (a) refutational analysis, (b) constant data comparison, (c) comprehensive data use, (d) inclusive use of the deviant case, and (e) use of tables.

Study Sample

A total of 15 HCPs ages 18 years and older were recruited from Hartford Hospital in Hartford, Connecticut. Hartford Hospital is located in the heart of the inner city, serving a diverse population of individuals with various health morbidities. To be eligible to participate in the study, the HCP must have been an employee of Hartford Hospital for a minimum of one year with experience working at the Helen and Harry Gray Cancer Center, the Oncology Department, and/or an affiliate department at the hospital. Those who were not employees or affiliates of the hospital branch were ineligible for participation.

Due to the nature of the research, it was required that participating HCPs had a minimum of 1 year of experience working with cancer survivors and/or practicing smoking cessation therapy in a health care setting amongst vulnerable groups. This requirement was to ensure that the participants were familiar with tobacco effects on vulnerable populations and what would be required to affect positive social change in the community. All individuals who had not practiced a minimum of 1 year of the related health service in a health setting were excluded from participation of the study. In addition, participants without a history of working with individuals with smoking

behavior or knowledge of smoking cessation practices were excluded. Participants were not excluded based on race, gender, employment status, or religion.

HCPs who were considered for participation in this voluntary research study possessed professional degrees and/or certifications related to the field of study. Participants were offered financial compensation as a token of appreciation and in recognition of their time. A $10.00 Starbucks gift card was provided to each participant who completed the research study.

Sampling Strategy/Recruitment/Setting

I posted a recruitment flyer for voluntary participation at Hartford Hospital after receiving approval from Walden University IRB and Hartford HealthCare IRB. Hartford Hospital has an oncology department that provides a good representation of cancer survivors as defined in this research study. This was used as an opportunity to capture data from HCPs who are actively working towards reducing tobacco use in patients that continue to smoke. The study sample consisted of these specialty HCPs and other health workers who were active with the targeted population at the time of the study.

The recruited HCPs did have some contact with the hospital's oncology department, the Helen and Harry Gray Cancer Center, or an affiliate department. When a potential participant contacted me to express interest in the study, I took the necessary steps that are suggested for successful participant screening. To determine if a potential participant met the criteria for the research study, I asked each prospective participant to complete a pre-screening survey to confirm their employment with the organization, the length of time employed with the organization, and their level of education. For those

HCPs who met the eligibility criteria of the study, I invited them to schedule a date and time for an interview.

Interviews were conducted in a private setting to ensure the confidentiality of each participant and at a date and time that was most suitable to their schedule. I was flexible to the needs of each HCP and was able to conduct interviews when they were free. All interviews were conducted on the grounds of the health organization during the HCPs' scheduled work hours. I conducted interviews and collect data over the course of a two-month time span with minimal issues.

As part of my analytical plan, the collected data was stored on a password-protected computer with no personal identifying information displayed. Paper-based data collection forms were stored in a locked file cabinet at Hartford Hospital that can only be accessed by authorized personnel. Electronic data was stored on a secure Hartford HealthCare network server that can only be accessed by authorized personnel. As the researcher, I did not use any of the participants' personal information for any purpose outside of the requirements for the research study. A copy of the data collected was provided to Hartford HealthCare IRB once the study was completed.

After 6 years, all electronic data stored at Hartford Hospital will be destroyed using the 'delete operation' query and any paper documents will be shredded. Research suggests that when the 'delete operation' query is performed, the data may be flagged as deleted and the query may no longer have access to the data (Bell, Haas, Luke, & Ricketts, 2018).

Ethical Considerations

I provided a copy of the research questions to each participant prior to the interview. Each participant was also made aware of the purpose of the study so that they clearly understood their contribution to the research. Upon receipt of the purpose of the research, participants were provided a copy of the informed consent form which protects participant confidentiality. This form also indicated the point of contact for the study should there be any questions or concerns, including the researcher, committee members related to the research study, and Walden University IRB. In addition, the informed consent provided participants with an option to check if they would like to receive a copy of the study results after the study has been completed.

There were no apparent ethical concerns that impacted participant recruitment or data collection. Participants were informed verbally and in writing upon review of the informed consent that their participation in the study would not cause any mental, emotional, or physical harm. Participants were also informed verbally and via the informed consent form that they could withdraw from the study at any time without consequence and they could take breaks at any time during the interview if needed.

Summary and Transition

In conclusion, Chapter 3 contained an overview of the methodology for the study, the recruitment process, the study sample, how data was collected, and how data was analyzed. This chapter also included the aim of the study, as well as ethical considerations such as the role of the researcher, reliability of the research, and validity of the data collection process. A qualitative approach was chosen to gain a better

understanding of HCPs' perceptions of smoking cessation in health care settings and how to overcome perceived barriers of cessation therapy when providing the service to patients in vulnerable populations. Chapter 4 will provide an overview of the results of the study. In Chapter 5, I discuss the implications of the results and future recommendations.

Chapter 4: Results

Introduction

The purpose of this phenomenological qualitative research study was to gain a better understanding of HCPs' perceptions of the effectiveness of smoking cessation in health care settings. A total of 15 HCPs who had a minimum of 1 year of experience working with cancer survivors and/or practicing smoking cessation therapy in a health care setting amongst vulnerable groups were recruited to participate in the research study. Interviews were used to collect data that addressed the following research questions:

RQ1: What are the perceptions of professional health care workers' level of preparedness regarding the delivery of smoking cessation based on training he/she received?

RQ2: What are the perceptions of professional health care workers regarding barriers to smoking cessation among cancer smokers?

RQ3: What changes in smoking cessation interventions or therapies do health care workers believe will improve success?

In Chapter 4, I address the results, study setting, participant demographics, data collection and analysis procedures, evidence of trustworthiness, and the themes that emerged from the data analysis.

Study Setting

All HCP interviews were conducted in a private setting at Hartford Hospital to ensure the confidentiality of participants in the research study. Each voluntary participant was interviewed separately to promote a sense of trust while maintaining their

confidentiality. Due to the private location being within the employees' work environment, the participants' comfort levels were enhanced. Each voluntary participant received a $10.00 Starbucks gift card as a thank-you for their time.

Participant Demographics

The study sample included 15 participants who were interviewed after consenting to participate in the research study. All 15 HCPs were employees of Hartford Hospital with various roles within the health organization. To protect the privacy of participants, identifiers such as the participant's name, contact information, and department name were kept private during the research process (see Table 1 for additional demographic information).

Table 1

Participants of Smoking Cessation Interview Protocol Demographics

Identifier	Education type	Length at organization
HCP 1	Doctor of Osteopathic Medicine	10 years
HCP 2	Medical Assistant Certificate	18 years
HCP 3	Doctor of Clinical Psychology	18 years
HCP 4	Master's in Nursing	21 years
HCP 5	Master's in Social Work	19 years
HCP 6	Bachelor's in Social Work	2 years
HCP 7	Bachelor's in Biology	20 years
HCP 8	Master's in Nursing	25 years
HCP 9	Bachelors' in Sociology	4 years
HCP 10	Bachelor's in Nursing	5 years
HCP 11	Bachelor's in Human Dev.	1 year
HCP 12	Bachelor's in Education	3 years
HCP 13	Bachelor's in Social Work	5 years
HCP 14	Bachelor's in Social Work	4.5 years
HCP 15	Bachelor's in Criminal Justice	7 years

Note. HCP = Health Care Professionals.

Participants self-reported their length of time at the health organization. Overall, the participants this organization worked an average of 10.8 years. The median length of time at the health organization was 7 years, with a range of 2 years to 30 years. Three of the HCPs had worked for the organization for over 20 years. Of the 15 participants, five individuals self-reported that they were former smokers themselves and considered themselves to be experienced in smoking cessation. All the participants had at least 1 year of experience delivering a form of smoking cessation therapy. It was beneficial that all the participants had an interest in improving smoking cessation in the community members in which they serve.

Data Collection

The data collection process was thoroughly examined to recruit eligible HCPs holding various titles and educational backgrounds. Once Hartford HealthCare and Walden University granted IRB approval, 15 HCPs were recruited to participate in the research study; all prospective participants were screened via phone to ensure that the study eligibility criteria were met. Prospective participants were asked their place of employment, education, and length of time at the organization. Once the criteria for participation were confirmed, the HCPs received an invitation for a face-to-face interview.

The interview protocol consisted of six open-ended questions and three demographic questions. The interview protocol used for the present study was not previously published. Each participant was provided an opportunity to review the informed consent documents in-person prior to the start of their interview. Participants

were informed that their participation was voluntary and that they could decline participation at any time. The informed consent form also included contact information for Walden University's IRB representative, Walden University's Vice President of Research, and the contact number for patient advocates at Hartford Hospital as additional resources to call if they had questions about the study. Participants were also allowed the opportunity to provide their email address on the consent form if they chose to receive a copy of the research results after the conclusion of the study. Approximately half of the participants opted to receive the results of the study. Once the HCP signed the informed consent form, I provided a brief explanation of the purpose of the study as well as my contact information in case the HCP had any questions. The interviews began once the participant's questions and concerns were addressed.

Location and Duration of Interviews

All 15 interviews were conducted in a private setting at the Hartford Hospital. Prior to each interview, participants were asked to sign a copy of the informed consent form to confirm that they understood their rights and could be referenced later if necessary. I countersigned the document in the presence of each participant prior to the start of the interview.

Each participant was informed that the interview was being recorded; they were also provided an opportunity to ask questions and express concerns prior to the interview. The duration of each interview ranged from 8 minutes to 20 minutes depending on the HCP's level of detail in their responses to the interview questions. This was an ideal

amount of time for each HCP to answer the research questions and speak in-depth about their perceptions of smoking cessation in the health care setting.

None of the participants needed to reschedule their interview time. Of the 15 participants, HCP3 did not begin her interview on time because a previous appointment with a patient ran over time; HCP3 had to leave their interview for another appointment with a patient and thought she would have more time to sit with me. Despite HCP's time limitations, the interview was conducted within the limited time frame. HCP13 needed to pick up their child from school at a certain time; however, this participant opted to continue with the interview.

The interview was guided by the interview protocol to ensure that each participant was asked the same questions (see Appendix A). There were six open-ended interview questions along with probing questions to guide the conversation. At the conclusion of each interview, the health professional was provided an opportunity to ask any questions or mention any concerns. Participants were reminded that their confidentiality was protected per the informed consent form and that their personal information will not be included in the study results. All 15 participants were given a $10.00 Starbucks gift card as a token of appreciation for their time. One interview ended with the HCP asking about my background of smoking cessation and how I came to pursue it as a dissertation topic. I was able to successfully answer their questions within the specified time frame of our interview.

Audio Recording and Transcription

A Sony ICD-PX370 recorder was used to record the audio from participant interviews. The Sony recorder was a useful device for recording and storing the audio obtained from the face-to-face interviews; the device also allowed me to upload the saved audio interview files to a password-protected computer. The audio files were saved by the date on which the interview was conducted; the name of the participant was not used as the file name. This was to ensure that the confidentiality of the participants' personal identifying information was kept secure.

The interviews were transcribed verbatim by listening to each recording and typing the spoken words into a Microsoft Word document. The transcripts were saved on a password-protected flash drive for an additional level of data security. The transcripts were also saved on a password-protected laptop with no participant identifiers associated with the files. As required by Hartford Hospital IRB, all hard copies of data collected during this process will be kept in a secure location only accessible by authorized personnel for 6 years; after 6 years, the data that has been stored at Hartford Hospital will be destroyed using the 'delete operation query' and any paper documents will be shredded.

Data Analysis

A phenomenological approach was used to gain a better understanding of HCPs' perceived barriers to adherence to smoking cessation services. The purpose was to explore what could be done to improve smoking cessation in health care settings. According to Sutton and Austin (2015), the role of the researcher in phenomenological

studies is to hear the voices of the participants so that others can learn from their experiences. During this time, it was important for me as a researcher to avoid any biases, assumptions, and past personal knowledge about HCPs' perception of smoking cessation.

To identify the essence of the phenomenon, I used "bracketing" to eliminate my biases to the interview responses (Allen-Collinson & Evans, 2019). The use of bracketing allowed me to conduct my data analysis without having any preconceived notions related to the research topic. This process allowed me to be open to the responses to the interview questions in order to document the most appropriate themes related to participants' perceptions about smoking cessation success.

During the data analysis process, I was able to listen and write the responses to each interview question and re-listen to the recorded interviews to ensure I obtained the most accurate responses. The purpose of listening to my interviews several times was not only to ensure accuracy of responses but to better identify themes in order to deliver thorough results. The transcript review process lasted four weeks because I wanted to ensure that I was gathering the most accurate responses from each participant. Next, I used the qualitative data analysis software NVivo to explore the interview data, manage codes, and develop emergent themes. Table 2 shows the themes that emerged from the data analysis conducted.

Table 2

Themes Frequency of Occurrence

Theme	Frequency
HCP Role and Level of Preparedness	20
HCP Participation in Reducing Tobacco Use	16
HCP Feelings Towards Patient Tobacco Use	24
Barriers to Smoking Cessation	6
Resources to Improve Smoking Cessation	20

The interview protocol consisted of six questions (see Appendix A). The interview questions were designed to address HCPs' perceptions of barriers to participation in smoking cessation therapy through the lens of the theory of planned behavior (TPB). Of the six research questions, five were used directly to answer the research questions. Questions 1 and 2 directly addressed RQ1, understanding HCPs' perceptions of their level of preparedness and the abilities of other HCPs to successfully provide smoking cessation therapy to their patients. Question 4 was directed towards RQ2 regarding the barriers to smoking cessation and TPB. Questions 3 and 5 were aligned to RQ3, which targeted how the HCPs were able to express the barriers that tobacco smokers face as well as their perceptions of patients' continued tobacco use despite the benefits of abstinence. Question 6 was designed to receive to receive feedback on the smoking cessation resources provided to patients. A follow-up question (6a) was added to gain further insight on the resources provided by HCPs that are cost-effective to their patients.

Evidence of Trustworthiness

To develop a trustworthy environment for participants during their interviews, I greeted them with a smile, shook their hand, and provided eye contact upon our

introduction. I was able to express my gratitude to each individual and put them at ease by sharing a silly joke to help them relax. Participants were informed again that they were not obligated to participate in the research project and could withdraw their participation at any time. If a participant was observed to have a puzzled look after a question was asked, I made sure to clarify the question's intent and did not rush any participants into answering the interview questions.

Credibility

To ensure credibility in this research study, the data collected from the interviews was interpreted verbatim. It was important that the findings of this study could be tracked by another researcher through what previous researchers discuss as an "audit trail" (Cutcliffe & McKenna, 1999). To ensure an audit trail, the researcher should not have any biases when conducting the research and ensure that the tools used to conduct the interviews were clear and understandable to the reader. Credibility is said to be imperative in determining that the theoretical foundation of a new construct is standing on a solid foundation and deemed trustworthy (Sinclair et al., 2018). Because more than one method was used to collect data, credibility was ensured in this qualitative research study via triangulation. Even through a small sample size of 15 participants, the HCPs included in the study were able to share the importance of smoking cessation in their health care settings; their assertive behavior increased the trustworthiness of the study (Cutcliffe & McKenna, 1999). The researcher followed all approved IRB guidelines as well as the interview protocol, producing an audit trail that is easy to follow for an outsider to replicate with very few issues or concerns.

Transferability

Transferability was determined by allowing the HCPs to describe their behaviors and experiences as they relate to smoking cessation in their health care setting (see Korstjens & Moser, 2018). By utilizing a strategy coined "thick description," I outlined the research process in great detail from start to finish; this level of detail allows the reader to apply and replicate this process in their own setting (see Korstjens & Moser, 2018). The verbiage used in this study can be easily understood.

Dependability

To ensure dependability in the research study, I followed the research plans that were approved by Walden University IRB and Hartford HealthCare IRB. Following the interview protocol, the semi-structured interviews were conducted and detailed to ensure that there was an audit trail of the data collection process (Forero et al., 2018).

Conformability

In order to practice conformability in this study, NVivo was used to upload the interview transcripts, code the transcript data, and highlight emergent themes. Utilizing NVivo to manage the data derived from interviews is an additional level of trustworthiness. The data stored in NVivo will be kept for a six-year time period as required by Hartford HealthCare IRB team; this includes any notes that were taken during the interviews and the audio recordings for all interviews. This data are accessible upon request and can only be retrieved by authorized personnel.

Results

The purpose of this research study was to identify HCPs' perceived barriers to adherence to smoking cessation services and what can be done to improve smoking cessation in health care settings. It was important that this research study provided clarity about HCPs' experiences with smoking cessation and how their skills in smoking cessation are utilized in the health care setting. This research also provided more clarity on the barriers that patients face while adhering to smoking cessation therapy, what can be done to improve smoking cessation outcomes, and the resources that could help improve smoking cessation therapies in the future. To gain a better understanding of the phenomenon the following three research questions were identified:

RQ1: What are the perceptions of professional health care workers' level of preparedness regarding the delivery of smoking cessation based on training he/she received?

RQ2: What are the perceptions of professional health care workers regarding barriers to smoking cessation among cancer smokers?

RQ3: What changes in smoking cessation interventions or therapies do health care workers believe will improve success?

In a detailed literature review as well as an analysis of the theoretical framework of the theory of planned behavior, I was able to develop research questions that would aide in analyzing the effectiveness of smoking cessation in the health care settings. The interview protocol helped me grasp a deeper understanding of the lived experiences of

the participating HCPs via their direct engagement with patients in their natural setting. To ensure confidentiality, the participating HCPs were labeled as HCP1 through HCP15.

Theme 1: HCPs' Roles and Levels of Preparedness

The first theme addressed HCPs' perceptions of their level of preparedness regarding the delivery of smoking cessation therapy. All 15 participants were asked this research question in order to gain a better understanding of this phenomenon. All responses related to this theme involved HCPs' roles and how they engaged with patients based on their role, the length of time that they had served in this role, and their work experience(s) with smoking cessation therapy.

The HCPs were able to describe their roles in great detail along with the length of time employed with Hartford HealthCare. With each HCP's job description being different from the next, it was important that I captured what role each participant played in the health setting and their level of preparedness in the delivery of cessation therapy. The responses related to this theme indicated the importance of their roles and how their qualifications and skill set contributed to cessation success.

The HCPs believed that, based on their trainings, there was a high level of confidence in educating patients on making healthier choice related to their smoking behavior. The participants were willing to talk about their level of preparation in providing smoking cessation therapy to patients. Although the HCPs' roles varied, all HCPs felt that their roles were equally as important as patients' success with smoking cessation regardless of their mental or physical health. The HCPs felt that the health organization prepared them to successfully perform the daily functions of their jobs and

promote their professional growth through continuing education and ongoing trainings. Their responses were as follows:

- "Primarily educating residents and overseeing adult primary care clinic at the hospital. I've been in the role for 6 years." (HCP1, personal communication, January 3, 2020)
- "I am very involved in patient care. This is a teaching clinic and there are a lot of residents. I place orders and schedule follow up appointments for patients. I schedule consults such as smoking cessation, as well as nutritional and psychology consults. I've been in this role for about 5 years." (HCP2, personal communication, January 3, 2020)
- "I assess patients that come in regarding mental health needs, both short term and long-term problems. Acute crisis interventions, referrals for different problems, collaborating with different providers. 4 years in this role." (HCP3, personal communication, January 3, 2020)
- "APRN that sees patients and been in this role for 21 years." (HCP4, personal communication, January 6, 2020)
- "Social worker/Community care manager that provides chronic care management to patients who are diagnosed with chronic illnesses such as: COPD and other respiratory illnesses. In this role for 8 years." (HCP5, personal communication, January 16, 2020)
- "Trained Tobacco Treatment Specialist. Primary focus on patients that are interested in quitting smoking referred by their PCP. I will be working with

specialty clinics on these referrals (Bariatrics, Pulmonology) to assist in patient interested in quitting or reducing smoking behaviors in 90 days. 2 years in this role." (HCP6, personal communication, January 22, 2020)

- "I am a Manager that oversee the Infectious Disease Department. I hold a National Certification in Tobacco Cessation for 3 years." (HCP7, personal communication, January 22, 2020)
- "I am a Nurse Practitioner. I work primarily with people with lung diseases, asthma, COPD. Both of which are affected by smoking. Smoking Cessation is an important part of my role as health care professionals. Until recently, I was a prescriber and I could work with people and prescribe inhaled medication or whatever they needed for their co morbid conditions. I have been in this role for 30 years." (HCP8, personal communication, January 22, 2020)
- "Providing support for people with mental health issues. As a residential counselor, I support those whom are mentally ill and have substance abuse issues. I help them with maintain a level of functioning in the community. Part of this treatment is smoking cessation." (HCP9, personal communication, January 31, 2020)
- "I provide transitional care as a care manager to patients after they have been discharged from the hospital. I've been in this role for 5 years. In my role I am providing resources to patients on living a healthier lifestyle, as well as reducing hospital admissions." (HCP10, personal communication, January 31, 2020)

- "I work with patients struggling with COPD, Emphysema, and lung cancer. I provide case management support for individuals with illnesses. I also connect them to resources to have better knowledge of risks and benefits that are present with smoking. 1 Year in this particular role." (HCP11, personal communication, February 1, 2020)
- "I have been working as a program manager for 3 years. In my role I am mostly managing daily functions and providing patients with education that can be beneficial to their chronic illness." (HCP12, personal communication, February 3, 2020)
- "I am an intake worker at Hartford hospital. I provide prescreening to patients, outreach and other services." (HCP13, personal communication, February 5, 2020)
- "My role is more of a supportive one in nature. I help adults with mental health disorders, substance use and providing case management to help them with finances, insurance, housing, medical appointments/transportation. I wear a lot of hats." (HCP14, personal communication, February 7, 2020)
- "I have been working as a counselor for 7 years. The primary description of my role is to provide education to patients on a healthier lifestyle." (HCP15, personal communication, February 25, 2020)

Theme 2: HCPs' Participation in Reducing Tobacco Use

The HCPs believed that there were several factors that could prohibit their patients from being successful in smoking cessation regardless of the stage of a patient's

illness or the HCP's efforts. According to the HCPs, patients have numerous reasons to resist tobacco treatment; coming from a non-judgmental standpoint could be beneficial to patients' success with smoking cessation. Their responses were as follows:

- "Counselling is the easier part. There is a time commitment and having the time to do that can be a challenge. Asking a question or 2 is not the difficult part, time is." (HCP1, personal communication, January 3, 2020)
- "For example, scheduling smoking cessation appointments… I have to know what it is that we do. I call to schedule smoking cessation appointments held here at clinic and patients will ask what that about, so I have to know what it is. I trained myself. Explaining to patients that their appointment will be one on one. I will explain if they will be getting therapy or meds." (HCP2, personal communication, January 3, 2020)
- "I reinforce what patients discuss in smoking cessation group, asking about what their triggers are, how you can deal with urges and withdrawal symptoms. I reinforce skills from counselors." (HCP3, personal communication, January 3, 2020)
- "Educate. Mostly do referrals to other providers for smoking cessation." (HCP4, personal communication, January 6, 2020)
- "I educate patients as well as provide them with resources to aide in supporting their illnesses. I also provide non-clinical therapy." (HCP5, personal communication, January 16, 2020)

- "We are finding that after referrals have been placed, patients are not coming in. They are not willing to quit or make a change. Patients' willingness to quit can be a barrier to our ability to provide cessation support. My ability is that I provide a service to providers on how to provide the 5 A's to patients. We had to tweak the education provided to providers." (HCP6, personal communication, January 22, 2020)
- "I feel very confident. I've been doing it for a couple years now. Currently I am serving as a backup person for when the tobacco specialists are not available, since my role has grown. I also make sure the providers are doing the referrals correctly." (HCP7, personal communication, January 22, 2020)
- "I'm not as good as I like to be. I use motivational interviewing whenever I can. I've been semi successful with a couple patients. I also understand the addiction of smoking is so strong, especially with anybody with mental illness. Several of my patients have either been schizophrenic, or major depressive disorder or PTSD, and they are the tougher ones. I am measuring myself only successful if I can have them quit smoking." (HCP8, personal communication, January 22, 2020)
- "I feel very confident and it's rewarding in a sense to help people through encouragement and motivation to improve their lives." (HCP9, personal communication, January 31, 2020)

- “I am able to educate patients on the risks and benefits as it relates to tobacco. Being able to listen to the patient and empathize with their lifestyle choices.” (HCP10, personal communication, January 31, 2020)
- “Just making sure they are able to get the services they need to prevent them from worsening their illness. I’ve been trained to do this.” (HCP11, personal communication, February 1, 2020)
- “I am able to provide smoking cessation successfully based on health education training I’ve received in the past. I use great techniques such as motivational interviewing to get to the root of my patients concerns related to their health.” (HCP12, personal communication, February 3, 2020)
- “I do ask these questions pertaining to smoking cessation upon intake. The assessment is repetitive, with the same questions being asked to each patient.” (HCP13, personal communication, February 5, 2020)
- “I feel confident to do the job I was trained to do. There are several opportunities for improvement in my role through year-round trainings.” (HCP14, personal communication, February 7, 2020)
- "I feel really good about it… and I know I am doing the best I can with the strategies taught to me.” (HCP15, personal communication, February 25, 2020)

Theme 3: HCPs’ Perceptions of Patient Tobacco Use

The HCPs had a strong opinion about effectiveness of smoking cessation in their work settings. HCPs wear many hats when it comes to caring for their patients. Overall,

the HCPs perceived that social influences could be a huge factor in patients' willingness to utilize smoking cessation therapies. The providers' perceptions of smoking were also a huge factor for identifying the core of patient attitudes towards continuing their smoking behavior. Some of the HCPs understood why their patients smoked; a few of the HCPs struggled with quitting tobacco themselves and indicated that longtime habits are often the hardest to break. Other HCPs were sterner towards their patients because of their continued smoking behavior despite being diagnosed with an illness directly related to it. Their responses were as follows:

- "A challenge can be to understanding risks of smoking and understanding how medications work. Some people may stop cessation too soon when they should continue. Follow up appointments are also important and addressing their needs in an appropriate time frame in order to make positive changes." (HCP1, personal communication, January 3, 2020)
- "Problem getting to appointments…Smoke due to a lot of stressors." (HCP2, personal communication, January 3, 2020)
- "Problem with stress management and addictions. Poverty, homelessness, trauma, and limited resources. Patients unable to manage all of these stressors." (HCP3, personal communication, January 3, 2020)
- "Environment in which they live makes it hard for them to engage in smoking program." (HCP4, personal communication, January 6, 2020)
- "From the perspective of a former smoker, I can say that you start very young. You think, as you get older, you can give it up but it's hard. One of the

hardest things is coming to the realization in some cases that it's a little bit too late." (HCP5, personal communication, January 16, 2020)

- "Patients want to quit, but not ready". They are in the pre-contemplation stage." (HCP6, personal communication, January 22, 2020)
- "A lot of patients we get their problems are more on the social side. Sometimes I feel like they have tried so many times but didn't try to quit using the therapy method. They try on their own…Educating the providers that we want them to make a change, not necessarily quit…changing the way that we educate the patient so we are allowing them to be more open to it. We tell them that having a "quit attempt" is good." (HCP7, personal communication, January 22, 2020)
- "Problems are people with a lot of stress in their lives and reiterating again, people with mental illness. People who have been smoking since their teen years. People who have friends and family members that still smoke…Those are the folks that are a little bit tougher." (HCP8, personal communication, January 22, 2020)
- "Lifestyle factors…some people find it difficult to improve their health." (HCP9, personal communication, January 31, 2020)
- "I think some tobacco smokers are set in their ways and don't want to quit. I think that their living and social circle can be a problem, and they may become easily influenced by others." (HCP10, personal communication, January 31, 2020)

- "Currently, I feel like people are struggling with finding the ability to stop. I think that once people stop smoking, it is hard for them to imagine their life without doing it, which makes it difficult for them to be able to find the motivation to stop even if they are diagnosed with an illness." (HCP11, personal communication, February 1, 2020)
- "Current tobacco smokers might have an issue riding themselves of smoking all together if they have been smoking for a long time. It can be hard to ignore the urge to smoke." (HCP12, personal communication, February 3, 2020)
- "They may have social issues." (HCP13, personal communication, February 5, 2020)
- "Other issues can be feeling that cutting down or quitting is pointless if they have been diagnosed with an illness directly related to their smoking choices." (HCP14, personal communication, February 7, 2020)
- "Bad influences from other smokers which are most likely friends or not having the resources." (HCP15, personal communication, February 25, 2020)

Theme 4: Barriers to Smoking Cessation

Barriers to smoking cessation varied between the HCPs, including high no-show rates for smoking cessation appointments based on transportation, concerns with pre-existing illnesses enabling low motivation to quit, and family/friend dynamics. The HCPs believed that providing patients with education on smoking cessation alongside motivational interviewing allowed the patients the opportunity to be more vocal on their

smoking behavior and feel more supported by their providers. Their responses were as follows:

- "Best approach is to educate and force our views on patients. Explain to them the reasoning why we want them to quit smoking." (HCP1, personal communication, January 3, 2020)
- "They don't come." (HCP2, personal communication, January 3, 2020)
- "I discuss what is preventing them from attending. Transportation, finances, family dynamics, mental health. Are we missing that culture? Counselling sometimes isn't a way to manage." (HCP3, personal communication, January 3, 2020)
- "Offer advice to places that give free patches/resources." (HCP4, personal communication, January 6, 2020)
- "Resistance: The patients with COPD, Asthma, and continuously in the hospital for upper respiratory issues; these types of patients (chronic) feels like it is barrier to their treatment. Getting patients into a little bit of treatment. When you've been a long-time smoker, you need long term treatment, therapy, and help." (HCP5, personal communication, January 16, 2020)
- "Best approach is an educational approach. We do not pressure the patient and we provide them with support. We also assist with medication management. A lot of patients tried nicotine replacement, but there needs to a combination of therapy for success. Providing patients with education gives them a little more

confidence to have a successful quit attempt. (HCP6, personal communication, January 22, 2020)

- "Resistance can happen when you tell them I am here to help you quit, or this program is to help you quit. They will have no interest and will verbally express that. It is important to explain to the patient that this is a partnership and I am here to help you. If we start with a goal of getting rid of 1 cigarette a day; it makes it easier for them to accept." (HCP7, personal communication, January 22, 2020)
- "To acknowledge to them how difficult it is to stop. Give them keys as to what it is they might be able to try. Also, having them express to me what the difficulties are and then to use any kind of motivational interviewing to move them forward. Barriers are primarily just the stress of living and they use cigarettes to calm themselves." (HCP8, personal communication, January 22, 2020)
- "Some people are accustomed to living a certain lifestyle." (HCP9, personal communication, January 31, 2020)
- "The patients I am in communication with having been smoking majority of their lives… using smoking as a coping mechanism to cope with illnesses they have." (HCP10, personal communication, January 31, 2020)
- "I like coming from a position where I'm not judging them." (HCP11, personal communication, February 1, 2020)

- "I use motivational interviewing and also share my past experience with tobacco so they don't feel as if I'm judging them for their behavior. In this case I am meeting the patient where they are." (HCP12, personal communication, February 3, 2020)
- "My best approach is to not be judgmental." (HCP13, personal communication, February 5, 2020)
- "For patients that are older, they are set in their ways on what they will and will not do. It's important to hear them out and not make decisions for them but guide them." (HCP14, personal communication, February 7, 2020)
- "I would allow patients to be a part of treatment and initially ask what they think can help them with the therapy. Barriers can include gaining trust and feeling like they are genuinely being assisted." (HCP15, personal communication, February 25, 2020)

Theme 5: Resources to Improve Smoking Cessation

Patients are provided many cost-effective resources to improve their smoking behaviors. The HCPs verbalized that Hartford Hospital refers patients to an internal smoking cessation program called the Smoking Tobacco Prevention and Cessation Program (STOPP). STOPP was described as a free tobacco prevention and cessation program patients on hospital grounds that is conducted in both English and Spanish languages. All 15 HCPs discussed the benefits of the STOPP program, indicating that patients receive on-going support throughout their quit journey, even for those individuals who are in the pre-contemplative stage of quitting smoking. Additionally, the

HCPs indicated that an additional resource provided to patients was the 1-800-QUIT-NOW Line.

- "Hartford Hospital has "STOPP Program" grant through UConn/Fei Wang to help patients in underserved areas. It's generally done when patients are more contemplative. "Patients are taking health care professionals up on that program." (HCP1, personal communication, January 3, 2020)
- "There is a referral list that health care professionals also call patients off of. We are reaching out to patients and mailing out letters." (HCP2, personal communication, January 3, 2020)
- "Direct referrals…. I think there are barriers for people coming to their first appointment here, and that needs to be explored." (HCP3, personal communication, January 3, 2020)
- "Hartford Hospital has a free program I refer them to and the 1-800-QUIT-NOW line." (HCP4, personal communication, January 6, 2020)
- "Hartford Hospital has a tobacco cessation program and Nurses that have been trained as tobacco cessation specialist. Patients are provided with education via their PCP office and provided with pamphlets, resources and information for Hartford Hospital Stop Program. Other resources provided are the American Cancer Society, American Lung Association, and Centers for Disease Control. I can't say if all the resources are cost effective. Some programs at Hartford Hospital are free, as well as the resources. It all depends on patients making that call and advocating for them self. We can find

resources for patients to get a nicotine patch, or prescribed medication to aide in smoking cessation. If medication is prescribed we try to prescribe the generic versus the name brand, so insurance can cover costs." (HCP5, personal communication, January 16, 2020)

- "Resources of one-to-one individual therapy…we provide group therapy through American Lung Association for six weeks. These resources are at no cost to the patient." (HCP6, personal communication, January 22, 2020)
- "We are lucky to have this program on site. Tobacco Specialist is very involved. It is covered through the patients Medicaid insurance that also gives them patches. We have a behind the scenes partnership with community pharmacy and if patients qualify, the tobacco specialist connects directly with pharmacy to get patients patches." (HCP7, personal communication, January 22, 2020)
- "Using either the gum or patch for smoking cessation has helped several of my patients. The use of cinnamon gum or cinnamon toothpicks. A couple of my patients will come in with the toothpick in their mouth." (HCP8, personal communication, January 22, 2020)
- "The STOPP program at Hartford Health care is free of charge. It a support system for people struggling with tobacco use." (HCP9, personal communication, January 31, 2020)

- “I share resources related to patients’ demographic area, whether it be cessation support groups, [1-800-QUIT-NOW] line and Hartford Hospitals STOPP program.” (HCP10, personal communication, January 31, 2020)
- “At Hartford Hospital we promote our STOPP program free of charge. A lot of our patients like to use this service because it doesn’t cost them anything and they’re not losing anything in the long run.” (HCP11, personal communication, February 1, 2020)
- “Insurance is not needed to use this service and patients can call the hot line for support and often times have free resources sent to their homes.” (HCP12, personal communication, February 3, 2020)
- “Hartford Hospital has a STOPP program and this is free of charge for each patient.” (HCP13, personal communication, February 5, 2020)
- “The [1-800-QUIT-NOW] line is offered to patients free of charge. Patients can call in at their conveniences and be offered free resources such as the patch or nicotine gum. We also have the STOPP program here at Hartford hospital, which is also free of charge. These options are patients’ choice, so it is up to them to make that initial step.”

  (HCP14, personal communication, February 7, 2020)
- “Clients are offered the STOPP program at Hartford Hospital for free counseling and resources for 6 weeks. Other avenues include patches, nicotine gum, etc.…” (HCP15, personal communication, February 25, 2020)

Discrepant Cases

The HCPs interviewed for this research study had strong opinions about the effectiveness of smoking cessation therapies in their work settings. Most HCPs expressed a sense of understanding for why patients continued to smoke tobacco despite being diagnosed with an illness directly related to their smoking behavior. However, others felt that there were several resources that tobacco smokers could utilize to be successful in smoking cessation therapy and/or their individual quit attempts. The HCPs were able to determine many factors that contribute the successful delivery of smoking cessation, including letting the patient contribute to their own treatment planning, not judging the patient on their health choices, and providing education to patients on the benefits of quitting. Other HCPs expressed opposing views, determining that smoking cessation was only effective if the patients quit smoking altogether.

Summary

In Chapter 4, I provided a qualitative analysis of the data obtained from 15 HCPs regarding their lived experiences delivering smoking cessation therapy. I began the chapter by describing the demographics of the study participants; this was followed by an outline of the data collection and data analysis processes. Next, I reported the themes that emerged through the data analysis in response to the research questions.

In the final chapter of this research study, Chapter 5, I discuss my conclusions, social change implications, and recommendations for future research based on this study's findings.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to gain a better understanding of the of smoking cessation therapy and patients' adherence to cessation services offered from the perspectives of HCPs. In this chapter, I discuss the research results that are explained in Chapter 4 within the context of prior research. The data collected through this research allowed HCPs to view not only their perspectives related to smoking cessation but what can be done to better support their patients where they are in their quitting stage. HCPs were granted an opportunity to be vocal about what worked for them when engaging with their patients on leading a healthier lifestyle; they were also able to share the barriers and challenges they faced during times of patient resistance. When the perceptions of HCPs are shared with other public HCPs across the spectrum of health care, the rates of smoking amongst those with existing comorbidities may be reduced.

The HCPs who participated in this study understood why their patients continued engage in tobacco use, reporting that there were so many opportunities available to patients to quit smoking or reduce their smoking behaviors while in the health care setting. The HCPs believed that patients could try harder to be involved in the decision-making process related to their health outcomes. HCPs identified that improvement in patients' tobacco behaviors takes patience, motivation, and a clear understanding of their role not to force the patient to make such a major change; instead, it is the role of the HCP to educate patients through the progress.

The HCPs interviewed in this study mentioned the importance of motivation and motivational interviewing came up several times. HCP6 stated,

> When patients meet with us for initial enrollment, we use motivational interviewing. We do not pressure the patient and we provide them with support. We also assist with medication management. A lot of patients tried nicotine replacement, but there needs to a combination of therapy for success. (HCP6, personal communication, January 22, 2020)

HCP12 also stated,

> I use motivational interviewing and also share my past experience with tobacco so they don't feel as if I'm judging them for their behavior. In this case I am meeting the patient where they are. I provide encouragement and educate them that cutting down on the amount of cigarettes they smoke are still progress. (HCP12, personal communication, February 3, 2020)

In this study, all 15 participants believed that various socioeconomic factors play an important role in an individual's willingness to quit smoking. HCP6 reported that it is important for HCPs to change the way they educate patients on smoking cessation so that they are more open to change. All HCPs in this study all readily agreed that Hartford Hospital's STOPP Tobacco Prevention & Cessation Program is the preferred resource available to patients to aide them on the journey of reducing smoking behavior via counseling support.

The participating HCPs also believed that there were socioeconomic barriers to their patients' adherence to smoking cessation services. Few participants believed that

HCPs needed more education in order to successfully deliver cessation therapy to their patients. Huo (2020) and Park (2015) reported that there is some inconsistency in how providers assist patients during the quitting process and start the conversation regarding the importance of abstinence. The present study supported the notion that although HCPs are implementing the smoking cessation techniques that they have learned, more training and education are needed so that HCPs can better engage patients that are in the pre-contemplation stage of smoking cessation.

According to Masoud (2019), Ostroff (2016), and Romani (2020), HCPs' level of knowledge and educational training in the clinical practices of smoking cessation therapy are barriers for most HCPs and can affect the professionals' resistance to cessation advice. A need for additional professional training on techniques that can be used when a patient is resistant to smoking cessation can possibly address this barrier for HCPs. This technique can also increase conversations between HCPs and patients so that HCPs have a better grasp of individual patient needs when it comes to their quitting journey and what would be most suitable from a supportive standpoint.

Ramsey, Prentice, Ballard, Chen, and Bierut (2019) proposed that individuals with chronic conditions have a higher prevalence of smoking than those in the general population. Treatment of health disparities coupled with counseling therapy can reduce the rate of smoking in individuals with chronic conditions. Ramsey et al. (2019) suggested that using the same strategies across the health care system can reduce smoking rates.

Interpretation of the Findings

The current research data supports the Healthy People 2020 initiative to improve length and quality of life in the United States by reducing the illnesses that are caused by tobacco and cancer (Kaul, Veeranki, Rodriguez, & Kuo, 2016). This research study served as a gateway for more studies on understanding the role of HCPs in the direct engagement of individuals who smoke tobacco and have contracted illnesses related to their smoking behavior.

Research Question 1

Most participants expressed that they were confident in their abilities to successfully provide smoking cessation therapy to patients. However, one participant shared that they were not as good as they would like to be; this HCP reported feeling successful in their duties only if the patient quit smoking altogether. Another HCP expressed that they were self-taught in smoking cessation therapies but were still able to provide high-quality smoking cessation services to patients in the health care setting. One HCP reported that having the time to deliver cessation services was a challenge; providing counseling was the easier part. Most of the participants in this study reported that being able to educate patients on this service is the best way to support patients as they improve their health; however, other participants reported that they were responsible for training other HCPs on the 5 A's model and preparing these providers to aide in change instead of providing cessation services directly to patients. HCPs' levels of preparedness were consistent with previous research studies that suggested there is need to train all providers in self-efficacy (Hasan, Hairi, Tajuddin, & Nordin, 2019). The

findings from this research study imply that self-efficacy training may increase the expectations of the 5 As, specifically Assist and Assess.

Research Question 2

Aligned with the findings from Chean et al. (2019), HCPs have the most opportunities to aide smokers in quitting through the identification of barriers their patients face. All 15 participants reported that socioeconomic factors served as barriers to smoking cessation for low-income patients. Some of the socioeconomic factors were identified as intrapersonal and interpersonal. HCP3 said that some barriers kept patients from attending their first appointment; these barriers need to be explored. Some HCPs shared that patients used smoking as a coping mechanism to relieve stress or to cope with their existing illnesses. HCP15 said he could understand why patients were using their tobacco behavior as a coping mechanism because most of his patients resided in a low-income community; he noted that their day-to-day lives were different from those who resided in a more affluent community. One participant reported that a lot of their patients were on disability and/or retired which were also barriers to smoking cessation. This HCP further explained that during the winter and colder months, patients are bored and there is less of an urgency to attend group therapy sessions and doctor appointments.

HCPs perceived that patients resistant to smoking cessation therapy do not want to be judged for their health decisions; instead, they rely on motivation to encourage a change in their health choices. Most of the participants reported that motivational interviewing is used frequently when conversing with patients about smoking cessation.

Some participants reported that patients refer to lifestyle factors to rationalize why they continue to smoke, and it is difficult for patients to make that change.

Aligned with a study conducted by Kale, Gilbert, and Sutton (2019), barriers were identified that contributed to patients' lack of success with smoking cessation therapy. Contributing factors were identified as a patient's readiness to quit smoking, work and time constraints, personal opinions about professional assistance, mobility limitations, and misinformation. HCPs were able to identify specific barriers related to their patient adherence to smoking cessation therapy.

Research Question 3

One participant believed that patients should have a better understanding of the risks related to smoking and understanding how medications work; this participant reported that some people stop cessation too soon when they should continue the program to completion. This participant further explained how imperative it was to address the needs of the patient during their follow-up appointments in an appropriate time frame to make positive changes. One participant reported that the in-service training provided to HCPs should better address how to provide the 5 As (Ask, Advise, Assess, Assist, and Arrange) when providing cessation support. Of the 15 participants, only one HCP reported patient anxiety when making that first appointment to see the provider for smoking cessation. Patient anxiety can be a concern and suggests the need for future changes in how smoking cessation is delivered upon first contact with the patient.

Limitations of the Study

The HCPs that volunteered for this research study were able to verbalize their opinions of smoking cessation as it related to their specific duties at their health care setting. These HCPs provided rich detail on how they provided this service to their patients at Hartford Hospital with the goal of improving an individual's overall health. Their opinions and views should not be generalized for all HCPs in general, only to each participant's individual experiences. Although there were 15 HCPs interviewed for this study, not all HCPs carried the same job title or educational background. Most HCPs had different functions within their hospital setting, which speaks to the limitation of provider functionality as it relates to the delivery of smoking cessation services.

Due to the use of convenience sampling in this research study, the data was limited to those who expressed interest in participating in the study. This research study only focused on HCPs and their experience with smoking cessation at one health care facility. The findings are a contribution to existing strategies and techniques that can aid in the increase of patients adhering to smoking cessation therapy. The opinions of the HCPs interviewed reflect what is happing in the health setting in which they work may differ in other health care settings.

Recommendations

Future research should explore additional opportunities for patients to participate in smoking cessation therapy during the winter or colder months, particularly for those who are disabled or not mobile. Prior research suggests that some participants need consistent service delivery in order to increase their engagement in their treatment and

improve their likelihood of quitting smoking. Cunningham (2014) conducted a cross-sectional study using multivariate regression analysis to patient success in smoking cessation based on their level of engagement. Cunningham reported that patients who are more engaged in their treatment process are more receptive to engaging in healthy behaviors.

Implications of Social Change

The findings from the study revealed that HCPs may understand the reasoning for their patients' smoking behavior. Even when presented with resources and treatment opportunities, HCPs may be empathetic to their patients' continuous smoking due to their own previous smoking behaviors; HCPs may also understand that smoking can be a stress reliever for their patients and all they have left to get them through the day. Most HCPs who participated in this study revealed that they were confident in delivering smoking cessation therapy; HCPs whose primary duties related to smoking cessation were more confident in their smoking cessation treatment abilities. HCPs who conducted smoking cessation therapy in tandem with other duties felt that there was room for improvement in their delivery of smoking cessation strategies to their patients.

Increased provider and patient education to provide a clearer idea of the initial smoking cessation visit is needed. HCPs reported that some patients were not as reluctant to change, especially if they were previously diagnosed with an illness. There is room to improve on the strategies used when engaging patients to consider a healthy lifestyle change. There is also room for HCPs to improve how they respond to patients when faced with barriers of resistance.

Alageel, Gulliford, McDermott, and Wright (2018) conducted a qualitative study using semi-structured interviews with HCPs to identify barriers and facilitators when multiple healthy behavior interventions occur simultaneously at an individual's primary care setting. There is an understanding that HCPs wear many different hats when it comes to promoting healthier behaviors in their patients, but there is only so much HCPs can do, especially when servicing a patient that has multiple needs. This research study determined that HCPs could feel overwhelmed when they oversee changing multiple health behaviors (Alageel et al., 2018).

Conclusion

In conclusion, this research study provided an important opportunity for HCPs to share their perspectives on the barriers they face when delivering smoking cessation services to patients. The participating HCPs were able to highlight their strengths and weaknesses related to patient resistance to treatment. This research provides key stakeholders with a better understanding of the role of the HCPs and how to possibly restructure the delivery of smoking cessation in health care settings. In my current role as a health care provider, I am grateful for the opportunity to contribute to positive social change in my community through health education and helping individuals with their transition to home care after hospitalization. I recognize that each patient is different and what may work for one person may not work for another. Learning to be flexible to the needs of each patient is important in behavior change.

In acknowledgement of COVID-19 pandemic that the country was facing as of the writing of this dissertation, the present study may contribute to the practices of HCPs

and their implementation of health programs in other health care settings. This research was able to provide the perceptions of patients' health behaviors through the eyes of their providers. With these shared experiences, it is my hope that other HCPs gain additional insight into how to motivate their patients when faced with resistance and understand the underlying factors that enable resistance. Being able to identify barriers when attempting to make a positive social change is important more than ever. Overall, the data obtained through this study could be used as a reference for future studies on how we can promote and encourage healthy behaviors in vulnerable populations.

References

Alageel, S., Gulliford, M. C., McDermott, L., & Wright, A. J. (2018). Implementing multiple health behaviour change interventions for cardiovascular risk reduction in primary care: A qualitative study. *BMC Family Practice*, *19*(1), 171. doi:10.1186/s12875-018-0860-0.

Allen-Collinson, J., & Evans, A. B. (2019). To be or not to be phenomenology: That is the question. *European Journal for Sport and Society*, *16*(4), 295-300. doi:10.1080/16138171.2019.1693148.

Arrazola, R. A., Ahluwalia, I. B., Pun, E., de Quevedo, I. G., Babb, S., & Armour, B. S. (2017). Current tobacco smoking and desire to quit smoking among students aged 13–15 years—Global Youth Tobacco Survey, 61 countries, 2012–2015. *MMWR. Morbidity and Mortality Weekly Report*, *66*(20), 533. doi:10.15585/mmwr.mm6620a3.

Bains, M., Britton, J., Marsh, J., Jayes, L., & Murray, R. L. (2014). Patients' and healthcare professionals' views on a specialist smoking cessation service delivered in a United Kingdom hospital: A qualitative study. *Tobacco Induced Diseases*, *12*(1), 2. doi:10.1186/1617-9625-12-2.

Bell, J. W., Haas, R., Luke, J. S., & Ricketts, J. A. (2018). *U.S. Patent No. 9,892,276*. Washington, DC: U.S. Patent and Trademark Office.

Berg, C. J., Thomas, A. N., Mertens, A. C., Schauer, G. L., Pinsker, E. A., Ahluwalia, J. S., & Khuri, F. R. (2013). Correlates of continued smoking versus cessation

among survivors of smoking-related cancers. *Psycho-Oncology*, *22*(4), 799-806. doi:10.1002/pon.3077.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219-234. doi:10.1177/1468794112468475.

Brown, C. H., Medoff, D., Dickerson, F. B., Fang, L. J., Lucksted, A., Goldberg, R. W., ... Dixon, L. B. (2015). Factors influencing implementation of smoking cessation treatment within community mental health centers. *Journal of Dual Diagnosis*, *11*(2), 145-150. doi:10.1080/15504263.2015.1025025.

Cancer Prevention and Control. (2018, September 18). Retrieved from https://www.cdc.gov/cancer/tobacco/index.htm.

Carter, B. D., Abnet, C. C., Feskanich, D., Freedman, N. D., Hartge, P., Lewis, C. E., ... Jacobs, E. J. (2015). Smoking and mortality—Beyond established causes. *New England Journal of Medicine*, *372*(7), 631-640. doi:10.1056/NEJMsa1407211.

Centers for Disease Control and Prevention (2018). Tobacco-related mortality, Retrieved from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm.

Chean, K. Y., Goh, L. G., Liew, K. W., Tan, C. C., Choi, X. L., Tan, K. C., & Ooi, S. T. (2019). Barriers to smoking cessation: A qualitative study from the perspective of primary care in Malaysia. *BMJ Open*, *9*(7), e025491. doi:10.1136/bmjopen-2018-025491.

Chiu, Y. L., Chou, Y. C., Chang, Y. W., Chu, C. M., Lin, F. G., Lai, C. H., ... Kao, S. (2019). Using an extended theory of planned behaviour to predict smoking cessation counsellors' intentions to offer smoking cessation support in the Taiwanese military: A cross-sectional study. *BMJ Open*, *9*(5), e026203. doi:10.1136/bmjopen-2018-026203.

Cooley, M. E., Lundin, R., & Murray, L. (2009). Smoking cessation Interventions in cancer care: Opportunities for oncology nurses and nurse scientists. *Annual Review of Nursing Research, 27*(1), 243-272. doi:10.1891/0739-6686.27.243.

Cunningham, P. (2014). Patient engagement during medical visits and smoking cessation counseling. *JAMA Internal Medicine*, *174*(8), 1291-1298. doi:10.1001/jamainternmed.2014.729.

Cutcliffe, J. R., & McKenna, H. P. (1999). Establishing the credibility of qualitative research findings: The plot thickens. *Journal of Advanced Nursing, 30*(2), 374-380. doi:10.1046/j.1365-2648.1999.01090.x.

Evans, W. D., Rath, J. M., Hair, E. C., Snider, J. W., Pitzer, L., Greenberg, M., ... Vallone, D. (2018). Effects of the Truth FinishIt brand on tobacco outcomes. *Preventive Medicine Reports*, *9*, 6-11. doi:10.1016/j.pmedr.2017.11.008.

Farley, A., Koshiaris, C., Oke, J., Ryan, R., Szatkowski, L., Stevens, R., & Aveyard, P. (2017). Physician support of smoking cessation after diagnosis of lung, bladder, or upper aerodigestive tract cancer. *The Annals of Family Medicine*, *15*(5), 443-450. doi:10.1370/afm.2100.

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., ... Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Services Research*, *18*(1), 120. doi:10.1186/s12913-018-2915-2.

Gallaway, M. S., Tai, E., & Rohan, E. A. (2018). Smoking cessation treatment programs offered at hospitals providing oncology services. *Journal of Smoking Cessation*, 1-7. doi:10.1017/jsc.2018.15.

Getachew, B., Payne, J. B., Vu, M., Pillai, D., Shah, J., Levine, H., & Berg, C. J. (2018). Perceptions of alternative tobacco products, anti-tobacco media, and tobacco regulation among young adults: A qualitative study. *American Journal of Health Behavior*, *42*(4), 118-130. doi:10.5993/AJHB.42.4.11.

Gichuki, J. W., Opiyo, R., Mugyenyi, P., & Namusisi, K. (2015). Healthcare providers' level of involvement in provision of smoking cessation interventions in public health facilities in Kenya. *Journal of Public Health in Africa*, *6*(2), 523. doi:10.4081/jphia.2015.523. doi:10.4081/jphia.2015.523.

Hasan, S. I., Hairi, F. M., Tajuddin, N. A. A., & Nordin, A. S. A. (2019). Empowering healthcare providers through smoking cessation training in Malaysia: a preintervention and postintervention evaluation on the improvement of knowledge, attitude and self-efficacy. *BMJ Open*, *9*(9), e030670. doi:10.1136/bmjopen-2019-030670.

Hayes, S., Wolf, C., Labbé, S., Peterson, E., & Murray, S. (2017). Primary health care providers' roles and responsibilities: A qualitative exploration of ‘who does what

‘in the treatment and management of persons affected by obesity. *Journal of Communication in Healthcare*, *10*(1), 47-54. doi:10.1080/17538068.2016.1270874.

Huo, J., Chung, T. H., Kim, B., Deshmukh, A. A., Salloum, R. G., & Bian, J. (2020). Provider-patient discussions about smoking and the impact of lung cancer screening guidelines: NHIS 2011–2015. *Journal of General Internal Medicine*, *35*(1), 43-50. doi:10.1007/s11606-019-05111-6.

Jordan, K. (2018). Validity, reliability, and the case for participant-centered research: Reflections on a multi-platform social media study. *International Journal of Human–Computer Interaction*, 1-9. doi:10.1080/10447318.2018.1471570.

Kaul, S., Veeranki, S. P., Rodriguez, A. M., & Kuo, Y. F. (2016). Cigarette smoking, comorbidity, and general health among survivors of adolescent and young adult cancer. *Cancer*, *122*(18), 2895-2905. doi:10.1002/cncr.30086.

Kale, D., Gilbert, H., & Sutton, S. (2019). An exploration of the barriers to attendance at the English Stop Smoking Services. *Addictive Behaviors Reports*, *9*. doi:10.1016/j.abrep.2018.10.005.

Kilbourne, A. M., Switzer, G., Hyman, K., Crowley-Matoka, M., & Fine, M. J. (2006). Advancing health disparities research within the health care system: A conceptual framework. *American Journal of Public Health*, *96*(12), 2113-2121. doi:10.2105/AJPH.2005.077628.

Krosnick, J. A. (2018). Questionnaire design. In *Palgrave Handbook of Survey Research* (pp. 439-455). Cham, Switzerland: Palgrave Macmillan.

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, *4*(3), 324-327. doi:10.4103/2249-4863.161306.

Levy, D. T., Yuan, Z., Luo, Y., & Mays, D. (2018). Seven years of progress in tobacco control: An evaluation of the effect of nations meeting the highest level MPOWER measures between 2007 and 2014. *Tobacco Control*, *27*(1), 50-57. doi:10.1136/tobaccocontrol-2016-053381.

Lewis, S. (2015). Qualitative inquiry and research design: Choosing among five approaches. *Health Promotion Practice*, *16*(4), 473-475. doi:10.1177/1524839915580941.

Li, I., Lee, S. Y. D., Chen, C. Y., Jeng, Y. Q., & Chen, Y. C. (2014). Facilitators and barriers to effective smoking cessation: Counselling services for inpatients from nurse-counsellors' perspectives—A Qualitative Study. *International Journal of Environmental Research and Public Health*, *11*(5), 4782-4798. doi:10.3390/ijerph110504782.

Little, M. A., Klesges, R. C., Bursac, Z., Ebbert, J. O., Halbert, J. P., Dunkle, A. N., ... Weksler, B. (2018). Why don't cancer survivors quit smoking? An evaluation of readiness for smoking cessation in cancer survivors. *Journal of Cancer Prevention*, *23*(1), 44. doi:10.15430/JCP.2018.23.1.44.

Marzorati, C., Riva, S., & Pravettoni, G. (2017). Who is a cancer survivor? A systematic review of published definitions. *Journal of Cancer Education: The Official*

Journal of the American Association for Cancer Education, 32(2), 228–237. doi:10.1007/s13187-016-0997-2.

Masud, H., Pervaiz, F., Azam, N., Niazi, Z. K., e Huma, Z., Khan, F., & Hammed, A. (2019). Preparedness of general healthcare practitioners in tobacco cessation counseling/treatment in twin cities: A cross-sectional study. *Pakistan Armed Forces Medical Journal*, *69*(SUPPL 2), S200-04. Retrieved from https://www.pafmj.org/index.php/PAFMJ/article/view/2878/2216.

McGrath, C., Palmgren, P. J., & Liljedahl, M. (2019). Twelve tips for conducting qualitative research interviews. *Medical Teacher*, *41*(9), 1002-1006. doi:10.1080/0142159X.2018.1497149.

Moore, P. M., Rivera, S., Bravo-Soto, G. A., Olivares, C., & Lawrie, T. A. (2018). Communication skills training for health care professionals working with people who have cancer. *Cochrane Database of Systematic Reviews*, *2013*(3): CD003751. doi:10.1002/14651858.CD003751.pub3.

Morphett, K., Partridge, B., Gartner, C., Carter, A., & Hall, W. (2015). Why don't smokers want help to quit? A qualitative study of smokers' attitudes towards assisted vs. unassisted quitting. *International Journal of Environmental Research and Public Health*, *12*(6), 6591-6607. doi:10.3390/ijerph120606591.

Muthukrishnan, A., & Warnakulasuriya, S. (2018). Oral health consequences of smokeless tobacco use. *The Indian Journal of Medical Research*, *148*(1), 35. doi:10.4103/ijmr.IJMR_1793_17.

National Cancer Institute (n.d.). Smoking cessation. *NCI Dictionary of Cancer Terms*. Retrieved December 11, 2018 from https://www.cancer.gov/publications/dictionaries/cancer-terms/def/smoking-cessation.

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing, 18*(2), 34-35. doi:10.1136/eb-2015-102054.

O'Neill, C., McCaughan, E., Semple, C. J., & Ryan, A. (2018). Fathers' experiences of living with cancer: A phenomenological study. *European Journal of Cancer Care, 27*(1), e12492. doi:10.1111/ecc.12492.

Ostroff, J. S., Copeland, A., Borderud, S. P., Li, Y., Shelley, D. R., & Henschke, C. I. (2016). Readiness of lung cancer screening sites to deliver smoking cessation treatment: Current practices, organizational priority, and perceived barriers. *Nicotine & Tobacco Research, 18*(5), 1067-1075. doi:10.1093/ntr/ntv177.

Papadakis, S., Cole, A. G., Reid, R. D., Coja, M., Aitken, D., Mullen, K. A., ... Pipe, A. L. (2016). Increasing rates of tobacco treatment delivery in primary care practice: Evaluation of the Ottawa model for smoking cessation. *The Annals of Family Medicine, 14*(3), 235-243. doi:10.1370/afm.1909.

Park, E. R., Gareen, I. F., Japuntich, S., Lennes, I., Hyland, K., DeMello, S., ... Rigotti, N. A. (2015). Primary care provider-delivered smoking cessation interventions and smoking cessation among participants in the National Lung Screening

Trial. *JAMA Internal Medicine*, *175*(9), 1509-1516. doi:10.1001/jamainternmed.2015.2391.

Petersen, P. E. (2017). Tobacco and oral health: The approach of the World Health Organization Oral Health Programme. *Oral Health & Preventive Dentistry*, *1*(4), 309-315. Retrieved from https://www.who.int/oral_health/publications/ohpd01/en/.

Qutoshi, S. B. (2018). Phenomenology: A philosophy and method of inquiry. *Journal of Education and Educational Development*, *5*(1), 215-222. doi:10.22555/JOEED.V5I1.2154.

Ramsey, A. T., Prentice, D., Ballard, E., Chen, L. S., & Bierut, L. J. (2019). Leverage points to improve smoking cessation treatment in a large tertiary care hospital: A systems-based mixed methods study. *BMJ Open*, *9*(7), e030066. doi:10.1136/bmjopen-2019-030066.

Raz, D. J., Wu, G., Nelson, R. A., Sun, V., Wu, S., Alem, A., ... Gould, M. K. (2019). Perceptions and utilization of lung cancer screening among smokers enrolled in a tobacco cessation program. *Clinical Lung Cancer*, *20*(1), e115-e122. doi:10.1016/j.cllc.2018.09.013.

ReSearCher, N. (2017). Use of theoretical and conceptual frameworks in qualitative research. *Nurse Researcher, 21*(6), 34-38. doi:10.7748/nr.21.6.34.e1252.

Rigotti, N. A., & Kalkhoran, S. (2017). Reducing health disparities by tackling tobacco use. doi:10.1007/s11606-017-4098-7.

Romani, M., Jawhar, S., Shalak, M., & Antoun, J. (2020). Waterpipe smoking cessation: Knowledge, barriers, and practices of primary care physicians - A questionnaire-based cross-sectional study. *BMC Family Practice*, *21*(1), 21. doi:10.1186/s12875-020-1095-4.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., ... Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893-1907. doi:10.1007/s11135-017-0574-8.

Sim, I., Hwang, E., & Sin, B. (2020). A self-reflection program for smoking cessation in adolescents: A phenomenological study. *International Journal of Environmental Research and Public Health*, *17*(3), 1085. doi:10.3390/ijerph17031085.

Sinclair, S., Jaggi, P., Hack, T. F., McClement, S. E., Raffin-Bouchal, S., & Singh, P. (2018). Assessing the credibility and transferability of the patient compassion model in non-cancer palliative populations. *BMC Palliative Care*, *17*(1), 108. doi:10.1186/s12904-018-0358-5.

Stopping Tobacco Use After a Cancer Diagnosis. (n.d.). Retrieved from https://www.cancer.net/sites/cancer.net/files/stopping_tobacco_use.pdf.

Subica, A. M., & Douglas, J. A. (2019). Engaging disadvantaged communities in targeting tobacco-related health disparities and other health inequities. *International Quarterly of Community Health Education*, doi:10.1177/0272684X19839866.

Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, *68*(3), 226. doi:10.4212/cjhp.v68i3.1456.

Thun, M. J., Carter, B. D., Feskanich, D., Freedman, N. D., Prentice, R., Lopez, A. D., ... & Gapstur, S. M. (2013). 50-year trends in smoking-related mortality in the United States. *New England Journal of Medicine*, 368(4), 351-364. doi:10.1056/NEJMsa1211127.

Twyman, L., Bonevski, B., Paul, C., & Bryant, J. (2014). Perceived barriers to smoking cessation in selected vulnerable groups: A systematic review of the qualitative and quantitative literature. *BMJ Open*, *4*(12), e006414. doi:10.1136/bmjopen-2014-006414.

Ucar, E. Y., Araz, O., Yilmaz, N., Akgun, M., Meral, M., Kaynar, H., & Saglam, L. (2014). Effectiveness of pharmacologic therapies on smoking cessation success: Three years' results of a smoking cessation clinic. *Multidisciplinary Respiratory Medicine*, 9(1), 9. doi:10.1186/2049-6958-9-9.

U.S. Department of Health and Human Services. (2014). *The health consequences of smoking—50 years of progress: A report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

van Eerd, E., Bech Risør, M., Spigt, M., Godycki-Cwirko, M., Andreeva, E., Francis, N., … Kotz, D. (2017). Why do physicians lack engagement with smoking cessation

treatment in their COPD Patients? A multinational qualitative study. *NPJ Primary Care Respiratory Medicine*, *27*(1), 41. doi:10.1038/s41533-017-0038-6.

van Rossem, C., Spigt, M. G., Kleijsen, J. R., Hendricx, M., van Schayck, C. P., & Kotz, D. (2015). Smoking cessation in primary care: Exploration of barriers and solutions in current daily practice from the perspective of smokers and healthcare professionals. *European Journal of General Practice*, *21*(2), 1-7. doi:10.3109/13814788.2014.990881.

Van Schayck, O. C. P., Williams, S., Barchilon, V., Baxter, N., Jawad, M., Katsaounou, P. A., ... Ostrem, A. (2017). Treating tobacco dependence: Guidance for primary care on life-saving interventions. Position statement of the IPCRG. *npj Primary Care Respiratory Medicine*, *27*(1), 38. doi:10.1038/s41533-017-0039-5.

Wells, M., Aitchison, P., Harris, F., Ozakinci, G., Radley, A., Bauld, L., ... Williams, B. (2017). Barriers and facilitators to smoking cessation in a cancer context: A qualitative study of patient, family and professional views. *BMC Cancer*, *17*(1), 348. doi:10.1186/s12885-017-3344-z.

World Health Organization (2005). The role of health professionals in tobacco control. *Geneva: WHO*, 44. Retrieved from https://www.who.int/tobacco/resources/publications/wntd/2005/bookletfinal_20april.pdf.

World Health Organization (2017). *WHO report on the global tobacco epidemic, 2017: monitoring tobacco use and prevention policies: Executive summary*. Retrieved from https://www.who.int/tobacco/global_report/2017/executive-summary/en/.

Zeller, M. (2018). The Future of Nicotine Regulation: Key Questions and Challenges. *Nicotine & Tobacco Research, 21*(3): 331-332. doi:10.1093/ntr/nty200.

Appendix A: Interview Protocol

Interview Protocol

Research Title**: The Effectiveness of Health Care Professionals Providing Smoking Cessation in Health Care Settings**
Date of Interview:
Location of Interview:
Start time: End time:
Name of Interviewee:
Name of Interviewer: **Tenishia Edwards**
Recording mechanism:

Introduction:
Good Morning/Good Afternoon, my name is Tenishia Edwards and I am a PhD candidate at Walden University. Thank you for taking the time out of your busy schedule to meet with me today. As mentioned on the consent form, your participation in this interview will contribute information for a research study to identify what professional health care workers perceive to be barriers to adherence to smoking cessation services. During this interview, I will be taking notes and recording your responses. This interview will take approximately 30 minutes to complete. Per the consistent form, you may decline to answer any question at any time, and can withdraw from the interview during any time. If you would like to take a break during this interview please let me know. Are there any questions before we begin?

Questions	**Notes**
Demographic Questions Health Organization name: Education: Length of time at organization:	
1. How would you describe your role as a health care professional? a. Please tell me more about this role…. b. How long have you been in this role?	
2. How do you feel about your ability to successfully provide smoking cessation therapy? a. Can you tell me more about your abilities?	
3. What problems do you think current tobacco smokers might have? This is your perception.	
4. What is your best approach amongst	

patients that are resistant to smoking cessation therapies? Can you describe those barriers?	
5. How do you feel about your patient's tobacco behavior? This is your perception.	
6. What type of smoking cessation resources are provided to your patients? a. Are these resources cost effective?	

Conclusion:

I would like to thank you for your time today and your contribution to this research study. There are no further questions from me at this time. Do you have and questions or comments for me? Upon your request, the research results can be shared with you through email, 3 months after this interview date. Again, I appreciate your time and participation.

Appendix B: Background of Expert Panel

Expert 1: This expert is a Nurse Care Manager who is working for a health care organization for 11 years services vulnerable population members needs of chronic illnesses. She holds a Bachelor's degree in Nursing, enrolled in a Masters of Nursing, APRN program.

Expert 2: The second expert is a Nurse Care Manager that provides telephonic chronic care management services to the vulnerable population at a local health care organization. This expert has been working in this field for 14 years. She holds an Associate's degree in Nursing as well as an Associate's degree in Business Management.

Expert 3: The third expert is a Medical Assistant at a local health care organization that provides various health services to the low-income population, including smoking cessation services.