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Trying to Quit: Low-income Smokers' Access to Cessation Care in a Managed Care Environment

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PEER REVIEWED

Track: Methods and Surveillance

This study describes 295 smokers in a managed care safety-net insurance program, where 63% received cessation advice during at least one visit in the previous year. Our study asks: Does longer program enrollment increase a smoker's likelihood of receiving cessation advice?

The study population is drawn from Advantage program clients who are predominantly minority, working poor with Medicaid/Medicare or are under-insured county residents who meet 200% or less of federal poverty guidelines. State medical school practitioners coordinate the program in seven primary care clinics in a Midwestern urban county.

Telephone surveys using Bellview CATI survey software (Pulse Train Software, Ltd, Surrey, UK) were administered in English or Spanish to 731 Advantage enrollees. Of these, 317 were enrolled for less than one year, 281 were enrolled for one year, and 133 were enrolled for more than one year. Of the 731 enrollees, 295 (40.4%) were current smokers. The current smokers were categorized by sex, ethnicity, age, education, knowledge of primary care physician (PCP), and coronary heart disease (CHD) risk other than smoking. The association of each characteristic with cessation advice was determined by chi-square tests of significance. Predisposing factors (sex, age, ethnicity), enabling factors (education, known PCP), health care need (other CHD risk), and program enrollment time were tested in a logistic model of cessation advisement, using a forward selection process.

Advantage smokers who are female (72.0%), white (70.4%), and over age 65 (85.0%) and who know their PCP (68.5%) and have another CHD risk factor (89.3%) report more advice than smokers who are male (49.0%), minority (54.5%), and under age 35 (35%) and who do not know their PCP (51.0%) or have any other CHD risk factors (46.2%). Individuals who were enrolled for more than one year (71.2%) report more advice than individuals enrolled for less than one year (53.1%). In logistic analysis, other CHD risk doubled the likelihood of cessation advice (odds ratio [OR], 2.02; 95% confidence interval [CI], 1.5–2.8), as did being female (OR, 1.95; CI, 1.1–3.3). Being over age 65 increased the likelihood of advisement (OR, 1.5; CI, 1.09–2.12), while minority status reduced the likelihood (OR, 0.41; CI, 0.24–.70). Enabling factors of education, enrollment time, or PCP recognition did not enter the model.

Safety-net programs increase access to and continuity of primary care in low-income communities where smoking is most prevalent. Advantage's 63% advisement rate exceeds that reported for other smokers using primary care and indicates appropriate outreach to high CHD risk smokers. More than one third (37%) of smokers in

Advantage's program, however, report no cessation counseling. We propose examination of visit patterns, language difficulties, and clinical smoking records as ways to track and target younger, male, and minority smokers for provider prompts and cessation support. Increasing access to cessation care would reduce CHD, respiratory, and adverse reproductive outcomes in this population.

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