Published in final edited form as:

J Assoc Nurses AIDS Care. 2018 ; 29(2): 338–344. doi:10.1016/j.jana.2017.09.007.

Meeting our patients “where they are”: Video-group smoking cessation for people living with HIV

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Keywords

ehealth; HIV; telemedicine; tobacco use cessation; videoconferencing

Cigarette smoking among people living with HIV (PLWH) is a critical public health problem. In the United States, PLWH (vs. other adults) are twice as likely to use tobacco, with approximately 42% of PLWH reporting tobacco use (Mdodo et al., 2015). Compared to non-PLWH smokers, PLWH smokers have been shown to have higher risks of smoking-related adverse outcomes, including cardiovascular complications and cancer (Engels et al., 2006; Helleberg et al., 2013; Hile, Feldman, Alexy, & Irvine, 2016). PLWH smokers (vs.

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Disclosures

All authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

PLWH non-smokers) were projected to have lifespans 6 to 15 years shorter (Helleberg et al., 2013; Reddy et al., 2016; Siddiqi & Mdege, 2016), higher rates of unsuppressed HIV viral loads, lower CD4+ T cell counts (Hile et al., 2016), and increased risks of HIV-associated pathologies such as pneumonia and tuberculosis (Siddiqi & Mdege, 2016). PLWH (vs. non-PLWH) smokers were also less likely to quit smoking (Mdodo et al., 2015).

Tobacco cessation interventions focused on the broader population of smokers may fail to meet the needs of PLWH, yet smoking trials targeting PLWH have generally failed to demonstrate lasting effects. The largest meta-analysis of PLWH tobacco treatment to date painted a bleak picture, concluding that, despite low quality evidence, PLWH tobacco treatments may have increased short-term quit rates, but did not achieve long-term abstinence efficacy compared to controls (RR = 1.00 [0.72–1.39]; Pool, Dogar, Lindsay, Weatherburn, & Siddiqi, 2016). A static web-based program for PLWH, called Positively Smoke Free (PSF), was found to be feasible and promising in a pilot trial (Shuter, Bernstein, & Moadel, 2012). One pilot tobacco cessation study ($n = 145$) of an in-person group program delivering PSF resulted in greater chances of quitting and greater motivation to quit, higher self-efficacy for cessation, and decreased daily cigarette consumption compared to standard care (Moadel et al., 2012), but participants experienced attendance challenges. People in need of assistance may not be able to attend in-person counseling sessions due to mobility limitations, lack of adequate transportation, living in areas where in-person sessions are not available, or difficulty traveling to in-person sessions (i.e., due to work, childcare; Marhefka et al., 2013), yet may benefit from an interactive, online, group-based format. eHealth smoking cessation options for PLWH may mitigate attendance challenges (Ledgerwood & Yskes, 2016).

Asynchronous web-based, app and text messaging programs have been tested, but evidence is limited on video-conferencing interventions (group- and individually-based) for both the general smoker population and for PLWH smokers. One telehealth program (Carlson et al., 2012) connected participant groups from remote sites to a group-based in-person program, but the participants did not access the program from their homes nor did they navigate the technology on their own (i.e., each site had a facilitator who managed the site's technology). Still, the study suggested that video-conferencing groups (VGs) might be a viable option for smoking cessation. VGs offer a structured and supportive environment, components that may be key to effective interventions (Lustria, Cortese, Noar, & Glueckauf, 2009). To date, no study has assessed smoking cessation via VGs for PLWH.

Our study aimed to: (a) test acceptability of a facilitator-led, PLWH VG tobacco cessation program accessed individually; and (b) assess factors impacting adoption of a PLWH VG tobacco cessation program.

Methods

We present findings of two pilot studies that investigated VG delivery of Positively Smoke Free (PSF-VG), a video-group-based tobacco cessation program for PLWH (Moadel et al., 2012). These studies were reviewed and approved by the Institutional Review Board at the University of South Florida. Participants met virtually using their own computers or tablets

and a commercial video-conferencing platform. Inclusion criteria were that participants had to: (a) be a PLWH, (b) be an active smoker interested in cessation, and (c) have access to a computer with an Internet connection. Exclusion criteria were: (a) mentally or physically unable to complete intervention sessions, or (b) have unstable or inconsistent Internet access. Two trained facilitators (both tobacco cessation specialists; one a former smoker and a PLWH) delivered eight sessions over 6 weeks. Sessions, based on Social Cognitive Theory (Bandura, 1989), focused on identifying triggers, determining alternative habits, introducing stress management techniques, and recognizing environmental and lifestyle cues.

In Study 1 (1 cohort, $N = 9$), participants completed surveys at baseline, midway through program completion, and at 90-days post-intervention paired with biochemical verification of tobacco use/non-use. Increased funding was available for Study 2 (2 cohorts, $N = 12$), allowing additional assessments. Participants completed surveys at baseline, program completion, 90-days post-, and 180-days post-intervention; biochemical verification was conducted at baseline and 90-days post-intervention. Seven-day point prevalence abstinence (7ppa), was measured by asking participants *Have you smoked cigarettes (even a puff) in the last 7 days, including today?* Oral swab test kits used to measure a tobacco metabolite (cotinine) were sent to participants, self-administered over individual video-conference for staff observation, and mailed to a lab. Quantitative analyses were conducted (SPSS v22; IBM Corp, 2013) using data from baseline and 90-day post-intervention, as these time-points could be compared across groups. Post-intervention focus groups and session notes were analyzed thematically (Guest, MacQueen, & Namey, 2012, guided by Diffusion of Innovations theory (Rogers, 2003).

Results

At baseline, all participants ($N = 21$) had smoked in the previous 7 days. At 3-month follow-up, 3 participants (14%) reported 7ppa; one additional participant reported not smoking in the previous 7 days but smoked one puff at a party; biomarker tests confirmed all 4 (19%) participants had cotinine levels inconsistent with smoking (see Table 1).

PSF-VG impacted several smoking habits. After PSF-VG, participants delayed their first cigarette ($p = .001$). At baseline, 6 (29%) participants smoked their first cigarette within 5 minutes post-waking, 13 (57%) within 6–30 minutes after waking, and 2 (10%) 31–60 minutes post-waking. At 3 months post-participation, of the 12 still smoking, no participants smoked 5 or fewer minutes post-waking, 8 (38%) smoked 6–30 minutes post-waking, 2 (10%) smoked within 31–60 minutes, and 2 (10%) smoked more than 60 minutes post-waking (data not available for 5 participants). Moreover, participants reduced their smoking frequency. At baseline, 18 (86%) smoked daily; at 3-month follow up, only 10 (63%) of 16 respondents smoked daily ($p = 0.219$). Although not statistically significant ($p = .366$), participants reduced the number of cigarettes they smoked each day. At baseline, 8 (38%) smoked 10 or fewer cigarettes/day, 8 (38%) smoked 11–20 cigarettes, and 5 (24%) smoked 21–30 cigarettes. Of the 12 participants who smoked at 3-month follow-up, 8 (38%) smoked 10 or fewer cigarettes/day and 4 (19%) smoked 11–20 cigarettes/day.

During sessions and post-program focus groups, participants expressed limited concerns over the risk associated with accessing VGs at home, such as fear that they “might be talking to this person, but who’s in the room with them?” (i.e., another person could be in the room with group members and limit privacy). For many, these concerns were alleviated by group members using a headset or trust developed between group members over time. Program acceptance was high, and data suggested promise for future adoption of such programs.

Participants reported low program complexity, even among those with low technology literacy (e.g., “for somebody who’s not tech savvy, it’s tech friendly and it wasn’t difficult”). A positive impact on social interactions was described. Despite initial reservations, participants formed a cohesive group and looked forward to group sessions. The relative advantage of participating via VGs was noted. Many participants said they would not have participated in an in-person smoking cessation group due to past negative experiences (e.g., “Sometimes with in-person groups it can become heated or confrontational.”), concerns about in-person group settings (e.g., “I have a lot of social anxiety, so I don’t do well with groups...This, however, there’s a comfort behind this, you know?”), or barriers to attending groups outside of their homes (e.g., “[with PSF-VG] I didn’t have to go anywhere”). The possibility of connecting from home and the high trialability and reversibility (e.g., “We’re all on videoconference and I can just turn the camera off and walk away, and you’re never gonna see me again”) made them willing to join.

In addition, participants felt PSF-VG was compatible with their needs, as it addressed challenges they faced (i.e., both smoking and HIV-related concerns), all group members and one facilitator were PLWH, and both facilitators were former smokers (e.g., “They came from a totally different approach than someone that has not walked in my shoes. You know, even down to the HIV.”). However, the program length was incompatible with their needs (i.e., participants stated additional sessions were needed after program completion). This resulted in participants suggesting at least one “follow-up session, say, 3 months out, and retouch with people, and see [if] anybody fall off the wagon. Are they still experiencing the issues they had before? Did they correct them?” Participants made substantial progress but wanted additional support. Despite any barriers to adoption and participation, all participants would recommend the program to other PLWH who wanted to quit smoking.

Discussion

VGs present an exciting opportunity to increase intervention reach, particularly for those who cannot or will not participate in in-person groups. Guided by Diffusion of Innovations theory (Rogers, 2003), our study highlights the acceptability and potential for future adoption of VG cessation programs for PLWH. Findings build on work demonstrating the acceptability, feasibility, and effectiveness of VG delivery of a secondary prevention program for PLWH (Green, Lockhart, & Marhefka, 2015; Marhefka et al., 2014; Marhefka et al., 2013). Participants liked accessing PSF-VG from home and viewed participation as low-risk because they could easily disconnect if they did not like the program. Quit rates (19% biochemical abstinence) were greater than other tobacco cessation programs for PLWH (Pool et al., 2016). Together, our findings suggest that PSF-VG, if proven effective,

could be an important option within a compendium of choices (Bekele et al, 2017; Ledgerwood & Yskes, 2016) to help PLWH smokers quit.

In addition to providing proof of concept, our findings suggest that booster sessions (Alharbi, Gallagher, Kirkness, Sibbritt, & Tofler, 2016) might be important for smoking cessation interventions with PLWH. After eight intensive group-based sessions, participants wanted additional sessions to help them meet and maintain their goals. Booster sessions have been shown to be effective in reducing biomarker levels when provided in a structured format that enhanced initial intervention content and involved problem solving strategies for behavioral changes (Goldberg, Lockwood, Garg, & Kuehl, 2015).

Marketing for VG-based tobacco cessation should highlight ease of use, low-risk investment (i.e., trialability and reversibility), and facilitators' smoking experiences. Potential participants, especially those with prior negative experiences with in-person groups, might be comforted knowing they could press a button to disconnect from the VG. Participants unable to access in-person groups might respond to the relative advantages and convenience of VGs (Green et al., 2015). Those intimidated by technology or ehealth could be persuaded by the low complexity of the technology.

Study limitations include the small sample size and lack of a control condition. Pilot groups were only in English. The follow-up period was short (90 days for all participants; 180 self-report, follow-up for Study 2 participants only). Yet findings highlighted factors important to individual adoption decisions regarding VG tobacco cessation and could be used to further develop VG-based tobacco cessation programs for PLWH, a high-priority group (Engels et al., 2006; Helleberg et al., 2013; Hile et al., 2016; Mdodo et al., 2015; Siddiqi & Mdege, 2016). Additionally, VGs may be a promising option for more general audiences.

Because some participants decreased their tobacco use but did not quit, and participants requested additional sessions (regardless of cessation status), booster sessions should be tested in a definitive PSF-VG trial. Hispanics/Latinos accounted for 24% of new HIV diagnoses in 2014 (Centers for Disease Control and Prevention, 2016, thus, PSF-VG should be tested with Spanish-speakers to expand potential reach. Long-term follow-up assessments are needed to determine effect maintenance over time (Hughes et al., 2003; Pool et. al., 2016). Regarding implementation, findings related to marketing VGs should also be tested. More broadly, research should explore the potential role of VGs in expanding access to smoking cessation for non-PLWH. State quit-line services could employ a tobacco cessation specialist to deliver VG programs from a centralized location at various times of the week or day to expand service costs effectively (Marhefka et al., 2013). Ultimately, VGs could help to achieve national smoking cessation objectives as well as reduce smoking-related morbidity and mortality.

Conclusion

VGs have the potential to expand access to care for people who may otherwise have limited opportunities to attend in-person group-based programs. Our mixed-method pilot study demonstrated the potential feasibility and acceptability of PSF-VG, an HIV-tailored smoking

cessation program delivered via VGs accessed on participants' own devices. Results suggest that high trialability and reversibility enhance the potential of PSF-VG to help reduce smoking among PLWH, literally by "meeting them where they are"—especially if enhanced with booster sessions.

Acknowledgments

This project was funded, in part, by a Proposal Enhancement Grant from the University of South Florida (PI: Marhefka). Dr. Shuter's effort on this project was supported in part by awards 1R01DA036445 (PI: Shuter), 1R01CA192954 (PIs: Shuter, Stanton), and 1R34DA037042 (PIs: Shuter, Abrams) from the National Institutes of Health. It was also supported, in part, by the Einstein-Rockefeller-CUNY Center for AIDS Research (P30-AI124414; PI: Goldstein) which is funded by the following NIH Co-Funding and Participating Institutes and Centers: NIAID, NCI, NICHD, NHBL, NIDA, NIMH, NIA, FIC and OAR. None of the funding sources had any role in study design, collection, analysis or interpretation of data, writing the manuscript, or the decision to submit the manuscript for publication.

We would like to acknowledge and thank our participants; without them this work would not be possible. Many thanks to our facilitators, who, in part, volunteered their time to assist with the project. Special thanks to Ms. Shanda Vereen, who managed data collection and group sessions.

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Table 1

Participant Characteristics (N = 21 unless noted)

Age	49 (± 7.6)
Race	
White	13 (57%)
African American	9 (39%)
Biracial	1 (4%)
Gender	
Male	14 (61%)
Female	9 (39%)
Education Status	
Some High School	1 (4%)
High School Graduate	3 (13%)
Some College	8 (35%)
College Graduate	10 (44%)
Housing Status	
Stable	18(78%)
Transitional	4 (17%)
Unsure	1 (4%)
Financial Status	
Comfortable with Some Extras	4 (17%)
Enough, but No Extras	8 (35%)
Have to Cut Back	4 (17%)
Cannot Make Ends Meet	7 (30%)
Tobacco Cessation	
Self-reported 7ppa at 90-days post intervention	3 (14%) ¹
Biochemical abstinence at 90-days post intervention	4 (19%) ¹
Concurrent results (self-reported and biochemical) at 90-days post intervention	3 (14%) ¹
Self-reported 7ppa at 180-days post intervention	3 (25%) ²
Self-reported 7ppa at 270-days post intervention	4 (33%) ²

Note. 7ppa = 7-day point prevalence abstinence.

¹One participant self-reported having one puff of his partner's cigarette and thus did not meet the abstinence criteria. The level of cotinine in his system did not reach the level needed for a positive cotinine test, resulting in a discordance between self-report and biochemical confirmation.

²Data available only for study 2 (n = 12); i.e. 3/12 self-reported cessation at 180 days; 4/12 self-reported cessation at 270 days.

Table 2

Application to Selected Constructs of Diffusion of Innovation Theory

Construct	Question for PSF-VG	Findings	Exemplary Quote
Relative Advantage	How does PSF-VG compare to other existing resources for tobacco cessation among PLWH?	PSF-VG was favorable over other group-based programs participants had tried, particularly for those with limited transportation options or who had experienced prior discomfort with in-person groups.	If it was out of my house and into a group somewhere else, I probably wouldn't participate so much... I'm more of a closed-in person. And with this being online and me being in my own house where I'm, I'm more comfortable, I seem to come out more, with being able to vocalize, what I'm going through, what I need, or what kind of direction I need help in, uh, with stopping smoking.
Compatibility	Is PSF-VG compatible with the needs of our population?	For those who took part in the program, compatibility was high. The group-based nature of the program allowed for social support, and the content specific to PLWH and who were smokers was appreciated.	I thought the conversation would be like confined to smoking. But it ... it went beyond and just took on ... enhancing our life, which I did expect to a degree because its focus is on persons with HIV to increase their health and lifespan and things.
Complexity	How complex, or not complex, is it to take part in PSF-VG?	Participants were able to take part in PSF-VG regardless of past technology experience. They indicated a low level of complexity with the intervention.	Am I going to have the technology to do this? Is my computer ... Is it going to be difficult for me to do? I didn't have ... It's that don't know, kind of anxiety more than anything else. Is it going to work? Is my computer going to work? Am I going to make ... Am I smart enough to do it? That kind of thing. But, once after the first interaction, I thought "Oh, this is so much easier than I thought it was."
Trialability/Reversibility	Can a PSF-VG participant try the program before adopting its long-term use? Can a PSF-VG participant change their course of action and not use PSF-VG?	Some participants stated that the remote nature of the program would allow them to not return to the program, i.e., logging onto the program at least one time before truly committing as a form of trialability. Participants noted that if they became uncomfortable during the group, they could simply close their computers or log off – allowing an easy out for those who had prior negative experiences with group-based programs for PLWH (i.e., reversing their course of action and ceasing use of PSF-VG).	It was easier to explain myself and my circumstances and what I'm going through and been through, um, because like [another participant] said, you can just turn off the camera, and that can be the last time you ever talk to somebody.

Note. PSF-VG = Positively Smoke Free-Video Group; PLWH = people living with HIV.