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Affecting Change in Tobacco Dependence through Nursing Education

Scholarly Project
Submitted in Partial Fulfillment
of the Requirements for the Degree of
Master of Arts- Nursing Education
St. Catherine University
St. Paul, Minnesota

Kelly Jean Henson-Evertz

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ST. CATHERINE UNIVERSITY
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This is to certify that I have examined this
Master of Nursing-Nurse Educator Scholarly Project
written by

Kelly Jean Henson-Evertz

and have found that it is complete and satisfactory in all respects,
and that any and all revisions required by
the final examining committee have been made.

Graduate Program Faculty

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Date

DEPARTMENT OF NURSING

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Abstract

More than 20% of the population in the United Sates (U.S.) is tobacco dependent. Tobacco abuse is a chronic relapsing condition that requires intervention with effective tobacco dependence treatment such as cessation education, counseling, and medication. Nurses are on the frontline of patient care education, and have the potential to be effective change agents in tobacco dependence. A literature review found a consistent lack of (a) standardized tobacco education curricula in nursing programs, (b) student tobacco cessation knowledge, (c) self-efficacy, (d) clinical experience with tobacco dependent patients, and (e) undergraduate nursing faculty beliefs, values, or perceptions. Recommendations call for instituting universal standardized tobacco education in U.S. nursing curricula, further research, and anti-tobacco advocacy.

Affecting Change in Tobacco Dependence Through Nursing Education

Significance

More than 20% of the population in the United Sates (U.S.) is tobacco dependent, and 443,000 Americans and 5.4 million people worldwide die annually of tobacco related illnesses (CDC, 2011). The economic impact of tobacco use in health care costs and loss of productivity is $193 billion annually (USHHS, 2010). Tobacco abuse is a chronic relapsing condition that requires intervention with effective tobacco dependence treatment such as cessation education, counseling, and medication (Fiore, 2008).

Repeated studies have demonstrated the significant cost of tobacco dependence. As a result, numerous positive changes have been enacted, such as indoor smoke free initiatives, higher taxes on tobacco, the World Health Organization's Framework Convention on Tobacco Control (2003) requiring countries to implement tobacco dependence treatment programs, and Healthy People 2020 goal of lowering tobacco dependence rates to 12% of the U.S. population by 2020. In spite of all these changes tobacco dependence remains a major public health problem.

Nurses are on the frontline of patient care education, and are effective change agents with proven success as tobacco cessation interventionalists (Fiore, 2000), yet there are still no universal established standards on structured tobacco education in U.S. nursing programs. It is imperative that nurses be properly educated with regard to tobacco dependence in order to affect positive change in this tremendous public health problem.

Statement of Problem

Nurses are in a unique position to make an enormous impact in tobacco cessation, but without standardized tobacco education in nursing curricula, future nurses will be unprepared to

carry out tobacco treatment guidelines set forth by the government, and will fail to meet the needs of their clients. Faculty knowledge, perceptions, and values of importance of tobacco curricula also impacts whether tobacco education is taught sufficiently to prepare future nurses for following governmental evidence based practice (EBP) guidelines to assist tobacco dependent clients with tobacco cessation.

Statement of Purpose

The purpose of this paper is threefold. The first aim is to determine the extent (amount of time), and type of tobacco education content (health effects, cessation techniques, clinical experience) included in U.S. schools of nursing curricula. Second, this paper will explore the literature related to faculty knowledge, beliefs, perceptions, and values as to the importance of standardized tobacco education curricular in U.S. nursing programs. Third, recommendations for addressing tobacco education in nursing curricula, tobacco research, and nursing advocacy in tobacco control and public policy will be presented.

Tobacco Dependence and Health Consequences

The history of tobacco and its effects have been well documented for more than a half of a century, although most were not known until the Minnesota tobacco settlement of 1998 required them to be publicly disclosed. This lawsuit unearthed more than 35 million pages of documents (Hurt et al., 2009) that had been deliberately suppressed by the tobacco industry, and made them public. The documents provided decades of evidence highlighting tobacco's massive impact, physically, psychologically, and economically.

In 1964 the Surgeon General issued the first report on the health consequences of tobacco. Twenty-nine more reports have followed that first report (USHHS, 2010). These reports have evaluated the evidence of the adverse health effects of smoking, and second-hand

smoke exposure, using guidelines for assessing causality of smoking with disease. The first report established a:

> comprehensive evidence model for evaluation…using this model, every report on health has found that smoking causes many diseases and other adverse effects. Repeatedly, the reports have concluded that smoking is the single greatest cause of avoidable morbidity and mortality in the United States (USHHS, 2004, p. 1).

The Surgeon General's 2004 study focused on the strength of causality to health consequences in relationship to active smoking. The strongest evidence was classified as "sufficient to infer a causal relationship" (USHHS, 2004, p.1). Repeated exposure to tobacco causes disease and premature death. No tobacco product is considered safe. Other Surgeon General studies have focused on passive smoke causality. The environmental tobacco smoke produced by tobacco products increases disease risk for those who inhale secondhand smoke.

Nicotine is a highly addictive substance found in all tobacco products. When tobacco is used, the nicotine from the tobacco product is absorbed and reaches the brain within seconds. When nicotine fills the nicotinic receptors in the brain it triggers a release of dopamine. This release creates a positive re-enforcement for the user, creating addiction. The tobacco user continues their use because of the power of addiction.

According to the Office of the Surgeon General "More deaths are caused each year by tobacco use than by all deaths from human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle accidents, suicides, and murders combined" (CDC, 2011). According to the WHO "Ten percent of the economic costs related to tobacco use are attributable to second-hand smoke. Tobacco use imposes both direct economic costs on society, such as those associated with treating tobacco-related diseases, and indirect costs, such as those associated with reduced productivity or lost wages because of death or illness" (2011). Cigarettes cause more than one of every five American deaths (CDC, 2011). When we think of

the human health impact, we need to recognize the fact that tobacco users lose an average of 14 years of their life (CDC, 2011). These people don't just die; they get sick, suffer, and then die. In addition to the disease and death tobacco use causes, it creates heartache and suffering for family and friends, places a huge burden on the health care system, and reduces worker productivity. Everyone pays the price for tobacco use.

There are an estimated 46.2 million smokers in the United States alone, and more than 70% of U.S. smokers polled stated they would like to quit. In 1996 the U.S. Department of Health and Human Services established the *Treating Tobacco Use and Dependence: Clinical Practice Guidelines* to provide effective clinical treatment for tobacco dependence, and enhance the quality of health care and health of Americans'. The guidelines were revised and updated in 2000, and again in 2008.

Literature Review

A literature review identified that most studies are quantitative, of baccalaureate and graduate level nursing programs, using questionnaires, with input from program directors and students. One Canadian qualitative study is included because of its appropriateness of focus and data revealed. Studies on tobacco cessation education provided to health care professions students, although not specific to nursing education, are included because they contain structured tobacco education in their programs. One graduate level nursing program study pertains to faculty factors influencing integration of tobacco education in to nursing curricula.

Lack of Tobacco Education

Quantitative Studies

In 1998 Kraatz, Dudas, Frerichs, Paice, and Swenson reported on a quantitative survey of multiple levels of Illinois nursing programs on tobacco education. According to the authors, a

computerized review of the literature from 1966 to 1994 yielded no prior studies addressing the issue of tobacco education or knowledge gained, in either nursing or medical education. The study included 70 undergraduate nursing programs, consisting of 30 Associate Degree Nursing (ADN) programs, 19 Licensed Practical Nursing (LPN) programs, 14 Bachelor of Science Degree in Nursing (BSN) programs, and seven BSN completion programs, and was conducted by the Nurses' Committee of the Illinois Division of the American Cancer Society (ACS). The purpose of the study was to measure the type and amount of tobacco-related knowledge nursing students acquired from their nursing programs. Data were collected via a questionnaire, completed by directors of the surveyed nursing schools. Findings revealed an overall lack of consistent tobacco education in nursing curricula across all levels of Illinois nursing programs. Total tobacco education time provided per program ranged from 20 minutes to 12 hours. The LPN programs (shortest duration program) provided the most time, and the BSN (longest duration program) provided the least amount of time to tobacco related education. Smokeless tobacco education received the least amount of time spent on education in all programs.

Wewers, Kidd, Armbruster, and Sarna (2004) surveyed a cross-section of baccalaureate and graduate nursing program Associate Deans whose school was a member of the American Association of Colleges of Nursing. The purpose of their study was to examine tobacco content, extent of tobacco education, and intervention skills included in U.S. baccalaureate and graduate nursing programs. The questionnaire was an adapted tool originally used to survey U.S. medical schools Associate Deans, with tobacco curricula content based on the Agency for Healthcare Research and Quality (AHRQ) clinical practice guidelines. The tool, a 23-item questionnaire (n=631), gathered data on individual nursing program tobacco curriculum content related to

health effects, cessation topics, the five A's, medications, and resources used for curriculum development.

The authors found most programs indicated tobacco education was taught, "less than one hour in each of the three years of undergraduate nursing curriculum" (Wewers et al., 2004, p.97), with no regional differences noted with regard to respondent statistics. "Less than 13% of baccalaureate and graduate programs spent more than 3 hours each year" (Wewers et al., 2004, p. 98). The majority of tobacco education was on the health effects of tobacco, which was integrated into required courses, with little, if any, clinical smoking cessation content. In fact 51% of baccalaureate programs and 27% of graduate programs in the study reported providing no clinical smoking cessation techniques content.

A quantitative descriptive survey of 675 Minnesota senior baccalaureate students, and 10 Minnesota BSN programs was conducted to ascertain whether Minnesota BSN students receive education related to tobacco use, dependence, harm, and cessation interventions (Lentz, 2009). Students completed a 46-item Likert questionnaire. Questions pertained to knowledge about tobacco treatment, tobacco use history, beliefs about smoking, self-efficacy, and behavioral application of cessation interventions (Lenz, 2009). Participant demographic information was also collected. Department chairs completed a questionnaire with two areas of focus, tobacco cessation curricular content, and treatment and action regarding tobacco cessation interventions. Findings demonstrated inadequacy and inconsistency in the transfer of knowledge from program to student on tobacco health effects and cessation content. Level of inadequacy was dependent upon where students attended school. Fifty percent of Minnesota BSN programs received the survey's lowest rating for the amount of tobacco content provided in their program. Seventy percent of programs surveyed were lacking skills or practice areas of learning, and the same 70%

of programs were also not incorporating basic tobacco cessation guidelines provided by the AHRQ into their programs.

Qualitative Study

Chalmers, Seguire and Brown (2003) conducted a qualitative descriptive study of 272 second (n=145), third (n=53), and fourth year (n=74) provincial baccalaureate nursing students, at four different University sites in Manitoba, Canada. The study explored the beliefs and experiences of student nurses in reference to tobacco and cessation education, and their personal tobacco use. The study also sought to understand why nurses, who have a primary focus of health promotion, were not actively engaging in tobacco cessation with their patients, and whether or not nurses' own health practices influenced their commitment to the role of health promotion .

Findings reported student nurses' understanding of their role in health promotion with regard to tobacco issues through five themes that emerged. Students discussed (a) who they were-who they were becoming, regarding personal tobacco use; (b) central beliefs and attitudes, about tobacco and their approaches to care; (c) learning the facts, which discussed their knowledge about tobacco issues; (d) practice world-limited options, which addressed students application of cessation knowledge in the clinical setting and; (e) role conflict, related to the professional role of health promotion and the students' personal choices in living a healthy lifestyle. Study findings highlighted the lack of structured tobacco education in nursing curricula and the student nurses' lack of self-efficacy in addressing tobacco dependence. Students' personal tobacco use also seemed to play a role in their health promotion role, as those who were smokers stated they felt "like a hypocrite" promoting smoking cessation. The authors' noted the need for increasing students' tobacco knowledge, as well as skills for tobacco cessation

interventions. This need was critical in specific practice situations, in community settings, and with high-risk populations, including the elderly. Chalmer's et al. (2003) stated tobacco education should also include ways to develop student skills in health promotion.

Tobacco Education Curricula Interventions

Effective education in tobacco cessation increases self-efficacy, and future nurses impact cessation rates. Butler, Rayens, Zhang, Maggio and Riker (2009) conducted a quasi-experimental study using two cohorts of BSN students. Cohort one consisted of 79 BSN students who participated in a pilot study, and cohort two consisted of 99 BSN students. Nursing students participated in either a 2-hour or 6-hour class of tobacco cessation education called *Rx. for Change*, which included didactic lecture content (epidemiology of tobacco use, nicotine, principles of addiction, and helping patients quitting). The six-hour class also included hands on interactive practice. Self-report surveys were completed pre and post intervention. No statistically significant difference was discovered between the two-hour versus the six-hour training. The study did however find statistically significant positive improvement in perceived confidence, skill, and knowledge for providing tobacco dependence treatment to patients, regardless of students smoking status, post intervention. An increased level of tobacco cessation counseling by clinicians who had been provided with tobacco cessation education was also noted. The authors' identified a need for curriculum change in order to include tobacco cessation education in nursing curriculum, as well as for further research leading to the development of standardized curriculum for nursing education.

Sarna, Bialous, Rice, and Wewers (2009) provided an overview of nursing and tobacco education literature. The authors' found that although the strategies of the 5 A's (Ask, Advise, Assess, Assist, and Arrange), cessation interventions and counseling, and pharmacotherapy, have

proven to be a cost effective means of improving the health of adults, and are recommended by the U.S. Health and Human Service's *Treating Tobacco Use and Dependence Clinical Practice Guidelines*, only a small percentage of patients receive them. The USHHS Clinical Practice Guidelines are not being broadly implemented in practice nor typically utilized as a teaching resource in nursing programs, and many nurses are not aware of them. Structured smoking cessation intervention delivered by a nurse is more effective than usual care on smoking cessation rates at six months or longer post treatment. Sarna et al. noted evidence of higher quit rates among patients who received cessation interventions from trials involving diverse health care providers, however noted that no trials were found where complete use of the 5 A's were implemented by nurses (2009).

Nurses' involvement in, and delivery of, tobacco dependence interventions has not been a traditional expectation of the role (Sarna et al., 2009), in spite of tobacco dependence being a major public health problem. The authors recommended that efforts be made to promote tobacco curriculum that ensures all nurses are competent in delivering tobacco cessation interventions and that all nursing students receive tobacco control content in their nursing curriculum. However, they also noted that due to the multiple levels of entry into the nursing profession, establishing tobacco control curriculum in nursing education is complex. Although most schools contain some education on the consequences of tobacco use, most nursing programs do not include information related to health benefits of cessation, nicotine addiction and withdrawal, or cessation treatment interventions. The authors' suggest that all nursing programs include tobacco dependence treatment knowledge and skills. Challenges noted for instituting such curricula included time constraints in present curricula, competing content priorities, lack of appropriate educational resources, and lack of trained faculty and administration. Other factors

that could impact instituting tobacco education curricula are faculty and student lack of interest on tobacco control, lack of clinical training laboratories and/or settings, and personal tobacco use by students and/or staff. Sarna et al. (2009) provided suggestions and strategies for addressing personal, professional, and institutional barriers in implementation of nursing curricula programs on tobacco control. These include providing continuing education for faculty to "train the trainer", institutionalizing the 5 A's in the health care system, providing clinical experiences for students, and inclusion of tobacco control policy efforts in the profession.

Schmelz, Nixon, McDaniel, Hudmon, and Zillich (2010) implemented, and then evaluated the impact a one credit online course had on developing health professions students proficiency in tobacco cessation counseling. The course was similar to, and incorporated some of the *Rx. for Change* curriculum. A tobacco cessation focus was used to facilitate professional student learning, and provide students with knowledge, skills, and a systematic approach to identifying and treating tobacco dependence (Schmelz et al., 2010). The desired outcome was increased tobacco cessation counseling in practice. The comprehensive course facilitated web-delivered learning, via multiple modalities. Some of the tobacco content topics included were (a) epidemiology, public health, tobacco related disease; (b) war on big tobacco; and (c) principles of addiction. Cessation topics included (a) USHHS Clinical Practice Guidelines, (b) pharmacological cessation agents, (c) application of Transtheoretical Model of Change, (c) non-pharmacologic therapies, (d) cognitive and behavioral strategies, and (e) counseling skills.

Pre (n=58) and post (n= 46) course surveys were conducted, with 87% of linkable respondent rate surveys completed by pharmacology students, 3% by nursing students, and 10% by other health professions students. Respondents rated 53% of overall course material as entirely new, while 35% of material was considered necessary review. Participants predicted an

estimated 81% of course material learned would be used when working with patients. Student post-course responses also elucidated that 92% of participants believed they would counsel more patients in tobacco cessation, with increased quality (95%), and related this to course gained knowledge and skills (Schmelz et al., 2010). The authors' expressed a need for training of faculty members to be able to address the needs of their students related to tobacco education. Sixty-eight percent of faculty identified lack of available curriculum time as a barrier for inclusion of tobacco cessation training in required coursework. The study also noted that although 50.5% of pharmacy faculty noted having received prior training on tobacco cessation, only 16.2% of faculty had received training on teaching this topic to students (Schmelz et al., 2010).

Nursing Faculty

One study on faculty factors influencing integration of tobacco education in to nursing curricula was found. Heath and Crowell (2007) reported on a national survey of (n=161) U.S. Advanced Practice Nursing (APN) faculty who completed an 88-question survey. The authors' explored external factors (self-efficacy in teaching tobacco education, attitudes, beliefs, perceptions), and components of the Theory of Reasoned Action Model (likelihood of engaging in given behavior) that might influence faculties' intentions to integrate tobacco education in their APN curricula. In spite of national health authorities setting mandates, standards, and goals related to tobacco cessation, and evidence that demonstrates health care providers who are trained in tobacco dependence treatment are more likely to assist patients with cessation, health care providers remain inadequately educated. This represents a missed opportunity for intervention with tobacco users.

Heath and Crowell identified four demographic characteristics that were significant to predict intentions to integrate tobacco education in curricula (2007). Those with higher intention scores were females, had completed a BSN degree (in comparison to a Master's or Doctoral level degree), were faculty with 1-8 years of teaching (rather than those with more teaching experience), and had both clinical and lecture responsibilities. No significant relationship for intent to teach was correlated to personal or family history of tobacco use, or cigarette taxes. Nearly sixty-five percent of respondents reported curriculum time of less than or equal to three hours (for the entire APN program) spent teaching tobacco content. The tobacco content on health effects received the most curriculum time. The least amount of curriculum time was spent on contents of cigarettes and symptoms of nicotine withdrawal. Self-efficacy correlated to time spent on topic, with higher self-efficacy reported in areas teaching health effects and cancers, and lowest self-efficacy with teaching content about cigarettes and nicotine withdrawal. Behavioral beliefs, defined as attitudes about tobacco education, proved to be the greatest link to intention to increase tobacco education (Heath and Crowell, 2007).

Summary

Literature review findings were congruent, and consistently noted lack of (a) standardized tobacco education curricula in all levels of U.S. nursing programs, (b) student tobacco cessation knowledge, (c) self-efficacy, and (d) clinical experience with tobacco dependent patients. There was a wide divide among nursing programs on tobacco education provided, with most of the education provided addressing health implications of tobacco use only. Almost none of the curricula studied provided cessation specific education, counseling, and/or cessation strategies, which would train future nurses to be functionally prepared agents of change with regard to tobacco dependence treatment in their patient population. There was a

consistent recommendation that called for expanded tobacco education in nursing curricula to include tobacco dependence treatment education, and provide for cessation education and clinical experiences with tobacco dependent patients. Other recommendations called for further nursing research in tobacco education, as well as anti-tobacco advocacy.

No literature explored undergraduate nursing faculty knowledge, beliefs, perceptions, and/or values related to the importance of standardized tobacco education curricula in U.S. nursing programs. Nor were there studies identified, that describe undergraduate faculty preparation, training, qualifications, and/or self-efficacy for providing evidence based tobacco cessation education in nursing curriculum. Undergraduate nursing tobacco curricula studies report collected data from students, nursing program directors' or department chairs', but not individual nursing faculty members. There was one study noted in the literature of APN faculty, which illuminated lack of self efficacy of faculty members teaching tobacco dependence treatment, with a high correlation of intent to teach related to behavioral beliefs (attitudes about tobacco education). Further research is needed, particularly in the undergraduate level of nursing faculty.

Recommendations

So how do we go about addressing tobacco dependence? Resolving the public health problem of tobacco dependence will not be swift or easily accomplished. Over the past decade a wealth of information has surfaced as to the far-reaching effects of tobacco. There is no quick fix, however with persistence and transparency, tobacco legislation and control, continuing research, education, and cessation help, great strides can be made on the path to the ultimate goal of decreasing the incidence of tobacco use. These changes will result in decreased tobacco

related morbidity and mortality, add quality of life, decrease tobacco related health care costs, and reduce health care system burden.

Effective tobacco dependence treatment therapies exist and nurses have demonstrated their effectiveness as interventionalists (Fiore et al., 2000), but these interventions have not been widely adopted as a part of standard nursing care. Nurses are the largest group of health providers and "have the potential to make a significant impact on national tobacco cessation goals. It is estimated that if each of the 2.2 million practicing nurses offered tobacco dependence treatment to one smoking patient, the annual smoking quit rate would triple" Tobacco Free Nurses Initiative (as cited in Butler, 2009, p 249).

Nurses have an ethical responsibility to address knowledge gaps, share knowledge on existing threats to health and safety, participate in efforts to educate the public, identify conditions that contribute to illness, foster healthy lifestyles, participate in institutional and legislative efforts to promote health, and meet national health objectives such as Healthy People 2020. Nurses also have a responsibility to collaborate with other health professionals and the public to met health needs by promoting community, national, and international efforts. Nurses are called upon to support initiatives that will address health disparities, and barriers to health and health care (ANA, 2008).

In order to affect positive change in tobacco dependence the nurses' call to action is three-fold. First standardized tobacco education needs to be established and instituted in all U.S. nursing program curricula. Second, nurses need to continue and broaden tobacco dependence research, and third, there needs to be greater nursing advocacy in the tobacco control and public health policy arena.

Institute Standardized Education in U.S. Nursing Curricula

Nurse educators have the opportunity to serve as models to facilitate learning, function as change agents and leaders, engage in scholarship, and participate in curriculum design and evaluation. In this way decisions based on sound educational principles, theory and research can be implemented (NLN, 2005). Nurse educators are uniquely positioned to address this educational gap, and affect positive change in tobacco dependence, by incorporating standardized tobacco education into nursing curricula.

In order to institute universal standardized tobacco education in U.S. nursing curricula, faculty educational gaps related to tobacco dependence treatment need to be addressed. Tobacco dependence treatment is a specialty topic, which requires specialized knowledge in order to facilitate the learners' needs. A model to "teach the teacher", through continuing education must be embraced, so that nurse educators possess the knowledge and self-efficacy for teaching tobacco curriculum to their students. This includes tobacco dependence treatment, and cessation strategies, as established by USHHS Clinical Practice Guidelines. If faculties are well versed in tobacco education and dependence treatment, they will be better equipped and possess greater self-efficacy in teaching cessation skills to their learners, thus improving learners' knowledge and self-efficacy.

Tobacco education in nursing curricula needs to include the pathophysiological changes that occur with tobacco use and/or tobacco smoke exposure, ensuring that learners understand the disease processes caused or complicated by tobacco use or exposure. Students also need to have an understanding of addiction, and EBP treatment options available for addressing addiction. These include a combination of counseling, motivational interviewing, pharmacological tobacco cessation medications, and coping strategies. Instruction should focus

on the Ten Key USHHS Clinical Practice Guideline Recommendations (see Appendix.), with opportunities for application of these guidelines in clinical practice. Future nurses who are equipped with knowledge about tobacco use and cessation will be more confident in addressing tobacco dependence in their clinical setting, and provide tobacco cessation counseling to their tobacco dependent clients.

Effective tobacco control strategies need to be taught in nursing curricula. Strategies should include (a) addressing disparities among specific high risk populations, (b) increasing smoke free initiatives such as indoor smoking bans, (c) increasing tobacco product pricing, (d) increasing tobacco cessation services with population specific treatment plans, and (e) reducing public tobacco advertising exposure. Tobacco curricula should include teaching students how they can become health care advocates and function as change agents with regard to tobacco control. Students can become involved in organizations or coalitions involved in tobacco control efforts, including educating the public about the costs of tobacco use and the available cessation resources. They can also lobby for better health care coverage for cessation treatment by collaborating with local, state and federal legislators, and anti-tobacco lobbying groups.

Nurse educators are on the frontline of educating their students, their clients and the public. They are in a unique position to affect positive change in tobacco dependence, but without standardized education in U.S. nursing curricula, we experience a missed opportunity. Universal standardized, EBP tobacco education needs to become a reality in nursing curricula. Students need to be prepared to address tobacco dependence in their practice. If we fail to provide tobacco education in nursing curricula, future nurses will lack the knowledge and self-efficacy to address tobacco dependence in their practice.

Tobacco Research

Tobacco dependence research needs to continue and broaden to affect positive change in tobacco dependence rates, decrease disparities in tobacco dependence, and decrease marketing (and targeting) to underserved populations. Faculty knowledge, beliefs, values and perceptions, about tobacco and the importance of standardized tobacco education in U.S. nursing curricula needs to be studied as they impact faculties' intentions and self-efficacy for teaching tobacco education. Understanding faculty values and importance of tobacco education, particularly at the undergraduate level of nursing, is needed in order to successfully institute universal standardized tobacco education. Research studies should also aim to understand, validate, and address concerns about how best to institute standardized tobacco education in nursing curricula related to time constraints in an already packed curricula, and overburdened faculty population.

Nurses have an ethical responsibility to address health disparities and provide equal and just care to all. The tobacco industry is well known for intentional targeting of (a) ethnic minorities; (b) the gay, lesbian, bisexual, and transgender population; (c) youth; (d) lower socioeconomic and; (e) underserved populations. Research in this area should focus on learning how to better address areas of disparities of economics, race, and sexuality, in order to better serve those targeted populations.

Nursing Advocacy in Tobacco Control and Public Policy

Tobacco control initiatives such as indoor smoke free initiatives and cessation treatment coverage impact tobacco use rates, which ultimately result in lower morbidity and mortality rates, decreased health care costs, and less health system burden. These initiatives need to be expanded. It is estimated that a 10% percent increase in tobacco prices reduces adolescent and

young adult consumption by 4%, which can lead to significant reductions in smoking prevalence and/or initiation among youth (CDC, 2011).

In addition to nursing education and research in tobacco, nurse educators can affect positive change by expanding the role of the nurse educator/nurse to become anti-tobacco advocates in the public health and policy arena. Tobacco dependence results in increased morbidity and mortality, and increased health care costs. Nurses are traditionally well-respected providers of health care who make a difference in the development of public health policies. Nurse educators need to be involved in anti-tobacco initiatives, and should empower their students' to become involved in tobacco control initiatives and public policy on the local, regional, and national levels. Involvement should include areas such as lobbying lawmakers for tighter control and restrictions on tobacco, providing health care coverage for cessation treatment, and for limiting the targeting and marketing of specific individuals/groups.

Currently tobacco dependence treatment is grossly underfunded. Policy makers need to understand that a moderate investment in providing cessation treatment on the front end of health care will produce large savings in the long run on health care costs. Nurses can provide that understanding, by educating/lobbying policy makers about tobacco's costs.

Conclusion

Nurses can and do make a difference in tobacco dependence. Nurse educators have an ethical responsibility to address tobacco dependence and treatment in their nursing program curriculum. Universal standardized tobacco curricula will provide consistent tobacco education across all U.S. nursing programs, prepare future nurses to provide EBP quality care to their tobacco dependent patients, reduce patient morbidity and mortality, and decrease health care costs. Continued research in tobacco will illuminate educational gaps so they can be addressed

appropriately, and provide evidence based practice grounding for what works in treating tobacco dependence. Nurses, nurse educators, and students' involvement in public policy change can also affect positive change in decreasing tobacco dependence rates. The nursing profession has the evidence-based tools for decreasing tobacco dependence. Nurses need to implement these tools via universal standardized tobacco education in U.S. nursing programs, in order to consistently affect positive change in tobacco dependence.

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Appendix. Ten Key USHHS Guideline Recommendations

1. Clinicians need to understand that tobacco dependence is a chronic relapsing condition that often requires repeated intervention.
2. Clinicians need to consistently identify and document tobacco use status, and treat every tobacco user .
3. Every patient willing to attempt a quit should be encouraged to use counseling treatments in combination with medications.
4. Brief tobacco treatment is effective and should be offered to every tobacco user
5. Individual, group and telephone counseling providing practical support (problem solving/skills training) and social support are effective, and effectiveness increases with intensity of counseling. Clinicians should use these when counseling patients making a quit attempt.
6. Numerous effective medications are available and should be offered to all tobacco dependent patients attempting to quit, except when medically contraindicated, or with certain populations for which there is insufficient evidence of effectiveness.
7. When used alone counseling and medications are effective treatments. When combined they are more effective. Clinicians should encourage a combination of both counseling and medications for quit attempts.
8. Telephone quitline counseling has broad reach and is effective with diverse populations. Clinicians should ensure patient access to and promote use of quitlines.
9. Motivational treatments, such as motivational interviewing, should be used with a patient unwilling to make a quit attempt at the time of visit. They are effective in increasing future quit attempts.

10. Insurers and purchasers of health care insurance should include coverage for counseling and medications for tobacco cessation, since tobacco dependence treatments are both clinically effective and highly cost-effective relative to other interventions for other clinical disorders.

    (Fiore et al., 2008)