

How-To Guide for Treating Patients Who Use Tobacco

Based on the Clinical Practice Guideline:
Treating Tobacco Use and Dependence 2008 Update



This **How-To Guide** is designed as a supplement to the United States Public Health Service-sponsored **Clinical Practice Guideline: *Treating Tobacco Use and Dependence 2008 Update***. Please refer to the full guideline for additional information. It can be obtained at <http://www.surgeongeneral.gov/tobacco/>.

Tobacco dependence is a chronic health condition that often requires multiple, discrete interventions by a clinician or team of clinicians. The “**5A’s**” of treating tobacco dependence (**Ask, Advise, Assess, Assist and Arrange follow-up**) is a useful way to understand tobacco dependence treatment and organize the clinical team. While a single clinician can provide all 5A’s, it is often most cost-effective to have the 5A’s implemented by a team of clinicians and ancillary staff. However when a team is used, coordination of efforts is essential with a single clinician retaining overall responsibility for the interventions. Clinician extenders such as quit lines, web-based interventions, local quit programs and tailored, self-help materials can often be, and should be, incorporated into the 5A’s approach. These treatment extenders can make clinical interventions more efficient.

This How-To Guide is organized around the 5A’s. However, we realize your clinical situation may suggest delivering these components in a different order or format.

Following the Guideline recommendations – every patient visiting a healthcare setting should be **Asked** if they use tobacco and his or her status documented clearly in the clinical record (e.g., as part of the vital signs, displayed prominently in the electronic medical record). Applying this first A (**Ask**) divides clinic patients into one of three statuses: current tobacco user, former tobacco user or never user. Next the clinician **Advises** any tobacco user in a clear, strong personalized way of the importance of quitting. Following this, the clinician **Assesses** the tobacco user, identifying those willing and unwilling to make a quit attempt at the present time.

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- Guidance for treating current tobacco users who **DO** want to make a quit attempt is on pages 4 to 15.
- Guidance for treating current tobacco users who **DO NOT** want to make a quit attempt at the present time can be found on pages 16 to 20.
- Guidance for treating tobacco users who have **RECENTLY QUIT** can be found on pages 21 to 22.
- **NEW RECOMMENDATIONS** in the 2008 update to the PHS-sponsored Clinical Practice Guideline: Treating Tobacco Use and Dependence are listed on page 23.

The "5A's" Model for Treating Tobacco Use and Dependence

<u>A</u>sk about tobacco use.	Identify and document tobacco use status of every patient at every visit.
<u>A</u>dvise to quit.	In a clear, strong and personalized manner urge every tobacco user to quit.
<u>A</u>ssess	For each current tobacco user, is he or she willing to make a quit attempt at this time? For the ex-tobacco user, how recent did he or she quit and are there any challenges to remaining abstinent?
<u>A</u>ssist	For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional behavioral treatment to help the patient quit. For patients unwilling to quit at this time, provide interventions designed to increase the likelihood of a future quit attempt. For the recent quitter and any with remaining challenges, provide relapse prevention.
<u>A</u>rrange	All those receiving the previous A's should receive follow-up.

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The 5 A's: Treating Tobacco Dependence as a Chronic Disease

ASK (Do you use tobacco)

Current
Smokers

Former
Smokers

Never
Smoker

ADVISE (to quit)

ASSESS
Willing to quit?

Recently quit?
Challenges?

Yes

No

Yes

No

ASSIST

Assist in
quit attempt

Intervene to
increase motivation

Provide relapse
prevention

ARRANGE for FOLLOW-UP

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For the Tobacco User Who IS Willing to Quit at the Present Time

Ask

Ask every patient at every visit if they use tobacco and his or her status documented clearly in the clinical record (e.g., as part of the vital signs, displayed prominently in the electronic medical record).

For patients who currently use tobacco:

Advice

In a *clear, strong, and personalized* manner, urge every tobacco user to quit.

Advice should be:

- **Clear**—“It is important that you quit smoking (or using chewing tobacco) now and I can help you.”
“Cutting down while you are ill is not enough.”
“Occasional or light smoking is still dangerous.”
- **Strong**—“As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you.”
- **Personalized**—Tie tobacco use to current symptoms and health concerns, and/or its social and economic costs, and/or the impact of tobacco use on children and others in the household. “Continuing to smoke makes your asthma worse and quitting may dramatically improve your health.” Or “quitting smoking may reduce the number of ear infections your child has.”

Assess

Assess whether the tobacco user is willing to make a quit attempt at this time. If the patient is willing to make a quit attempt now, use the specific counseling and medication treatments that follow.

Assist

The effects of counseling or coaching for quitting and the use of recommended medications are additive. Therefore, unless otherwise indicated, every tobacco user should be provided with both medication and counseling. There is also a clear dose-response relationship between the intensity of treatment for tobacco dependence and a favorable outcome. Therefore, every tobacco user should be encouraged to receive as much counseling as practical.

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Action	Strategies for implementation
<p>Help the patient with a quit plan.</p>	<p><i>A patient's preparations for quitting (STAR):</i></p> <ul style="list-style-type: none"> • Set a quit date. Ideally, the quit date should be within 2 weeks. • Tell family, friends, and coworkers about quitting and request understanding and support • Anticipate challenges to the upcoming quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. • Remove tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car). Make your home smoke-free.
<p>Recommend the use of FDA approved medication, except where contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers and adolescents).</p>	<p>Explain how these medications increase quitting success and reduce withdrawal symptoms. FDA-approved medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch and varenicline. There is insufficient evidence to recommend medications for pregnant women, adolescents, smokeless tobacco users and light (< 10 cigarettes/day) smokers.</p>

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Providing Counseling

<p>Provide practical counseling (problem-solving/skills training).</p>	<p><i>Abstinence.</i> Striving for total abstinence is essential. <i>“Not even a single puff after the quit date.”</i></p> <p><i>Past quit experience.</i> Identify what helped and what hurt in previous quit attempts. Build on past success.</p> <p><i>Anticipate triggers or challenges for the upcoming attempt.</i> Discuss challenges/triggers and how patient will successfully overcome them (e.g., avoid triggers, alter routines). Emphasize self-efficacy.</p> <p><i>Alcohol.</i> Since alcohol is associated with relapse, the patient should consider limiting/abstaining from alcohol while quitting. (Note that reducing alcohol intake could precipitate withdrawal in alcohol dependent persons.)</p> <p><i>Other smokers in the household.</i> Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or not smoke in their presence.</p>
<p>Provide intra-treatment support.</p>	<p>Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. <i>“My office staff and I are available to assist you.” “I’m recommending treatment that can provide ongoing support.”</i></p>
<p>Provide supplementary materials, including information on quitlines.</p>	<p><i>Sources:</i> Federal agencies, nonprofit agencies, national quitline network (1-800-QUIT-NOW), or local/state/tribal health departments/quitlines.</p> <p><i>Type:</i> Culturally/racially/educationally/age appropriate for the patient.</p> <p><i>Location:</i> Readily available at every clinician’s workstation.</p>
<p>Recognize danger situations. Identify events, internal states, or activities that increase the risk of smoking or relapse.</p>	<ul style="list-style-type: none"> • Negative affect and stress • Being around other tobacco users • Drinking alcohol • Experiencing urges • Smoking cues and availability of cigarettes

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Counseling should include teaching practical problem solving skills and providing support and encouragement.

<p>Develop coping skills. Identify and practice coping or problem-solving skills. Typically, these skills are intended to cope with danger situations.</p>	<ul style="list-style-type: none"> • Learning to anticipate and avoid temptation and trigger situations. • Learning cognitive strategies that will reduce negative moods. • Accomplishing lifestyle changes that reduce stress, improve quality of life, and reduce exposure to smoking cues. • Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention; changing routines).
<p>Provide basic information. Provide basic information about smoking and successful quitting.</p>	<ul style="list-style-type: none"> • The fact that any smoking (even a single puff) increases the likelihood of a full relapse. • Withdrawal symptoms typically peak within 1-2 weeks after quitting but may persist for months. These symptoms include negative mood, urges to smoke, and difficulty concentrating. • The addictive nature of smoking.
<p>Encourage the patient about the quit attempt.</p>	<ul style="list-style-type: none"> • Note that effective tobacco dependence treatments are now available. • Note that one-half of all people who have ever smoked have now quit. • “You can do this. We can help.” • Encourage patient self-efficacy.
<p>Communicate caring and concern.</p>	<ul style="list-style-type: none"> • Ask how patient feels about quitting. • Directly express concern and willingness to help as often as needed. • Ask about the patient’s fears and ambivalence regarding quitting.
<p>Encourage the patient to talk about the quitting process.</p>	<p>Ask about:</p> <ul style="list-style-type: none"> • Reasons the patient wants to quit. • Concerns or worries about quitting. • Success the patient has achieved. • Difficulties encountered while quitting.

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For the Tobacco User Who IS Willing to Quit at the Present Time (continued)

Providing Counseling – Frequently Asked Questions

1. My patient doesn't want counseling, only medication. What should I do?

Point out that medication plus counseling works better than medication alone. Explain the nature of counseling (or coaching) as providing the practical skills necessary to quit successfully. Use the motivational interventions designed for tobacco users who do not want to quit (see pages 16 to 17) to motivate your patient to accept counseling. For example, develop discrepancy by noting the inconsistency between not using effective counseling for something that is as important and difficult as quitting tobacco. If the patient still declines counseling, then provide medication because medication alone has been shown effective. But during follow-up, continue to provide the key elements of counseling: Practical skills and support.

2. My patient wants to use a method of quitting not known to be effective-- such as acupuncture, hypnosis or laser therapy. What do I do?

Ask the patient to consider increasing the odds that efforts to quit will be successful by augmenting the selected method of quitting with appropriate medication and counseling. Do not denigrate any attempt to quit, as there is something to be learned from every effort. If the patient declines to augment the selected method of treatment, support the effort to quit but ask for an agreement that, should it not work, the patient will consider methods that include medication and counseling.

3. My patient is concerned about gaining weight.

Steer toward bupropion, gum or and/or lozenge as these can help delay (but do not necessarily prevent) weight gain. Recommend your patient start or increase physical activity. For example, take a walk during break time rather than smoking.

4. My patient is concerned about using NRT because they believe nicotine to be one of the harmful ingredients in tobacco products.

Explain that nicotine by itself is minimally harmful. The other thousands of chemicals, including 40 carcinogens, in cigarettes are what are harming their health. Nicotine in small doses has been proven to greatly reduce withdrawal symptoms in many people.

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For the Tobacco User Who IS Willing to Quit at the Present Time (continued)

Providing Counseling – Frequently Asked Questions

5. My patient does not want to use medication because he or she is:

- Afraid the medication is addictive.
- Doesn't believe medication will help.
- Has recovered from another dependency and believes recovery is not possible if a medication that contains nicotine is used.

Point out:

- The medication is not like smoking and developing a dependency on the medication is rare.
- The probability of successful quitting is much higher with medication.
- Substance abuse counselors routinely use medication to help people quit. The goal remains not using any nicotine and the use of nicotine-containing medication is a transition step toward that goal to quit.
- There are quit-tobacco medications that don't contain nicotine.

6. My patient says her life is too stressful to quit smoking, and she needs to smoke to relax.

Acknowledge that, for many people, smoking is one way to deal with stress. But it is only one way. And counseling will help her develop new ways. It will take some time and at first; the new ways will not be as good as smoking but, over time, she will have even better, more effective ways to deal with stress. And her health will improve.

7. My patient says he has been smoking for 30 years without any health problem, plus his grandfather smoked two packs a day and still lived to be 105.

Consider saying something like, "There are certainly people who smoke for many years without apparent tobacco-related diseases. But many suffer from tobacco-induced illnesses that don't kill them but decrease their quality of life. Plus about half of smokers will die from a tobacco-related illness, and the average smoker lives 10 years shorter than non-smokers. I know it is hard to quit, but is that any reason to gamble with your health when you know that there is a 50-percent chance you will die from a tobacco related disease?"

See FDA package inserts for more information, including more detailed safety information. Ask your doctor if one of these options is right for you.

Medication	Cautions/Warnings	Side Effects	Dosage	Use	Availability (check insurance)
Bupropion SR 150	Not for use if you: * Currently use monoamine oxidase (MAO) inhibitor * Use bupropion in any other form * Have a history of seizures * Have a history of eating disorders	* Insomnia * Dry mouth	* Days 1-3: 150 mg each morning * Days 4–end: 150 mg twice daily	Start 1-2 weeks before quit date; use 2 to 6 months	Prescription Only: * Generic * Zyban * Wellbutrin SR
Nicotine Gum (2 mg or 4 mg)	* Caution with dentures * Do not eat or drink 15 minutes before or during use	* Mouth soreness * Stomach ache	* 1 piece every 1 to 2 hours * 6-15 pieces per day * If ≤ 24 cigs: 2 mg * If ≥ 25 cigs/day: 4 mg	Up to 12 weeks or as needed	OTC Only: * Generic * Nicorette
Nicotine Inhaler	* May irritate mouth/throat at first (but improves with use)	* Local irritation of mouth & throat	* 6-16 cartridges/day * Inhale 80 times/cartridge * May save partially-used cartridge for next day	Up to 6 months; taper at end	Prescription Only: * Nicotrol inhaler
Nicotine Lozenge (2 mg or 4 mg)	* Do not eat or drink 15 minutes before or during use * One lozenge at a time * Limit 20 in 24 hours	* Hiccups * Cough * Heartburn	* If smoke ≥ 30 minutes after waking: 2 mg * If smoke ≤ 30 minutes after waking: 4 mg * Weeks 1-6: 1 every 1-2 hrs * Wks 7-9: 1 every 2-4 hrs * Wks 10-12: 1 every 4-8 hrs	3-6 months	OTC Only: * Generic * Commit
Nicotine Nasal Spray	* Not for patients with asthma * May irritate nose (improves over time) * May cause dependence	* Nasal irritation	* 1 “dose” = 1 squirt per nostril * 1 to 2 doses per hour * 8 to 40 doses per day * Do NOT inhale	3-6 months; taper at end	Prescription Only: * Nicotrol NS
Nicotine Patch	* Do not use if you have severe eczema or psoriasis	* Local skin reaction * Insomnia	* One patch per day * If ≥ 10 cigs/day: 21 mg 4 wks, 14 mg 2-4 wks, 7 mg 2-4 wks	8-12 weeks	OTC or prescription: * Generic * Nicoderm CQ * Nicotrol
Varenicline	Use with caution in patients: * With significant renal impairment * With serious psychiatric illness * Undergoing dialysis FDA Warning: Varenicline patients have reported depressed mood, agitation, changes in behavior, suicidal ideation and suicide.	* Nausea * Insomnia * Abnormal, vivid or strange dreams	* Days 1-3: 0.5 mg every morning * Days 4-7: 0.5 mg twice daily * Day 8–end: 1 mg twice daily	Start 1 week before quit date; use 3-6 months	Prescription only: * Chantix
Combinations: 1) Patch + bupropion 2) Patch + gum 3) Patch + [lozenge or inhaler]	* Only patch + bupropion is currently FDA-approved. * Follow instructions for individual medications.	See individual medications above.	See individual medications above.	See above.	See above.

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For the Tobacco User Who IS Willing to Quit at the Present Time (continued)

Providing Medication

1. Who should receive medication for tobacco use? Are there groups of smokers for whom medication has not been shown to be effective?

All smokers trying to quit should be offered medication, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers and adolescents).

2. What are the recommended first-line medications?

All seven of the FDA-approved medications for treating tobacco use are recommended: bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, the nicotine patch and varenicline. The clinician should consider the first-line medications shown to be more effective than the nicotine patch alone: 2 mg/day varenicline or the combination of long-term nicotine patch use + ad libitum NRT. Unfortunately, there are no well accepted algorithms to guide optimal selection among the first-line medications.

3. Are there contraindications, warnings, precautions, other concerns and side effects regarding the first-line medications recommended in this Guideline Update?

All seven FDA-approved medications have specific contraindications, warnings, precautions, other concerns and side effects. Please refer to FDA-package inserts for this complete information and FDA updates.

4. What other factors may influence medication selection?

Pragmatic factors may also influence selection—such as insurance coverage or out-of-pocket patient costs, likelihood of adherence, dentures when considering the gum, or dermatitis when considering the patch.

5. Is a patient's prior experience with a medication relevant?

Prior successful experience (sustained abstinence with the medication) suggests that the medication may be helpful to the patient in a subsequent quit attempt, especially if the patient found the medication to be tolerable and/or easy to use. However, it is difficult to draw firm conclusions from prior failure with a medication. Some evidence suggests that re-treating relapsed smokers with the same medication produces small or no benefit while other evidence suggests that it may be of substantial benefit.

6. What medications should a clinician use with a patient who is highly nicotine dependent?

The higher-dose preparations of the nicotine gum, patch or lozenge have been shown to be effective in highly dependent smokers. Also, there is evidence that combination-NRT therapy may be particularly effective in suppressing tobacco-withdrawal symptoms. Thus, it may be that NRT combinations are especially helpful to highly dependent smokers or those with a history of severe withdrawal.

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For the Tobacco User Who is Willing to Quit at the Present Time (continued)

Providing Counseling – Frequently Asked Questions

7. Is gender a consideration in selecting a medication?

There is evidence that NRT can be effective with both sexes; however, evidence is mixed as to whether NRT is less effective in women than men. This may encourage the clinician to consider use of another type of medication with women such as bupropion SR or varenicline.

8. Are cessation medications appropriate for light smokers (i.e., <10 cigarettes/day)?

As noted above, cessation medications have not been shown to be beneficial to light smokers. However, if NRT is used with light smokers, clinicians may consider reducing the dose of the medication. No adjustments are necessary when using bupropion SR or varenicline.

9. When should second-line agents be used for treating tobacco dependence?

Consider prescribing second-line agents (clonidine and nortriptyline) for patients unable to use first-line medications because of contraindications. Or for patients for whom the group of first-line medications has not been helpful. Assess patients for the specific contraindications, precautions, other concerns and side effects of the second-line agents. Please refer to FDA-package inserts for this information.

10. Which medications should be considered with patients particularly concerned about weight gain?

Data show that bupropion SR and nicotine-replacement therapies, in particular 4 mg nicotine gum and 4 mg nicotine lozenge, delay, but do not prevent, weight gain.

11. Are there medications that should be especially considered in patients with a past history of depression?

Bupropion SR and nortriptyline appear to be effective with this population, but nicotine-replacement medications also appear to help individuals with a past history of depression.

12. Should nicotine-replacement therapies be avoided in patients with a history of cardiovascular disease?

No. The nicotine patch in particular has been demonstrated as safe for cardiovascular patients.

13. May tobacco-dependence medications be used long-term (e.g., up to six months)?

Yes. This approach may be helpful with smokers who report persistent withdrawal symptoms during the course of medications, who have relapsed in the past after stopping medication, or who desire long-term therapy. A minority of individuals who successfully quit smoking use ad-libitum NRT medications (gum, nasal spray, inhaler) long-term.

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The use of these medications for up to six months does not present a known health risk and developing dependence is uncommon. Additionally, the FDA has approved the use of bupropion SR, varenicline and some NRT medications for six-month use.

14. Is medication adherence important?

Yes. Patients frequently do not use cessation medications as recommended (e.g., they don't use them at recommended doses or for recommended durations) and this may reduce their effectiveness.

15. May medications ever be combined?

Yes. Among first-line medications, evidence exists that combining the nicotine patch long-term (> 14 weeks) with nicotine gum or nicotine nasal spray, the nicotine patch with the nicotine inhaler, or the nicotine patch with bupropion SR, increases long-term abstinence rates relative to placebo treatments.

16. My patient can't afford medications and doesn't have insurance or insurance doesn't cover it. What can I do?

- Most pharmaceutical companies have programs to provide medications to those who cannot afford them. See the next page for details.
- Instruct patients to set aside all the money they would have spent on tobacco once they quit. After initial use of medication, they will be able to afford medication going forward.
- Many clinics that serve people with no health insurance will provide treatment for tobacco dependence, including medication. Check for ones in your area and have them available for staff and patients as a referral source.
- As a clinician, you can call the Wisconsin Tobacco Quit Line (**1-800-QUIT-NOW**) and ask about any sources of free or reduced-cost medication for your patients. The phone number works nationwide and seamlessly routes patients to the state that coincides with the area code assigned to their phone.
- If your patient qualifies for Medicaid or Medicare, these programs cover some tobacco dependence treatment medications. Get this information for your state and have it available for staff and patients.

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How to Help Patients Get Quit-Smoking Medications for FREE or Cheaper

Partnership for Prescription Assistance

- **WHAT:** *This program will help you learn whether you're eligible for help to pay for prescription medications.*
- **MORE INFORMATION:** Call **1-888-4PPA-NOW** or log on to www.pparx.org. In a few minutes, pparx.org will help you determine if you're eligible for programs like Connection to Care, Bridges to Access, Together RX Access and more.

Connection to Care Program (Pfizer)

- **WHAT:** *This program offers discounts on Varenicline, Nicotrol Inhaler and Nasal Spray. In some cases, medications are free.*
- **TO QUALIFY:** You must be an uninsured U.S. resident. PfizerHelpfulAnswers.com has an interactive site to help you determine your eligibility.
- **HOW TO GET STARTED:** Talk to your doctor to complete an application together.
- **HOW TO GET YOUR MEDICATIONS:** Pfizer will ship a three-month supply of medications to your doctor's office for pickup in three weeks. You must apply for each refill.
- **MORE INFORMATION:** Call 1-866-776-3700.

Bridges to Access Program (GlaxoSmithKline)

- **WHAT:** This program may help to cover the cost of Zyban and Bupropion SR.
- **TO QUALIFY:** You must be a U.S. resident without prescription drug benefits. Your household income must be: \$19,599 or less if you are single; \$26,400 or less if you live with one other person; \$33,200 for a family of three; \$39,996 for a family of four.
- **HOW TO GET STARTED:** You will need an "Advocate" from your doctor's office to complete your enrollment form and call 1-866-728-4368 to get you started. Usually this is a doctor, nurse, social worker or other care provider. Neither you, nor your friends or family members, may act as your Advocate.
- **HOW TO GET YOUR MEDICATIONS:** Once you are signed up, you may pick up your medications at a local drug store. You will get a supply to last you two months. Your Advocate can sign you up for one refill to last three additional months. Every year, you must submit a new form and call a hotline to receive more medication.
- **MORE INFORMATION:** Visit www.bridgestoaccess.gsk.com

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How to Help Patients Get Quit-Smoking Medications for FREE or Cheaper

Together RX Access

- **WHAT:** This program offers savings on the Nicotine Inhaler and Nicotine Nasal Spray (Nicotrol) as well as Varenicline (Chantix). Savings vary by medication and location.
- **TO QUALIFY:** This program is for legal U.S. residents with no health insurance and who are not eligible for Medicare. You must have a household income equal or less than: \$30,000 for a single person; \$40,000 for a family of two; \$50,000 for a family of three; \$60,000 for a family of four; \$70,000 for a family of five.
- **HOW TO GET STARTED:** You may enroll by mail or through the Together RX Access website.
- **MORE INFORMATION:** Call 1-800-444-4106 or visit www.togetherrxaccess.com

Arrange Follow-up

Tobacco dependence is an addiction. Quitting is very difficult for most tobacco users. It is essential that the patient trying to quit has scheduled follow-up. This is especially important when the treatment is shared by a team of clinicians and includes treatment extenders such as quitline counseling.

Timing

Follow-up contact should begin soon after the quit date, preferably during the first week. The reason for this is that many patients trying to quit have their worst withdrawal symptoms during the first week when they are at greatest risk for relapse. At a minimum, a second follow-up contact is recommended within the first month. Schedule further follow-up contacts as needed.

Actions during follow-up contact

For all patients, identify problems already encountered and anticipate challenges in the immediate future. Assess medication use and any problems. Remind patients of quitline support (1-800-QUIT-NOW). Address tobacco use at next clinical visit (treat tobacco use as a chronic disease).

When a patient is abstinent, congratulate him or her on that success!

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For the Tobacco User Who is NOT Willing to Make a Quit Attempt at the Current Time

Ask

Ask every patient at every visit if he or she uses tobacco and document his or her status clearly (e.g., as part of the vital signs, displayed prominently in the electronic medical record).

For patients who currently use tobacco:

Advice

In a *clear, strong and personalized* manner, urge every tobacco user to quit. Advice should be:

- **Clear**—“It is important that you quit smoking (or using chewing tobacco) now and I can help you. Cutting down while you are ill is not enough. Occasional or light smoking is still dangerous.”
- **Strong**—“As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you.”
- **Personalized**—Tie tobacco use to current symptoms and health concerns, and/or its social and economic costs, and/or the impact of tobacco use on children and others in the household. “Continuing to smoke makes your asthma worse and quitting may dramatically improve your health. Quitting smoking may reduce the number of ear infections your child has.”

Assess

Assess whether the tobacco user is willing to make a quit attempt at this time. If the patient is unwilling to make a quit attempt at the present time, use the motivational strategies on the following pages to increase the likelihood of quitting in the future.

Assist

Assist tobacco users who do not want to quit by providing specific interventions designed to increase the likelihood will later. Such interventions could incorporate the 5R's. In these interventions, the clinician can introduce the topic of quitting, but it is important that the tobacco users address each topic in their own words. The clinician can then help refine the patient's responses and add to them as needed.

Enhancing Motivation to Quit Tobacco – the "5 R's"

<p><u>R</u>everance</p>	<p>Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).</p>
<p><u>R</u>isks</p>	<p>The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars and pipes) will not eliminate these risks. Examples of risks are:</p> <ul style="list-style-type: none"> • <i>Acute risks:</i> Shortness of breath, exacerbation of asthma or bronchitis, increased risk of respiratory infections, harm to pregnancy, impotence, and infertility. • <i>Long-term risks:</i> Heart attacks and strokes, lung and other cancers (e.g., larynx, oral cavity, pharynx, esophagus, pancreas, stomach, kidney, bladder, cervix and acute myelocytic leukemia), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), osteoporosis, long-term disability and need for extended care. • <i>Environmental risks:</i> Increased risk of lung cancer and heart disease in spouses; increased risk for low birth weight, sudden infant death syndrome (SIDS), asthma, middle ear disease and respiratory infections in children of smokers.
<p><u>R</u>ewards</p>	<p>The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of rewards:</p> <ul style="list-style-type: none"> • Improved health. • Food will taste better. • Improved sense of smell. • Saving money. • Better self esteem. • Home, car, clothing and breath will smell better. • They'll set a better example for children and decrease the likelihood that they will smoke. • Healthier babies and children. • Better physical fitness. • Improved appearance, including reduced wrinkling/aging of skin and whiter teeth.

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Enhancing Motivation to Quit Tobacco – the "5 R's" (Continued)

R oadblocks	The clinician should ask the patient to identify barriers or impediments to quitting and provide treatment (problem-solving counseling, medication) that could address barriers. Typical barriers might include: <ul style="list-style-type: none">• Withdrawal symptoms.• Fear of failure.• Weight gain.• Lack of support.• Depression.• Enjoyment of tobacco.• Being around other tobacco users.• Limited knowledge of effective treatment options.
R epetition	The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful and that you will continue to raise their tobacco use with them.

Interventions to increase the likelihood that a tobacco user who does not want to quit will decide to quit can draw upon the principles of motivational interviewing:

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Motivational Interviewing Strategies

Express Empathy	<ul style="list-style-type: none">• Use open-ended questions to explore:<ul style="list-style-type: none">○ The importance of addressing smoking or other tobacco use (e.g., “How important is it for you to quit?”).○ Concerns and benefits of quitting (e.g., “What might happen if you quit?”).• Use reflective listening to seek shared understanding:<ul style="list-style-type: none">○ Reflect words or meaning (e.g., “So you think smoking helps you to maintain your weight”).○ Summarize (e.g., “What I have heard so far is that smoking is something you enjoy. On the other hand, your boyfriend hates your smoking and you are worried you might develop a serious disease.”).• Normalize feelings and concerns (e.g., “Many people worry about managing without cigarettes.”).• Support the patient’s autonomy and right to choose or reject change (e.g., “I hear you saying you are not ready to quit smoking right now. I’m here to help you when you are ready.”).
Develop Discrepancy	<ul style="list-style-type: none">• Highlight the discrepancy between the patient’s present behavior and expressed priorities, values and goals (e.g., “It sounds like you are very devoted to your family. How do you think your smoking is affecting your children and spouse/partner?”).• Reinforce and support “change talk” and “commitment” language.<ul style="list-style-type: none">○ “So, you realize how smoking is affecting your breathing and making it hard to keep up with your kids.”○ “It’s great that you are going to quit when you get through this busy time at work.”• Build and deepen commitment to change.<ul style="list-style-type: none">○ “There are effective treatments that will ease the pain of quitting, including counseling and many medication options.”○ “We would like to help you avoid a stroke like the one your father had.”

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Motivational Interviewing Strategies

Roll with Resistance	<ul style="list-style-type: none">• Back off and use reflection when the patient expresses resistance.<ul style="list-style-type: none">○ “Sounds like you are feeling pressured about your tobacco use.”• Express empathy.<ul style="list-style-type: none">○ “You are worried about how you would manage withdrawal symptoms.”• Ask permission to provide information.<ul style="list-style-type: none">○ “Would you like to hear about some strategies that can help you address that concern when you quit?”
Support Self-Efficacy	<ul style="list-style-type: none">• Help the patient to identify and build on past successes.<ul style="list-style-type: none">○ “So you were fairly successful the last time you tried to quit...”• Suggest options for achievable small steps toward change.<ul style="list-style-type: none">○ Call the Wisconsin Tobacco Quit Line (1-800-QUIT-NOW) for advice and information○ Read about quitting benefits and strategies○ Change smoking patterns (e.g., no smoking in the home)○ Ask the patient to share his or her ideas about quitting strategies

Arrange Follow-Up

More than one motivational intervention may be required before the hardened tobacco user commits to trying to quit. It is essential that the patient trying to quit has scheduled follow up. Provide follow up at the next visit and at additional interventions to motivate and support the decision-making process.

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For the Tobacco User who ALREADY HAS Recently Quit

Ask

Ask every patient at every visit if they use tobacco. Document status in the clinical record (e.g., as part of the vital signs, displayed prominently in the electronic medical record).

Assess

Ask every former tobacco user:

1. How long has it been since you quit?

Most relapse occurs within the first two weeks after the quit date, and the risk decreases over time. Tobacco users who have very recently quit should be provided assistance. But the risk for relapse can persist for a long time for many tobacco users. Therefore, assess all former tobacco users, regardless of how long ago they quit, about challenges by asking:

2. Do you still have urges to use tobacco or challenges to remaining tobacco free?

Any recent quitter or former tobacco-users still experiencing challenges should receive assistance.

Assist

1. Congratulate success and encourage patients to remain abstinent.

When encountering a recent quitter, use relevant, open-ended questions to discover whether the patient wishes to discuss issues related to quitting:

- The benefits the patient may derive from cessation
- Any success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc.)
- The problems encountered--or anticipated threats--to maintaining abstinence (e.g., depression, weight gain, alcohol, other tobacco users in the household, significant stressors)
- A medication check-in, including effectiveness and adherence

2. A patient who previously used tobacco might identify specific challenges to abstinence. See page 22 for specific challenges and potential responses.

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Challenges

Lack of support

Responses

- Schedule follow-up visits or telephone calls with the patient.
- Urge the patient to call the Wisconsin Tobacco Quit Line (**1-800-QUIT-NOW**).
- Help each patient identify sources of support within his or her environment.
- Refer the patient to an appropriate organization that offers counseling or evidence-based support.

Negative mood or depression

- If significant, provide counseling, prescribe appropriate medication, or refer the patient to a specialist.

Strong or prolonged withdrawal symptoms

- If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved medication or adding/combining medications to reduce strong withdrawal symptoms.

Weight gain

- Recommend starting or increasing physical activity.
- Reassure the patient that some weight gain after quitting is common and is usually self-limiting.
- Emphasize the health benefits of quitting relative to the health risks of modest weight gain.
- Emphasize the importance of a healthy diet and active lifestyle.
- Suggest low-calorie substitutes such as sugarless chewing gum, vegetables or mints.
- Maintain the patient on medication known to delay weight gain (e.g., bupropion SR, NRTs, particularly 4 mg nicotine gum, and lozenge).
- Refer the patient to a nutrition counselor.

Smoking slips

- Suggest continued use of quit-tobacco medications, which can reduce the likelihood that a slip will lead to a full relapse.
- Encourage another quit attempt or a recommitment to total abstinence.
- Reassure that quitting may take multiple attempts and use the lapse as a learning experience.
- Provide or refer for intensive counseling.

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New Recommendations in the 2008 PHS-Sponsored Clinical Practice Guideline: *Treating Tobacco Use and Dependence*

Most, but not all, of the new recommendations appearing in the 2008 Treating Tobacco Use and Dependence Update resulted from new meta-analyses of the topics chosen by the Guideline panel.

1. Formats of Psychosocial Treatments

Recommendation: Tailored materials, both print- and web-based, appear to be effective in helping people quit. Therefore, clinicians may choose to provide tailored, self-help materials to their patients who want to quit.

2. Combining Counseling and Medication

Recommendation: The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking.

Recommendation: There is a strong relation between the number of sessions of counseling (when combined with medication) and the likelihood of successful smoking abstinence. Therefore, to the extent possible, clinicians should provide multiple counseling sessions, in addition to medication, to their patients who are trying to quit smoking.

3. For Smokers Not Willing to Make a Quit Attempt at This Time

Recommendation: Motivational-intervention techniques appear to be effective in increasing a patient's likelihood of making a future quit attempt. Therefore, clinicians should use motivational techniques to encourage smokers who are not currently willing to quit to consider making a quit attempt in the future.

4. Nicotine Lozenge

Recommendation: The nicotine lozenge is an effective smoking-cessation treatment that patients should be encouraged to use.

5. Varenicline

Recommendation: Varenicline is an effective smoking-cessation treatment that patients should be encouraged to use.

6. Specific Populations

Recommendation: The interventions found to be effective in this Guideline have been shown to be effective in a variety of populations. In addition, many of the studies supporting these interventions comprised diverse samples of tobacco users. Therefore, interventions identified as effective in this Guideline are recommended for all individuals who use tobacco, except when medically contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers (< 10 cigarettes/day) and adolescents).

7. Light Smokers

Recommendation: Light smokers (< 10 cigarettes/day) should be identified, strongly urged to quit and provided counseling interventions.