NYSMPEP Smoking Cessation Guidance:
Key Message 1

Key Message 1: Tobacco dependence is a chronic disease notable for an addiction to nicotine that requires continued education, counseling, medication to manage the addiction and advice. The **first step** in treating tobacco use and dependence is identification/recognition.

Early identification of tobacco use may facilitate assessment of willingness to quit and determination of appropriate interventions.

Cigarette smoking is the leading cause of preventable disease and death in the United States.[1] Smoking affects nearly every organ in the body and causes more than 480,000 premature deaths per year in the United States. The estimated total annual health and economic costs attributable to smoking and secondhand exposure to tobacco smoke is over $300 billion per year.[2] In New York State alone, approximately 2.1 million adults smoke and more than 0.5 million live with serious illnesses and disabilities secondary to tobacco use.[3] Smoking kills an estimated 28,200 adults in New York State annually and is associated with yearly state-wide healthcare costs of approximately $10.4 billion.

Health Risks of Smoking[1]	
Cardiovascular disease	Hypertension, stroke, heart disease, peripheral vascular disease
Respiratory disease	COPD, emphysema, chronic bronchitis, asthma attack
Cancer	Bladder, blood, cervix, colon, esophagus, kidney, larynx, liver, oropharynx, pancreas, stomach, lung
Oral hygiene	Bad breath, stained teeth, gum disease, oral cancer
Pregnancy	Infertility, preterm, stillbirth, low birth weight, SIDS, ectopic pregnancy, orofacial clefts

COPD=chronic obstructive pulmonary disease; SIDS=sudden infant death syndrome

Benefits of smoking cessation include **reduced risk** of:[2,4,5,6]

- lung cancer and many other types of cancer
- heart disease, stroke, and peripheral vascular disease
- respiratory symptoms such as coughing, wheezing, and shortness of breath
- other respiratory conditions such as chronic obstructive pulmonary disease (COPD)
- infertility and other pregnancy-related complications

Tobacco dependency has many features of a chronic disease that requires on-going rather than acute care. A **chronic disease model** recognizes the long-term nature of tobacco use and dependence with an expectation that patients may have periods of *relapse and remission*.[7]

Tobacco dependence is a chronic disease that requires continued education, counseling, medication and advice. Physicians should screen all patients for tobacco use, utilizing the “5 A’s” method for brief interventions.

Routine Screening for Tobacco Use:
Screening for current or past tobacco use is typically associated with 4 scenarios: (1) The patient currently uses tobacco and is willing to make a quit attempt at this time; (2) The patient currently uses tobacco but is <u>not</u> willing to make a quit attempt at this time; (3) The patient once used tobacco but has since quit; (4) The patient has never regularly used tobacco.[7]

For the Patient Willing to Make a Quit Attempt

Table 1a: **The "5 A's" Model for Treating Tobacco Use and Dependence**[7]

The 5 A's	Action	Strategies for Implementation
Ask about tobacco use.	Identify and document tobacco use status for every patient at every visit.	Implement an office-wide system that ensures that, for every patient at every clinic visit, tobacco use status is queried and documented. Expand the vital signs to include tobacco use or use an alternative universal identification system.
Advise to quit.	In a clear, strong, and personalized manner, urge every tobacco user to quit.	*Clear*: "It is important that you quit smoking now, and I can help you." "Cutting down while you are ill is not enough." *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, its social and economic costs, and the impact of tobacco use on children and others in the household.
Assess willingness to make a quit attempt.	Ask, "Are you willing to give quitting a try?"	If patient will participate in an intensive treatment, deliver such a treatment or link/refer to an intensive intervention.
Assist in quit attempt.	Offer medication and provide counseling or additional treatment to help the patient quit. Refer for additional assistance.	Help the patient with a quit plan ("STAR"): ***S****et* a quit date (ideally within 2 weeks). ***T****ell* family, friends, and coworkers about quitting, and request understanding and support. ***A****nticipate* challenges to the upcoming quit attempt, particularly during critical first few weeks (e.g., nicotine withdrawal). ***R****emove* tobacco products from the environment and make home smoke-free. Provide practical counseling, intra-treatment social support, supplementary materials, and information on quitlines (*refer to* ***key message 2***). Recommend use of approved medication (*refer to* ***key message 3***).
Arrange follow-up.	Arrange for follow-up contacts, beginning within the first week after the quit date.	First contact within the first week, second within first month, then continue as needed. Identify problems already encountered and anticipate challenges in the immediate future. Assess medication use and problems. Remind patients of quitline support.

These strategies are designed to be brief and require ≤3 minutes of direct clinician time. They need not be applied in a rigid, invariant manner, and the clinician need not deliver all elements personally. Evidence shows that brief physician advice significantly increases long-term smoking abstinence rates. However, there is a strong dose-response relation between the session length of person-to-person contact and successful treatment outcomes. Therefore, more intensive interventions should be used whenever possible.[7]

For the Patient Unwilling to Make a Quit Attempt

Patients unwilling to make a quit attempt during a visit may respond to motivational interventions. These techniques, referred to as the 5 R's, focus on tobacco user's feelings, beliefs, ideas, and values regarding tobacco use in an effort to uncover any ambivalence about using tobacco. If there is ambivalence, the clinician selectively elicits, supports, and strengthens the patient's "change talk" and "commitment language."[7]

<table>
<tr><th colspan="3">Table 2: Motivational Interviewing Strategies[7]</th></tr>
<tr><td>Relevance</td><td>Encourage patient to indicate why quitting is personally and specifically relevant (e.g., disease status/health concerns, family or social situation, age, gender, prior experience).</td><td rowspan="5">Express empathy
Use open-ended questions to explore importance of addressing smoking and concerns and benefits of quitting
Use reflective listening to seek shared understanding
Normalize feeling and concerns
Support patient's autonomy and right to choose or reject change
Develop discrepancy
Highlight discrepancy between patient's present behavior and expressed priorities, values, and goals
Reinforce and support "change talk" and "commitment language"
Build and deepen commitment to change
Roll with resistance
Back off and use reflection when patient expresses resistances
Ask permission to provide information
Support self-efficacy
Help patient to identify and build on past successes
Offer options for achievable small steps toward change</td></tr>
<tr><td>Risks</td><td>Ask the patient to identify potential negative consequences of tobacco use; suggest and highlight those that seem most relevant (acute, long-term, and environmental).</td></tr>
<tr><td>Rewards</td><td>Ask the patient to identify potential benefits of smoking cessation; suggest and highlight those that seem most relevant.
Examples: improved health of patient and family members, improved appetite/taste of food, improved sense of smell, saving money, feeling better, setting a good example for children, having healthier babies and children, performing better, improved appearance</td></tr>
<tr><td>Roadblocks</td><td>Ask the patient to identify barriers or impediments to quitting, and provide treatments that could address barriers.
Examples: 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</td></tr>
<tr><td>Repetition</td><td>Repeat motivational interventions every time an unmotivated patient visits the clinic setting.</td></tr>
</table>

For the Patient Who Recently Quit

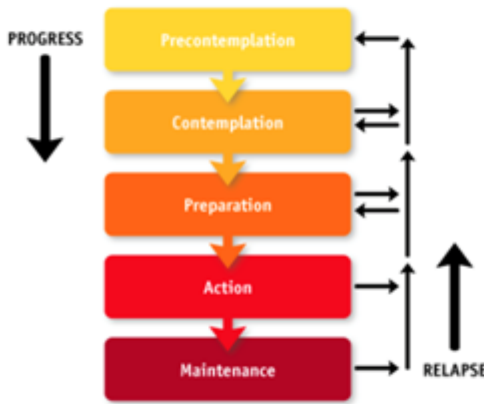
Offer congratulations to the former tobacco user on any success and provide strong encouragement to remain abstinent. Use open-ended questions to determine if the patient wishes to discuss issues related to quitting.

Table 3: **Addressing Problems Encountered by Former Smokers**[7]

Problem	Response
Lack of support for cessation	Schedule follow-up visits or telephone calls Identify sources of support within environment Urge use of quitline network Refer to counseling or support organizations
Negative mood or depression	Provide counseling Prescribe appropriate medication(s) Refer to specialist
Strong/prolonged withdrawal symptoms	Consider extending use of medications or adding/changing medications
Weight gain	Emphasize importance of healthy diet and active lifestyle Remind of the health benefits of quitting Maintain patient on medication(s) known to delay weight gain/promote weight loss Refer to nutritional counselor or program
Smoking lapses	Suggest continued use of medications Encourage another quit attempt Provide or refer for intensive counseling

Tools for Tobacco Dependence Assessment[7]

Stages of Change Assessment



Stages of Change	
Stage	**Situation**
Pre-contemplation	The patient has not considered quitting and may be defensive and unwilling when approached about smoking cessation.
Contemplation	The patient has considered quitting but has not made a decision to take action.
Preparation	The patient is willing and ready to try quitting and has made a commitment to action.
Action	The patient is within 6 months of his/her quit date.
Maintenance	The patient has maintained smoke-free status for at least 6 months.

Readiness to Change Ruler

1. Ask patient to mark where they are on the continuum in regard to smoking cessation.
2. If closer to left, ask patient about barriers to change.
3. If closer to right, ask patient about additional tools to motivate change.

Fagerström Tolerance Scale[9]

Scoring: Add points for all questions. Total: 0 to 4 points = minimal dependence; 4 to 6 points = moderately dependent; 7 to 10 points = highly dependent

1. How soon after you wake up do you smoke your first cigarette?
   - Within 5 minutes (3 points)
   - 5 to 30 minutes (2 points)
   - 31 to 60 minutes (1 point)
   - After 60 minutes (0 points)
2. Do you find it difficult to refrain from smoking in places where it is forbidden, such as the library, theatre, or doctor's office?
   - Yes (1 point)
   - No (0 point)
3. Which cigarette would you most hate to give up / which cigarette do you treasure the most?
   - The first one in the morning (1 point)
   - Any other one (0 points)
4. How many cigarettes do you smoke each day?
   - 10 or fewer (0 points)
   - 11 to 20 (1 point)
   - 21 to 30 (2 points)
   - 31 or more (3 points)
5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?
   - Yes (1 point)
   - No (0 points)
6. Do you smoke even if you are so ill that you are in bed most of the day?
   - Yes (1 point)
   - No (0 points)

REFERENCES:
1. Smoking & Tobacco Use. Centers for Disease Control and Prevention. http://www.cdc.gov/tobacco/index.htm. Accessed March 10, 2016.
2. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. http://www.surgeongeneral.gov/library/reports/50-years-of-progress/fact-sheet.html. Accessed May 13, 2016.
3. Smoking and Tobacco Use. New York State Department of Health. https://www.health.ny.gov/prevention/tobacco_control/. Accessed March 14, 2016.
4. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General.http://www.cdc.gov/tobacco/data_statistics/sgr/2010/index.htm. Accessed May 13, 2016.
5. The Health Consequences of Smoking: A Report of the Surgeon General. http://www.cdc.gov/tobacco/data_statistics/sgr/2004/. Accessed May 21, 2015.
6. The Health Benefits of Smoking Cessation: A Report of the Surgeon General. https://profiles.nlm.nih.gov/NN/B/B/C/T/. Accessed May 21, 2014.
7. Treating Tobacco Use and Dependence: 2008 Update – Clinical Practice Guideline. Agency for Healthcare Research and Quality. 2008. http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf.
8. Establishing tobacco-free communities: A practical guide for pharmacists. International Pharmaceutical Federation (FIP). 2015. http://fip.org/files/fip/publications/2015-12-Establishing-tobacco-free-communities.pdf.
9. Heatherton, Todd F. et al. 1991 The Fagerström Test for Nicotine Dependence: a revision of the Fagerström Tolerance Questionnaire. *British Journal of Addiction* 86:1119-1127.