

## Clinical Practice Guideline

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# Treating Tobacco Use and Dependence: 2008 Update

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## Chapter 2 Assessment of Tobacco Use

At least 70 percent of smokers see a physician each year, and almost one-third see a dentist.<sup>19,110</sup> Other smokers see physician assistants, nurse practitioners, nurses, physical and occupational therapists, pharmacists, counselors, and other clinicians. Therefore, virtually all clinicians are in a position to intervene with patients who use tobacco. Moreover, 70 percent of smokers report wanting to quit,<sup>111</sup> and almost two-thirds of smokers who relapse want to try quitting again within 30 days.<sup>112</sup> Finally, smokers cite a physician's advice to quit as an important motivator for attempting to stop smoking.<sup>113-118</sup> These data suggest that most smokers are interested in quitting, clinicians and health systems are in frequent contact with smokers, and clinicians have high credibility with smokers.

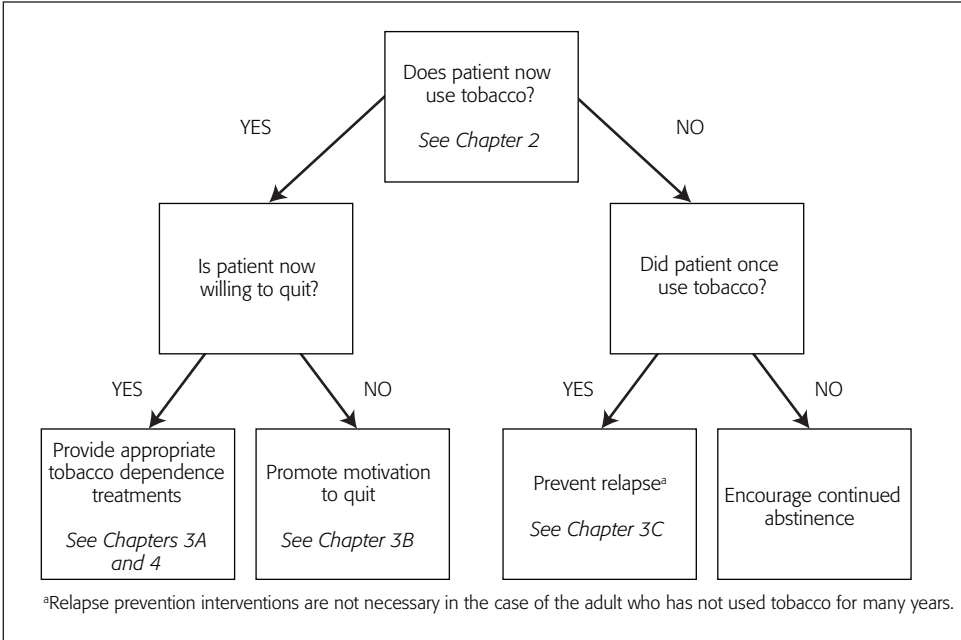
Unfortunately, clinicians and health systems do not capitalize on this opportunity consistently. According to the National Committee for Quality Assurance's (NCQA) *State of Health Care Quality Report*,<sup>119</sup> there has been some improvement in tobacco dependence clinical intervention for the insured population. In 2005, 71.2 percent of commercially insured smokers received cessation advice (up slightly from 69.6% in 2004); and 75.5 percent of Medicare smokers received advice to quit, up 11 percentage points from 2004 for this group. Despite this progress, there is a clear need for additional improvement. Only 25 percent of Medicaid patients reported any practical assistance with quitting or any ensuing followup of their progress.<sup>22</sup> Only one-third of adolescents who visited a physician or dentist report receiving counseling about the dangers of tobacco use, according to the 2000 National Youth Tobacco Survey.<sup>120</sup> Pregnant women who smoke were identified at 81 percent of physician visits but received counseling at only 23 percent of these visits.<sup>121</sup> In addition, few smokers get specific help with quitting. Recent Healthcare Effectiveness Data and Information Set (HEDIS) data showed that only 39 percent of smokers reported that their clinician discussed either medications or counseling strategies to quit ([www.web.ncqa.org/tabid/59/Default.aspx](http://www.web.ncqa.org/tabid/59/Default.aspx)). To capitalize on this opportunity, the 2008 Guideline update provides empirically validated tobacco treatment strategies designed to spur clinicians, tobacco treatment specialists, and health systems to intervene effectively with patients who use tobacco.

The first step in treating tobacco use and dependence is to identify tobacco users. As the data analysis in Chapter 6 shows, the identification of smok-

ers itself increases rates of clinician intervention. Effective identification of tobacco use status not only opens the door for successful interventions (e.g., clinician advice and treatment), but also guides clinicians to identify appropriate interventions based on patients' tobacco use status and willingness to quit. Based on these findings, the Guideline update recommends that clinicians and health care systems seize the office visit for universal assessment and intervention. Specifically, ask every patient who presents to a health care facility if s/he uses tobacco (Ask), advise all tobacco users to quit (Advise), and assess the willingness of all tobacco users to make a quit attempt at this time (Assess) (the first 3 of the 5 A's; see Chapter 3).

Screening for current or past tobacco use will result in four possible responses: (1) the patient uses tobacco and is willing to make a quit attempt at this time; (2) the patient uses tobacco but is not willing to make a quit attempt at this time; (3) the patient once used tobacco but has since quit; and (4) the patient never regularly used tobacco. This Clinical Practice Guideline is organized to provide the clinician with simple but effective interventions for all of these patient groups (see Figure 2.1).

**Figure 2.1. Algorithm for treating tobacco use**



# Chapter 3 Clinical Interventions for Tobacco Use and Dependence

## Background

This section of the Guideline presents specific strategies to guide clinicians providing brief interventions (less than 10 minutes). These brief interventions can be provided by all clinicians but are most relevant to clinicians who see a wide variety of patients and are bound by time constraints (e.g., physicians, nurses, physician assistants, nurse practitioners, medical assistants, dentists, hygienists, respiratory therapists, mental health counselors, pharmacists, etc.). The strategies in this chapter are based on the evidence described in Chapters 6 and 7, as well as on Panel opinion. Guideline analysis suggests that a wide variety of clinicians can implement these strategies effectively.

Why should members of a busy clinical team consider making the treatment of tobacco use a priority? The evidence is compelling: (1) clinicians can make a difference with even a minimal (less than 3 minutes) intervention (see Chapter 6); (2) a relation exists between the intensity of intervention and tobacco cessation outcome (see Chapter 6); (3) even when patients are not willing to make a quit attempt at this time, clinician-delivered brief interventions enhance motivation and increase the likelihood of future quit attempts<sup>122</sup> (see Chapter 6); (4) tobacco users are being primed to consider quitting by a wide range of societal and environmental factors (e.g., public health messages, policy changes, cessation marketing messages, family members); (5) there is growing evidence that smokers who receive clinician advice and assistance with quitting report greater satisfaction with their health care than those who do not;<sup>23,87,88</sup> (6) tobacco use interventions are highly cost effective (see Chapter 6); and (7) tobacco use has a high case fatality rate (up to 50% of long-term smokers will die of a smoking-caused disease<sup>123</sup>).

The goal of these strategies is clear: to change clinical culture and practice patterns to ensure that every patient who uses tobacco is identified,

advised to quit, and offered scientifically sound treatments. The strategies underscore a central theme: it is essential to provide at least a brief intervention to every tobacco user at each health care visit. Responsibility lies with both the clinician and the health care system to ensure that this occurs. Several observations are relevant to this theme. First, although many smokers are reluctant to seek intensive treatments,<sup>124,125</sup> they nevertheless can receive a brief intervention every time they visit a clinician.<sup>66,126</sup> Second, institutional support is necessary to ensure that all patients who use tobacco are identified and offered appropriate treatment (see Chapter 5, Systems Interventions: Importance to Health Care Administrators, Insurers, and Purchasers). Third, the time limits on primary care physicians in the United States today (median visit = 12–16 minutes),<sup>127,128</sup> as well as reimbursement restrictions, often limit providers to brief interventions, although more intensive interventions would produce greater success. Finally, given the growing use of electronic patient databases, smoker registries, and real-time clinical care prompts, brief interventions may be easier to fit into a busy practice and may be implemented in a variety of ways.

This chapter is divided into three sections to guide brief clinician interventions with three types of patients: (A) current tobacco users willing to make a quit attempt at this time; (B) current tobacco users unwilling to make a quit attempt at this time; and (C) former tobacco users who have recently quit. Patients who have never used tobacco or who have been abstinent for an extended period should be congratulated on their status and encouraged to maintain their tobacco-free lifestyle.

Given that more than 70 percent of tobacco users visit a physician and more than 50 percent visit a dentist each year,<sup>129</sup> it is essential that these clinicians be prepared to intervene with all tobacco users. The five major components (the “5 A’s”) of a brief intervention in the primary care setting are listed in Table 3.1. It is important for a clinician to *ask* the patient if he or she uses tobacco (Strategy A1), *advise* him or her to quit (Strategy A2), and *assess* willingness to make a quit attempt (Strategy A3). Strategies A1 to A3 need to be delivered to each tobacco user, regardless of his or her willingness to quit.

If the patient is willing to quit, the clinician should *assist* him or her in making a quit attempt by offering medication and providing or referring for counseling or additional treatment (Strategy A4), and *arrange* for fol-

**Table 3.1. The “5 A’s” model for treating tobacco use and dependence**

<p><b>Ask</b> about tobacco use.</p>	<p>Identify and document tobacco use status for every patient at every visit. (Strategy A1)</p>
<p><b>Advise</b> to quit.</p>	<p>In a clear, strong, and personalized manner, urge every tobacco user to quit. (Strategy A2)</p>
<p><b>Assess</b> willingness to make a quit attempt.</p>	<p>Is the tobacco user willing to make a quit attempt at this time? (Strategy A3)</p>
<p><b>Assist</b> in quit attempt.</p>	<p>For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional treatment to help the patient quit. (Strategy A4)</p> <p>For patients unwilling to quit at the time, provide interventions designed to increase future quit attempts. (Strategies B1 and B2)</p>
<p><b>Arrange</b> followup.</p>	<p>For the patient willing to make a quit attempt, arrange for followup contacts, beginning within the first week after the quit date. (Strategy A5)</p> <p>For patients unwilling to make a quit attempt at the time, address tobacco dependence and willingness to quit at next clinic visit.</p>

lowup contacts to prevent relapse (Strategy A5). If the patient is unwilling to make a quit attempt, the clinician should provide a motivational intervention (Strategies B1 and B2) and *arrange* to address tobacco dependence at the next clinic visit. The Strategy tables below (A1–A5) comprise suggestions for the content and delivery of the 5 A’s. The strategies are designed to be brief and require 3 minutes or less of direct clinician time. These intervention components constitute the core elements of a tobacco intervention, but they need not be applied in a rigid, invariant manner. For instance, the clinician need not deliver all elements personally. One clinician (e.g., a medical assistant) may ask about tobacco use status; and a prescribing clinician (e.g., physician, dentist, physician assistant, nurse practitioner) may deliver personal advice to quit, assess willingness to quit, and assist with medications, but then refer the patient to a tobacco intervention resource (e.g., a tobacco cessation quitline, health educator) that would deliver additional treatment to the patient. The clinician would remain responsible for the patient receiving appropriate care and subsequent followup, but, as with other sorts of health care, an individual clinician would not need to

deliver all care personally.<sup>130</sup> Evidence indicates that full implementation of the 5 A's in clinical settings may yield results that are superior to partial implementation.<sup>131</sup>

The effectiveness of tobacco intervention may reflect not only the contributions of the individual clinician, but also the systems and other clinical resources available to him or her. For instance, office systems that institutionalize tobacco use assessment and intervention will greatly foster the likelihood that the 5 A's will be delivered (see Chapter 5). The 5 A's, as described in Table 3.1, are consistent with those recommended by the NCI<sup>132,133</sup> and the American Medical Association,<sup>77</sup> as well as others.<sup>75,134-137</sup> The clinical situation may suggest delivering these intervention components in an order or format different from that presented, however. For example, clinical interventions such as: Ask/Assess, Advise, Agree on a goal, Assist, Arrange followup; Ask and Act; and Ask, Advise, and Refer have been proposed.<sup>116,130,138-140</sup>

When "Assisting" smokers, in addition to counseling, all smokers making a quit attempt should be offered medication, except when contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). See Tables 3.2 to 3.11 for guidelines for prescribing medication for treating tobacco use and dependence.

## A. For the Patient Willing To Quit

### Strategy A1. Ask—Systematically identify all tobacco users at every visit

Action	Strategies for implementation
Implement an officewide system that ensures that, for every patient at every clinic visit, tobacco use status is queried and documented. <sup>a</sup>	Expand the vital signs to include tobacco use, or use an alternative universal identification system. <sup>b</sup> <b>VITAL SIGNS</b> Blood Pressure: _____ Pulse: _____ Weight: _____ Temperature: _____ Respiratory Rate: _____ Tobacco Use (circle one): Current Former Never

<sup>a</sup> Repeated assessment is *not* necessary in the case of the adult who has never used tobacco or has not used tobacco for many years and for whom this information is clearly documented in the medical record.

<sup>b</sup> Alternatives to expanding the vital signs include using tobacco use status stickers on all patient charts or indicating tobacco use status via electronic medical records or computerized reminder systems.

**Strategy A2. Advise—Strongly urge all tobacco users to quit**

Action	Strategies for implementation
<p>In a <i>clear, strong, and personalized</i> manner, urge every tobacco user to quit.</p>	<p>Advice should be:</p> <ul style="list-style-type: none"> <li>• <i>Clear</i>—"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."</li> <li>• <i>Strong</i>—"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."</li> <li>• <i>Personalized</i>—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."</li> </ul>

**Strategy A3. Assess—Determine willingness to make a quit attempt**

Action	Strategies for implementation
<p>Assess every tobacco user's willingness to make a quit attempt at the time.</p>	<p>Assess patient's willingness to quit: "Are you willing to give quitting a try?"</p> <ul style="list-style-type: none"> <li>• If the patient is willing to make a quit attempt at the time, provide assistance (see Chapter 3A, Strategy A4). <ul style="list-style-type: none"> <li>– If the patient will participate in an intensive treatment, deliver such a treatment or link/refer to an intensive intervention (see Chapter 4).</li> <li>– If the patient is a member of a special population (e.g., adolescent, pregnant smoker, racial/ethnic minority), consider providing additional information (see Chapter 7).</li> </ul> </li> <li>• If the patient clearly states that he or she is unwilling to make a quit attempt at the time, provide an intervention shown to increase future quit attempts (see Chapter 3B).</li> </ul>

**Strategy A4. Assist—Aid the patient in quitting (provide counseling and medication)**

Action	Strategies for implementation
<p>Help the patient with a quit plan.</p>	<p><i>A patient's preparations for quitting:</i></p> <ul style="list-style-type: none"> <li>• <b>Set a quit date.</b> Ideally, the quit date should be within 2 weeks.</li> <li>• <b>Tell</b> family, friends, and coworkers about quitting, and request understanding and support.</li> <li>• <b>Anticipate</b> challenges to the upcoming quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms.</li> <li>• <b>Remove</b> 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.</li> </ul>
<p>Recommend the use of approved medication, except when 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>Recommend the use of medications found to be effective in this Guideline (see Table 3.2 for clinical guidelines and Tables 3.3–3.11 for specific instructions and precautions). Explain how these medications increase quitting success and reduce withdrawal symptoms. The first-line medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, and varenicline; second-line medications include: clonidine and nortriptyline. There is insufficient evidence to recommend medications for certain populations (e.g., pregnant women, smokeless tobacco users, light smokers, adolescents).</p>
<p>Provide practical counseling (problemsolving/skills training).</p>	<p><i>Abstinence.</i> Striving for total abstinence is essential. Not even a single puff after the quit date.<sup>141</sup></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 in the upcoming attempt.</i> Discuss challenges/triggers and how the patient will successfully overcome them (e.g., avoid triggers, alter routines).</p> <p><i>Alcohol.</i> Because 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 to not smoke in their presence.</p> <p>For further description of practical counseling, see Table 6.19.</p>

**Strategy A4. Assist—Aid the patient in quitting (provide counseling and medication) (continued)**

Action	Strategies for implementation
Provide intratreatment social support.	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> For further description of intratreatment social support, see Table 6.20.
Provide supplementary materials, including information on quitlines.	<i>Sources:</i> Federal agencies, nonprofit agencies, national quitline network (1-800-QUIT-NOW), or local/state/tribal health departments/quitlines (see Appendix B for Web site addresses).  <i>Type:</i> Culturally/racially/educationally/age-appropriate for the patient.  <i>Location:</i> Readily available at every clinician's workstation.
For the smoker unwilling to quit at the time	See Section 3B.

**Strategy A5. Arrange—Ensure followup contact**

Action	Strategies for implementation
Arrange for followup contacts, either in person or via telephone.	<i>Timing:</i> Followup contact should begin soon after the quit date, preferably during the first week. A second followup contact is recommended within the first month. Schedule further followup contacts as indicated.  <i>Actions during followup contact:</i> For all patients, identify problems already encountered and anticipate challenges in the immediate future. Assess medication use and problems. Remind patients of quitline support (1-800-QUIT-NOW). Address tobacco use at next clinical visit (treat tobacco use as a chronic disease).  For patients who are abstinent, congratulate them on their success.  If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Consider use of or link to more intensive treatment (see Chapter 4).
For smokers unwilling to quit at the time	See Section 3B.

**Table 3.2. Clinical guidelines for prescribing medication for treating tobacco use and dependence**

<p>Who should receive medication for tobacco use? Are there groups of smokers for whom medication has not been shown to be effective?</p>	<p>All smokers trying to quit should be offered medication, except when contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents; see Chapter 7).</p>
<p>What are the first-line medications recommended in this Guideline update?</p>	<p>All seven of the FDA-approved medications for treating tobacco use are recommended: bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, 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 + <i>ad libitum</i> nicotine replacement therapy (NRT). Unfortunately, there are no well-accepted algorithms to guide optimal selection among the first-line medications.</p>
<p>Are there contraindications, warnings, precautions, other concerns, and side effects regarding the first-line medications recommended in this Guideline update?</p>	<p>All seven FDA-approved medications have specific contraindications, warnings, precautions, other concerns, and side effects. Refer to FDA package inserts for this complete information and FDA updates to the individual drug tables in this document (Tables 3.3–3.9). (See information below regarding second-line medications.)</p>
<p>What other factors may influence medication selection?</p>	<p>Pragmatic factors also may influence selection, such as insurance coverage, out-of-pocket patient costs, likelihood of adherence, dentures when considering the gum, or dermatitis when considering the patch.</p>
<p>Is a patient's prior experience with a medication relevant?</p>	<p>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,<sup>142,143</sup> whereas other evidence suggests that it may be of substantial benefit.<sup>144</sup></p>

**Table 3.2. Clinical guidelines for prescribing medication for treating tobacco use and dependence (continued)**

<p>What medications should a clinician use with a patient who is highly nicotine dependent?</p>	<p>The higher-dose preparations of nicotine gum, patch, and lozenge have been shown to be effective in highly dependent smokers.<sup>145-147</sup> Also, there is evidence that combination NRT therapy may be particularly effective in suppressing tobacco withdrawal symptoms.<sup>148,149</sup> Thus, it may be that NRT combinations are especially helpful for highly dependent smokers or those with a history of severe withdrawal.</p>
<p>Is gender a consideration in selecting a medication?</p>	<p>There is evidence that NRT can be effective with both sexes;<sup>150-152</sup> however, evidence is mixed as to whether NRT is less effective in women than men.<sup>153-157</sup> This may encourage the clinician to consider use of another type of medication with women, such as bupropion SR or varenicline.</p>
<p>Are cessation medications appropriate for light smokers (i.e., &lt; 10 cigarettes/day)?</p>	<p>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.</p>
<p>When should second-line agents be used for treating tobacco dependence?</p>	<p>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. Refer to FDA package inserts for this information and to the individual drug tables in this document (Tables 3.10 and 3.11).</p>
<p>Which medications should be considered with patients particularly concerned about weight gain?</p>	<p>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.</p>
<p>Are there medications that should especially be considered for patients with a past history of depression?</p>	<p>Bupropion SR and nortriptyline appear to be effective with this population<sup>158-162</sup> (see Chapter 7), but nicotine replacement medications also appear to help individuals with a past history of depression.</p>

**Table 3.2. Clinical guidelines for prescribing medication for treating tobacco use and dependence (continued)**

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. See Tables 3.3–3.9 and FDA package inserts for more complete information.
May tobacco dependence medications be used long-term (e.g., up to 6 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 <i>ad libitum</i> NRT medications (gum, nasal spray, inhaler) long-term. The use of these medications for up to 6 months does not present a known health risk, and developing dependence on medications is uncommon. Additionally, the FDA has approved the use of bupropion SR, varenicline, and some NRT medications for 6-month use.
Is medication adherence important?	Yes. Patients frequently do not use cessation medications as recommended (e.g., they do not use them at recommended doses or for recommended durations); this may reduce their effectiveness.
May medications ever be combined?	Yes. Among first-line medications, evidence exists that combining the nicotine patch long-term (> 14 weeks) with either 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. Combining varenicline with NRT agents has been associated with higher rates of side effects (e.g., nausea, headaches).

**Table 3.3. Clinical use of bupropion SR (See FDA package insert for more complete information.)**

	Clinical use of bupropion SR 150 (FDA approved)
Patient selection	Appropriate as a first-line medication for treating tobacco use
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. Bupropion has not been shown to be effective for tobacco dependence treatment in pregnant smokers. (Bupropion is an FDA pregnancy Class C agent.) Bupropion has not been evaluated in breastfeeding patients.</p> <p><i>Cardiovascular diseases</i> – Generally well-tolerated; occasional reports of hypertension.</p>

**Table 3.3. Clinical use of bupropion SR (See FDA package insert for more complete information.) (continued)**

	Clinical use of bupropion SR 150 (FDA approved)
Precautions, contraindications, and side effects (continued)	<p><i>Side effects</i> – The most common reported side effects were insomnia (35–40%) and dry mouth (10%).</p> <p><i>Contraindications</i> – Bupropion SR is contraindicated in individuals who have a history of seizures or eating disorders, who are taking another form of bupropion, or who have used an MAO inhibitor in the past 14 days.</p>
Dosage	<p>Patients should begin bupropion SR treatment 1–2 weeks before they quit smoking. Patients should begin with a dose of 150 mg every morning for 3 days, then increase to 150 mg twice daily. Dosage should not exceed 300 mg per day. Dosing at 150 mg twice daily should continue for 7–12 weeks. For long-term therapy, consider use of bupropion SR 150 mg for up to 6 months postquit.</p>
Availability	Prescription only
Prescribing instructions	<p><i>Stopping smoking prior to quit date</i> – Recognize that some patients may lose their desire to smoke prior to their quit date or will spontaneously reduce the amount they smoke.</p> <p><i>Dosing information</i> – If insomnia is marked, taking the PM dose earlier (in the afternoon, at least 8 hours after the first dose) may provide some relief.</p> <p><i>Alcohol</i> – Use alcohol only in moderation.</p>
Cost <sup>a</sup>	1 box of 60 tablets, 150 mg = \$97 per month (generic); \$197 to \$210 (Brand name)

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

**Table 3.4. Clinical use of nicotine gum (See FDA package insert for more complete information.)**

	Clinical use of nicotine gum (FDA approved)
Patient selection	Appropriate as a first-line medication for treating tobacco use
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. Nicotine gum has not been shown to be effective for treating tobacco dependence in pregnant smokers. (Nicotine gum is an FDA pregnancy Class D agent.) Nicotine gum has not been evaluated in breastfeeding patients.</p>

**Table 3.4. Clinical use of nicotine gum (See FDA package insert for more complete information.) (continued)**

	Clinical use of nicotine gum (FDA approved)
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list) (continued)	<p><i>Cardiovascular diseases</i> – NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) postmyocardial infarction period, those with serious arrhythmias, and those with unstable angina pectoris.</p> <p><i>Side effects</i> – Common side effects of nicotine gum include mouth soreness, hiccups, dyspepsia, and jaw ache. These effects are generally mild and transient and often can be alleviated by correcting the patient’s chewing technique (see <i>prescribing instructions</i>, below).</p>
Dosage	Nicotine gum (both regular and flavored) is available in 2-mg and 4-mg (per piece) doses. The 2-mg gum is recommended for patients smoking less than 25 cigarettes per day; the 4-mg gum is recommended for patients smoking 25 or more cigarettes per day. Smokers should use at least one piece every 1 to 2 hours for the first 6 weeks; the gum should be used for up to 12 weeks with no more than 24 pieces to be used per day.
Availability	OTC only
Prescribing instructions	<p><i>Chewing technique</i> – Gum should be chewed slowly until a “peppery” or “flavored” taste emerges, then “parked” between cheek and gum to facilitate nicotine absorption through the oral mucosa. Gum should be slowly and intermittently “chewed and parked” for about 30 minutes or until the taste dissipates.</p> <p><i>Absorption</i> – Acidic beverages (e.g., coffee, juices, soft drinks) interfere with the buccal absorption of nicotine, so eating and drinking anything except water should be avoided for 15 minutes before or during chewing.</p> <p><i>Dosing information</i> – Patients often do not use enough <i>prn</i> NRT medicines to obtain optimal clinical effects. Instructions to chew the gum on a fixed schedule (at least one piece every 1–2 hours) for at least 1–3 months may be more beneficial than <i>ad libitum</i> use.</p>
Cost <sup>a</sup>	<p>2 mg (packaged in different amounts), boxes of 100–170 pieces = \$48 (quantity used determines how long supply lasts)</p> <p>4 mg (packaged in different amounts), boxes of 100–110 pieces = \$63 (quantity used determines how long supply lasts)</p>

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

**Table 3.5. Clinical use of the nicotine inhaler (See FDA package insert for more complete information.)**

	Clinical use of nicotine inhaler (FDA approved)
Patient selection	Appropriate as a first-line medication for treating tobacco use
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. The nicotine inhaler has not been shown to be effective for treating tobacco dependence in pregnant smokers. (The nicotine inhaler is an FDA pregnancy Class D agent.) The nicotine inhaler has not been evaluated in breastfeeding patients.</p> <p><i>Cardiovascular diseases</i> – NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) postmyocardial infarction period, those with serious arrhythmias, and those with unstable angina pectoris.</p> <p><i>Local irritation reactions</i> – Local irritation in the mouth and throat was observed in 40% of patients using the nicotine inhaler. Coughing (32%) and rhinitis (23%) also were common. Severity was generally rated as mild, and the frequency of such symptoms declined with continued use.</p>
Dosage	A dose from the nicotine inhaler consists of a puff or inhalation. Each cartridge delivers a total of 4 mg of nicotine over 80 inhalations. Recommended dosage is 6–16 cartridges/day. Recommended duration of therapy is up to 6 months. Instruct patient to taper dosage during the final 3 months of treatment.
Availability	Prescription only
Prescribing instructions	<p><i>Ambient temperature</i> – Delivery of nicotine from the inhaler declines significantly at temperatures below 40°F. In cold weather, the inhaler and cartridges should be kept in an inside pocket or other warm area.</p> <p><i>Absorption</i> – Acidic beverages (e.g., coffee, juices, soft drinks) interfere with the buccal absorption of nicotine, so eating and drinking anything except water should be avoided for 15 minutes before or during use of the inhaler.</p> <p><i>Dosing information</i> – Patients often do not use enough <i>prn</i> NRT medicines to obtain optimal clinical effects. Use is recommended for up to 6 months, with gradual reduction in frequency of use over the last 6–12 weeks of treatment. Best effects are achieved by frequent puffing of the inhaler and using at least six cartridges/day.</p>
Cost <sup>a</sup>	1 box of 168 10-mg cartridges = \$196 (quantity used determines how long supply lasts)

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

**Table 3.6. Clinical use of the nicotine lozenge (See FDA package insert for more complete information.)**

	Clinical use of nicotine lozenge (FDA approved)
Patient selection	Appropriate as a first-line medication for treating tobacco use
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. The nicotine lozenge has not been shown to be effective for treating tobacco dependence for pregnant smokers. The nicotine lozenge has not been evaluated in breastfeeding patients. Because the lozenge was approved as an OTC agent, it was not evaluated by the FDA for teratogenicity.</p> <p><i>Cardiovascular diseases</i> – NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) postmyocardial infarction period, those with serious arrhythmias, and those with unstable angina pectoris.</p> <p><i>Side effects</i> – The most common side effects of the nicotine lozenge are nausea, hiccups, and heartburn. Individuals on the 4-mg lozenge also had increased rates of headache and coughing (less than 10% of participants).</p>
Dosage	Nicotine lozenges are available in 2-mg and 4-mg (per piece) doses. The 2-mg lozenge is recommended for patients who smoke their first cigarette more than 30 minutes after waking, and the 4-mg lozenge is recommended for patients who smoke their first cigarette within 30 minutes of waking. Generally, smokers should use at least nine lozenges per day in the first 6 weeks; the lozenge should be used for up to 12 weeks, with no more than 20 lozenges to be used per day.
Availability	OTC only
Prescribing instructions	<p><i>Lozenge use</i> – The lozenge should be allowed to dissolve in the mouth rather than chewing or swallowing it.</p> <p><i>Absorption</i> – Acidic beverages (e.g., coffee, juices, soft drinks) interfere with the buccal absorption of nicotine, so eating and drinking anything except water should be avoided for 15 minutes before or during use of the nicotine lozenge.</p> <p><i>Dosing information</i> – Patients often do not use enough <i>prn</i> NRT medicines to obtain optimal clinical effects. Generally, patients should use 1 lozenge every 1–2 hours during the first 6 weeks of treatment, using a minimum of 9 lozenges/day, then decrease lozenge use to 1 lozenge every 2–4 hours during weeks 7–9, and then decrease to 1 lozenge every 4–8 hours during weeks 10–12.</p>
Cost <sup>a</sup>	<p>2 mg, 72 lozenges per box = \$34 (quantity used determines how long supply lasts)</p> <p>4 mg, 72 lozenges per box = \$39 (quantity used determines how long supply lasts)</p>

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

**Table 3.7. Clinical use of the nicotine nasal spray (See FDA package insert for more complete information.)**

	Clinical use of nicotine nasal spray (FDA approved)
Patient selection	Appropriate as a first-line medication for treating tobacco use
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. Nicotine nasal spray has not been shown to be effective for treating tobacco dependence in pregnant smokers. (Nicotine nasal spray is an FDA pregnancy Class D agent.) Nicotine nasal spray has not been evaluated in breastfeeding patients.</p> <p><i>Cardiovascular diseases</i> – NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) postmyocardial infarction period, those with serious arrhythmias, and those with unstable angina pectoris.</p> <p><i>Nasal/airway reactions</i> – Some 94% of users report moderate to severe nasal irritation in the first 2 days of use; 81% still reported nasal irritation after 3 weeks, although rated severity typically was mild to moderate. Nasal congestion and transient changes in sense of smell and taste also were reported. Nicotine nasal spray should not be used in persons with severe reactive airway disease.</p> <p><i>Dependency</i> – Nicotine nasal spray produces higher peak nicotine levels than other NRTs and has the highest dependence potential. Approximately 15–20% of patients report using the active spray for longer periods than recommended (6–12 months); 5% used the spray at a higher dose than recommended.</p>
Dosage	A dose of nicotine nasal spray consists of one 0.5-mg dose delivered to each nostril (1 mg total). Initial dosing should be 1–2 doses per hour, increasing as needed for symptom relief. Minimum recommended treatment is 8 doses/day, with a maximum limit of 40 doses/day (5 doses/hour). Each bottle contains approximately 100 doses. Recommended duration of therapy is 3–6 months.
Availability	Prescription only
Prescribing instructions	<i>Dosing information</i> – Patients should not sniff, swallow, or inhale through the nose while administering doses, as this increases irritating effects. The spray is best delivered with the head tilted slightly back.
Cost <sup>a</sup>	\$49 per bottle (quantity used determines how long supply lasts)

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

**Table 3.8. Clinical use of the nicotine patch (See FDA package insert for more complete information.)**

	Clinical use of the nicotine patch (FDA approved)	
Patient selection	Appropriate as a first-line medication for treating tobacco use	
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. The nicotine patch has not been shown to be effective for treating tobacco dependence treatment in pregnant smokers. (The nicotine patch is an FDA pregnancy Class D agent.) The nicotine patch has not been evaluated in breastfeeding patients.</p> <p><i>Cardiovascular diseases</i> – NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) postmyocardial infarction period, those with serious arrhythmias, and those with unstable angina pectoris.</p> <p><i>Skin reactions</i> – Up to 50% of patients using the nicotine patch will experience a local skin reaction. Skin reactions usually are mild and self-limiting, but occasionally worsen over the course of therapy. Local treatment with hydrocortisone cream (1%) or triamcinolone cream (0.5%) and rotating patch sites may ameliorate such local reactions. In fewer than 5% of patients, such reactions require the discontinuation of nicotine patch treatment.</p> <p><i>Other side effects</i> – insomnia and/or vivid dreams</p>	
Dosage	Treatment of 8 weeks or less has been shown to be as efficacious as longer treatment periods. Patches of different doses sometimes are available as well as different recommended dosing regimens. The dose and duration recommendations in this table are examples. Clinicians should consider individualizing treatment based on specific patient characteristics, such as previous experience with the patch, amount smoked, degree of dependence, etc.	
Availability	OTC or prescription	
Type	Duration	Dosage
Step-Down Dosage	4 weeks then 2 weeks then 2 weeks	21 mg/24 hours 14 mg/24 hours 7 mg/24 hours
Single Dosage	Both a 22 mg/24 hours and an 11 mg/24 hours (for lighter smokers) dose are available in a one-step patch regimen.	

**Table 3.8. Clinical use of the nicotine patch (See FDA package insert for more complete information.) (continued)**

	Clinical use of the nicotine patch (FDA approved)
Prescribing instructions	<p><i>Location</i> – At the start of each day, the patient should place a new patch on a relatively hairless location, typically between the neck and waist, rotating the site to reduce local skin irritation.</p> <p><i>Activities</i> – No restrictions while using the patch</p> <p><i>Dosing information</i> – Patches should be applied as soon as the patient wakes on the quit day. With patients who experience sleep disruption, have the patient remove the 24-hour patch prior to bed-time, or use the 16-hour patch (designed for use while the patient is awake).</p>
Cost <sup>a</sup>	<p>7 mg, box = \$37 (quantity used determines how long supply lasts)</p> <p>14 mg, box = \$47 (quantity used determines how long supply lasts)</p> <p>21 mg, box = \$48 (quantity used determines how long supply lasts)</p>

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

**Table 3.9. Clinical use of varenicline (See FDA package insert for more complete information.)**

	Clinical use of varenicline (FDA approved)
Patient selection	Appropriate as a first-line medication for treating tobacco use
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. Varenicline has not been shown to be effective for treating tobacco dependence in pregnant smokers. (Varenicline is an FDA pregnancy Class C agent.) Varenicline has not been evaluated in breastfeeding patients.</p> <p><i>Cardiovascular diseases</i> – Not contraindicated</p> <p><i>Precautions</i> – Use with caution in patients with significant kidney disease (creatinine clearance &lt; 30mL/min) or who are on dialysis. Dose should be reduced with these patients. Patients taking varenicline may experience impairment of the ability to drive or operate heavy machinery.</p>

**Table 3.9. Clinical use of varenicline (See FDA package insert for more complete information.) (continued)**

	Clinical use of varenicline (FDA approved)
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list) (continued)	<p><i>Warning</i> – In February 2008, the FDA added a warning regarding the use of varenicline. Specifically, it noted that depressed mood, agitation, changes in behavior, suicidal ideation, and suicide have been reported in patients attempting to quit smoking while using varenicline. The FDA recommends that patients should tell their health care provider about any history of psychiatric illness prior to starting this medication, and clinicians should monitor patients for changes in mood and behavior when prescribing this medication. In light of these FDA recommendations, clinicians should consider eliciting information on their patients’ psychiatric history.</p> <p><i>Side effects</i> – Nausea, trouble sleeping, abnormal/vivid/strange dreams</p>
Dosage	Start varenicline 1 week before the quit date at 0.5 mg once daily for 3 days, followed by 0.5 mg twice daily for 4 days, followed by 1 mg twice daily for 3 months. Varenicline is approved for a maintenance indication for up to 6 months. Note: Patient should be instructed to quit smoking on day 8, when dosage is increased to 1 mg twice daily.
Availability	Prescription only
Prescribing instructions	<p><i>Stopping smoking prior to quit date</i> – Recognize that some patients may lose their desire to smoke prior to their quit date or will spontaneously reduce the amount they smoke.</p> <p><i>Dosing information</i> –To reduce nausea, take on a full stomach. To reduce insomnia, take second pill at supper rather than bedtime.</p>
Cost <sup>a</sup>	1 mg, box of 56 = \$131 (about 30-day supply)

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

**Table 3.10. Clinical use of clonidine (See FDA package insert for more complete information.)**

	Clinical use of clonidine (not FDA approved for smoking cessation)
Patient selection	Appropriate as a second-line medication for treating tobacco use
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. Clonidine has not been shown to be effective for tobacco cessation in pregnant smokers. (Clonidine is an FDA pregnancy Class C agent.) Clonidine has not been evaluated in breastfeeding patients.</p> <p><i>Activities</i> – Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of a possible sedative effect of clonidine.</p> <p><i>Side effects</i> – Most commonly reported side effects include dry mouth (40%), drowsiness (33%), dizziness (16%), sedation (10%), and constipation (10%). As an antihypertensive medication, clonidine can be expected to lower blood pressure in most patients. Therefore, clinicians should monitor blood pressure when using this medication.</p> <p><i>Rebound hypertension</i> – When stopping clonidine therapy, failure to reduce the dose gradually over a period of 2–4 days may result in a rapid increase in blood pressure, agitation, confusion, and/or tremor.</p>
Dosage	Doses used in various clinical trials have varied significantly, from 0.15–0.75 mg/day by mouth and from 0.10–0.20 mg/day transdermal (TTS), without a clear dose-response relation to treatment outcomes. Initial dosing is typically 0.10 mg b.i.d. PO or 0.10 mg/day TTS, increasing by 0.10 mg/day per week if needed. The dose duration also varied across the clinical trials, ranging from 3–10 weeks.
Availability	Oral – Prescription only Transdermal – Prescription only
Prescribing instructions	<p><i>Initiate</i> – Initiate clonidine shortly before (up to 3 days), or on the quit date.</p> <p><i>Dosing information</i> – If the patient is using transdermal clonidine, at the start of each week, he or she should place a new patch on a relatively hairless location between the neck and waist. Users should not discontinue clonidine therapy abruptly.</p>
Cost <sup>a</sup>	Oral – .1 mg, box of 60 = \$13 (daily dosage determines how long supply lasts) Transdermal – 4-pack TTS = \$106

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

**Table 3.11. Clinical use of nortriptyline (See FDA package insert for more complete information.)**

	Clinical use of nortriptyline (not FDA approved for smoking cessation)
Patient selection	Appropriate as a second-line medication for treating tobacco use
Precautions, warnings, contraindications, and side effects (see FDA package insert for complete list)	<p><i>Pregnancy</i> – Pregnant smokers should be encouraged to quit without medication. Nortriptyline has not been shown to be effective for tobacco cessation in pregnant smokers. (Nortriptyline is an FDA pregnancy Class D agent.) Nortriptyline has not been evaluated in breastfeeding patients.</p> <p><i>Side effects</i> – Most commonly reported side effects include sedation, dry mouth (64–78%), blurred vision (16%), urinary retention, lightheadedness (49%), and shaky hands (23%).</p> <p><i>Activities</i> – Nortriptyline may impair the mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a car; therefore, the patient should be warned accordingly.</p> <p><i>Cardiovascular and other effects</i> – Because of the risk of arrhythmias and impairment of myocardial contractility, use with caution in patients with cardiovascular disease. Do not co-administer with MAO inhibitors.</p>
Dosage	Doses used in smoking cessation trials have initiated treatment at a dose of 25 mg/day, increasing gradually to a target dose of 75–100 mg/day. Duration of treatment used in smoking cessation trials has been approximately 12 weeks, although clinicians may consider extending treatment for up to 6 months.
Availability	Nortriptyline HCl – prescription only
Prescribing instructions	<p><i>Initiate</i> – Therapy is initiated 10–28 days before the quit date to allow nortriptyline to reach steady state at the target dose.</p> <p><i>Therapeutic monitoring</i> – Although therapeutic blood levels for smoking cessation have not been determined, therapeutic monitoring of plasma nortriptyline levels should be considered under American Psychiatric Association Guidelines for treating patients with depression. Clinicians may choose to assess plasma nortriptyline levels as needed.<sup>163</sup></p> <p><i>Dosing information</i> – Users should not discontinue nortriptyline abruptly because of withdrawal effects.</p> <p>Overdose may produce severe and life-threatening cardiovascular toxicity, as well as seizures and coma. Risk of overdose should be considered carefully before using nortriptyline.</p>
Cost <sup>a</sup>	25 mg, box of 60 = \$24 (daily dosage determines how long supply lasts)

<sup>a</sup>Cost data were established by averaging the retail price of the medication at national chain pharmacies in Atlanta, GA, Los Angeles, CA, Milwaukee, WI, Sunnyside, NY, and listed online during January 2008 and may not reflect discounts available to health plans and others.

## **B. For the Patient Unwilling To Quit**

### ***Promoting the Motivation To Quit***

All patients entering a health care setting should have their tobacco use status assessed routinely. Clinicians should advise all tobacco users to quit and then assess a patient's willingness to make a quit attempt. For patients not ready to make a quit attempt at the time, clinicians should use a brief intervention designed to promote the motivation to quit.

Patients unwilling to make a quit attempt during a visit may lack information about the harmful effects of tobacco use and the benefits of quitting, may lack the required financial resources, may have fears or concerns about quitting, or may be demoralized because of previous relapse.<sup>164-167</sup> Such patients may respond to brief motivational interventions that are based on principles of Motivational Interviewing (MI),<sup>168</sup> a directive, patient-centered counseling intervention.<sup>169</sup> There is evidence that MI is effective in increasing future quit attempts;<sup>170-174</sup> however, it is unclear that MI is successful in boosting abstinence among individuals motivated to quit smoking.<sup>173,175,176</sup>

Clinicians employing MI techniques focus on exploring a tobacco user's feelings, beliefs, ideas, and values regarding tobacco use in an effort to uncover any ambivalence about using tobacco.<sup>169,177,178</sup> Once ambivalence is uncovered, the clinician selectively elicits, supports, and strengthens the patient's "change talk" (e.g., reasons, ideas, needs for eliminating tobacco use) and "commitment language" (e.g., intentions to take action to change smoking behavior, such as not smoking in the home). MI researchers have found that having patients use their own words to commit to change is more effective than clinician exhortations, lectures, or arguments for quitting, which tend to increase rather than lessen patient resistance to change.<sup>177</sup>

The four general principles that underlie MI are: (1) *express empathy*, (2) *develop discrepancy*, (3) *roll with resistance*, and (4) *support self-efficacy*.<sup>168,179</sup> Specific MI counseling strategies that are based on these principles are listed in Strategy B1. Because this is a specialized technique, it may be beneficial to have a member of the clinical staff receive training in motivational interviewing. The content areas that should be addressed in a motivational counseling intervention can be captured by the "5 R's": relevance, risks, rewards, roadblocks, and repetition (Strategy B2). Research suggests that the "5 R's" enhance future quit attempts.<sup>169,180</sup>

**Strategy B1. Motivational interviewing strategies**

<p><b>Express empathy.</b></p>	<ul style="list-style-type: none"> <li>• Use open-ended questions to explore:             <ul style="list-style-type: none"> <li>– The importance of addressing smoking or other tobacco use (e.g., “How important do you think it is for you to quit smoking?”)</li> <li>– Concerns and benefits of quitting (e.g., “What might happen if you quit?”)</li> </ul> </li> <li>• Use reflective listening to seek shared understanding:             <ul style="list-style-type: none"> <li>– Reflect words or meaning (e.g., “So you think smoking helps you to maintain your weight.”).</li> <li>– 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.”).</li> </ul> </li> <li>• Normalize feelings and concerns (e.g., “Many people worry about managing without cigarettes.”).</li> <li>• 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.”).</li> </ul>
<p><b>Develop discrepancy.</b></p>	<ul style="list-style-type: none"> <li>• 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?”).</li> <li>• Reinforce and support “change talk” and “commitment” language:             <ul style="list-style-type: none"> <li>– “So, you realize how smoking is affecting your breathing and making it hard to keep up with your kids.”</li> <li>– “It’s great that you are going to quit when you get through this busy time at work.”</li> </ul> </li> <li>• Build and deepen commitment to change:             <ul style="list-style-type: none"> <li>– “There are effective treatments that will ease the pain of quitting, including counseling and many medication options.”</li> <li>– “We would like to help you avoid a stroke like the one your father had.”</li> </ul> </li> </ul>
<p><b>Roll with resistance.</b></p>	<ul style="list-style-type: none"> <li>• Back off and use reflection when the patient expresses resistance:             <ul style="list-style-type: none"> <li>– “Sounds like you are feeling pressured about your smoking.”</li> </ul> </li> <li>• Express empathy:             <ul style="list-style-type: none"> <li>– “You are worried about how you would manage withdrawal symptoms.”</li> </ul> </li> <li>• Ask permission to provide information:             <ul style="list-style-type: none"> <li>– “Would you like to hear about some strategies that can help you address that concern when you quit?”</li> </ul> </li> </ul>
<p><b>Support self-efficacy.</b></p>	<ul style="list-style-type: none"> <li>• Help the patient to identify and build on past successes:             <ul style="list-style-type: none"> <li>– “So you were fairly successful the last time you tried to quit.”</li> </ul> </li> <li>• Offer options for achievable small steps toward change:             <ul style="list-style-type: none"> <li>– Call the quitline (1-800-QUIT-NOW) for advice and information.</li> <li>– Read about quitting benefits and strategies.</li> <li>– Change smoking patterns (e.g., no smoking in the home).</li> <li>– Ask the patient to share his or her ideas about quitting strategies.</li> </ul> </li> </ul>

**Strategy B2. Enhancing motivation to quit tobacco—the “5 R’s”**

<b>Relevance</b>	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).
<b>Risks</b>	<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"> <li>• <i>Acute risks:</i> Shortness of breath, exacerbation of asthma, increased risk of respiratory infections, harm to pregnancy, impotence, infertility.</li> <li>• <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.</li> <li>• <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.</li> </ul>
<b>Rewards</b>	<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 follow:</p> <ul style="list-style-type: none"> <li>• Improved health</li> <li>• Food will taste better</li> <li>• Improved sense of smell</li> <li>• Saving money</li> <li>• Feeling better about oneself</li> <li>• Home, car, clothing, breath will smell better</li> <li>• Setting a good example for children and decreasing the likelihood that they will smoke</li> <li>• Having healthier babies and children</li> <li>• Feeling better physically</li> <li>• Performing better in physical activities</li> <li>• Improved appearance, including reduced wrinkling/aging of skin and whiter teeth</li> </ul>

**Strategy B2. Enhancing motivation to quit tobacco—the “5 R’s” (continued)**

<b>Roadblocks</b>	The clinician should ask the patient to identify barriers or impediments to quitting and provide treatment (problemsolving counseling, medication) that could address barriers. Typical barriers might include: <ul style="list-style-type: none"><li>• Withdrawal symptoms</li><li>• Fear of failure</li><li>• Weight gain</li><li>• Lack of support</li><li>• Depression</li><li>• Enjoyment of tobacco</li><li>• Being around other tobacco users</li><li>• Limited knowledge of effective treatment options</li></ul>
<b>Repetition</b>	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.

## **C. For the Patient Who Has Recently Quit**

### ***Treatments for the Recent Quitter***

Smokers who have recently quit face a high risk of relapse. Although most relapse occurs early in the quitting process,<sup>96,101,181</sup> some relapse occurs months or even years after the quit date.<sup>181-184</sup> Numerous studies have been conducted to identify treatments that can reduce the likelihood of future relapse. These studies attempt to reduce relapse either by including special counseling or therapy in the cessation treatment, or by providing additional treatment to smokers who have previously quit. In general, such studies have failed to identify either counseling or medication treatments that are effective in lessening the likelihood of relapse,<sup>185</sup> although there is some evidence that special mailings can reduce the likelihood of relapse.<sup>186,187</sup> Thus, at present, the best strategy for producing high long-term abstinence rates appears to be use of the most effective cessation treatments available; that is, the use of evidence-based cessation medication during the quit attempt and relatively intense cessation counseling (e.g., four or more sessions that are 10 minutes or more in length).

Ex-smokers often report problems that have been worsened by smoking withdrawal or that coexisted with their smoking. If a clinician encounters a tobacco user who recently quit, the clinician might reinforce the patient’s

success at quitting, review the benefits of quitting, and assist the patient in resolving any residual problems arising from quitting (Strategy C1). Such expressions of interest and involvement on the part of the clinician might encourage the patient to seek additional help with cessation should she or he ultimately relapse. When the clinician encounters a patient who is abstinent from tobacco and is no longer engaged in cessation treatment, the clinician may wish to acknowledge a patient's success in quitting. The abstinent former smoker also may experience problems related to cessation that deserve treatment in their own right (see Strategy C2).

### **Strategy C1. Intervening with the patient who has recently quit**

The former tobacco user should receive congratulations on any success and strong encouragement to remain abstinent.

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

- The benefits, including potential health 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 side effects if the patient is still taking medication

### **Strategy C2. Addressing problems encountered by former smokers**

A patient who previously smoked might identify a problem that negatively affects health or quality of life. Specific problems likely to be reported by former smokers and potential responses follow:

<b>Problems</b>	<b>Responses</b>
Lack of support for cessation	<ul style="list-style-type: none"><li>• Schedule followup visits or telephone calls with the patient.</li><li>• Urge the patient to call the national quitline network (1-800-QUIT-NOW) or other local quitline.</li><li>• Help the patient identify sources of support within his or her environment.</li><li>• Refer the patient to an appropriate organization that offers counseling or support.</li></ul>
Negative mood or depression	<ul style="list-style-type: none"><li>• If significant, provide counseling, prescribe appropriate medication, or refer the patient to a specialist.</li></ul>

**Strategy C2. Addressing problems encountered by former smokers (continued)**

Problems	Responses
Strong or prolonged withdrawal symptoms	<ul style="list-style-type: none"><li>• 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.</li></ul>
Weight gain	<ul style="list-style-type: none"><li>• Recommend starting or increasing physical activity.</li><li>• Reassure the patient that some weight gain after quitting is common and usually is self-limiting.</li><li>• Emphasize the health benefits of quitting relative to the health risks of modest weight gain.</li><li>• Emphasize the importance of a healthy diet and active lifestyle.</li><li>• Suggest low-calorie substitutes such as sugarless chewing gum, vegetables, or mints.</li><li>• Maintain the patient on medication known to delay weight gain (e.g., bupropion SR, NRTs—particularly 4-mg nicotine gum<sup>147</sup>—and lozenge).</li><li>• Refer the patient to a nutritional counselor or program.</li></ul>
Smoking lapses	<ul style="list-style-type: none"><li>• Suggest continued use of medications, which can reduce the likelihood that a lapse will lead to a full relapse.</li><li>• Encourage another quit attempt or a recommitment to total abstinence.</li><li>• Reassure that quitting may take multiple attempts, and use the lapse as a learning experience.</li><li>• Provide or refer for intensive counseling.</li></ul>

## Chapter 4 Intensive Interventions for Tobacco Use and Dependence

### Background

Intensive tobacco dependence treatment can be provided by any suitably trained clinician. The evidence in Chapter 6 shows that intensive tobacco dependence treatment is more effective than brief treatment. Intensive interventions (i.e., more comprehensive treatments that may occur over multiple visits for longer periods of time and that may be provided by more than one clinician) are appropriate for any tobacco user willing to participate in them; neither their effectiveness nor cost-effectiveness is limited to a subpopulation of tobacco users (e.g., heavily dependent smokers).<sup>188-194</sup> In addition, patients, even those not ready to quit, have reported increased satisfaction with their overall health care as tobacco counseling intensity increases.<sup>50,88</sup>

In many cases, intensive tobacco dependence interventions are provided by clinicians who specialize in the treatment of tobacco dependence. Such specialists are not defined by their certification, professional affiliation, or by the field in which they trained. Rather, specialists view tobacco dependence treatment as a primary professional role. Specialists possess the skills, knowledge, and training to provide effective interventions across a range of intensities. They often are affiliated with programs offering intensive treatment interventions or services (e.g., programs with staff dedicated to tobacco interventions in which treatment involves multiple counseling sessions, including quitlines). In addition to offering intensive treatments, specialists sometimes conduct research on tobacco dependence and its treatment.

As noted above, substantial evidence shows that intensive interventions produce higher success rates than do less intensive interventions. In addition, the tobacco dependence interventions offered by specialists represent an important treatment resource for patients even if they received tobacco dependence treatment from their own clinician.

The advent of state tobacco quitlines available through a national network at 1-800-QUIT-NOW (1-800-784-8669) means that intensive, specialist-delivered interventions are now available to smokers on an unprecedented basis. In addition to providing their own clinical tobacco dependence interventions, clinicians and health systems can take advantage of this availability by implementing systems that regularly refer patients to quitlines either directly or using fax referrals (e.g., via “fax-to-quit” referral procedures).<sup>195-199</sup>

Specialists also may contribute to tobacco control efforts through activities such as the following:

- Serving as a resource to nonspecialists who offer tobacco dependence services as part of general health care delivery. This might include training nonspecialists in counseling strategies, providing consultation on difficult cases or for inpatients, and providing specialized assessment services for high-risk populations.
- Developing, evaluating, and implementing changes in office/clinic procedures that increase the rates at which tobacco users are identified and treated.<sup>200</sup>
- Conducting evaluation research to determine the effectiveness of ongoing tobacco dependence treatment activities in relevant institutional settings.
- Developing and evaluating innovative treatment strategies that may increase the effectiveness and utilization of tobacco dependence treatments.

## **Strategies for Intensive Tobacco Dependence Intervention**

Table 4.1 highlights Guideline findings based on meta-analyses and Panel opinion (see Chapters 6 and 7) that are particularly relevant to the implementation of intensive treatment programs. The findings in Table 4.1 support recommendations for components of an intensive intervention (Table 4.2). Of course, implementation of this strategy depends on factors such as resource availability and time constraints.

**Table 4.1. Findings relevant to intensive interventions**

Intensive counseling is especially effective. There is a strong dose-response relation between counseling intensity and quitting success. In general, the more intense the treatment intervention, the greater the rate of abstinence. Treatments may be made more intense by increasing (a) the length of individual treatment sessions and (b) the number of treatment sessions.
Many different types of providers (e.g., physicians, nurses, dentists, psychologists, social workers, cessation counselors, pharmacists) are effective at increasing quit rates; involving multiple types of providers can enhance abstinence rates.
Individual, group, and telephone counseling are effective tobacco use treatment formats.
Particular types of counseling strategies are especially effective. Practical counseling (problemsolving/skills-training approaches) and the provision of intratreatment social support are associated with significant increases in abstinence rates.
Medications such as bupropion SR, nicotine replacement therapies, and varenicline consistently increase abstinence rates. Therefore, their use should be encouraged for all smokers except in the presence of contraindications or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). In some instances, combinations of medications may be appropriate. In addition, combining counseling and medication increases abstinence rates.
Tobacco dependence treatments are effective across diverse populations (e.g., populations varying in gender, age, and race/ethnicity).

**Table 4.2. Components of an intensive tobacco dependence intervention**

Assessment	Assessments should determine whether tobacco users are willing to make a quit attempt using an intensive treatment program. Other assessments can provide information useful in counseling (e.g., stress level, dependence; see Chapter 6A, Specialized Assessment).
Program clinicians	Multiple types of clinicians are effective and should be used. One counseling strategy would be to have a medical/health care clinician deliver a strong message to quit and information about health risks and benefits, and recommend and prescribe medications recommended in this Guideline update. Nonmedical clinicians could then deliver additional counseling interventions.
Program intensity	There is evidence of a strong dose-response relation; therefore, when possible, the intensity of the program should be: <i>Session length</i> – longer than 10 minutes <i>Number of sessions</i> – 4 or more

**Table 4.2. Components of an intensive tobacco dependence intervention (continued)**

Program format	Either individual or group counseling may be used. Telephone counseling also is effective and can supplement treatments provided in the clinical setting. Use of self-help materials and cessation Web sites is optional. Followup interventions should be scheduled (see Chapter 6B).
Type of counseling and behavioral therapies	Counseling should include practical counseling (problemsolving/skills training) (see Table 6.19) and intratreatment social support (see Table 6.20).
Medication	Every smoker should be offered medications endorsed in this Guideline, except when contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents; see Table 3.2 for clinical guidelines and Tables 3.3–3.11 for specific instructions and precautions). The clinician should explain how medications increase smoking cessation success and reduce withdrawal symptoms. The first-line medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, and varenicline. Certain combinations of cessation medications also are effective. Combining counseling and medication increases abstinence rates.
Population	Intensive intervention programs may be used with all tobacco users willing to participate in such efforts.

# Chapter 5 Systems Interventions— Importance to Health Care Administrators, Insurers, and Purchasers

## Background

Efforts to integrate tobacco intervention into the delivery of health care require the active involvement of clinicians, health care systems, insurers, and purchasers of health insurance. Such integration represents an opportunity to increase rates of delivering tobacco dependence treatments, quit attempts, and successful smoking cessation.<sup>201</sup>

In contrast to strategies that target only the clinician or the tobacco user, systems strategies are intended to ensure that tobacco use is systematically assessed and treated at every clinical encounter. Importantly, these strategies are designed to work synergistically with clinician- and patient-focused interventions, ultimately resulting in informed clinicians and patients interacting in a seamless way that facilitates the treatment of tobacco dependence.<sup>202-204</sup>

Several considerations argue for the adoption of systems-level tobacco intervention efforts. First, such strategies have the potential to substantially improve population abstinence rates. Levy et al. estimated that, over time, widespread implementation of such strategies could produce a 2 percent to 3.5 percent reduction in smoking prevalence rates.<sup>205</sup> Second, despite recent progress in this area, many clinicians have yet to use evidence-based interventions consistently with their patients who use tobacco.<sup>23,48,51</sup> Some evidence indicates that institutional or systems support (e.g., adequate clinician training or automated smoker identification systems) improves the rates of clinical interventions.<sup>206-208</sup> Finally, agents such as administrators, insurers, employers, purchasers, and health care delivery organizations have the potential to craft and implement supportive systems, policies, and environmental prompts that can facilitate the delivery of tobacco dependence treatment for millions of Americans. For example, managed care organizations and other insurers influence

medical care through formularies, performance feedback to clinicians, specific coverage criteria, and marketing approaches that prompt patient demand for particular services.<sup>139,209</sup> Purchasers also have begun to use tobacco measures in pay-for-performance initiatives in which managed care organizations, clinics, and individual physicians receive additional reimbursement by achieving specific tobacco treatment-related goals. Indeed, research clearly shows that systems-level changes can reduce smoking prevalence among enrollees of managed health care plans.<sup>210-212</sup>

Unfortunately, the potential benefits of a collaborative partnership among health care organizations, insurers, employers, and purchasers have not been fully realized. For example, treatments for tobacco use (both medication and counseling) are not provided consistently as paid services for subscribers of health insurance packages.<sup>213-215</sup> Although substantial progress has been made since the publication of the first Guideline in 1996,<sup>1,216-218</sup> neither private insurers nor state Medicaid programs consistently provide comprehensive coverage of evidence-based tobacco interventions.<sup>206,214,219</sup> Findings such as these resulted in the *Healthy People 2010* objective:

*Increase insurance coverage of evidence-based treatment for nicotine dependency to 100 percent.*<sup>220</sup>

In sum, without supportive systems, policies, insurance coverage, and environmental prompts, the individual clinician likely will not assess and treat tobacco use consistently. Therefore, just as clinicians must assume responsibility to treat their patients for tobacco use, so must health care administrators, insurers, and purchasers assume responsibility to craft policies, provide resources, and display leadership that results in a health care system that delivers consistent and effective tobacco use treatment.

## **Cost-Effectiveness of Tobacco Use Treatments**

Tobacco use treatments are not only clinically effective, but are cost-effective as well. Tobacco use treatments, ranging from clinician advice to medication to specialist-delivered intensive programs, are cost-effective in relation to other medical interventions such as treatment of hypertension and hyperlipidemia and to other preventive interventions such as periodic mammography.<sup>194,221-224</sup> In fact, tobacco use treatment has been referred to as the “gold standard” of health care cost-effectiveness.<sup>225</sup> Tobacco use treatment remains highly cost-effective, even though a single application

of any effective treatment for tobacco dependence may produce sustained abstinence in only a minority of smokers. Finally, evidence-based tobacco dependence interventions produce a favorable return on investment from the perspective of both the employer and health plan due to reduced health care consumption and costs.<sup>226-228</sup> The cost-effectiveness of Guideline recommendations for tobacco use treatment is addressed in detail in Chapter 6.

## **Recommendations for Health Care Administrators, Insurers, and Purchasers**

Health care delivery administrators, insurers, and purchasers can promote the treatment of tobacco dependence through a systems approach. Purchasers (often business entities or other employers, State or Federal units of government, or other consortia that purchase health care benefits for a group of individuals) should make tobacco assessment and coverage of treatment a contractual obligation of the health care insurers and/or clinicians who provide services to them. In addition to improving the health of their employees or subscribers, providing coverage for tobacco dependence treatment will result in lower rates of absenteeism<sup>229,230</sup> and lower utilization of health care resources.<sup>229,231</sup> Health care administrators and insurers should provide clinicians with assistance to ensure that institutional changes promoting tobacco dependence treatment are implemented universally and systematically. Various institutional policies would facilitate these interventions, including:

- Implementing a tobacco user identification system in every clinic (Systems Strategy 1).
- Providing adequate training, resources, and feedback to ensure that providers consistently deliver effective treatments (Systems Strategy 2).
- Dedicating staff to provide tobacco dependence treatment and assessing the delivery of this treatment in staff performance evaluations (Systems Strategy 3).
- Promoting hospital policies that support and provide tobacco dependence services (Systems Strategy 4).

- Including tobacco dependence treatments (both counseling and medication) identified as effective in this Guideline as paid or covered services for all subscribers or members of health insurance packages (Systems Strategy 5).

These strategies are based on the evidence described in Chapter 6, as well as on Panel opinion.

## **Strategies for Health Care Administrators, Insurers, and Purchasers**

### **Systems Strategy 1. Implement a tobacco user identification system in every clinic**

Action	Strategies for implementation
Implement an office-wide system that ensures that for every patient at every clinic visit, tobacco use status is queried and documented.	<p>Office system change: Expand the vital signs to include tobacco use, or implement an alternative universal identification system.</p> <p>Responsible staff: Nurse, medical assistant, receptionist, or other individual already responsible for recording the vital signs. These staff must be instructed regarding the importance of this activity and serve as nonsmoking role models.</p> <p>Frequency of utilization: Every visit for every patient, regardless of the reason for the visit.<sup>a</sup></p> <p>System implementation steps: Routine smoker identification can be achieved by modifying electronic medical record data collection fields or progress notes in paper charts to include tobacco use status as one of the vital signs.</p> <p>VITAL SIGNS                      Blood Pressure: _____                      Pulse: _____ Weight: _____                      Temperature: _____                      Respiratory Rate: _____                      Tobacco Use (circle one): Current Former Never</p>

<sup>a</sup> Repeated assessment is not necessary in the case of the adult who has never used tobacco or who has not used tobacco for many years, and for whom this information is clearly documented in the medical record.

### Systems Strategy 2. Provide education, resources, and feedback to promote provider intervention

Action	Strategies for implementation
<p>Health care systems should ensure that clinicians have sufficient training to treat tobacco dependence, clinicians and patients have resources, and clinicians are given feedback about their tobacco dependence treatment practices.</p>	<p><i>Educate</i> all staff. On a regular basis, offer training (e.g., lectures, workshops, inservices) on tobacco dependence treatments, and provide continuing education (CE) credits and/or other incentives for participation.</p> <p><i>Provide resources</i> such as ensuring ready access to tobacco quitlines (e.g., 1-800-QUIT-NOW) and other community resources, self-help materials, and information about effective tobacco use medications (e.g., establish a clinic fax-to-quit service, place medication information sheets in examination rooms).</p> <p><i>Report</i> the provision of tobacco dependence interventions on report cards or evaluative standards for health care organizations, insurers, accreditation organizations, and physician group practices (e.g., HEDIS, The Joint Commission, and Physician Consortium for Performance Improvement).</p> <p><i>Provide feedback</i> to clinicians about their performance, drawing on data from chart audits, electronic medical records, and computerized patient databases. Evaluate the degree to which clinicians are identifying, documenting, and treating patients who use tobacco.</p>

### Systems Strategy 3. Dedicate staff to provide tobacco dependence treatment, and assess the delivery of this treatment in staff performance evaluations

Action	Strategies for implementation
<p>Clinical sites should communicate to all staff the importance of intervening with tobacco users and should designate a staff person (e.g., nurse, medical assistant, or other clinician) to coordinate tobacco dependence treatments. Nonphysician personnel may serve as effective providers of tobacco dependence interventions.</p>	<p><i>Designate</i> a tobacco dependence treatment coordinator for every clinical site.</p> <p><i>Delineate</i> the responsibilities of the tobacco dependence treatment coordinator (e.g., ensuring the systematic identification of smokers, ready access to evidence-based cessation treatments [e.g., quitlines], and scheduling of followup visits).</p> <p><i>Communicate</i> to each staff member (e.g., nurse, physician, medical assistant, pharmacist, or other clinician) his or her responsibilities in the delivery of tobacco dependence services. Incorporate a discussion of these staff responsibilities into training of new staff.</p>

**Systems Strategy 4. Promote hospital policies that support and provide inpatient tobacco dependence services**

Action	Strategies for implementation
<p>Provide tobacco dependence treatment to all tobacco users admitted to a hospital.</p>	<p><i>Implement</i> a system to identify and document the tobacco use status of all hospitalized patients.</p> <p><i>Identify</i> a clinician(s) to deliver tobacco dependence inpatient consultation services for every hospital and reimburse them for delivering these services.</p> <p><i>Offer</i> tobacco dependence treatment to all hospitalized patients who use tobacco.</p> <p><i>Expand</i> hospital formularies to include FDA-approved tobacco dependence medications.</p> <p><i>Ensure</i> compliance with The Joint Commission regulations mandating that all sections of the hospital be entirely smoke-free and that patients receive cessation treatments.</p> <p><i>Educate</i> hospital staff that first-line medications may be used to reduce nicotine withdrawal symptoms, even if the patient is not intending to quit at this time.</p>

**Systems Strategy 5. Include tobacco dependence treatments (both counseling and medication) identified as effective in this Guideline as paid or covered services for all subscribers or members of health insurance packages**

Action	Strategies for implementation
<p>Provide all insurance subscribers, including those covered by managed care organizations (MCOs), workplace health plans, Medicaid, Medicare, and other government insurance programs, with comprehensive coverage for effective tobacco dependence treatments, including medication and counseling.</p>	<p><i>Cover</i> effective tobacco dependence treatments (counseling and medication) as part of the basic benefits package for all health insurance packages.</p> <p><i>Remove</i> barriers to tobacco treatment benefits (e.g., copays, utilization restrictions).</p> <p><i>Educate</i> all subscribers and clinicians about the availability of covered tobacco dependence treatments (both counseling and medication), and encourage patients to use these services.</p>