Blueprint for Implementing Clinically-Based Tobacco Cessation Programs

With Special Insights about Working with Low Socio-Economic Status Women of Childbearing Age

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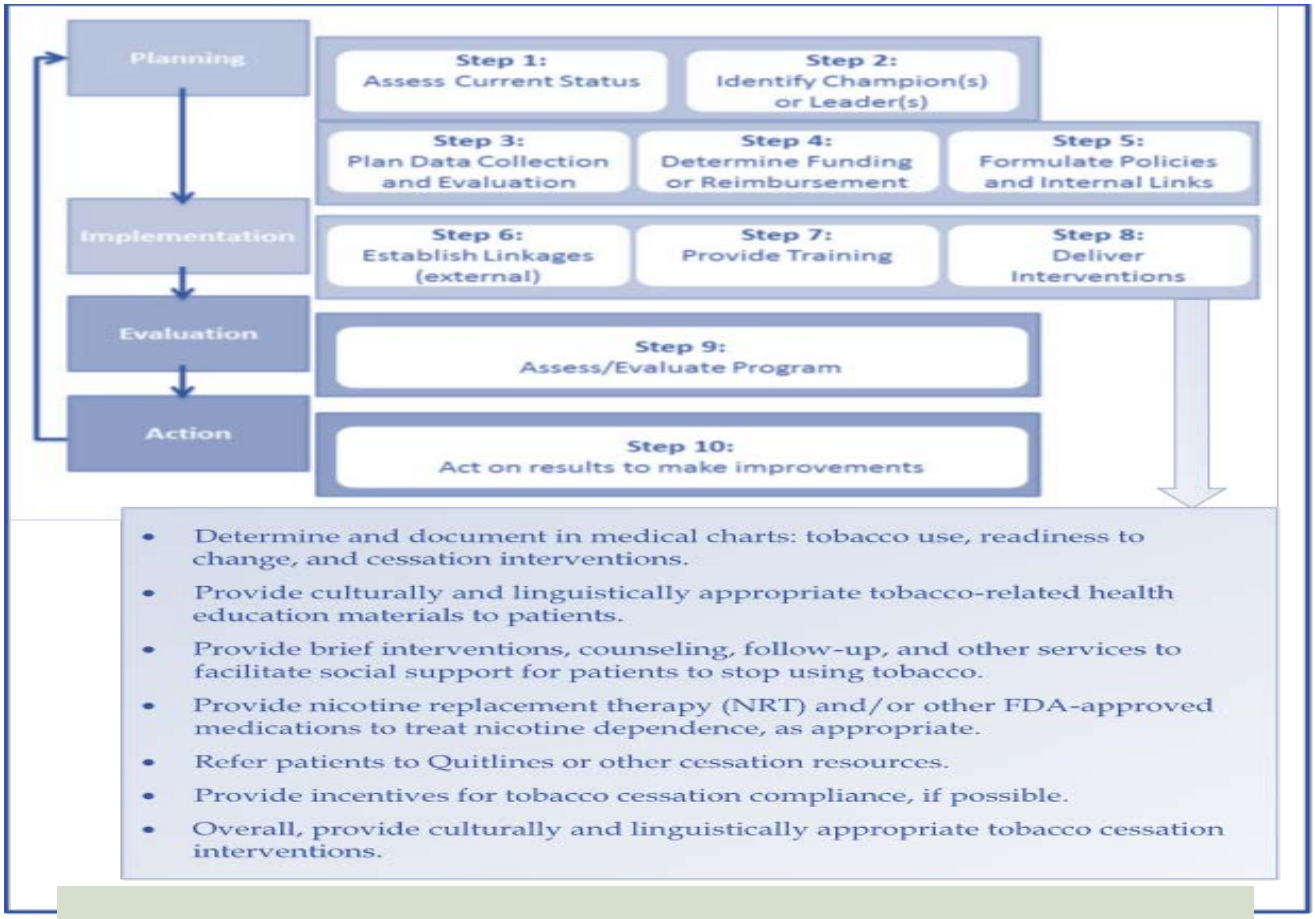

FINAL GRANT REPORT: Sustainable Comprehensive Tobacco Cessation and Prevention Clinical Program for Low, Socio-Economic Status Women of Childbearing Age

Acknowledgements

The United States Department of Health and Human Services, Office on Women's Health implemented a three-phase Program with the goals to reduce tobacco use among low socio-economic status (LSES) women of childbearing age and thus reduce the impact of tobacco use and exposure on their families and children. This Blueprint for Implementing Clinically-Based Tobacco Cessation Programs summarizes the results of that Program.

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  - Department of Health and Human Services, Office of the Assistant Secretary for Health (DHHS, OASH)
  - Department of Health and Human Services, Office on Minority Health (DHHS, OMH)
  - Department of Health and Human Services, Office on Women's Health (DHHS, OWH)
  - Health Resources and Services Administration (HRSA)
  - Indian Health Service (IHS)
  - National Cancer Institute (NCI)
  - National Center for Research Resources (NCRR)
  - National Institute of Dental and Craniofacial Research (NIDCR)
  - National Institute on Drug Abuse (NIDA)
  - National Institutes of Health (NIH)

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    - ARIZONA: **White River Indian Hospital**
    - IDAHO: **Shoshone-Bannock Tribes Health & Human Services**
    - ILLINOIS: **American Indian Health Services of Chicago**
    - MICHIGAN: **Keweenaw Bay Indian Community**
    - NEBRASKA: **Winnebago Indian Health Services**
    - NEVADA: **Indian Walk-In Center & Medical Clinic**
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    - **Agency for Healthcare Research and Quality (AHRQ)**
    - **Centers for Disease Control and Prevention (CDC)**
    - **Department of Health and Human Services, Office of the Assistant Secretary for Health (DHHS, OASH)**
    - **Department of Health and Human Services, Office on Women's Health (DHHS, OWH)**
    - **Health Resources and Services Administration (HRSA)**
    - **Indian Health Service (IHS)**
    - **National Cancer Institute (NCI)**
    - **National Center for Research Resources (NCRR)**
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    - **Tennessee Primary Care Association**
    - **Urban Indian Center of Salt Lake**
- The many **providers** and **patients** who participated in the Program from their individual clinics.

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Acronym and Abbreviation List

5 A's	The Five A Model
AHRQ	Agency for Healthcare Research and Quality
CCLCF	Community Care of the Lower Cape Fear
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control and Prevention
CEU	Continuing Education Unit
CIS	Cancer Information Service
CTRI	University of Wisconsin, Center for Tobacco Research and Intervention
DHHS	United States Department of Health and Human Services
EMR	Electronic Medical Records
FDA	Food and Drug Administration
HRSA	Health Resources and Services Administration
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IPM	Implementation Process Model
LSES	Low Socio-Economic Status
MA	Medical Assistant
NCI	National Cancer Institute
NCI	National Cancer Institute
NRT	Nicotine Replacement Therapy
OMH	Office of Minority Health
OPM	United States Office of Personnel Management
OTC	Over the Counter
OWH	Office on Women's Health
PDSA	Plan, Do, Study, Act
PHS	Public Health Service
QIC	Quality Improvement Coordinator
SAMHSA	Substance Abuse and Mental Health Services Administration
TCDP	Tobacco Clinical Demonstration Projects
TPCA	Tennessee Primary Care Association
TTM	Transtheoretical Model
UA	University of Arizona
UNC	University of North Carolina
US	United States
WATCH	Women and Tobacco Coalition for Health
WWHF	Wisconsin Women's Health Foundation
WWQP	Wisconsin Women's Quit Project

Blueprint for Implementing Clinically-Based Tobacco Cessation Programs

With Special Insights about Working with Low Socio-Economic Status Women of Childbearing Age

Blueprint Overview

This document includes many details, options, tools and resources to implement tobacco cessation programs in healthcare clinics. Readers should start by reading the questions below, and reviewing the **Quick Study Guide** in the next section. Then, they can refer to more detailed information throughout the text as needed.

What is the Blueprint for Implementing Clinically-Based Tobacco Cessation Programs?

This Blueprint is a guide for clinicians and administrators to implement tobacco cessation programs for patients in individual clinics, hospitals, or other healthcare settings. Program implementation is based on the Implementation Process Model (IPM). The IPM was funded by the United States Department of Health and Human Services' (DHHS) Office on Women's Health (OWH), through grant programs that researched steps and tested the model in dozens of clinics over more than five years. The IPM sets forth a comprehensive model to implement the principles of the United States Public Health Service's (PHS) **Treating Tobacco Use and Dependence, Clinical Practice Guideline 2008 Update** (2008) (the PHS Guideline) at the clinical level.

This Blueprint gives providers skills, tools, resources, and processes to create effective, evidence-based tobacco cessation programs, which follow the PHS Guideline, for their individual patient populations.

Who should use the Blueprint?

Any member of a clinical practice or supporting organization who is interested in developing or improving a tobacco cessation program for patients can use this Blueprint. Partners who assisted in developing and testing the model included a wide range of healthcare settings, including, for example:

- Federally Qualified Health Centers
- Native American clinics and hospitals

- Statewide organizations supporting government-funded clinics
- University organizations funded to support healthcare delivery or training
- Non-profit organizations supporting clinical tobacco cessation or women's health programs

The IPM is designed so that all members of a clinical staff may have a role in the tobacco cessation process. The more awareness and training among all clinical staff members, the more effective the program can be for patients and clients.

Why is the Blueprint necessary?

Providers know their patient populations best. However, they are often so busy with day-to-day delivery of care that implementing a new program and all of its component parts may seem daunting. This Blueprint helps providers, other clinical personnel, or support organizations to quickly start a program, with minimal disruption to the current tasks that require their time and efforts. More importantly, this document provides resources that clinical or administrative staff members will need to initiate a program, so that time spent researching, developing or creating tools can be minimized as much as possible.

How should we start to use the Blueprint?

Using the Blueprint is simple. Begin with the **Quick Study Guide** on page 11. The Blueprint document that follows mirrors the **Quick Study Guide** and provides more detailed information for each step in the process. Resources for additional information are included in the Appendix: Providers' Toolkit.

How do I obtain additional resources?

Every step of the Blueprint includes multiple references to tools and additional resources, which can be accessed through direct links from the Blueprint document. Also, the Appendix includes specific tools and references for more resources. A PowerPoint™ presentation that highlights this Blueprint is also available. Find the Blueprint document and presentation at www.YouQuitTwoQuit.org.

The Tobacco Problem and Steps to Address It

The Tobacco Problem

The U.S. Surgeon General's tobacco report (2014) states that more than 480,000 deaths are attributable annually to tobacco use in the United States. The Centers for Disease Control and Prevention (CDC) (2014) reports that tobacco use is the leading preventable cause of death. In addition, according to the U.S. Department of Health and Human Services (DHHS) Tobacco Control Strategic Action Plan (2010), members of certain racial/ethnic minority groups, individuals of low socio-economic status (LSES), pregnant women, and others carry a disproportionate burden of risk for tobacco use and related illness and death:

- Smoking rates are highest among American Indians/Alaska Natives (32.4%).

- Although African Americans have lower smoking rates compared with American Indians/Alaska Natives and whites (21.3%, 32.4%, and 22% respectively), they bear the greatest burden of tobacco-caused cancer.
- Thirty-one percent of persons living in poverty smoke and the challenges continue to be greatest among adults with low educational attainment.
- Enormous disparities exist by race/ethnicity, age, and socio economic status in secondhand smoke exposure. Among the highest exposed are: 71% of African Americans, 63% of low-income individuals, and 61% of children aged 4-11 years.

While tobacco use is a universal concern, there are unique considerations for tobacco use and women. For example, about one in six American women currently smoke (CDC 2014b). According to the 2014 Surgeon General's report:

- Women who smoke increase their risk of dying from bronchitis and emphysema by 12 times. They increase their risk of dying from cancer of the trachea, lung, and bronchus by more than 12 times.
- Smoking increases the risk of dying from coronary cardiovascular disease among middle-aged women by almost five times.
- During 2010–2014, almost 282,000 women (56,359 women each year) will die from lung cancer.
- According to the 2001 Surgeon General's Report, in 1987, lung cancer surpassed breast cancer to become the leading cause of cancer death among U.S. women.

Tobacco use is especially concerning for women of childbearing age, who may use tobacco during and after pregnancy, with damaging effects for their children. For example, smoking during pregnancy increases the risk of pregnancy complications, premature delivery, low birth weight, stillbirth, and sudden infant death syndrome (CDC 2004). Despite this, Ashford, et. al., report that only about 18% to 25% of women quit smoking when learning that they are pregnant. Additionally, postpartum smoking relapse may be as high as 85%, and of those who relapse, 67% resume smoking at three months, and up to 90% by six months (Scheibmier and O'Connell, Ershoff et. al, and Fingerhut et. al.). Exposure to smoking is a serious issue for children. For example, serious health effects include weak lungs, severe asthma, breathing problems, and ear infections (DHHS, NCI 2014).

The DHHS OWH is particularly interested in special tobacco problems that have been identified for LSES women of childbearing age because age, education levels, and poverty status are risk factors for tobacco use for women. For example, expert panelists, at a 2008 meeting sponsored by OWH and the Tobacco and Young LSES Women Federal Collaboration to Make a Difference interagency working group (the Collaboration,), presented research about the special burdens of tobacco use for LSES women of childbearing age:

- Tobacco may be used as self-medication for stress and depression due to poverty and other factors.

- Healthcare services for tobacco use may not be covered by insurance. Even if insurance is available, there are obstacles to clinic visits, such a childcare concerns and lack of trust in healthcare systems.
- Living with others who smoke creates greater risks for starting or resuming tobacco use.
- Body weight concerns and/or mental health issues such as mood and stress contribute to tobacco use.
- Lack of social support contributes to difficulties in quitting tobacco use.
- The tobacco industry targets LSES women when marketing tobacco products.

Steps to Address the Tobacco Problem

To address the tobacco problem, the United States Public Health Service (PHS) updated its Treating Tobacco Use and Dependence, Clinical Practice Guideline 2008 Update (the PHS Guideline) (2008) and DHHS created its Tobacco Control Strategic Action Plan (DHHS Action Plan) (2010). The PHS Guideline provides information about tobacco cessation at the public health/public policy level and gives instructions for providers about tobacco assessment and treatment. Table 1 provides a verbatim list of the Ten Key Guideline Recommendations.[1] The DHHS Action Plan provides a long-term strategy for addressing tobacco use and its health implications for Americans. This DHHS Office on Women's Health (OWH) Blueprint helps to implement the DHHS Action Plan by providing clinicians with a step-by-step implementation process to use the PHS Guideline recommendations in individual clinics.

Table 1: Ten Key PHS Guideline Recommendations

"The overarching goal of these recommendations is that clinicians strongly recommend the use of effective nicotine dependence counseling and medication treatments to their patients who use tobacco, and that healthcare systems, insurers, and purchasers assist clinicians in making such effective treatments available.
1. Nicotine dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.
2. It is essential that clinicians and healthcare delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a healthcare setting.
3. Nicotine dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in this Guideline.
4. Brief nicotine dependence treatment is effective. Clinicians should offer every

[1] Treating Tobacco Use and Dependence, 2008 Update: Clinical Practice Guideline, U.S. Department of Health and Human Services, Public Health Service, May 2008, pp. 6-8.

patient who uses tobacco at least the brief treatments shown to be effective in this Guideline.

5. Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt:
   - Practical counseling (problem solving/skills training)
   - Social support delivered as part of treatment

6. Numerous effective medications are available for nicotine dependence, and clinicians should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).

   Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:
   - Bupropion SR
   - Nicotine gum
   - Nicotine inhaler
   - Nicotine lozenge
   - Nicotine nasal spray
   - Nicotine patch
   - Varenicline

   Clinicians also should consider the use of certain combinations of medications identified as effective in this Guideline.

7. Counseling and medication are effective when used by themselves for treating nicotine dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, clinicians should encourage all non-pregnant individuals making a quit attempt to use both counseling and medication.

8. Telephone Quitline counseling is effective with diverse populations and has broad reach. Therefore, clinicians and healthcare delivery systems should both ensure patient access to Quitlines and promote Quitline use.

9. If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivational treatments shown in this Guideline to be effective in increasing future quit attempts.

10. Nicotine dependence treatments are both clinically effective and highly cost-effective relative to interventions for other clinical disorders. Providing coverage for these treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans include the counseling and medication identified as effective in this Guideline as covered benefits."

As mentioned earlier, OWH has focused its tobacco-related interests on LSES women of childbearing age and their children, because they have unique burdens related to tobacco use. As the leader of a collaborative group of Federal agencies with similar interests, OWH implemented a three-phase initiative with the goals to reduce tobacco use among LSES women of childbearing age and thus reduce the impact of tobacco use and exposure on their families and children.

- **Phase 1–Tobacco Clinical Demonstration Programs (TCDP) for Young LSES Women of Childbearing Age** involved implementing the PHS Guideline, or similar tobacco cessation programs, in ten Health Resources and Services Agency (HRSA) primary care associations, and thirteen Indian Health Service (IHS) funded clinics. The focus of Phase 1 was to implement and test possibilities for systems change related to tobacco programs in clinical settings, based on the PHS Guideline.
- **Phase 2–Expansion Planning** involved using lessons learned from the TCDP to plan expansion to women in the population served through Federal healthcare dollars. The lessons learned were summarized into an Implementation Process Model (IPM). (See page 12 for a diagram of the IPM).
- **Phase 3–Comprehensive and Sustainable Funded Projects** involved testing the IPM. As described briefly above, IHS and HRSA organizations implemented tobacco cessation programs in a sample of their respective health clinics, and provided feedback about their lessons learned from the experience. Based on this feedback, OWH developed the IPM. To test the model, OWH provided grants to six organizations. Two organizations received larger grants to test the complete model. Four organizations received small grants to incorporate the model into ongoing programs and test specific aspects of the model. Table 2 identifies and gives a brief description of each grantee partner, including the contact for this program. These grantees:
  - Partnered with Federally-funded healthcare organizations and/or Medicaid-reimbursed providers (hereafter referred to as "Federal Clinical Partners") that served LSES women of childbearing age.
  - Provided training, materials, and technical assistance to implement a comprehensive and sustainable tobacco cessation and prevention program in the Federal Clinical Partners' organizations for LSES women of childbearing age, based on the PHS Guideline.
  - Assisted the Federal Clinical Partners to implement a process model to create an organizational culture of tobacco awareness and action that resulted in increased quit attempts, abstinence, and/or cessation for LSES women of childbearing age.

- Contributed new information and resources that will assist other Federally-funded clinics to replicate the program.

Table 2: Grantee Partners and Their Programs

Grantee Partners	Program Description
Hillary Whitehorse **Wisconsin Women's Health Foundation (WWHF) and Wisconsin Women's Quit Project (WWQP)** 2503 Todd Drive Madison, WI 53713 Tel: 608-51-1675 800-448-5148 Fax: 608-251-4136 www.wwhf.org wwhf@wwhf.org	The Wisconsin Women's Quit Project (WWQP) serves LSES women age 18 to 44 at eight Federal Clinical Partner locations. The WWQP builds upon the success of the WWHF's existing First Breath prenatal smoking cessation program and expands cessation support to women of childbearing age. The WWQP utilizes evidence-based cessation strategies and social support to address the unique needs of LSES women. Federal Clinical Partners received staff training, technical support, client incentives, and client education materials. The WWQP includes a strong partnership with the University of Wisconsin-Center for Tobacco Research & Intervention (CTRI) and the Wisconsin Tobacco Quitline. All women had access to tobacco cessation specialists and women who were not pregnant or breastfeeding had access to up to six weeks of nicotine replacement therapy (NRT) through the Quitline. The WWQP also included a pilot Peer Mentor project specifically designed to help postpartum women quit or stay quit, providing the social support that is often lacking for many women after their baby is born. During the grant period, WWHF trained and provided technical assistance to providers in eight Federally Qualified Health Centers, who treated 146 women as part of the First Breath tobacco cessation program. Historically, with more than 13,000 participants, the First Breath program has maintained an average 35% quit rate for participants.
Sarah Verbiest Erin K. McClain **University of North Carolina Center for Maternal & Infant Health** CB# 7181 Chapel Hill, NC 27599-7181 Tel: 919-843-7865 Fax: 919-843-0960 DIRECT: 919-808-0989 erin_mcclain@unc.edu, sarah_verbiest@med.unc.edu http://youquittwoquit.com/	You Quit, Two Quit is a tobacco cessation quality improvement project targeting providers who serve LSES women of childbearing age within six North Carolina (NC) counties. This work builds on three years of successful pilot projects that took place in four NC health departments in Columbus, Richmond, Wilkes, and Davidson Counties. You Quit, Two Quit is implemented by the UNC Center for Maternal and Infant Health in partnership with the Women and Tobacco Coalition for Health (WATCH), the NC Division of Public Health Tobacco Prevention and Control Branch, and Community Care of the Lower Cape Fear (CCLCF). Funding is through the DHHS OWH. You Quit, Two Quit focuses on providing training and technical assistance to healthcare providers on incorporating the evidence-based best practices outlined in the Clinical Practice Guideline. The project is firmly rooted in the UNC Center for Maternal and Infant Health's long term goal of serving high-risk mothers and infants in NC through modeling of state of the art care, leading the translation of evidence-based research into community practice, and expanding health services research in preconception, perinatal, and infant health. This project centered around Community Care of the Lower Cape Fear (CCLCF), a non-profit partnership with primary care providers, local hospitals, health departments, and other healthcare organizations. You Quit, Two Quit worked with individual

Grantee Partners	Program Description
	practices that serve Medicaid enrollees, sought to strengthen CCLCF's culture of tobacco awareness and action, and to increase CCLCF's capacity to promote and sustain this work with all of the practices in their service area. CCLCF is one of 14 networks participating in a statewide healthcare quality improvement strategy called Community Care of North Carolina (CCNC), which has a history of leveraging successful local network pilot programs into statewide quality initiatives. The UNC Center for Maternal and Infant Health trained and provided ongoing support to 335 individuals as part of this program. During the six-month quality improvement initiative, the participating practices screened 1,548 non-pregnant reproductive age women, of whom 776 (50%) were current tobacco users, and 408 pregnant women, of whom 61 (15%) were currently using tobacco. Twenty percent of the non-pregnant women smokers and 61% of the pregnant smokers were ready to quit; 98% of those ready to quit received the full, documented 5 A Model. (Note, this model will be further discussed later in this document).
Louise J. Strayer **University of Arizona HealthCare Partnership** Babcock Building PO Box 210151 1717 E. Speedway Suite 3106 Tucson AZ 85721-0151 Cell: 520-235-9908 Fax: 520-626-9355 lstrayer@email.arizona.edu www.healthcarepartnership.org	The University of Arizona (UA) Healthcare Partnership www.healthcarepartnership.org is a nationally recognized continuing education and certification program. UA is part of the University of Arizona, College of Science, Department of Psychology. The UA's Nicotine Dependence Continuing Education and Certification programs have been demonstrated to be effective in enabling health and human service professionals to teach their personnel and colleagues about evidence-based practices for nicotine dependence treatment, prevention, and control and for personnel to apply the practices when serving patients who use nicotine products. During the Tobacco Clinical Collaborative Phase I period, UA supported 13 cross-national Indian Health Service (IHS) and Tribal Service Clinics, and developed a guide entitled Building Communities of Healthy Native Women, Children & Families through Prevention and Treatment of Commercial Tobacco Use to actualize the recommendations of the PHS Guideline. Participating clinics supported certification of point-of-care staff in the prevention and treatment of nicotine dependence through a training course entitled Basic Tobacco Intervention Skills Certification for Maternal and Child Health. Clinics also supported the certification of Instructors who were then able to teach the program. During Phase III of this program, UA utilized the Implementation Process Model (IPM, discussed in detail later in this document) to plan, deliver, evaluate and follow-up with 66 Conference Clusters to certify providers in Basic Tobacco Intervention Skills Certification programs specific to their targeted communities. Throughout the course of the phases, UA certified, provided tools, and awarded continuing education/continuing medical education credit to more than 1,300 providers. Based on the American Health Association "CPR" and Advanced Cardiac Life Support (ACLS) model, the capacity-building Nicotine Dependence Treatment Certification Programs are replicated nationally and internationally. The program has designed and evaluated 15 adaptations that recognize and are intended for differing contexts, intensities and

Grantee Partners	Program Description
	provider roles in the delivery of nicotine dependence treatment. The capacity building intent of the model is actualized by implementing a train-the-trainer method to encourage systems change through organizational ownership. Certification programs are premised on an integrated Five A Model (5 A's) that blend the Transtheoretical Model (TTM) and motivational interviewing to evoke those who are dependent on nicotine products to move toward a nicotine-free lifestyle. Certification programs are evaluated pre and post-delivery, both quantitatively and qualitatively to ensure that participants have gained specific skills, and apply them in their clinical practices. (The 5 A's, TTM, and motivational interviewing are fully discussed throughout this document).
Mary Linden Kathleen Mayo **Keweenaw Bay Indian Community,** **Department of Health & Human Services**, Donald A. LaPointe Health Center 102 Superior Ave Baraga, MI 49908 Tel: 906-353-4519 Fax: 906-353-8799 kmayo@kbic-nsn.gov mlinden@kbic-nsn.gov http://www.kbic-nsn.gov/	The Keweenaw Bay Indian Community in Northern Michigan participated in Phases 1 and 3 of the OWH program. They developed a model in which patients who used tobacco were referred by clinical staff to a support center staffed by nurses. The center assessed tobacco use, readiness to quit, and other factors. Along with supporting patients with other health-related information and counseling, the nurses at the center provided educational materials and support for those who wished to reduce or cease tobacco use. The Keweenaw Bay Indian Community is small, so enrollments for the tobacco program numbered in the single digits. However, the nurses reported ongoing success with reduction in tobacco use for those involved in the support activities.
Ed Napia **Urban Indian Center of Salt Lake,** **Indian Walk In Center** 120 West 1300 South Salt Lake City, Utah 84115 Tel: 866-687-4942 801-486-4877 Fax: 801-486-9943 enapia@iwic.org http://indianwalkincenter.org/	The Urban Indian Center of Salt Lake is a Title V Urban Indian Program that provides health referral, health and wellness education, and behavioral health services for American Indians and Alaska Natives living along the Wasatch Front including the Utah counties of Weber, Davis, Salt Lake, and Utah and portions of Tooele County. The Center has been a recipient of a commercial tobacco prevention grant from the Utah Department of Health since 2004. This has given impetus to developing partnerships with state, county, and city agencies, school districts, academics, and private organizations. However, the grant which comes from Master Settlement Agreement funds, does not allow for direct services, including commercial tobacco cessation. Activities resulting from involvement with the Tobacco Advisory Council are a part of a comprehensive effort to improve the health and wellness of American Indian and Alaska Native women living in the service area through a collaborative effort involving the University of Utah Office of Excellence in Women's Health and the Utah Women and Girls Health Coalition, four other disparity community groups, and the Utah Department of Health.

Grantee Partners	Program Description
	The Urban Indian Center of Salt Lake reported success in integrating tobacco cessation education and interventions as part of their overall women's health program.
Terri Crutcher **Tennessee Primary Care Association** 416 Wilson Pike Circle; Brentwood, TN 37027 Tel: 615-329-3836 x5845 800-343-3136 Fax: 615-425-5875 terri@tnpca.org www.tnpca.org	The Tennessee Primary Care Association (TPCA) started in 1975 as a leadership, advocacy, support, and community organization dedicated to improving access to primary healthcare. TPCA supports over 30 non-profit primary care clinics operating more than 200 sites. These sites are the primary source of care for poor and uninsured Tennesseans. TPCA has assisted with planning and implementing tobacco cessation programs throughout their clinical network. This includes inquiring about, and documenting tobacco use, determining readiness to change, weighing benefits and costs with patients, referring to the state Quitline, offering pharmaceutical therapy where appropriate, and providing case management for pregnant patients. They have developed communication systems to provide tobacco information and education to providers through newsletters, annual meetings, and other methods. TPCA is also working with vendors to ensure that tobacco questions and reminders are an integral part of their electronic medical records (EMR) system.

Throughout the phases of this project, clinicians have asked for more detailed information to interpret the PHS Guideline, implement tobacco cessation programs at the clinical level, and medically manage tobacco cessation with individual patients. This Blueprint answers that request.

Quick Study Guide

The US Department of Health and Human Services, Office on Women's Health (DHHS OWH) funded implementation programs to create this Blueprint for Implementing Clinically-based Tobacco Cessation Programs specifically for clinicians. The Blueprint provides practical, step-by-step advice and resources for clinicians to help patients and clients reduce or stop using tobacco. Clinicians can use the Blueprint to create tobacco cessation programs for everyone they treat. Plus, the Blueprint has special information to assist providers in working with LSES women of childbearing age.

The Blueprint, based on research and information gleaned from implementation in dozens of clinics over more than five years, starts with the Implementation Process Model (IPM). This Quick Study Guide provides an introduction to the IPM, and an overview of its process steps, objectives, core principles, and activities. The rest of the Blueprint provides more detailed information, and options for optimizing the model for individual clinics' or patients' needs.

Implementation Process Model for Tobacco Cessation Programs

The IPM (Figure 1) consists of ten steps, organized into a quality improvement "Plan, Do, Study, Act" (PDSA) cycle. Each step involves specific activities, which can be modified as necessary to meet individual clinic's needs. The core principles and basic activities to get started are included in this Quick Study Guide. The following Step-by-Step Instructions for Implementing Clinically-Based Tobacco Cessation Programs offers more detailed information and options for modifying the activities to meet individual clinics' and patient's needs.

The PHS Guideline lays out evidence-based approaches for providers, as described earlier in this document. The IPM mirrors the PHS Guideline, and aims to assist providers in establishing an overall tobacco cessation program to support implementing the PHS Guideline in clinical situations.

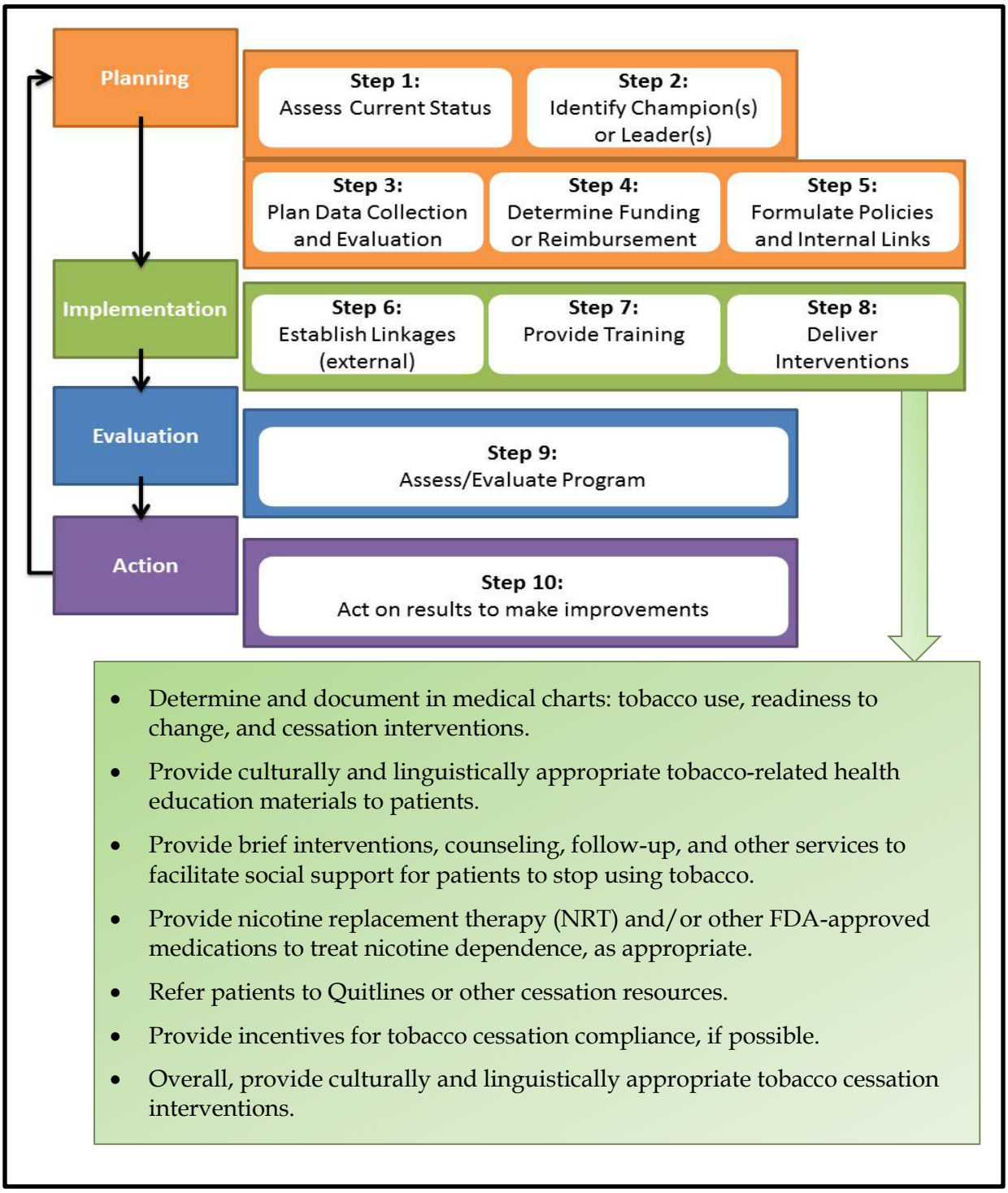


Figure 1: Implementation Process Model

Core Principles and Basic Activities to Get Started

Table 3 lists each step of the IPM, with its corresponding objective, core principles and basic activities to get started. The table provides a checklist, so that those involved in implementing the tobacco program can track their status along the way. It is important to understand that some clinical organizations may already have completed some of the steps as a part of their normal business practices. For example, Step 1 involves collecting patient population data to understand current demographics, tobacco use statistics, and so forth. Some clinical organizations, particularly those with electronic medical records (EMR) in place may already have sufficient data and do not need to repeat data collection for Step 1.

It is important to understand that the steps and activities do need integration. This means that some activities may occur in tandem, and that others will be iterative. For example, creating data collection tools to track tobacco cessation (Step 3) needs to be integrated with developing internal policies related to the tobacco program (Step 5). Similarly, both data forms and policies will need assessment, and possibly revision, as clinicians actually use them in "real time" with patients. Each step in Table 3 is further discussed in the next section of this document.

Table 3: Core Principles and Basic Activities Checklist

Categories	Items to Complete
Step	**1. Assess Current Status**
Objective	☐ Determine baseline data to collect and how to collect it.
Core Principles	☐ Know the patient population and prevalence of tobacco use. ☐ Know what resources are available and the extent of their use.
Basic Activities to Get Started	☐ Access national, state, and local health data and determine, to the most local extent possible, tobacco use prevalence. It is especially important to analyze rates by gender, and by racial and ethnic categories. Identify, to the greatest extent possible, the rates for populations that most closely mirror the clinic's client/patient profile. ☐ Research specific challenges or difficulties that your client/patient population may have with tobacco use, reduction, or cessation. ☐ Study the pathophysiology on nicotine dependence and the variables that promote dependence. ☐ Research resources for tobacco reduction and cessation. Every state has a Quitline, and many have additional opportunities for patients to receive assistance in reducing tobacco use. Many Federal and state government websites also provide free resources for patients and

Categories	Items to Complete
	providers. ☐ Assess the knowledge and attitudes of clinical staff members and providers regarding tobacco use assessment and nicotine treatment practices. This will help to determine their readiness for implementing a program, and their level of training needed.
Step	**2. Identify Champion(s) or Leader(s)**
Objective	☐ Identify a person or persons with the ability to lead in creating a culture of tobacco awareness and cessation in the clinic environment.
Core Principles	☐ Champions/leaders are persons who are dedicated, enthusiastic, and able to lead tobacco program efforts "on the ground." ☐ Champions/leaders must understand the role of social issues, including poverty and education level, in tobacco use and cessation.
Basic Activities to Get Started	☐ Determine specific qualities and characteristics needed to serve as a champion/leader for the tobacco program. Remember that enthusiasm and commitment are important attributes, so think through personality competencies in making the list. ☐ Lay out requirements and expectations for the position, including, for example, duties, time requirements, duration (for example, this position could rotate annually if there are enough qualified candidates), reporting and authority channels, pay differential if applicable, and measures of success. ☐ Create a list of candidates based on the organization's human resource guidelines. (For example, are positions like this advertised, selected from volunteers, assigned by management, and so forth?) Think through the full slate of staff members who could be included, not just those already in leadership positions. ☐ Select the best candidate, based on the organization's criteria. ☐ Ensure that the champion/leader receives appropriate training. ☐ Ensure that the rest of the staff members understand the significance of the tobacco program and the champion's role.
Step	**3. Plan Data Collection and Evaluation**
Objective	☐ Have the ability to collect and retrieve pertinent data from electronic medical records (EMR) or other data collection tools.

Categories	Items to Complete
Core Principles	☐ Document tobacco use and status for all patients. ☐ Document both treatment and outcomes. ☐ Analyze and use the data to track progress for individual patients and make program improvements.
Basic Activities to Get Started	☐ Identify core data points and questions and methods to collect them. The questions might include, for example, whether a patient uses tobacco or ever used tobacco, the use of nicotine products in their environment, how often and how much tobacco is used, whether the patient is ready to attempt quitting, resources used for quitting or reducing tobacco use, and results. ☐ Specifically determine how each data point will be reported or used for evaluation or assessment of the program. If the data do not have a specific use for evaluation, they do not need to be collected. ☐ Determine how the data will be collected. For example, add questions to the EMR or other data collection tool to collect the core data points. Note that some or all of the data may already be collected under current clinical procedures. ☐ Work with providers to ensure that the data collection tools and processes are not burdensome. It may take several iterations to find the right format to obtain necessary information in a way that complements clinic schedules and client caseloads.
Step	**4. Determine Funding or Reimbursement**
Objective	☐ Fund tobacco cessation and prevention activities apart from global billing activities.
Core Principles	☐ Understand and use billing/coding related to tobacco cessation for specific reimbursement agencies (e.g., private insurers, Medicaid, and others).
Basic Activities to Get Started	☐ Determine the full range of possible funding sources and their requirements (e.g., insurance, government funding or reimbursement, grant funds at Federal, state, and local levels, and other sources). ☐ Select the best possible ways to obtain reimbursement for tobacco cessation services and activities. For example, some clinics may have resources to apply for grant funding, while others might want to focus on insurance billing. Or, some may have behavioral counselors eligible to bill for their time, while others may not.

Categories	Items to Complete
	☐ Ensure that billing procedures include specific coding for tobacco cessation services where allowed. (For example, Medicaid allows billing for tobacco cessation, so these activities should not just be "lumped in" with prenatal care global billing). ☐ Obtain training to ensure that clinical staff members know how to bill for tobacco cessation services. ☐ Apply for grants or other funding sources for tobacco cessation programs, if this is a reasonable approach for your clinic or organization.
Step	**5. Formulate Policies and Internal Links**
Objective	☐ Create and support a culture of tobacco awareness and cessation in the clinic environment.
Core Principles	☐ Tobacco use should not be allowed on clinical property for staff or patients. ☐ Tobacco use should be treated as a vital sign in clinic visits, and nicotine dependence should be treated as a chronic disease. ☐ The clinic should have internal policies and procedures that clearly delineate the tobacco cessation process and culture in the clinic, and should instruct/train all staff members about tobacco cessation initiatives for patients.

Basic Activities to Get Started	☐ Develop a no-tobacco use policy in the clinic.
	☐ Create incentives for staff to stop using tobacco.
	☐ Provide nicotine dependence treatment support for clinic staff members who need it.
	☐ Develop internal procedures that clearly delineate the treatment for nicotine dependence process and culture in the clinic. The procedures should include, for example:
	  ☐ Workflow policies and documents that delineate roles and responsibilities related to who should ask patients about tobacco use, how to ask, and when to ask.
	  ☐ Procedures and guidelines for tobacco use interventions for patients at various stages of readiness to quit.
	  ☐ Documentation of procedures for tobacco use status and interventions.
	☐ Use the data collection form (including electronic form) to help plan

Categories	Items to Complete
	the process and vice versa (e.g., assess what forms are needed, who needs them, and the intended result of collecting the data; then determine how all of this informs the workflow and process in the clinic and where and how tobacco data can be used). (Also see Step 3). ☐ Create "key evidence-based messages" about tobacco dependence treatment interventions and ensure that all staff members know them, and reflect them to patients. ☐ Instruct/train all staff about all processes and procedures related to tobacco policies and the tobacco cessation program.
Step	**6. Establish Linkages (External)**
Objective	☐ Leverage resources, information, and knowledge with partners.
Core Principles	☐ Seek opportunities to link with others to exchange lessons learned and resources. This can include state tobacco prevention and control programs, local university or hospital tobacco research programs, and other clinical care organizations. ☐ Establish relationships/partnerships that will ensure sustainability and replication of the program.
Basic Activities to Get Started	☐ Identify and work with others creating similar programs, (including tobacco or other addiction or behavior-related programs), possibly to share resources, or at least to share lessons learned. ☐ Make connections with states and determine state resources (e.g., Quitlines, Medicaid policies). ☐ Use technology to connect networks of people and information. For example, especially in a time of budget constraints, making full use of available webinars, online training, and internet videos can extend program benefits to patients and staff with significantly reduced costs.
Step	**7. Provide Training**
Objective	☐ Establish a tobacco cessation culture within the clinic by training all staff to ensure that each person can deliver an evidence-based brief intervention and can articulate the overall tobacco cessation program and his/her role.
Core Principles	☐ Provide useful, meaningful, credible and reliable evidence-based training for all staff, based on the clinic's overall tobacco cessation plan/program. The training should provide practical and usable knowledge and skills, and should create and reinforce a tobacco

Categories	Items to Complete
	cessation culture in the clinic.
Basic Activities to Get Started	☐ Identify and engage training resources that can educate all staff members in: ☐ the implementation process steps, ☐ their role in the process, ☐ basic information about tobacco use, prevention, cessation and treatment, and ☐ basic information about patient resources for tobacco cessation. ☐ Identify and engage training resources that can teach providers or others who will work directly with patients to reduce or cease tobacco use. At a minimum, the training should cover: ☐ the 5 A's,[2] ☐ motivational interviewing[3] or other brief interventions, ☐ pharmacological interventions (prescribed and over-the-counter) for tobacco cessation, ☐ referral resources (such as Quitlines), and ☐ targeted health education information for patients. ☐ As may be necessary, accommodate schedules or develop incentives for staff members to participate in the training.
Step	**8. Deliver Interventions**
Objective	☐ Provide a full range of options for smoking cessation interventions, based on the PHS Guideline, to the clinic's patient population.
Core Principles	☐ Approach tobacco use as a vital sign in clinical visits (just as providers approach weight and blood pressure). ☐ For patients ready to quit or reduce tobacco use, or those in the

2 The 5 A's refer to a model for providers to use in determining tobacco use and additional treatment steps. The 5 A's are described in detail later in this document, and stand for: Ask, Advise, Assess, Assist, and Arrange.

[3]Motivational interviewing is an empathic, supportive counseling style that supports the conditions for change, but does not confront to avoid defensiveness and resistance (SAMHSA, 2014a).

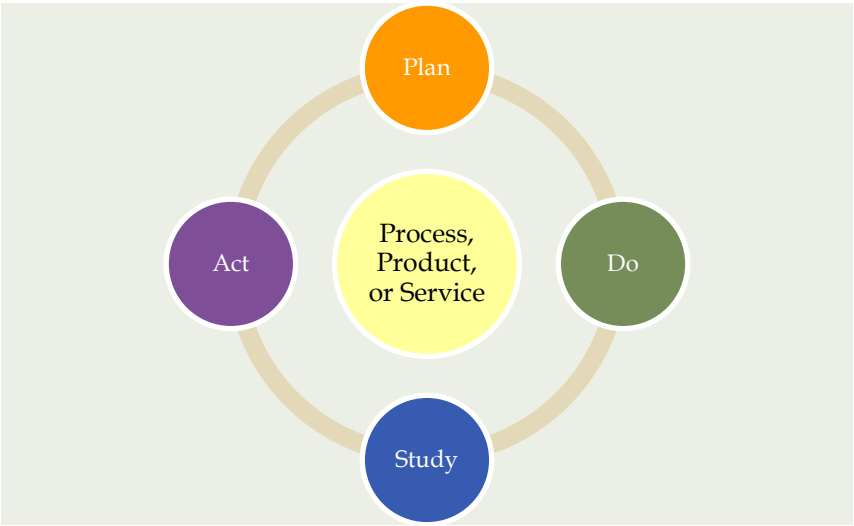
Categories	Items to Complete
	process, provide appropriate (evidence-based and/or scientifically proven) medical and/or behavioral interventions and follow-up.
Basic Activities to Get Started	☐ Determine, and document in medical charts, tobacco use, readiness to quit, and interventions. At a minimum, and depending on the patient's tobacco use profile and health considerations, the program and its providers and staff should be prepared to deliver these interventions: ☐ Evidence-based, and culturally and linguistically appropriate, tobacco-related patient informational and educational materials, suited for specific population groups. ☐ Brief interventions, counseling, follow-up, and other services to provide social and behavioral support to stop using tobacco. ☐ Prescription tobacco-dependence medications and/or nicotine replacement therapies (NRT). ☐ Referrals to Quitlines or other cessation resources. ☐ Incentives for tobacco cessation compliance (if possible).
Step	**9. Assess / Evaluate Program**
Objective	☐ Use data to determine program progress and outcomes and to make program improvements.
Core Principles	☐ Collect data regularly on each patient, including documenting all interventions, and compare outcomes with baseline data to determine increased tobacco use quit attempts, abstinence, and cessation in the targeted population. ☐ Determine what works and what does not work for implementing the PHS Guideline and employing the implementation process steps in a particular clinic situation.
Basic Activities to Get Started	☐ Analyze collected program data to answer evaluation questions laid out in Step 3. ☐ Report analysis to share both positive and negative findings with providers, administrators, and others who are a part of the process. ☐ Obtain feedback from those participating in the program about changes or improvements that need to be made based on the data results.
Step	**10. Act on Results to Make Improvements**

Categories	Items to Complete
Objective	☐ Improve the program based on evaluative results.
Core Principles	☐ Use the data and feedback from participants to determine where change and improvements are needed.
Basic Activities to Get Started	☐ Make identified changes and improvements in the program. Such changes may range from revising a data collection form, to providing additional training, to working with pharmacists to change formularies. Any aspect of the program should be considered open for improvement if data and participant feedback determine that changes are desirable.

Step-by-Step Instructions for Implementing Clinically-Based Tobacco Cessation Programs

The Concept of a Plan-Do-Study-Act Cycle

Figure 2: Plan-Do-Study-Act Cycle



The planning cycle concept has varied nomenclature depending on the organization or discipline using it. Despite differences in terms, all of the cycles refer to a method for ensuring the highest quality in processes, products, and services. Throughout this project, we referred to the idea as the Plan-Do-Study-Act (PDSA) cycle (Figure 2). Table 4 generally describes each aspect of the cycle, and the related steps of the Implementation Process Model (IPM).

Table 4: PDSA Cycle and IPM Steps

PDSA Cycle Phase	IPM Steps
Plan: Ensure that actions have been clearly thought through, and that they relate directly to the overall strategy and the intended outcomes.	Steps 1 through 5
Do: Implement planned actions.	Steps 6 through 8
Study: Evaluate or assess the implemented actions to determine whether they are meeting intended goals and outcomes.	Step 9
Act: Take actions, or make changes in actions, based on data learned in the study phase.	Step 10

The cycle then repeats with the new actions, so that everything about the project is constantly being improved over time.

Many healthcare related organizations and industries use the PDSA cycle to plan and evaluate their programs, and we highly recommend using the cycle in each step of the IPM. In fact, the IPM itself is a form of PDSA, recommending specific steps for Planning (Plan), Implementation (Do), Evaluation (Study), and making necessary changes to specific steps (Act) that correspond with what does, and does not, work effectively in a given clinical organization.

As a resource to assist with using the PDSA cycle, the Agency for Healthcare Research and Quality (AHRQ) sets forth the Institute for Healthcare Improvement's (IHI) Model for Improvement.[4] AHRQ describes the tool as "a simple yet powerful tool for accelerating quality improvement."

- A general overview of Healthcare Quality Improvement is at: http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx
- Specific information about the PDSA cycle is at: http://www.ihi.org/knowledge/Pages/Tools/PlanDoStudyActWorksheet.aspx

Step-by-Step Implementation

The remainder of this document provides the following information for each step of the IPM:

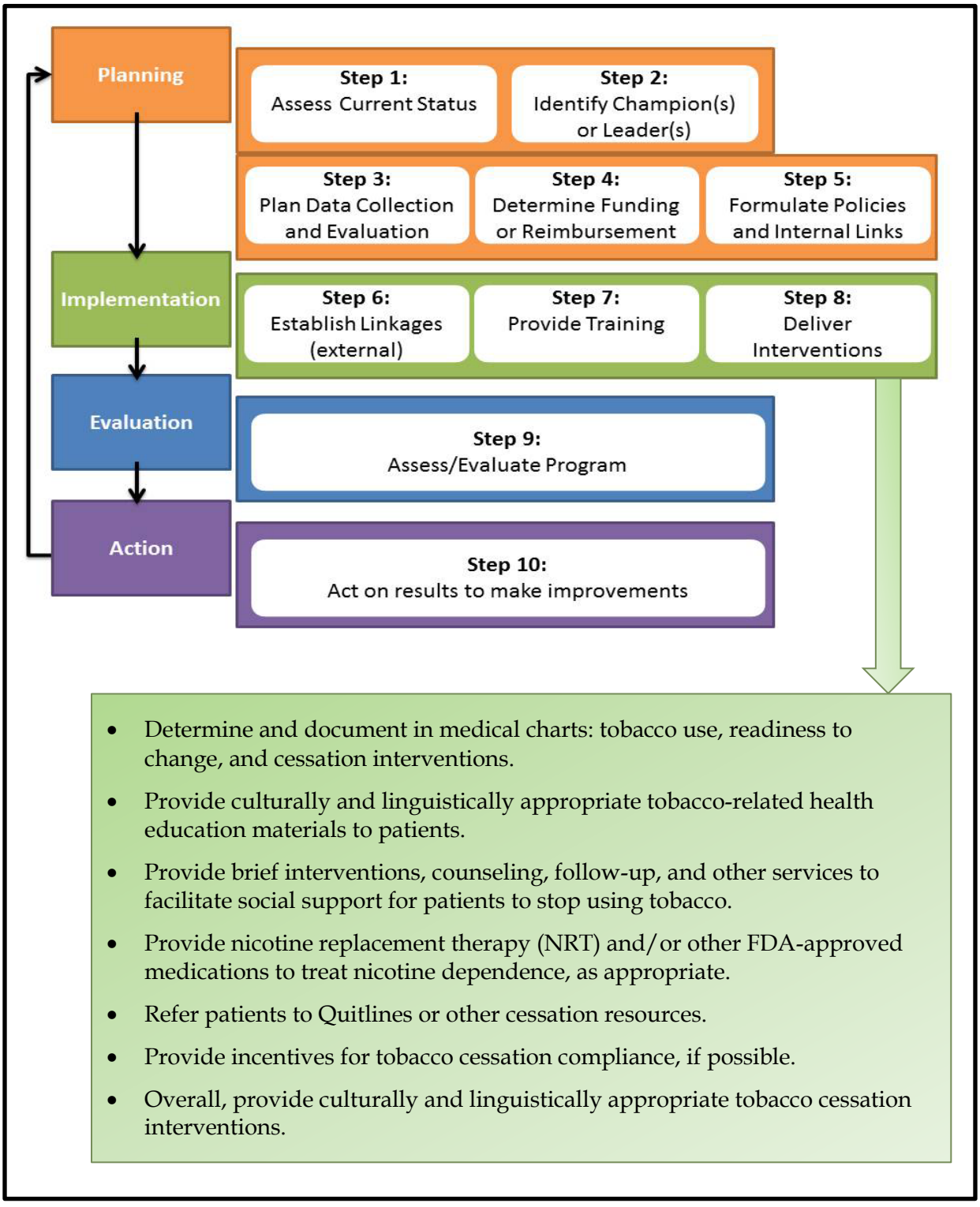
- Title
- Objective
- Core Principles and Basic Activities
- Lessons Learned and Additional Options, Approaches and Activities
- Tools and Resources

Example(s) and Insights for Working with LSES Women of Childbearing Age are also interspersed throughout the document.

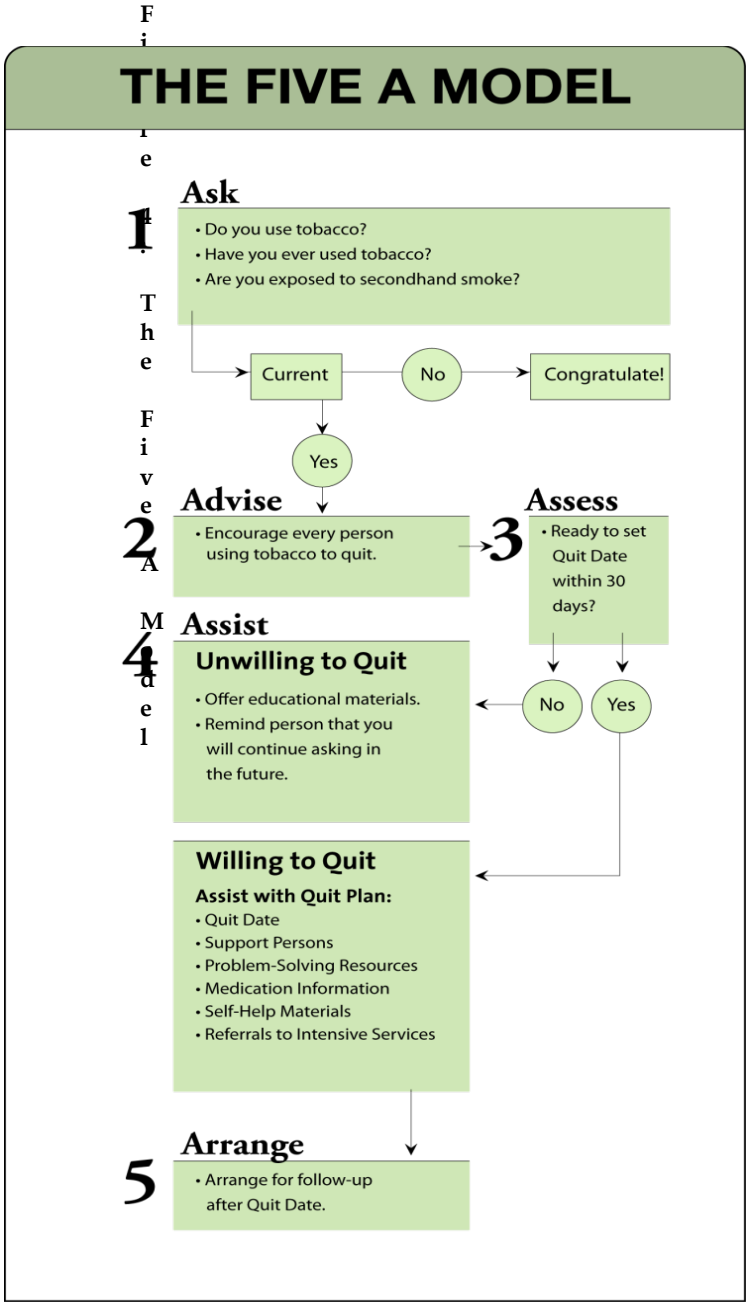
The Appendix: Providers' Toolkit features a Practice Bulletin, additional resources, and tools that can be used directly, or customized for individual clinic's needs.

[4] http://www.innovations.ahrq.gov/content.aspx?id=2398

Figure 3: Implementation Process Model



The Five A Model



A core concept that will be referred to throughout this document is the Five A Model (5 A's). This model will be discussed in further detail, and a 5 A's tool is included in the Appendix. For now, it is important to understand that the 5 A's are an evidence-based method for providers to work with patients to determine tobacco use and readiness to quit. The 5 A's, as depicted in Figure 4, are: Ask, Advise, Assess, Assist, and Arrange.

For patients not ready to quit using tobacco, discussions around the "5 R's" may also be helpful. These include:

- **Relevance** to help the patient understand reasons to quit that are most relevant to her/his own life, health, and situation.
- **Risks** or negative outcomes that could arise from continued tobacco use.
- **Rewards** or positive benefits from quitting using tobacco.
- **Roadblocks** or barriers/obstacles to quitting and how they might be overcome.

- **Repetition**, so that tobacco use is addressed with the patient at each visit.

Step 1: Assess Current Status

Objective

The objective of this step is to: Determine baseline data to collect and how to collect it.

The idea behind this step is to "know where you are before you decide where to go." Having data about tobacco use and resources in a local population helps to design programs and services best suited to clients' and patients' needs. Good data, especially at the local level, may be difficult to obtain initially. However, using available data sources and getting started with tobacco reduction and cessation programs is better than either planning without data, or waiting an extensive time for local data systems to be developed.

Core Principles and Basic Activities

Core Principles. The two core principles of this step are to:

- Know the patient population and prevalence of tobacco use.
- Know what resources are available and the extent of their use.

Basic Activities. Activities in this step include the following:

- Access national, state, and local health data and determine, to the most local extent possible, tobacco use prevalence. While overall rates are informative, it is especially important to analyze rates by gender, and by racial and ethnic categories. As the example in this section shows, wide tobacco use disparities may exist in certain populations. You want to be able to identify, to the greatest extent possible, the rates for populations that most closely mirror your client/patient profile.
- Research specific challenges or difficulties that your client/patient population may have with tobacco use, reduction, or cessation. For example, Native peoples may use tobacco ceremonially. This may require additional education for providers and patients to understand the differences between ceremonial and commercial tobacco and their uses and impacts. As another example, women in a younger patient population may need more specific information about tobacco use during pregnancy. Or, populations in geographic areas or age categories most prone to high blood pressure would require information about the effects of tobacco on cardiovascular health.
- Study the pathophysiology on nicotine dependence and the variables that promote dependence.
- Research resources for tobacco reduction and cessation. Every state has a Quitline, and many have additional opportunities for patients to receive assistance in reducing tobacco use. Many Federal and state government websites also provide free resources for patients and providers. In addition, not-for-profit agencies such as the American Lung Association, American Cancer Society, and American Legacy Foundation offer programs to help people reduce or abstain from tobacco use. Knowing the resources available and how to provide them to clients, or refer patients to them, is critical in implementing a successful program. See the Appendix for more information about resources.

- Assess the knowledge and attitudes of clinical staff members and providers regarding tobacco use assessment and nicotine treatment practices. This will help to determine their readiness for implementing a program, and their level of training needed.

Lessons Learned and Additional Options, Approaches and Activities

Clinic Level Data. While there are numerous sources of state and county-level data, it can be much more difficult to find clinic-specific data. Also, agencies or clinics may be asking or recording the data in different ways than the standardized data sources and their neighbors, so there may be little available for comparison. This difficulty may decline as successful use of electronic medical (EMR) records grows. In the interim, it is important to collect and use the best data that is available. Over time, with refined EMR and other clinical-level data collections methods, data can be further focused on individual clinics. It is better to begin programs with available data, than to wait for finer level data that may not be available for a significant time, if ever.

Patient Support. While many patients successfully use Quitlines, others are not comfortable calling them. When additional patient support services are needed, considering partnering with county health departments or community health organizations to obtain peer support or counseling services. In addition, grantees have been successful in merging tobacco programs with programs for other health conditions, such as diabetes, obesity, or cardiovascular health. This pools resources, and allows providers and counselors to work on multiple interrelated health concerns at the same time.

Tools and Resources

- A great place to start is at the Centers for Disease Control and Prevention website: http://www.cdc.gov/tobacco/. The website provides multiple sources for data and statistics, state and local resources, and even free print materials.
- For information about state health departments, there is an interactive map at: http://www.cdc.gov/mmwr/international/relres.html
- The DHHS Office of Minority Health (OMH) provides data and statistics on numerous tobacco-related health issues, organized by minority populations. They also provide census profiles for various populations. See http://minorityhealth.hhs.gov/ and select tabs related to Data and Statistics, Health Topics or Minority Populations.
- www.HealthcarePartnership.org (click on Native American Resources, then IHS), provides a Tobacco Counseling Practices Survey to assess knowledge and attitudes of clinical staff. A copy of this survey is also available in the Appendix.

Example

In 1999, Wisconsin first collected data about maternal smoking. The state determined that its maternal smoking rates were alarming, at 17.8% compared to 12.6% nationally. Other drastic disparities also became apparent. For example, the prevalence of smoking during pregnancy among:

- African American women in Wisconsin was 19.6% in 2000, compared to Caucasian women at 17.1%.
- American Indian women in Wisconsin was more than twice that of Caucasian women at 39.5%.

Differences in the prevalence of smoking during pregnancy between Wisconsin and the United States varied by race/ethnicity as well. The prevalence of smoking for African American, Hispanic, and American Indian women in Wisconsin were double the prevalence for each respective minority group in the United States.

By analyzing the data and understanding where to focus resources, Wisconsin's First Breath program has served over 12,000 women averaging a 35% program smoking abstinence rate. The program continues to analyze data to determine maternal smoking rates and further refine its programs and services.

Insights for Working with LSES Women of Childbearing Age

There is ongoing debate about the accuracy of smoking data from birth certificates. Clinics can address this barrier by accepting the limitation of the data and using it in appropriate ways. For example, knowing the exact number of women who actually smoke in each county may be difficult, but the data can still be used to see trends and identify areas of greatest need.

Step 2: Identify Champion/Leader(s)

Objective

The objective of this step is to: Identify a person or persons with the ability to lead in creating a culture of tobacco dependence awareness and treatment in the clinic environment.

Champions or leaders are those who have an interest in preventing and treating nicotine dependence, and who can keep momentum for the program and ensure its continued progress. There may be more than one champion/leader in the organization but at least one must be in a position to make policy decisions and lead other staff. Organizations may also have a champion/leader who is responsible for working directly with clinical staff and patients to ensure that the treatment modalities move patients toward a nicotine-free life.

Core Principles and Basic Activities

Core Principles. There are two core principles to this step:

- Champions/leaders are persons who are dedicated, enthusiastic, and able to lead tobacco program efforts "on the ground."
- Champions/leaders must understand the addictive nature of nicotine and the role of social issues, including poverty and education level, in tobacco use and cessation.

Basic Activities. Activities in this step include the following:

- Determine specific qualities and characteristics needed to serve as a champion/leader for the tobacco program. Remember that enthusiasm and commitment are important attributes, so think through personality competencies in making your list.
- Lay out requirements and expectations for the position, including, for example, duties, time requirements, duration (for example, this position could rotate annually if there are enough qualified candidates), reporting and authority channels, pay or differential if applicable, and measures of success.
- Create a list of candidates, based on your organization's human resource guidelines. (For example, are positions like this advertised, selected from volunteers, assigned by management, and so forth?) Think through the full options of staff members who could be included, not just those already in leadership positions.
- Select the best candidate, based on your organization's criteria, and ensure that the person receives appropriate training, and that the rest of the staff members understand the significance of the nicotine dependence treatment program.

Lessons Learned and Additional Options, Approaches and Activities

Finding a Champion/Leader. Identifying champions/leaders is critical to keep the program progressing, but finding a suitable person for the role may take some time and thought. Many organizational leaders are already too busy, and might feel that an added administrative responsibility is more than they can handle. This difficulty can be handled in several ways. For example:

- There may be people already involved in specialized health issues or coalitions that could serve as the champion or leader. For example, a person leading efforts in cardiovascular health could take on the tobacco program as one aspect of cardiovascular health initiatives. In several of our study clinics, the public health nurses were already working with individual patients on diabetes or obesity issues, for example. It worked well for them to include tobacco cessation in their encounters with patients.
- A more a junior level staff person could take on the role, if they have regular access to higher management levels. So, a less senior staff person might have the enthusiasm and time to take on the tobacco program. To ensure that the program receives appropriate attention, the champion/leader could report on tobacco intervention activities directly to a senior staff member (e.g., medical director, or head nurse) on a regular basis.
- In some cases, especially because turnover can be a problem, the only option is to "take who is available." In those cases, training in prevention and treatment of tobacco dependence may help the champion/leader to develop additional skills and interests in the program.
- Because of barriers like time constraints, extended absence (e.g., sick or maternity leave), and re-location, it is useful to identify a "backup" champion so that continuity is not lost.

Involving the Champion/Leader in Planning. Several partners reported that the champions/leaders have been instrumental in describing their individual practice workflow, guiding the decision-making process for how to best implement the screening and counseling intervention, and determining the methodology to assure data collection.

Example

Some organizations have also found innovative ways to identify champions/leaders. For example, in one clinic, the pharmacist led the tobacco cessation efforts. When the clinic staff identified patients as ready to quit, or needing nicotine dependence medications, they referred those patients to the pharmacy. There, patients received additional tobacco cessation information, worked with the pharmacist or pharmacy assistant on a quit plan, and were offered weekly drop-in support meetings, led by pharmacy staff. In other situations, dental clinics provide tobacco cessation support programs.

In another example, champions were identified for each clinic in a network of clinics participating in the program. The champions functioned as key contacts for the local quality improvement coordinator (QIC) to assure consistent and effective communication, identify further training needs, and monitor the ongoing need for provider and patient education materials and resources. Each champion was tasked to conduct ongoing analyses within the practice to evaluate the efficacy of the selected approach to implementation, recommend and make necessary adjustments based on observation and feedback, and to alert the QIC of any modifications deemed necessary. Of note, the champions/leaders in this example do not receive any compensation from the project for their time. Rather, their work represents true engagement and investment in this issue from each of the practices.

Step 3: Plan Data Collection and Evaluation

Objective

The objective of this step is to: Have the ability to collect and retrieve pertinent data from electronic medical records (EMR) or other data collection tools.

Having specific data about tobacco use that is uniformly collected assists clinics in assessing the need for tobacco cessation programs, identifying target audiences, and evaluating progress toward goals. While some programs have EMR sections that cover tobacco use, others must find other ways to obtain the data. This step covers data collection with or without an EMR system.

Core Principles and Basic Activities

Core Principles. The three core principles for this step are:

- Document tobacco use and status for all patients.
- Document both treatment and outcomes.
- Analyze and use the data to track progress for individual patients and make program improvements based on aggregated data.

Basic Activities. Activities for this step include the following:

- Identify core questions and add them to the EMR or other data collection tool. The questions would include for example, whether a patient uses tobacco or ever used tobacco,

the use of nicotine products in their environment, how often and how much tobacco is used, whether the patient is ready to attempt quitting, resources used for quitting or reducing tobacco use, and results.

- Work with others, in a consortium where possible, to ensure efficiency and effectiveness of EMR tobacco module development and costs. EMR vendors may already have developed tobacco dependence treatment queries that can be incorporated into other systems or customized at lower cost than developing from scratch. In addition, healthcare providers and clinics in the same categories (e.g., small hospitals or group practices), networks, or regions may be able to work together to develop a shared tobacco module at less cost than each entity developing the module on its own. Contacting local or national nonprofit organizations, or your state health department can result in valuable resource information. See the Appendix for more information on resources.
- Use existing surveys or forms, whenever possible, to reduce the time needed to develop questions and surveys. It is advisable to capture data consistent with the minimal data set forth by the North American Quitline Consortia.
- Using the data to decrease tobacco use and improve programs is the objective, and standardizing data collection across related organizations as much as possible will help in this regard. In addition to making the data useful in a larger context, and with a larger population, standardizing data collection also allows joint training for clinical staff to learn how to analyze and use the data.
- Work with providers to ensure that the data collection tools and processes are not burdensome. It may take several iterations to find the right format to obtain necessary information in a way that complements clinic schedules and patient caseloads.

Lessons Learned and Additional Options, Approaches and Activities

Flexibility with Data Needs. One of our partner's data collection form did not include date of birth, insurance coverage, and age. They determined that this information would have been useful to be available "at their fingertips." (This is particularly an issue for practices not using EMR). In addition, one clinic found it useful to include the age that a patient started using tobacco on the data collection form. This assisted with decision-making as to appropriate pharmacologic interventions given long-term, chronic nicotine dependence.

Response Rates and Tools. The most common tobacco use surveys (ASK questions from the 5 A's and the short Fagerstrom Test for Nicotine Dependence) (Heatherton et. al., 1991) are validated for self-administration. However, some practices have found it useful for an office staff member or provider to ask the questions of the patient, and complete the form during the time that the patient is in the office. This may not be practical in many busy offices. In that case, to ensure good response rates, patients can be asked to complete the survey while they are in the office.

Engaging Providers in Data Collection. The North Carolina project found that, when working with providers, billing and reimbursement information for cessation counseling will often "get you in the door." Yet, providers are willing to commit to the work for the long-haul because they truly care about their patients. They also found that providers need "credit" for

the vast amount of harm reduction work they engage in with patients. Tobacco cessation is a multi-stage process, and providers do a lot of work to help patients move toward being willing to quit. Additionally, providing "credit" – both in the form of recognition of their harm reduction work and reimbursement for counseling – enables and encourages providers to continue to engage with patients, even if the patient is not yet ready to attempt quitting.

Tools and Resources

Sample data collection forms, including intake and follow-up forms, and pre-natal and post-natal forms can be found at the following websites. Copies are also available in the Appendix.

- You Quit, Two Quit resources for clinical practices: http://www.youquittwoquit.com/PracticeResources.aspx
- www.Healthcarepartnership.org (click on Native American Resources, then IHS).

Example

For organizations that support a network of clinics, do not assume anything! In one case, when the participating providers were questioned about their use of the state Quitline as a resource, many stated that they used the resource. When asked to clarify their referral protocols, most were only providing the toll-free number to patients with no further follow-up and few were able to articulate what service the Quitline provided. Once Quitline referral data was shared with participating providers, they were surprised at the referral numbers (some were zero!).

In general, be sure to understand the information behind the data being collected. In addition, this case illustrates the importance of using evaluative data, not assumptions, to determine program results and make improvements. (Also see Step 9).

Step 4: Determine Funding/Reimbursement

Objective

The objective of this step is to: Fund tobacco cessation and prevention activities apart from global billing activities.

As awareness of the health consequences of tobacco use becomes more prevalent, insurers and government payers are providing coverage specifically for tobacco cessation and prevention clinical activities. It is important that clinical staff understand billing procedures and requirements so that their time for working with patients to reduce or cease tobacco use can be compensated. This will help to ensure that adequate time is spent with each patient in addressing tobacco use. In addition, depending on the patient population and staff certifications or licenses, the compensation may adequately cover engaging a specially trained person to work with patients on managing their tobacco use.

Core Principles and Basic Activities

Core Principles. The core principle for this step is:

- Understand and use billing/coding related to tobacco cessation for specific reimbursement agencies (e.g., private insurers, Medicaid, and others).

Basic Activities. Activities for this step include the following:

- Determine the full range of possible funding sources and their requirements (e.g., insurance, government funding or reimbursement, grant funds at Federal, state, and local level, and other sources).
- Determine all possible ways to obtain reimbursement for tobacco cessation services and activities.
- Ensure that billing procedures include specific coding for tobacco cessation services where allowed. (For example, Medicaid allows billing for tobacco cessation, so these activities should not just be "lumped in" with prenatal care global billing).
- Obtain training to ensure that clinical staff members know how to bill for tobacco cessation services.
- Apply for grants or other funding sources for tobacco cessation programs, if this is a reasonable approach for your clinic or organization.

Lessons Learned and Additional Options, Approaches and Activities

Tracking Changing Requirements. Make an effort to know staff members from your state Medicaid office, so that you can stay abreast of changes in requirements, and have a ready source to answer billing questions or direct you to additional resources.

Tools and Resources

- See the University of Wisconsin, Center for Tobacco Research and Intervention for a fact sheet about Smoking-Cessation Billing and Diagnostic Counseling Codes http://www.ctri.wisc.edu/News.Center/Fact%20Sheets/Updated%20ROS%20Handouts/14.Codes.pdf
- The Appendix includes a Practice Bulletin from the University of North Carolina that also includes information about billing and diagnostic codes.

Insights for Working with LSES Women of Childbearing Age

Medicaid and other insurance providers now reimburse for some tobacco cessation services, especially for pregnant women. Clinics should make efforts to thoroughly understand insurance reimbursement requirements and plan their programs to provide the most effective treatments allowed for their patients.

Step 5: Formulate Policies and Internal Links

Objective

The objective of this step is to: Create and support a culture of tobacco awareness and cessation in the clinic environment.

First, the clinic should assess policies about using tobacco for its own staff. For example, many of our partner clinics have established smoke-free, or clean air policies anywhere in their buildings or campuses. In addition, the clinic should have a specific process for learning whether a patient uses tobacco, assessing whether the patient is ready to reduce or cease use, providing a full range of interventions to ensure that the patient has the greatest chance possible for success, supporting the patient between visits, and treating nicotine dependence as a chronic condition that requires follow-up. Messages to patients about the health dangers of tobacco and options for quitting should be seamless and pervasive throughout a patient's encounters in the clinic.

Core Principles and Basic Activities

Core Principles. The core principles of this step are:

- Tobacco use should not be allowed on clinical property for staff or patients.
- Tobacco use should be treated as a vital sign in clinic visits, and nicotine dependence should be treated as a chronic disease.
- The clinic should have internal policies and procedures that clearly delineate the tobacco cessation process and culture in the clinic and instruct/train all staff members about tobacco cessation initiatives for patients.

Basic Activities. Basic activities include the following:

- Develop a no-tobacco use policy in the clinic, create incentives for staff to stop using tobacco, and provide nicotine dependence treatment support for clinic staff members who need it.
- Develop internal procedures that clearly delineate the process and culture in the clinic related to the assessment for tobacco use and nicotine dependence interventions. The procedures should include, for example:
    - Workflow policies and documents that delineate roles and responsibilities related to who should ask patients about tobacco use, how to ask, and when to ask. (See Figure 5). These policies would include, for example:
        - Obtain tobacco use information on the intake form, and have the clinical process seamlessly connect the patient with a trained tobacco cessation staff member during the visit.
        - For tobacco users, invoke the 5A's (Ask, Advise, Assess, Assist, Arrange) as appropriate.
        - Use brief interventions, as appropriate, and provide follow-up with each patient who uses tobacco.
    - Develop procedures and guidelines for the full range of tobacco interventions for patients at various stages of readiness to quit.

  - Create a process for documenting procedures for tobacco use status and interventions.
- Use the medical records form (including electronic form) to help plan the process and vice versa (e.g., assess what forms are needed, who needs them, and the intended result of collecting the data; then determine how all of this informs the workflow and process in the clinic and where and how tobacco data can be used.)
- Create "key evidence-based messages" about tobacco dependence treatment interventions and ensure that all staff members know them, and reflect them to patients. One example is the Food and Drug Administration (FDA) message: Smoking Causes Immediate Damage to Your Body
- Instruct/train all staff about all processes and procedures related to tobacco policies and the tobacco cessation program.

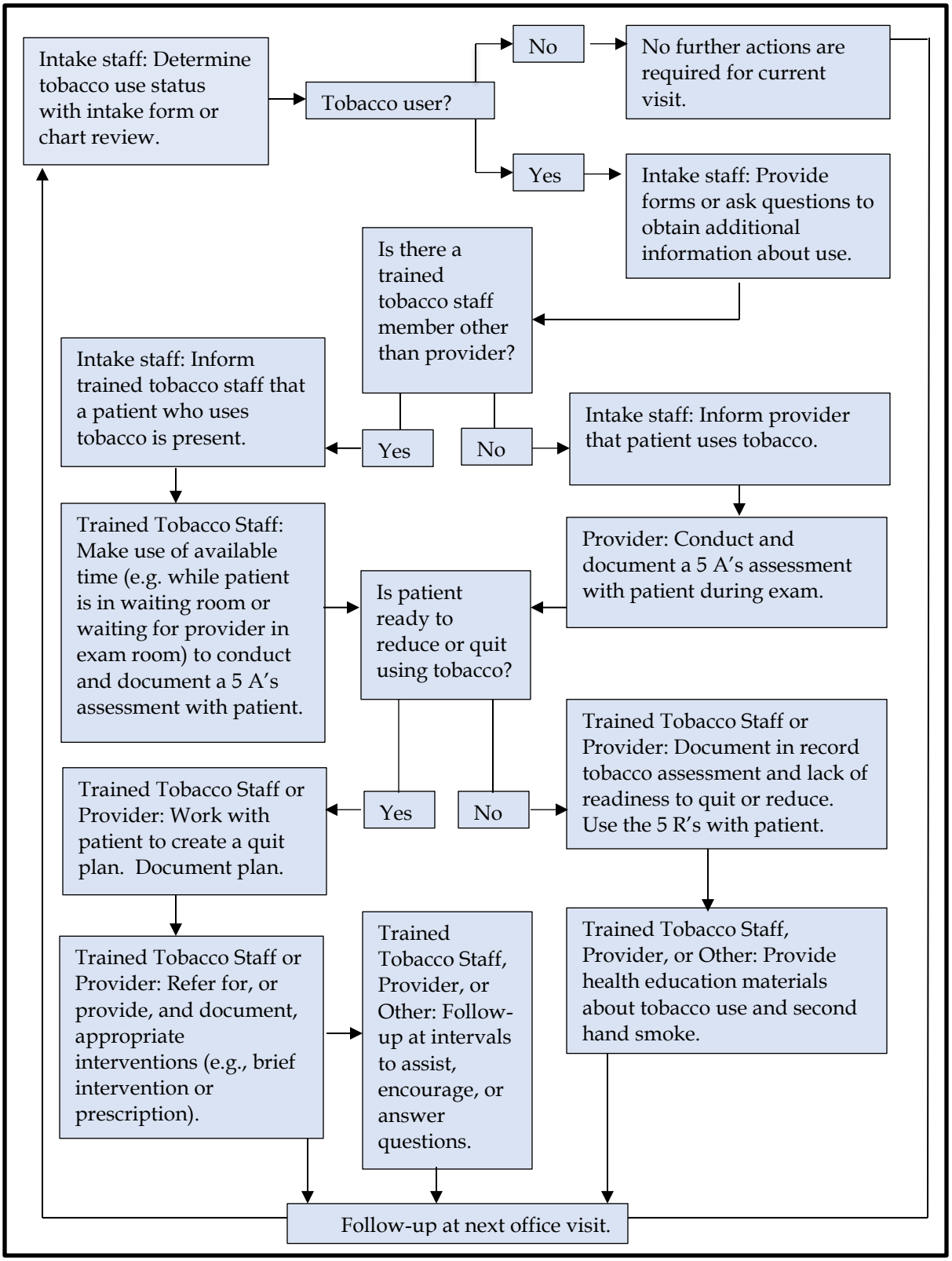
Lessons Learned and Additional Options, Approaches and Activities

Starting the Conversation. It is really important for all providers to understand that a major goal of a tobacco cessation program is to reduce the risk of disease, disability, and premature death as a result of long term use of nicotine. As a result, while quitting, or never starting tobacco use, is the "gold standard," even starting a conversation about tobacco use is beneficial. Most tobacco users benefit from many instances of encouragement, as quitting is an iterative process that often involves multiple instances of relapse. However, more instances of quitting do lead to more eventually successes in quitting permanently. So, providers should be aware that any reduction in tobacco use is beneficial and should be encouraged, and that even starting the conversation can be a step toward eventual success at abstinence.

Repetitive Inquiries. Some of our partners found that repetitive inquiries about tobacco use improved opportunities for open discussion with patients. They recommend using every opportunity to inquire about tobacco use. For example, all clinical providers who come in contact with a patient ask about tobacco use. This includes doctors, nurses, dentists, therapists, pharmacists, and others.

Providing Information. Information, such as QUIT cards, which have referral information for Quitlines are readily available, both for staff members to distribute to patients and for patients to help themselves. Additional information may be available through local health departments or nonprofit organizations. Or, an internet search will provide many resources. Information about resources for patients, or scripts for staff to address tobacco use can be printed on business cards and made available as necessary.

Figure 5: Sample Internal Process for Tobacco Cessation Program



Chronic Disease. Tobacco users may make many quit attempts before achieving long-term success. Not only is it important to ask regularly about tobacco use and readiness to quit, but it is also important to treat nicotine dependence as a chronic disease that needs ongoing care, not just as a one-time assessment or referral. In addition, referral to a Quitline does not constitute complete care for a patient who uses tobacco. The PHS Guideline is clear that all available evidence-based interventions should be used, including brief interventions, medications when medically appropriate, and others.

Quitline Follow-up. If patients are referred to a Quitline, it is important for providers to understand the Quitline requirements. For example, providers who are not familiar with the Quitline may simply provide the telephone number (1-800-QUIT-NOW) to the patient. However, most Quitlines require that providers fax a copy of their referral directly to the Quitline. In addition, Quitlines provide follow-up information for referred patients. Providers may be surprised to find that patients they refer to the Quitline do not call the service. Requesting a report of patients who actually contacted the Quitline and used its services can be helpful when treating a patience with nicotine dependence.

Involve All Staff. Here is an example of why all office staff should have basic training in tobacco cessation and resources. A patient casually mentioning stepping out for a cigarette to the reception staff is an opportunity for that staff member to say, "Have you ever tried to quit? Be sure to tell the [provider] that you smoke. They have lots of resources to help you cut back or quit. You'll be new woman without tobacco!"

Post Policies. Clinics with tobacco-free policies should post these policies in the office, on their website, and in other visible places to reinforce the message. In addition, several clinics in our project set up tables or stations in waiting rooms, exam rooms, and other locations to provide information about quitting, smoke-free environments, and related topics.

Tools and Resources

- See the agency for Healthcare Research and Quality (AHRQ) website for information about systems change related to tobacco cessation programs. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/decisionmakers/systems/index.html
- There are many resources for providers to learn and use the 5 A's. For a useful pocket guide, see Helping Smokers Quit: A Guide for Physicians. May 2008. (This includes instructions for using the 5 A's, and a medication overview.) http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/clinhlpsmksqt.pdf
- Resources for varied audiences (including governments, retailers, and those interested in tobacco and health) are available at: http://www.fda.gov/TobaccoProducts/ResourcesforYou/default.htm.
    - This website also includes information and examples of advertising campaigns and messages for patients and the public.
    - The resources include widgets and buttons that can be downloaded to clinic websites.

Example

This example demonstrates both how the process can work, and how it may be revised as providers and patients use it over time. In North Carolina, one practice analyzed workflow during the early part of program implementation and made a change to their screening protocol. When the Medical Assistant (MA) identified a positive screen for tobacco use, the MA placed a Quitline fax referral form in the exam room for the provider. This served as a visual prompt for the provider during the exam, facilitated the referral process and gave the patient the opportunity to read the form and about the Quitline services while awaiting the provider's arrival to the exam room. Providers and staff members were educated about updating the "health tab" with reminders for all screenings and referrals in the EMR modifications. Patient education packets were put together and provided to tobacco users; these packets included tobacco cessation materials as well as information about the Quitline. This same practice made modifications to its EMR to be able to report out individual patients screened, by pregnant and non-pregnant status, by target and non-target populations, and with referrals to behavioral health, and/or the Quitline.

Insights for Working with LSES Women of Childbearing Age

LSES women of childbearing age use tobacco for many reasons, including to reduce stress, and to feel increased stamina in difficult life situations. It is important that the women be "met where they are" in working on their tobacco use and attempts to quit. For example, for someone who uses tobacco to get her through her second job after a long day, it may seem impossible, at first, to imagine quitting altogether. However, setting a goal to wait 15 minutes after a meal before lighting up, or to have one cigarette, not two, first thing in the morning, might be a doable small step to begin the process.

Tobacco use may be very tied to social supports for LSES women. Their ability to reduce or stop using tobacco may be hampered by friends, family, neighbors, or co-workers who also smoke. It is important to address tobacco use in the larger context, and to help patients plan how to manage their environment when they want to reduce tobacco use, but have limited support to do so.

The tobacco industry targets advertising toward LSES tobacco users, especially women. It is important to understand the many forces pushing women toward tobacco, and the few forces holding them back. Convincing LSES women to stop using tobacco with shame or guilt does not provide the support they need to develop a plan and workable strategies to reduce their use.

Step 6: Establish Linkages (External)

Objective

The objective of this step is to: Leverage resources, information, and knowledge with partners.

Such information sharing will help to ensure efficiency and effectiveness in program implementation and evaluation. The PHS Guideline lays out the important and evidence-based approaches, so it is not necessary to "start from scratch." Instead, the objective is to learn the best way to implement the approaches in specific clinic types or patient populations. Those who have implemented the approaches before can serve as a rich source of knowledge. In addition, there may be opportunities to share resources, which can reduce implementation time and costs.

Core Principles and Basic Activities

Core Principles. The core principles for this step are:

- Seek opportunities to link with others to exchange lessons learned and resources. This can include state tobacco prevention and control programs, local university or hospital tobacco research programs, and other clinical care organizations.
- Establish relationships/partnerships that will ensure sustainability and replication of the program.

Basic Activities. Activities for this step are:

- Work with others creating similar programs, (including tobacco or other addiction or behavior-related programs).
- Make connections with states and determine state resources (e.g., Quitlines, Medicaid policies).
- Use technology to connect networks of people and information. Especially in a time of budget constraints, making full use of available webinars, online training, and internet videos can extend program benefits to patients with significantly reduced costs.

Lessons Learned and Additional Options, Approaches and Activities

Linking with Others. Our partners have found it very helpful to participate in national programs and/or conferences on tobacco prevention or cessation to link with others who are doing similar work. In addition, many states have tobacco cessation programs and online tools that are publicly available.

Identify Key Stakeholders. It is important to identify key stakeholders early on, and make efforts to network. This can improve program design, engender collaboration, and potentially provide economic efficiencies.

Understanding Public Policy. Understanding tobacco and health related legislation is important, to ensure that providers have notice and knowledge of changes in requirements, reimbursement, and a host of other issues on which legislation has an impact.

Example

The Tennessee Primary Care Association (TPCA) worked with many external partners to create tobacco cessation policies and programs with their partner clinics. For example, they

contacted employee assistance programs in their state to obtain information about tools and resources for creating "no tobacco" policies in the TPCA and associated clinics. They also worked with employee health insurance carriers to obtain support for employee's efforts to quit using tobacco. Information from a number of tobacco cessation organizations provided them with knowledge of tobacco cessation resources, which was beneficial in working with patients to understand the costs of tobacco use and benefits of quitting or reducing use.

Working with TennCare, the state funder for low-income health services, the TPCA obtained information for providers about the TennCare formulary and over-the-counter (OTC) costs for tobacco cessation medications. Where a patient's health considerations allowed a choice, providers could use those medications available through the formulary or least expensive OTC. TPCA also worked with the state Quitline to obtain ample supplies of Quitline cards, which provided information for patients about how to contact the Quitline. These cards were then available in several places in the clinics for patients to help themselves, and for providers to distribute. Information from the state about reimbursement also allowed the clinics to provide case management support for all pregnant patients, which included support for quitting tobacco during pregnancy and staying quit postpartum.

The TPCA also worked directly with information technology providers to ensure that the clinic's EMRs collected useful data without overburdening providers. This included working with the contractors to retrieve data related to smoking status and use, to determine how to document treatment and outcomes, and to standardize data collection across the organization.

Insights for Working with LSES Women of Childbearing Age

Because tobacco use during pregnancy is such a health concern for babies and young children, there are many resources available to assist women with quitting and maintaining a tobacco-free lifestyle. This includes resources such as Quitlines for support, text messages for reminders and encouragement, and direct medical and behavioral health services reimbursed through Medicaid and other insurers. It is important for a clinic to identify these resources in its state and to make use of them. The resources benefit patients while being free or reimbursed to the clinic.

Step 7: Provide Training

Objective

The objective of this step is to: Establish a tobacco cessation culture within the clinic by training all staff to ensure that each person knows the overall tobacco cessation program and his/her role.

The training should also ensure that each staff member has the specific knowledge and skills required to fulfill that role. For example, everyone should know who might handle questions related to quitting resources. Everyone who works directly with patients should also know basic information about tobacco use, prevention, cessation and treatment. Providers or trained tobacco cessation staff should also know the 5 A's and how to use them with patients.

Core Principles and Basic Activities

Core Principles. The core principle for this step is to:

- Provide useful, meaningful, credible and reliable evidence-based training for all staff, based on the clinic's overall tobacco cessation plan/program. The training should provide practical and usable knowledge and skills, and should create and reinforce a tobacco cessation culture in the clinic. At the end of the training, each person should be able to deliver an evidence-based brief intervention, and articulate the overall tobacco cessation program and his or her role.

Basic Activities. Activities for this step include the following:

- Identify and engage training resources that can train all staff members in: (1) the implementation process steps, (2) their role in the process, and (3) basic information about tobacco use, prevention, cessation and treatment, (4) the 5 A's, and (5) evidence-based brief interventions, such as motivational interviewing.
- As may be necessary, accommodate schedules or develop incentives for staff members to participate in the training.

Lessons Learned and Additional Options, Approaches and Activities

Overcoming Barriers. Our partners found that the greatest barrier to training was lack of time, and the busy clinic schedule of office staff members and providers. They provided a series of suggestions that worked to alleviate time barriers, as listed below.

- Provide training incentives, including, for example, continuing education units (CEU), rewards for completing the training, holding the training in a desirable venue, or serving food as part of the training. It may also work to tie the training to other professional conferences or events.
- For some portions of the training, materials may be made available online or in Webinars, which can make completing the training easier due to scheduling flexibility. Also, early morning, lunch, and evening hours might be most effective to deliver training. Generally, if training will take place in the clinical setting, flexibility is key. Besides making timing most convenient, the training may need to be broken into smaller modules to cover during available time.
- "Sell" providers on the efficacy of treatment, including providing evidence that nicotine dependence treatment works.

Usable Skills. Every staff member who participates in the training should walk away with usable skills that they can implement right away. This means that training should focus on specific practical information. The training should also be tailored for its audience. For example, providers likely know the health effects of tobacco use. Their training should focus on how to work with patients to prevent or cease tobacco use, not on its effects. The training should provide opportunities to practice specific skills during the session, so that participants feel confident in their ability to use their new skills in patient care immediately.

Tools and Resources

- The Wisconsin Women's Health Foundation (WWHF) new training manual can be found online at:

  http://www.wwhf.org/wp-content/uploads/2012/02/First-Breath-Manual-4.5.13-HW.pdf

- Multiple vendors provide training related to tobacco cessation approaches in clinics. See the following websites about training information. All of these provided training for partners in this project.
  - Mayo Clinic Nicotine Dependence Center: http://www.mayo.edu/research/centers-programs/nicotine-dependence-center
  - University of Arizona Healthcare Partnership: http://www.healthcarepartnership.org/
  - University of Wisconsin Center for Tobacco Research and Intervention: http://www.ctri.wisc.edu/

Insights for Working with LSES Women of Childbearing Age

- For clinics with large populations of LSES women of childbearing age, training modules on the unique concerns of this population would be advisable. For some examples of useful information, see the following websites:
  - University of Arizona Healthcare Partnership: http://www.healthcarepartnership.org/, (to order Maternal and Child Health Companion Guide)
  - University of North Carolina Center for Maternal and Infant Health: http://www.mombaby.org/
  - For A Guide for Counseling Women Who Smoke: Helping Women Eliminate Tobacco Use and Exposure, see: http://whb.ncpublichealth.com/provPart/pubmanbro.htm

Step 8: Deliver Interventions

Objective

The objective of this step is to: Provide a full range of options for smoking cessation interventions, based on the PHS Guideline, to the clinic's patient population.

Core Principles and Basic Activities

Core Principles. The core principles of this step are to:

- Approach tobacco use as a vital sign in clinical visits (just as providers approach weight and blood pressure), and treat nicotine dependence as a chronic condition.
- For patients ready to quit or reduce tobacco use, or those in the process, provide evidence-based and/or scientifically proven medical and/or behavioral interventions and follow-up.

Basic Activities. Activities include the following:

- Determine, and document in medical charts, tobacco use, readiness to quit, and interventions. Depending on the patient's tobacco use profile and health considerations, interventions may include, for example:
  - Evidence-based, and culturally and linguistically appropriate, tobacco-related patient informational and educational materials, suited for specific population groups.
  - Brief interventions, counseling, follow-up, and other services to provide social and behavioral support to stop using tobacco.
  - Prescription tobacco-dependence medications and/or nicotine replacement therapies (NRT).
  - Referrals to Quitlines or other cessation resources.
  - Incentives for tobacco cessation compliance (if possible).

Lessons Learned and Additional Options, Approaches and Activities

Trained/Certified Tobacco Specialists. Some partners have found that a staff member specially trained in tobacco cessation can help provide many interventions, to ensure that the provider's time is used most efficiently. This trained person, could, for example:

- Assist patients with completing quit plans.
- Provide information and referrals to Quitlines, Web-based cessation services, and other resources.
- Provide information about tobacco cessation medications, insurance coverage, and so forth.
- Coordinate incorporating tobacco cessation with other services, (for example pharmacy services or weight reduction programs).
- Coordinate tobacco use interventions with treatment for other chronic diseases and conditions such as diabetes and cardiovascular disease. (i.e., understand and address issues related to tobacco use).
- Follow-up between office visits with patients who are reducing or ceasing tobacco use.
- Research partners or funders who could provide incentives for patients to sustain abstinence or reduction in tobacco use and avoid relapse.

Transtheoretical Model. Some of our partners used the transtheoretical model (TTM) to determine a patient's readiness to change. This stages of change model includes five stages: pre-contemplation, contemplation, preparation/determination, action/willpower, and maintenance (SAMHSA, 2014b).

Motivational Interviewing. Motivational interviewing has been found to be an integral part of success in tobacco cessation treatment. Motivational interviewing is an empathic, supportive counseling style that supports the conditions for change, but does not confront to avoid defensiveness and resistance (SAMHSA, 2014a).

Quitlines. For providers who are referring patients to Quitlines, it is important to have an ample supply of Quitline cards and fax referral forms. These can be obtained from state Quitline services, by calling 1-800-QUIT NOW, or through the North American Quitline Consortium (NAQC) http://www.naquitline.org/.

- NAQC provides a national map of Quitlines, with contact information and service descriptions http://map.naquitline.org/)
- Query the Quitline provider about their feedback loop to determine patient utilization and outcomes.

Phone Text Support. Patients can also receive phone text support for quitting. They can sign up at http://smokefree.gov/smokefreetxt.

Other Resources. Additional resources may be available locally, from state health departments, or local chapters of such organizations as the American Cancer Society, American Heart Association, American Lung Association, or Legacy. Information about how to reach these organizations is included in the Appendix.

Tools and Resources

- A common instrument to assess nicotine dependence is the Fagerstrom Test for Nicotine Dependence (Figure 6). A pdf version of this test can be found at http://www.uclahealth.org/workfiles/smoke-free/Fagerstrom-Nicotine-Dependence-Test.pdf.
- Rustin's (2000) discussion of additional instruments to assess nicotine dependence can be found at http://www.aafp.org/afp/2000/0801/p579.html. This article also provides a patient information handout on nicotine dependence, written by the same author.
- The DHHS Office of Minority Health (OMH) provides information, including training for providers, on many topics related to culturally and linguistically appropriate interventions. They also provide data and statistics on numerous tobacco-related health issues, census profiles for various populations. See http://minorityhealth.hhs.gov/ and select tabs related to Data and Statistics, Cultural Competency, Health Topics and Minority Populations.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) website provides information and training on both TTM and motivational interviewing. http://samhsa.gov/co-occurring/topics/training/change.aspx.
- The University of Arizona Healthcare Partnership (www.healthcarepartnership.org) features evidence-based tools specific to maternal and child health and tobacco dependence treatment. The website includes tools adapted for Native Women and their families.
- See the You Quit, Two Quit resources for providers at http://youquittwoquit.com/HeathProfessionals.aspx. This includes information on the 5 A's, fact sheets, and other free resources for patients and providers.

Figure 6: Fagerstrom Test for Nicotine Dependence

Fagerstrom Test for Nicotine Dependence *

Is smoking "just a habit" or are you addicted? Take this test and find out your level of dependence on nicotine.

1. How soon after you wake up do you smoke your first cigarette?
   - After 60 minutes (0)
   - 31-60 minutes (1)
   - 6-30 minutes (2)
   - Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?
   - No (0)
   - Yes (1)

3. Which cigarette would you hate most to give up?
   - The first in the morning (1)
   - Any other (0)

4. How many cigarettes per day do you smoke?
   - 10 or less (0)
   - 11-20 (1)
   - 21-30 (2)
   - 31 or more (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?
   - No (0)
   - Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?
   - No (0)
   - Yes (1)

* Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom KO. The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addictions 1991;86:1119-27

(continued on next page)

Fagerstrom Test for Nicotine Dependence (cont.)

Your score was:_____

Your level of dependence on nicotine is:

0-2 Very low dependence	6-7 High dependence
3-4 Low dependence	8-10 Very high dependence
5 Medium dependence	

Scores under 5: "Your level of nicotine dependence is still low. You should act now before your level of dependence increases."

Score of 5: "Your level of nicotine dependence is moderate. If you don't quit soon, your level of dependence on nicotine will increase until you may be seriously addicted. Act now to end your dependence on nicotine."

Score over 7: "Your level of dependence is high. You aren't in control of your smoking – it is in control of you! When you make the decision to quit, you may want to talk with your doctor about nicotine replacement therapy or other medications to help you break your addiction."

Step 9: Assess/Evaluate Program

Objective

The objective of this step is to: Use data to determine program progress and outcomes and to make program improvements.

Core Principles and Basic Activities

Core Principles. The core principles of this step are to:

- Collect data regularly on each patient, including documenting all interventions, and compare outcomes with baseline data to determine increased tobacco use quit attempts, abstinence, and cessation in the targeted population.
- Determine what works and what does not work for implementing the PHS Guideline and employing the implementation process steps in a particular clinic situation.

Basic Activities. Basic activities for this step are to:

- Analyze collected program data to answer evaluation questions laid out in Step 3.

- Report analysis to share both positive and negative findings with providers, administrators, and others who are a part of the process.
- Obtain feedback from those participating in the program about changes or improvements that need to be made based on the data results.

Step 10: Act on Results to Make Improvements

Objective

The objective of this step is to: Improve the program based on evaluative results.

Core Principles and Basic Activities

Core Principle. The core principle of this step is to:

- Use the data and feedback from participants to determine where change and improvements are needed.

Basic Activity. The basic activity for this step is to:

- Make identified changes and improvements in the program. Such changes may range from revising a data collection form, to providing additional training, to working with pharmacists to change formularies. Any aspect of the program should be considered open for improvement if data and participant feedback determine that changes are desirable.

Example

The Wisconsin Women's Health Foundation (WWHF) regularly obtains information from providers to learn how they can improve their program. Responses to a survey alerted them to providers' concerns that the data collection forms were onerous and took too much time to complete. WWHF assessed the forms and which data they were actually using that provided the best information. They revised the forms, which now only collect the most vital information, and addressed the providers' concerns about time constraints.

Conclusion

This document provides step by step information, in the form of an implementation process model, to create tobacco cessation programs in clinical settings. We urge clinicians to develop programs for their clients and patients. The process is not arduous, and there are many resources to assist every step of the way. Reducing the harm of tobacco use is a critical need, and every effort toward that end saves lives. Thank you for your good work in helping others to stop using tobacco!

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APPENDIX: Providers' Toolkit

Part 1: Clinical Practice Bulletin

This Clinical Practice Bulletin was developed as part of the You Quit Two Quit program at the University of North Carolina (UNC) Center for Maternal and Infant Health in partnership with the Women and Tobacco Coalition for Health (WATCH), the NC Division of Public Health Tobacco Prevention and Control Branch, and Community Care of the Lower Cape Fear (CCLCF). Although some of the information is specific to North Carolina, most of the information is applicable to clinical practices throughout the nation. Those topic focused on North Carolina still provide a starting point about how to obtain similar information in other states. The Bulletin provides information on the following topics:

- The 5 A Model (5 A's)
- Integrating Tobacco Use Screening
- Billing for Cessation Counseling
- How to Proactively Refer to the [Quitline]
- Pharmacotherapy for Tobacco Cessation
- Pharmacotherapy During Pregnancy, Lactation and Postpartum
- Resources
- Environmental Changes
- You Quit, Two Quit Program and Contacts

In addition to being a resource immediately useful in conjunction with this Blueprint document, the Bulletin is also a great example of useful communication to providers that can foster successful tobacco cessation and treatment programs.

you quit two quit

PRACTICE BULLETIN

June 2012

UNC SCHOOL OF MEDICINE

Inside...

Note: References are available for healthcare professionals at www.youquittwoquit.com

Smoking Cessation: An Essential Women's Health Intervention

Despite the well-known consequences of tobacco use, over one in five women of reproductive age in the United States still smoke.[1] Lung cancer has replaced breast cancer as the leading cause of cancer death among women, and the overwhelming majority of lung cancer deaths are directly attributable to tobacco use.[2] Smoking increases the risk of numerous health problems: multiple types of cancer, heart disease, stroke and Chronic Obstructive Pulmonary Disease (COPD), among others.[2,3] More COPD deaths occur among women than men.[3] Tobacco use by women contributes to many devastating and costly poor health outcomes.

Tobacco use among women of reproductive age is particularly dangerous given the potential for multigenerational harm. Smoking is associated with numerous poor reproductive health outcomes including infertility, ectopic pregnancy, and spontaneous abortion.[4] With regard to birth outcomes, tobacco use during pregnancy strongly contributes to preterm birth, low birth weight, stillbirth and Sudden Infant Death Syndrome (SIDS).[4] In North Carolina, the infant mortality rate would drop 10-20% if women were able to completely stop smoking during pregnancy.[5]

Tobacco use after pregnancy also poses serious risks for women and their families. Twenty-seven percent of US children aged 6 years and under live with a parent or other family member who smokes; the annual direct medical costs associated with this exposure to parental smoking is estimated at $4.6 billion.[6]

Secondhand smoke can contribute to an increase in respiratory illnesses in mothers and babies, middle ear infections in children, children with impaired lung function[7], and an increase in SIDS.[8] It is particularly important to include young adults in screening and counseling efforts. The decrease in smoking by high school girls has slowed in recent years.[9] Teens

and young adults who start smoking are more likely to develop a severe nicotine addiction than those who initiate later, and young women have the highest rates of maternal smoking during pregnancy.[9]

The *Treating Tobacco Use and Dependence: 2008 Update* provides recommendations specific to promoting tobacco cessation in women. Psychosocial interventions, including individually tailored follow-up and advice geared toward children's health when applicable, have been proven effective.[10] Women also benefit from pharmacotherapies, especially Bupropion SR and Varenicline, in combination with individual counseling.[10]

Smoking cessation screening and counseling before, during and after pregnancy must be a core component of every family medicine, maternity care, and pediatric practice. This practice bulletin offers a number of evidence-based, best practice strategies and resources to health care providers to support this important intervention. The consequences of neglecting this essential prevention opportunity span generations.

The 5 A's: An Evidence-Based, Best Practice Intervention

As documented in the clinical practice guideline *Treating Tobacco Use and Dependence: 2008 Update*, a brief counseling intervention of 5 to 15 minutes, when delivered by a trained health care professional and augmented with pregnancy- and/or parent-specific self-help materials, can double or, in some cases, triple smoking cessation rates among pregnant and postpartum women.[1] For non-pregnant adults, individual counseling, in combination with pharmacotherapy when appropriate, is an effective strategy for increasing the success of cessation attempts. The 5 A's is a brief, evidence-based intervention that providers can use to help their patients quit smoking. The components and anticipated amount of time required for the 5 A's are as follows[1]:

ASK – 1 minute
Ask patient about smoking status using a structured question. The use of a multiple choice question, as opposed to a yes/no question, increases the disclosure of tobacco use - among pregnant women disclosure is increased by 40%.[1]

ADVISE – 1 minute
Provide clear, strong advice to quit with personalized messages about the impact of smoking on the woman and, if appropriate, her baby. Follow with personalized message stressing the impact of continued use on the patient and her family.

ASSESS – 1 minute
Assess the willingness of the patient to make a quit attempt within the next 30 days.

ASSIST – 3 minutes +
Suggest and encourage the use of problem-solving methods and skills for cessation. Provide social support as part of the treatment. Arrange for support in the smoker's environment, such as proactive referral to Quitline NC. If applicable, provide pregnancy and/or parent specific self-help smoking cessation materials.

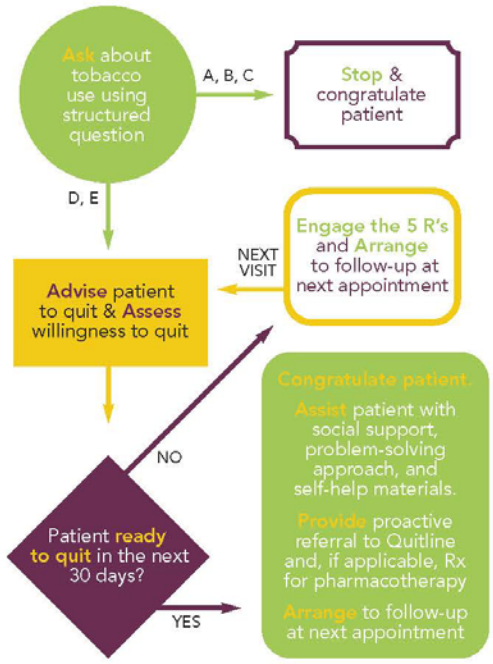
ARRANGE – 1 minute
Periodically assess smoking status and, if she is a continuing smoker, encourage cessation.

While all women should be screened for tobacco use using the structured question, only a subset will be tobacco users requiring assessment of their willingness to quit. Of those, only a smaller subset will be willing to quit in the next 30 days, requiring the full intervention.

When Tobacco Users are Reluctant to Quit

When women are unwilling or unsure about quitting, it can be helpful to focus your discussion about tobacco use around the following 5 R's.[1]

The 5 A's Algorithm



RELEVANCE
Help patient figure out the reasons to quit that are most relevant to their lives, based on their health, environment, and individual situation.

RISKS
Encourage patient to identify possible negative outcomes to continued tobacco use.

REWARDS
Help patient identify possible benefits to cessation.

ROADBLOCKS
Work with patient to identify obstacles to quitting, and encourage her to think about how she might overcome them.

REPETITION
Address tobacco use and cessation with patients at each visit.

Prenatal ASK

Ask client to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime.
B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
D. I smoke some now, but have cut down since I found out I am pregnant.
E. I smoke about the same amount now as I did before I found out I was pregnant.

Postpartum ASK

Ask client to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime.
B. I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
D. I stopped smoking during pregnancy, but I am smoking now.
E. I smoked during pregnancy, and I am smoking now.

Spanish versions of the prenatal & postpartum questions are available at www.youquittwoquit.com

ASK for Non-Pregnant Adult

1. Do you use tobacco?
- ☐ No, I have never used tobacco
- ☐ No, I quit using tobacco (How long ago? _____)
- ☐ Yes, occasionally (How often? _____)
- ☐ Yes, daily

2. Does anyone smoke at home or in your car?
☐ Yes ☐ No

If yes, please complete the following quest
- ☐ Someone smokes inside of my house
- ☐ Someone smokes inside of my car
- ☐ People smoke around me and/or my children

3. Is smoking allowed in your workplace?
☐ Yes ☐ No

Integrating Tobacco Use Screening Into Your Clinic

Having a plan and a system in place to insure that all patients are screened and counseled appropriately for tobacco use will facilitate more consistent performance within offices. There are three best practices that physicians, nurses, and clinic managers can implement in their settings to integrate tobacco screening and treatment. It is important to note that non-physician personnel can serve as highly effective providers of tobacco cessation counseling and treatment.[1] A key component of providing comprehensive tobacco cessation services is to implement a tobacco user identification system. One way to ensure that every patient is screened for tobacco dependence is to make tobacco use status a vital sign. The structured ASK question works well and should be asked of all patients by the health care providers already responsible for vital signs.[1] Each patient's response should be marked in a visible place on her chart so that other members of the team can easily identify her tobacco use status.

A second suggestion is to provide education, resources, and feedback to all staff members. All employees, clinicians and non-clinicians, should be educated on tobacco use screening and treatment through in-services, continuing education, or workshops.[1] Regular feedback should be provided to those personnel responsible for providing the 5 A's. Chart audits and electronic medical records can often provide helpful information.[1] There are several resources available for providers and patients (see the resources section). Sample screening forms are available at www.youquittwoquit.com.

A third suggestion is to decide who is responsible for providing tobacco screening and treatment. Delineating each staff member's role as it relates to tobacco use screening and cessation counseling is critical for ensuring continuity of care. These roles should be communicated to new employees and updated as needed.

[1] Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

3

Billing for Cessation Counseling

Most insurance programs, including Medicaid and Medicare, State Health Plan, and Blue Cross Blue Shield of North Carolina, will reimburse healthcare providers for providing individual cessation counseling for your patients. Below are the codes, reimbursement rates, and frequently asked questions about billing for cessation counseling.

Counseling Codes & Current Reimbursement Rates for Tobacco Cessation

Medicaid (all patients):	Medicare (symptomatic patients)	Medicare (PartB) (asymptomatic patients)
99406: $11.93 (3-10 min.) (intermediate)	99406: $12.55 (3-10 min) (intermediate)	*G0436: $13.60 (3-10 min) (intermediate)
99407: $23.05 (>10 min.) (intensive)	99407: $24.27 (>10 min) (intensive)	*G0437: $26.18 (>10 min.) (intensive)

*Medicare will waive the deductible and coinsurance/copayment for counseling and billing with the G codes

Short Descriptor for 99406 and G0436 - Tobacco use counsel 3-10 min.
Short Descriptor for 99407 and G0437 - Tobacco use counsel > 10 min.

What diagnosis codes should be used?

Medicaid and Medicare (Part B) (asymptomatic patients):
- 305.1 – Tobacco use disorder and (or V15.82 – Tobacco use disorder).

Medicare (symptomatic patients):
- 305.1 – Tobacco use disorder (or V15.82 – Tobacco use disorder) Diagnosis Code for related condition or interference with medication. (Ex. 439.9 Asthma)

Use appropriate E/M code and when reporting any significant and separately identifiable E/M service on the same date as tobacco use cessation counseling, append modifier 25 to the E/M code.

How often can the counseling be billed?

Medicaid

Unlimited, but a provider may only bill for one counseling session per patient per day.

Medicare

Two individual counseling attempts per patient per year composed of four intermediate or intensive sessions (eight individual counseling sessions).

Who can bill for this counseling?

In addition to physicians, nurse practitioners, and health departments, these codes can be billed "incident to" the physician by the following professional specialties:

- Licensed psychologists and psychological associates
- Licensed clinical social workers
- Licensed professional counselors
- Licensed marriage and family counselors
- Certified nurse practitioners
- Certified clinical nurse specialists
- Licensed clinical addictions specialists or
- Certified clinical supervisors
- Registered Nurses
- Enhanced-role Registered Nurses
- Physician assistants

Currently, Medicaid is in the process of requiring providers to enroll. When this process is completed, providers listed above who are enrolled will be able to bill for providing counseling, but will no longer be able to bill "incident to" a physician.

Medicaid requirements of "incident to" a physician:

The physician must have initially seen the patient and provide evidence of management of the patient's care. The physician employs the practitioner or the practitioner and the physician are employed by the same entity.

Dually eligible Medicare/Medicaid patients:

The physician must provide direct supervision and be able to provide evidence of management of the patient's care. The physician has initially seen the patient and is present in the office where the practitioner is providing service, and is immediately accessible in the event of an emergency.

CPT codes are not reimbursable for Medicaid when provided by a federally qualified health center or rural health clinic on the same day that a core service is provided.

Can Health Departments bill Medicaid these codes?

Yes, the same as the general list above. (*Medicaid Bulletin: Jan. 2009 Update*)

Can 99406 or 99407 be used for group sessions in Medicaid?

No, these codes are for face to face services provided to an individual. NC Medicaid does not reimburse for tobacco treatment group sessions or classes.

Can providers caring for a woman receiving family planning through the Family Planning Waiver (FPW) also bill for counseling?

Services required to manage or treat medical conditions discovered during a FPW screening are not covered. They should be referred to a provider who can provide the service needed.

Can providers bill for a prenatal visit and then also for the cessation counseling at the same time?

Yes.

Do these same codes work for any Medicaid patient–a woman with a chronic disease in for a blood pressure check who is then counseled about smoking?

Yes.

If someone receives cessation pharmacotherapy, does it count towards the number of prescriptions Medicaid recipients are allowed each month?

Yes it does. There is a six prescription limit and recipient lock-in to one pharmacy each month. (2005 information)

4

Pharmacotherapy for Tobacco Cessation

Counseling and medication are effective when used by themselves for treating tobacco dependence; however, counseling and medication used together is more effective than either alone.[1] Several effective medications are available to help treat tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking–except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).[1]

Medication	Trade Name	Schedule	Side Effects	Length of Treatment	Cost	Additional Information
Nicotine-Based Agents						
Nicotine Patches	Over the counter (OTC)	21 mg first 4 weeks 14 mg for 2 weeks 7 mg last 2 weeks	-Local skin reactions -Insomnia -Vivid dreams	8-12 weeks	$35/14 patches	The largest patch (21 mg) equals ~3/4 pack of cigarettes per day. Depends on nicotine content of cigarette.
	Nicoderm CQ (OTC)	21 mg first 6 weeks 14 mg for 2 weeks 7mg last 2 weeks		8-12 weeks	$50/14 patches	
Nicotine Nasal Spray	Nicotrol NS (Prescription)	2 sprays = 1 mg (1/nost) = 1 dose 1-2 doses/hr max: 5 doses/hr 40 doses/day	-Nasal irritation	3-6 months	$45/10 ml bottle (10 mg in 10 ml)	Patients with nasal or sinus problems, allergies or asthma should avoid using this product.
Nicotine Gum	Nicorette 2mg (OTC)	1-24 cigarettes/day = 9-12 pieces/day (2 mg/piece) max 24	-Mouth soreness -Upset stomach	4-6 months	Brand: $54/100 $35/40 Generic: $39/110 $23/50	Each piece, 2 and 4 mg, delivers about 50% of its nicotine. White Ice Mint, Cinnamon Surge, Fruit Chill, Fresh Mint, Mint and Original
	Nicorette 4 mg (OTC)	>25 cigarettes/day = 9-12 pieces/day (4 mg/piece) max 24		4-6 months		
Nicotine Oral Inhaler	Nicotrol Inhaler (Prescription)	6-16 cartridges/day	-Local mouth & throat irritation	8-12 weeks	$45/42 cartridges ~$180/month	May assist patients with handling component.
Nicotine Lozenges	Nicorette (OTC)	One piece every: 1-2 hrs (weeks 1-5) 2-4 hrs (weeks 7-9) 4-8 hrs (weeks 10-12)	-Sore throat -Heartburn -Hiccups -Nausea	12 weeks	$41/72 $30/48	Time to first cigarette dosing: less than 30 minutes use 4 mg, greater than 30 minutes use 2 mg. Original, Mint and Cherry
Nicotine Mini Lozenges	Nicorette Mini Lozenges	Same as above	Same as above	Same as above	——	Breath mint-sized lozenges. Mint dissolves up to three times faster.
Non-Nicotine: First Line FDA Approved Agents						
Bupropion	Zyban/Wellbutrin (Prescription)	150 mg once daily in the AM for 3 days then twice daily with second dose 8 hrs after first	-Insomnia -Dry mouth	2-3 months	$70/month $36/34 tablets (Walmart)	Helps minimize withdrawal symptoms. Black Box Warning: mood change
Varenicline	Chantix (Prescription)	0.5 mg once daily for 3 days then 0.5 mg BID for 4 days, then 1 mg BID to end tx.	-Nausea	12 weeks + optional additional 12 weeks	$125/month	Quit date - Tx Day 8-35 Take with food to minimize nausea. Discuss: Cardiovascular Safety Black Box Warning: mood change
Non-Nicotine: Second Line Non-FDA Approved Agents						
Clonidine	Generic Catapress (Prescription)	0.15-0.75 mg per day	-Dry mouth -Dizziness -Sedation	3-10 weeks	~$15/month	Risk: rebound hypertension
Nortriptyline	Generic Pamelor (Prescription)	75-100 mg per day	-Sedation -Dry mouth	12 weeks	~$22/month	Risk: arrhythmias

[1] Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
[2] Koval P. Evidence Based Interventions for Smoking Cessation. Greensboro Area Health Education Center Pharmacy Updates, 2011. Available from: http://www.gahec.org/pharmupd/

Proactively Refer to QuitlineNC

QuitlineNC provides free, confidential, one-on-one counseling to assist tobacco users ready to quit. The quitline is staffed by professional tobacco quit coaches who follow approved protocols based on the caller's needs, including specialized protocols for pregnant women.

LANGUAGES
English, Spanish, and other languages as needed.

HOW TO REFER
Persons ready to quit using tobacco can call QuitlineNC directly and healthcare providers can refer their patients proactively–increasing the odds that their patient will enroll in QuitlineNC's services.

Via Web or Fax: Go to www.quitlinenc.com and click on "For Medical/Health Professionals" and follow the instructions listed.

1-800-QUIT-NOW
24 HRS A DAY, EVERY DAY
WWW.QUITLINENC.COM

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Resources for Your Practice

There is a wealth of resources for providers and women on tobacco cessation. All of the resources below are linked on the You Quit, Two Quit website.

www.youquittwoquit.com

For Patients

Print:

• *If You Smoke and Are Pregnant* is a self-help booklet for women who are pregnant or thinking about pregnancy. Call 919-828-1819 to order.

• *Oh Baby! We Want to Keep You Safe From Second Hand Smoke* offers helpful tips for avoiding secondhand smoke while pregnant and creating a smoke free home and car after the baby is born. Call 919-828-1819 to order.

• *You Quit, Two Quit: A Guide to Help New Mothers Stay Smoke-Free* provides helpful tips for new mothers on staying free of tobacco. Call 919-828-1819 to order.

• You Quit, Two Quit posters are available for pregnant women and new mothers in English and Spanish. Call 919-843-7865 to order.

Phone:

• QuitlineNC at 1-800-QUIT-NOW (1-800-784-8669) is a free tobacco cessation resource for patients and their families.

Web:

• Web-Based Quit Tobacco Coach: www.quitlinenc.com

• Become an Ex at becomeanex.org

• Smokefree Women at women.smokefree.gov

• Women's Health: Mental Health & Addiction at womenshealth.gov/mental-health/

For Health Care Providers

From You Quit, Two Quit:

• Pocket-sized flip cards that display the 5A's and ASK questions.

• Additional copies of this Practice Bulletin and forms to use for screening and tracking.

• To access these items, contact the You Quit, Two Quit project – info on page 8.

Web:

• *A Guide for Counseling Women Who Smoke: Helping Women Eliminate Tobacco Use and Exposure* can be downloaded free of charge from the NC Division of Public Health's website at http://whb.ncpublichealth.com/provPart/pubmanbro.htm

• QuitlineNC: www.quitlinenc.com

• American College of Chest Physicians Tobacco Dependence Treatment Toolkit at tobaccodependence.chestnet.org

• Community Care of the Lower Cape Fear: www.carelcf.org

Get Involved

Contact Judy Ruffin at 919-707-5712 or judy.ruffin@dhhs.nc.gov to learn more about the Women And Tobacco Coalition for Health (WATCH). Contact the You Quit, Two Quit project at 919-843-7865 to find out more about our work.

Policies Make a Difference

Environmental changes play a key role in helping women achieve their tobacco cessation goals. An important North Carolina law known as House Bill 2 took effect in January 2010. This law 1) Made it illegal for people to smoke in enclosed areas of almost all restaurants and bars; 2) Disallowed smoking in enclosed areas of other establishments such as hotels that prepare and serve food or drink; and 3) Gave local governments new authority to regulate smoking in public places. For more information go to **www.smokefree.nc.gov.**

You can also visit the NC Alliance for Health which supports tobacco policies, including laws that will guarantee employees smoke-free worksites in North Carolina. They are also focused on increasing the tax on tobacco products, an act that has been shown to decrease smoking among youth and pregnant women. Numerous experts and internal tobacco company documents have identified raising cigarette taxes as one of the most effective methods to both prevent smoking initiation and reduce smoking prevalence. To learn more go to **www.ncallianceforhealth.org.**

Another promising policy, set to go into full effect in 2012, is the requirement of graphic warning labels on all cigarette packages and advertisements in the U.S. These labels are supported by a wealth of evidence from other countries that have already adopted this strategy. Graphic warning labels: 1) Increase awareness about the health risks of smoking; 2) Help prevent initiation; and 3) Encourage smokers to quit. The day the U.S. Food and Drug Administration released their new graphic warning labels, calls to the toll-free Quitline more than doubled.

You Quit, Two Quit: A Tobacco Cessation Program for Women of Reproductive Age

In 2008, the North Carolina Health and Wellness Trust Fund awarded a three-year grant to the UNC Center for Maternal and Infant Health to implement You Quit, Two Quit, a statewide project to promote evidence-based tobacco cessation interventions to healthcare providers working with pregnant and postpartum women. Through demonstration projects in four county health departments and statewide outreach to providers serving pregnant women and new mothers, You Quit, Two Quit developed successful models for providing training and technical assistance to healthcare providers on helping pregnant women quit using tobacco and stay quit postpartum.

Moving forward, You Quit, Two Quit is continuing to fulfill its core mission of reducing perinatal tobacco use state-wide with support from the NC Department of Health and Human Services, Tobacco Prevention and Control Branch, while broadening its focus to all reproductive age women through the implementation of a tobacco cessation quality improvement program funded by the US Department of Health and Human Services, Office of Women's Health, that targets providers serving low income women of childbearing age within six southeastern counties in North Carolina. This project centers around Community Care of the Lower Cape Fear (CCLCF), a non-profit partnership with primary care providers, local hospitals, health departments, and other healthcare organizations. This program will work with individual practices that serve Medicaid enrollees, strengthen CCLCF's culture of tobacco awareness and action, and increase CCLCF's capacity to promote and sustain this work with all of the practices in their service area. CCLCF is one of 14 networks participating in a statewide healthcare quality improvement strategy called Community Care of North Carolina (CCNC), which has a history of leveraging successful local network pilot programs into statewide quality initiatives.

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you quit two quit

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Part 2: Additional Resources

This section provides resources from Federal government organizations and others. All of the tools provided in this document can also be accessed through this resource list.

Federal Government Organizations

Organization	Resources

Agency for Healthcare Research and Quality (AHRQ),
Public Health Service
540 Gaithersburg Road
Rockville, MD 20850
301-427-1364
1-800-358-9295 (to request materials on all AHRQ Smoking Cessation Guidelines)
http://www.ahrq.gov/
	AHRQ is the lead agency charged with supporting research designed to improve the quality of healthcare, reduce its cost, and broaden access to essential services. AHRQ's broad programs of research, clinical guideline development, and technology assessment bring practical, science-based information to medical practitioners and to consumers and other healthcare purchasers.
	AHRQ has many resources for tobacco programs. Two examples are:
	• Help for Smokers and Other Tobacco Users: Quit Smoking. May 2008. (This includes cards to provide patients to encourage abstinence or reduction in tobacco use).
	  • http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/tearsheets/helpsmokers.html
	• Helping Smokers Quit: A Guide for Physicians. May 2008. (This includes instructions for using the 5 A's, and a medication overview.)
	  • http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/clinhlpsmksqt.pdf

Centers for Disease Control and Prevention, **Office on Smoking and Health,** **National Center for Chronic Disease Prevention and Health Promotion** Mail Stop K-50, 4770 Buford Highway, NE Atlanta, GA 30341-3724 770-488-5705 1-800-CDC-1311	The Office on Smoking and Health serves as the Federal focal point for activities on smoking and health and as the national and world center for scientific and technical information. The Office produces the Surgeon General's annual report related to smoking and health, and carries out a public education and a tobacco epidemiology program. • The CDC tobacco Website http://www.cdc.gov/tobacco/ provides a wealth of information, including tobacco surveillance data by state, Quitline information, and numerous reports, including the annual Surgeon General's Report. • Information for employers about tobacco control policies is at: http://www.cdc.gov/tobacco/basic_information/secondhand_smoke/index.htm.

Organization	Resources
	• One example is Implementing a Tobacco-Free Campus Initiative in Your Workplace. • For information about state health departments, there is an interactive map at: http://www.cdc.gov/mmwr/international/relres.html
U.S. Office of Personnel Management (OPM) 1900 E Street, N.W., Rm. 7H24 Washington, DC 20415 202-606-1858 Email: worklife@opm.gov	OPM is responsible for Federal employee health and assistance-related personnel policy guidance and technical assistance. • The OPM information on employee programs for tobacco cessation is very useful for any organization, not just Federal agencies. See: https://www.opm.gov/policy-data-oversight/worklife/reference-materials/tobacco-cessation-guidance-on-establishing-programs-designed-to-help-employees-stop-using-tobacco/
Cancer Information Service (CIS), National Cancer Institute (NCI) 31 Center Drive MSC2580 Building 31, Room 10A31 Bethesda, MD 20892-2580 1-800-4-CANCER (1-800-422-6237) 1-800-332-8615 - TTY	The Cancer Information Service (CIS) provides information on cancer to patients and their families, health professionals, and the general public. The CIS serves as a resource for state and regional organizations by providing expertise in program planning, use of NCI materials, media relations, networking and coalition building. • The CIS website http://www.cancer.gov/cancertopics/tobacco/smoking provides tools, including widgets and other electronic links to tobacco cessation materials and resources. • Another website sponsored by CIS, http://women.smokefree.gov/, deals exclusively with tobacco issues for women, including many tools and supports to stop smoking.
Office on Women's Health (OWH), **U.S. Department of Health and Human Services (DHHS)** 200 Independence Avenue, SW Room 712E Washington, DC 20201 Phone: 202-690-7650 Fax: 202-205-2631 www.Womenshealth.gov	OWH offers a website dedicated to helping women quit using tobacco, including tools, support resources, and additional information. • See: http://www.womenshealth.gov/smoking-how-to-quit/
Center for Tobacco Products, Food and Drug Administration (FDA) 10903 New Hampshire Avenue Building 71, Room G335 Silver Spring, MD 20993-0002	General information about tobacco and tobacco policy is available at: http://www.fda.gov/TobaccoProducts/default.htm • Resources for varied audiences (including governments, retailers, and others, including those interested in tobacco and health) are available

Organization	Resources
1-877-CTP-1373 1-877-287-1373 For General Inquiries: AskCTP@fda.hhs.gov	at: http://www.fda.gov/TobaccoProducts/ResourcesforYou/default.htm • The resources include widgets and buttons that can be downloaded to clinic websites.
Office of Minority Health (OMH), **U.S. Department of Health and Human Services (DHHS)** The Tower Building 1101 Wootton Parkway, Suite 600 Rockville, MD 20852 Phone: 240-453-2882 Fax: 202-453-2883 http://www.minorityhealth.hhs.gov/	The DHHS Office of Minority Health (OMH) provides information, including training for providers, on many topics related to culturally and linguistically appropriate interventions. They also provide data and statistics on numerous tobacco-related health issues. The data are organized by minority populations. They also provide census profiles for various populations. See http://minorityhealth.hhs.gov/ and select tabs related to Data and Statistics, Cultural Competency, Health Topics and Minority Populations.

Other Organizations

Organization	Resources
American Cancer Society (ACS), National Headquarters 1599 Clifton Road, N.E. Atlanta , GA 30329-4251 404-320-3333 or call the local number listed in the telephone directory. http://www.cancer.org/	The American Cancer Society (ACS) is dedicated to eliminating cancer through research, education, advocacy and service. ACS offers the "Fresh Start" program designed to help participants stop smoking. The program offers a variety of brochures, videos and other resources on smoking cessation. The information on tobacco cessation counseling can be found on the ACS website http://www.cancer.org/by typing in cancer AND counseling in the search box located in the upper right corner of the home page.
American Heart Association (AHA), National Center 7320 Greenville Avenue Dallas , TX 75231 214-750-5300 or call the local number listed in the telephone directory	American Heart Association (AHA) provides research support, public and professional education, and community programs in the fight against cardiovascular diseases and stroke. • AHA also offers The Heart at Work health promotion program, including a module on smoking cessation. http://www.cardiovascular.org/HEARTORG/GettingHealthy/QuitSmoking/Quit-Smoking_UCM_001085_SubHomePage.jsp • The program can be implemented with program support provided by a local AHA representative.
American Lung Association (ALA), Headquarters	The American Lung Association (ALA) supports research and other efforts to better understand why smokers are addicted and how to help them. Programs include a stop-smoking program, Freedom

Organization	Resources
61 Broadway New York, NY 10006 212-315-8700 or call the local number listed in the telephone directory.	from Smoking, http://www.quitterinyou.org/,which is also available online as well as self-help options including guidebooks, videotapes and audiotapes.
Legacy 1724 Massachusetts Ave, NW Washington, DC 20036 info@legacyforhealth.org	Legacy is the largest non-profit public health organization in the nation devoted specifically to tobacco control. Their website http://www.legacyforhealth.org/?o=4075 provides verified facts and data about tobacco, and lays out several tobacco control campaigns (for example truth® for youth and young adults, and *EX*® to help people "re-learn life without cigarettes"). The campaigns include tools and resources that can be downloaded.
North American Quitline Consortium 3219 E. Camelback Road, #416 Phoenix, AZ 85018 Phone: 800.398.5489 Fax: 800.398.5489 www.naquitline.org	The North American Quitline Consortium (NAQC) provides information about many aspects of Quitlines, including, for example: • A national map of Quitlines, with contact information and service descriptions (see: http://map.naquitline.org/) • A webinar series exploring delivering new and emerging treatment options • Multiple additional resources
University of Arizona HealthCare Partnership Babcock Building PO Box 210151 1717 E. Speedway Suite 3106 Tucson AZ 85721-0151 Cell: 520-235-9908 Fax: 520-626-9355 www.healthcarepartnership.org	WWW.Healthcarepartnership.org (click on Native American Resources, then IHS). This website provides the following tools that can be modified for individual needs. • Assessment Survey Tool: Assess Knowledge and Attitudes of Your Clinical Staff • Patient Intake Form: This form will help to conduct a counseling session and to document the intervention • Follow-Up Form: To document follow-up, both attempted and completed • Healthcarepartnership.org also has multiple tools for patients and providers available for purchase.
University of Michigan Tobacco Resource Network Clifford E. Douglas, J.D. Director, Tobacco Research Network University of Michigan School of Public Health Department of Health Management and Policy 109 Observatory, Room M3110 Ann Arbor, MI 48109-2029	This site provides links to many additional resources for tobacco information, including in the following categories: • Tobacco News & Information • Government Organizations • Tobacco Control Organizations • Voluntary and Professional Societies • Cessation Sites • Journals and Magazines

Organization	Resources
Phone: 734-936-0939 Fax: 734-764-4338 E-mail: cdoug@umich.edu	• Sites with Multiple Additional Tobacco Links • Tobacco Document Links • Miscellaneous
University of North Carolina Center for Maternal & Infant Health CB# 7181 Chapel Hill, NC 27599-7181 Tel: 919-843-7865 Fax: 919-843-0960 http://youquittwoquit.com/	The You Quit, Two Quit website provides a wealth of information and tools for tobacco use prevention and cessation, focused on women, especially before, during, and after their pregnancies. This Blueprint document includes references to many of the resources available at http://youquittwoquit.com/.
University of Wisconsin, Center for Tobacco Research and Intervention 1930 Monroe, Suite 200 Madison, WI 53711 Phone: 608-262-8673 Fax: 608-265-3102 http://www.ctri.wisc.edu/index.html	The Center for Tobacco Research and Intervention (CTRI) provides resources for healthcare providers, smokers, and employers, including scenarios, webinars, videos, and multiple other resources. • See: http://www.ctri.wisc.edu/HC.Providers/healthcare_ondemand.htm

Part 3: Sample Tools

This part provides a set of tools that can be printed and used directly in a clinical setting. Some of the tools (for example, the intake form) can also be modified for individual practice use. The tools included are listed below. Additional resources and links to tools are included in the previous section.

- Core Principles and Basic Activities Checklist
- Tobacco Counseling Practices Survey
- Tobacco Use Questionnaire (for Patients)
- Tobacco Treatment Follow-Up Data Collection Form
- Pre-Natal 5 A's Intervention Record
- Post-Partum 5 A's Intervention Record
- Fagerstrom Test for Nicotine Dependence
- Fagerstrom Test for Nicotine Dependence Score Sheet and Interpretation
- Pharmacotherapy (for Nicotine Treatment)
- The Five A Model

Core Principles and Basic Activities Checklist

Categories	Items to Complete
Step	**1. Assess Current Status**
Objective	☐ Determine baseline data to collect and how to collect it.
Core Principles	☐ Know the patient population and prevalence of tobacco use. ☐ Know what resources are available and the extent of their use.
Basic Activities to Get Started	☐ Access national, state, and local health data and determine, to the most local extent possible, tobacco use prevalence. It is especially important to analyze rates by gender, and by racial and ethnic categories. Identify, to the greatest extent possible, the rates for populations that most closely mirror the clinic's client/patient profile. ☐ Research specific challenges or difficulties that your client/patient population may have with tobacco use, reduction, or cessation. ☐ Study the pathophysiology on nicotine dependence and the variables that promote dependence. ☐ Research resources for tobacco reduction and cessation. Every state has a Quitline, and many have additional opportunities for patients to receive assistance in reducing tobacco use. Many Federal and state government websites also provide free resources for patients and providers. ☐ Assess the knowledge and attitudes of clinical staff members and providers regarding tobacco use assessment and nicotine treatment practices. This will help to determine their readiness for implementing a program, and their level of training needed.
Step	**2. Identify Champion(s) or Leader(s)**
Objective	☐ Identify a person or persons with the ability to lead in creating a culture of tobacco awareness and cessation in the clinic environment.
Core Principles	☐ Champions/leaders are persons who are dedicated, enthusiastic, and able to lead tobacco program efforts "on the ground." ☐ Champions/leaders must understand the role of social issues, including poverty and education level, in tobacco use and cessation.
Basic Activities to Get Started	☐ Determine specific qualities and characteristics needed to serve as a champion/leader for the tobacco program. Remember that enthusiasm and commitment are important attributes, so think

Categories	Items to Complete
	through personality competencies in making the list. ☐ Lay out requirements and expectations for the position, including, for example, duties, time requirements, duration (for example, this position could rotate annually if there are enough qualified candidates), reporting and authority channels, pay differential if applicable, and measures of success. ☐ Create a list of candidates based on the organization's human resource guidelines. (For example, are positions like this advertised, selected from volunteers, assigned by management, and so forth?) Think through the full slate of staff members who could be included, not just those already in leadership positions. ☐ Select the best candidate, based on the organization's criteria. ☐ Ensure that the champion/leader receives appropriate training. ☐ Ensure that the rest of the staff members understand the significance of the tobacco program and the champion's role.
Step	**3. Plan Data Collection and Evaluation**
Objective	☐ Have the ability to collect and retrieve pertinent data from electronic medical records (EMR) or other data collection tools.
Core Principles	☐ Document tobacco use and status for all patients. ☐ Document both treatment and outcomes. ☐ Analyze and use the data to track progress for individual patients and make program improvements.
Basic Activities to Get Started	☐ Identify core data points and questions and methods to collect them. The questions might include, for example, whether a patient uses tobacco or ever used tobacco, the use of nicotine products in their environment, how often and how much tobacco is used, whether the patient is ready to attempt quitting, resources used for quitting or reducing tobacco use, and results. ☐ Specifically determine how each data point will be reported or used for evaluation or assessment of the program. If the data do not have a specific use for evaluation, they do not need to be collected. ☐ Determine how the data will be collected. For example, add questions to the EMR or other data collection tool to collect the core data points. Note that some or all of the data may already be collected under current clinical procedures.

Categories	Items to Complete
	☐ Work with providers to ensure that the data collection tools and processes are not burdensome. It may take several iterations to find the right format to obtain necessary information in a way that complements clinic schedules and client caseloads.
Step	**4. Determine Funding or Reimbursement**
Objective	☐ Fund tobacco cessation and prevention activities apart from global billing activities.
Core Principles	☐ Understand and use billing/coding related to tobacco cessation for specific reimbursement agencies (e.g., private insurers, Medicaid, and others).
Basic Activities to Get Started	☐ Determine the full range of possible funding sources and their requirements (e.g., insurance, government funding or reimbursement, grant funds at Federal, state, and local levels, and other sources). ☐ Select the best possible ways to obtain reimbursement for tobacco cessation services and activities. For example, some clinics may have resources to apply for grant funding, while others might want to focus on insurance billing. Or, some may have behavioral counselors eligible to bill for their time, while others may not. ☐ Ensure that billing procedures include specific coding for tobacco cessation services where allowed. (For example, Medicaid allows billing for tobacco cessation, so these activities should not just be "lumped in" with prenatal care global billing). ☐ Obtain training to ensure that clinical staff members know how to bill for tobacco cessation services. ☐ Apply for grants or other funding sources for tobacco cessation programs, if this is a reasonable approach for your clinic or organization.
Step	**5. Formulate Policies and Internal Links**
Objective	☐ Create and support a culture of tobacco awareness and cessation in the clinic environment.
Core Principles	☐ Tobacco use should not be allowed on clinical property for staff or patients. ☐ Tobacco use should be treated as a vital sign in clinic visits, and nicotine dependence should be treated as a chronic disease.

Categories	Items to Complete
	☐ The clinic should have internal policies and procedures that clearly delineate the tobacco cessation process and culture in the clinic, and should instruct/train all staff members about tobacco cessation initiatives for patients.
Basic Activities to Get Started	☐ Develop a no-tobacco use policy in the clinic. ☐ Create incentives for staff to stop using tobacco. ☐ Provide nicotine dependence treatment support for clinic staff members who need it. ☐ Develop internal procedures that clearly delineate the treatment for nicotine dependence process and culture in the clinic. The procedures should include, for example: ☐ Workflow policies and documents that delineate roles and responsibilities related to who should ask patients about tobacco use, how to ask, and when to ask. ☐ Procedures and guidelines for tobacco use interventions for patients at various stages of readiness to quit. ☐ Documentation of procedures for tobacco use status and interventions. ☐ Use the data collection form (including electronic form) to help plan the process and vice versa (e.g., assess what forms are needed, who needs them, and the intended result of collecting the data; then determine how all of this informs the workflow and process in the clinic and where and how tobacco data can be used). (Also see Step 3). ☐ Create "key evidence-based messages" about tobacco dependence treatment interventions and ensure that all staff members know them, and reflect them to patients. ☐ Instruct/train all staff about all processes and procedures related to tobacco policies and the tobacco cessation program.
Step	**6. Establish Linkages (External)**
Objective	☐ Leverage resources, information, and knowledge with partners.
Core Principles	☐ Seek opportunities to link with others to exchange lessons learned and resources. This can include state tobacco prevention and control programs, local university or hospital tobacco research programs, and other clinical care organizations. ☐ Establish relationships/partnerships that will ensure sustainability

Categories	Items to Complete
	and replication of the program.
Basic Activities to Get Started	☐ Identify and work with others creating similar programs, (including tobacco or other addiction or behavior-related programs), possibly to share resources, or at least to share lessons learned. ☐ Make connections with states and determine state resources (e.g., Quitlines, Medicaid policies). ☐ Use technology to connect networks of people and information. For example, especially in a time of budget constraints, making full use of available webinars, online training, and internet videos can extend program benefits to patients and staff with significantly reduced costs.
Step	**7. Provide Training**
Objective	☐ Establish a tobacco cessation culture within the clinic by training all staff to ensure that each person can deliver an evidence-based brief intervention and can articulate the overall tobacco cessation program and his/her role.
Core Principles	☐ Provide useful, meaningful, credible and reliable evidence-based training for all staff, based on the clinic's overall tobacco cessation plan/program. The training should provide practical and usable knowledge and skills, and should create and reinforce a tobacco cessation culture in the clinic.
Basic Activities to Get Started	☐ Identify and engage training resources that can educate all staff members in: ☐ the implementation process steps, ☐ their role in the process, ☐ basic information about tobacco use, prevention, cessation and treatment, and ☐ basic information about patient resources for tobacco cessation. ☐ Identify and engage training resources that can teach providers or others who will work directly with patients to reduce or cease tobacco

Categories	Items to Complete
	use. At a minimum, the training should cover: □ the 5 A's,[5] □ motivational interviewing[6] or other brief interventions, □ pharmacological interventions (prescribed and over-the-counter) for tobacco cessation, □ referral resources (such as Quitlines), and □ targeted health education information for patients. □ As may be necessary, accommodate schedules or develop incentives for staff members to participate in the training.
Step	**8. Deliver Interventions**
Objective	□ Provide a full range of options for smoking cessation interventions, based on the PHS Guideline, to the clinic's patient population.
Core Principles	□ Approach tobacco use as a vital sign in clinical visits (just as providers approach weight and blood pressure). □ For patients ready to quit or reduce tobacco use, or those in the process, provide appropriate (evidence-based and/or scientifically proven) medical and/or behavioral interventions and follow-up.
Basic Activities to Get Started	□ Determine, and document in medical charts, tobacco use, readiness to quit, and interventions. At a minimum, and depending on the patient's tobacco use profile and health considerations, the program and its providers and staff should be prepared to deliver these interventions: □ Evidence-based, and culturally and linguistically appropriate, tobacco-related patient informational and educational materials, suited for specific population groups. □ Brief interventions, counseling, follow-up, and other services to

[5] The 5 A's refer to a model for providers to use in determining tobacco use and additional treatment steps. The 5 A's are described in detail later in this document, and stand for: Ask, Advise, Assess, Assist, and Arrange.

[6]Motivational interviewing is an empathic, supportive counseling style that supports the conditions for change, but does not confront to avoid defensiveness and resistance (SAMHSA, 2014a).

Categories	Items to Complete
	provide social and behavioral support to stop using tobacco. ☐ Prescription tobacco-dependence medications and/or nicotine replacement therapies (NRT). ☐ Referrals to Quitlines or other cessation resources. ☐ Incentives for tobacco cessation compliance (if possible).
Step	**9. Assess / Evaluate Program**
Objective	☐ Use data to determine program progress and outcomes and to make program improvements.
Core Principles	☐ Collect data regularly on each patient, including documenting all interventions, and compare outcomes with baseline data to determine increased tobacco use quit attempts, abstinence, and cessation in the targeted population. ☐ Determine what works and what does not work for implementing the PHS Guideline and employing the implementation process steps in a particular clinic situation.
Basic Activities to Get Started	☐ Analyze collected program data to answer evaluation questions laid out in Step 3. ☐ Report analysis to share both positive and negative findings with providers, administrators, and others who are a part of the process. ☐ Obtain feedback from those participating in the program about changes or improvements that need to be made based on the data results.
Step	**10. Act on Results to Make Improvements**
Objective	☐ Improve the program based on evaluative results.
Core Principles	☐ Use the data and feedback from participants to determine where change and improvements are needed.
Basic Activities to Get Started	☐ Make identified changes and improvements in the program. Such changes may range from revising a data collection form, to providing additional training, to working with pharmacists to change formularies. Any aspect of the program should be considered open for improvement if data and participant feedback determine that changes are desirable.

Tobacco Counseling Practices

This questionnaire asks about the integration of tobacco cessation advice into your clinic, and how effective you perceive your clinic's current tobacco cessation efforts to be.

1. What percentage of <u>your</u> patients do you think are <u>tobacco users</u>? (please write in your answer, or indicate that you do not see this age group.)

8-12 year olds	%
13-17 year olds	%
Adults (18 or older)	%

2. In 1996, a national guideline for the treatment of tobacco use was first released by the Agency for Health Care Policy and Research (AHCPR), called the Clinical Practice Guideline for Smoking Cessation. An updated guideline, Treating Tobacco Use and Dependence, was released by the Public Health Service (PHS) in 2000 and a third updated version of the guideline was released in 2008. (ie. Ask, Advise, Assess, Assist, Arrange follow-up).

   What best describes your level of awareness of these national guidelines for tobacco cessation? (Please check one):

   ___I am not aware of either guideline
   ___I am aware of one or both guidelines, but have not reviewed either
   ___I have briefly reviewed one or both guidelines
   ___I have reviewed one or both guidelines in depth

3. How interested are you in receiving training in tobacco prevention/cessation? (please circle your answer)

Very Uninterested 1	Somewhat Uninterested 2	Neither Interested nor Uninterested 3	Somewhat Interested 4	Very Interested 5

4. Has your clinic made any changes in tobacco prevention/cessation counseling in the last 12 months? (please circle your answer)

   1. No
   2. Yes, we are counseling more
   3. Yes, we are counseling less

5. Which of the following describes your plans regarding tobacco prevention/cessation counseling in your clinic?

   1. I don't see a need to change tobacco prevention/cessation counseling in my clinic.
   2. I am seriously thinking about ways to improve tobacco prevention/cessation counseling in my clinic in the next year.
   3. I am planning to make significant changes to improve tobacco prevention/cessation counseling in my clinic in the next 6 months.

6. How interested are you in having more tobacco prevention counseling/cessation services available in your clinic? (please circle your answer)

Very Uninterested 1	Somewhat Uninterested 2	Neither Interested nor Uninterested 3	Somewhat Interested 4	Very Interested 5

7. How difficult do you think it would be to integrate more tobacco prevention/cessation services into your clinic? (please circle your answer)

Very Difficult 1	Somewhat Difficult 2	Not Very Difficult 3	Not Difficult At All 4

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Source: www.healthcarepartnership.org

8. How much do you agree or disagree with each of the following statements? (please circle your answer)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
It is the role of the health provider to assist patients to stop using tobacco.	1	2	3	4	5
It is the role of the health provider to help prevent adolescents from starting to use tobacco products.	1	2	3	4	5
Advice given by a physician has more impact on patient behavior than advice given by other health care staff, such as a nurse or health educator.	1	2	3	4	5
The health provider's time can be better spent doing things other than trying to reduce tobacco use in patients.	1	2	3	4	5
Health care providers should receive training on ways to help their patients who use tobacco to stop.	1	2	3	4	5
Health care providers should receive training on ways to encourage their adolescent patients who show no signs of tobacco use to never start tobacco use.	1	2	3	4	5
There are better places for tobacco prevention than the doctor's office.	1	2	3	4	5
Physicians don't have time to provide tobacco counseling.	1	2	3	4	5
The clinic may lose patients if the health care providers give tobacco advice.	1	2	3	4	5
Tobacco advice might offend young patients or their parents.	1	2	3	4	5
There is no place to send patients who need help with tobacco cessation.	1	2	3	4	5
I don't have adequate skills to discuss tobacco with patients.	1	2	3	4	5
Tobacco cessation counseling is more effective if combined with pharmacotherapy.	1	2	3	4	5
Most tobacco users can stop without help if they really want to.	1	2	3	4	5

9. Please circle **True** or **False** for each of the following statements.

T	F	The amount of weight a person is likely to gain from quitting smoking is a minor health risk as compared to the risk of continued smoking.
T	F	Any smoking (even a single puff) increases the likelihood of full relapse.
T	F	Withdrawal typically peaks within 1-3 weeks after quitting.
T	F	In general, tobacco users trying to quit should be given pharmacotherapy.
T	F	The nicotine patch is safe and has been shown not to cause cardiovascular problems.
T	F	Tobacco dependence pharmacotherapies may be safely used long-term (i.e. 6 months or more).
T	F	The more tobacco cessation counseling a person receives the more likely he/she is to quit and remain abstinent.
T	F	Most people make repeated quit attempts before they are successful.

The following questions will help us characterize the participants in this survey. (please circle your answer)

10. Which of the following most closely describes <u>your</u> use of tobacco?(Circle all that apply)

1. Never used tobacco
2. Ex-smoker, cigarette
3. Ex-smoker, cigar or pipe
4. Ex-smokeless tobacco user
5. Current cigarette smoker
6. Current cigar or pipe smoker
7. Current smokeless tobacco user

11. What is your professional degree?

1. M.D.
2. D.O.
3. Dentist
4. N.P.
5. P.A.
6. R.N.
7. L.P.N.
8. CMA
9. Health educator
10. Administrator
11. Other (please specify)_____

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Source: www.healthcarepartnership.org

12. What is your **primary** clinical specialty? (Check one)
___Not Applicable
___Family Practice
___Internal Medicine
___General Practice
___OB/Gyn
___Pediatrics
___Other (please specify):_____

13. What year did you graduate from school for the degree above?

19_____

14. In what year were you born? _____

15. What is your gender?
1. male
2. female

16. What types of training in tobacco dependence and treatment have you received? (Check all that apply):

___Never had tobacco-specific education or training
___Medical or health professional training included curriculum on tobacco use
___Attended a lecture on tobacco use and approach to treatment.
___Participated in a training or conference on tobacco use treatment strategies.
___Received specific training on how to counsel smokers on quitting
(e.g. skills training with demonstrations, role play, etc.)
___Interaction or office visit by a pharmaceutical company representative
___Other (please specify)_____

NON-HEALTH CARE PROVIDERS STOP HERE
Thank you very much for your time!

18. How do you usually find out that a patient uses tobacco? (circle all that apply)

1. Patient volunteers information
2. Information is on the encounter form
3. Parent or relative volunteers information
4. You ask the patient if he/she uses tobacco
5. You can't tell if a patient uses tobacco
6. Other (please describe)_____

19. In the past 12 months, in about what percentage of your encounters with <u>patients you had not seen before</u> did you ask the patient whether or not he/she used tobacco? (please circle your answer)

8-12 year olds	Don't see this age group	None (0%)	1-25%	26-50%	51-75%	76-100%
13-17 year olds	Don't see this age group	None (0%)	1-25%	26-50%	51-75%	76-100%
Adults (18 or older)	Don't see this age group	None (0%)	1-25%	26-50%	51-75%	76-100%

20. In the past 12 months, in about what percentage of your encounters with <u>continuing patients</u> did you ask the patient whether or not he/she used tobacco? (please circle your answer)

8-12 year olds	Don't see this age group	None (0%)	1-25%	26-50%	51-75%	76-100%
13-17 year olds	Don't see this age group	None (0%)	1-25%	26-50%	51-75%	76-100%
Adults (18 or older)	Don't see this age group	None (0%)	1-25%	26-50%	51-75%	76-100%

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Source: www.healthcarepartnership.org

21. In the last 12 months, of all your encounters with patients who use tobacco, during what percentage did you counsel the patient to stop use? (please circle your answer)

8-12 year olds	Don't see this age group	None (0%)	1-25%	26-50%	51-75%
13-17 year olds	Don't see this age group	None (0%)	1-25%	26-50%	51-75%
Adults (18 or older)	Don't see this age group	None (0%)	1-25%	26-50%	51-75%

22. During the past 12 months, when you counseled a patient about stopping tobacco use, about how long did you spend on average? (please circle your answer)

1. Did not discuss
2. Less than 1 minute
3. 1-2 minutes
4. 3-5 minutes
5. 6-9 minutes
6. 10 minutes or more

23. In the last 12 months, when you counseled a patient to stop tobacco use, how often did you: (please circle your answer)

	Never / Not Possible	Sometimes	About Half the Time	Often	Usually or Always
Advise setting a specific "stop" date?	1	2	3	4	5
Determine if tobacco using patients were interested in stopping (assess motivation)?	1	2	3	4	5
Identify patient's reasons for smoking or quitting, or discuss prior quit attempts (assess pros and cons, barriers)?	1	2	3	4	5
Call or have a staff member call the patient a week after the stop date?	1	2	3	4	5
Prepare the patient for withdrawal symptoms?	1	2	3	4	5
Prescribe a nicotine patch or gum?	1	2	3	4	5
Provide self-help materials?	1	2	3	4	5
Refer the patient to a nicotine treatment program?	1	2	3	4	5

24. Please identify all nicotine treatment services to which you regularly referred patients in the last 12 months? (Check all that apply):

___Never referred patients
___Alaska "Quit" Line
___National "Quit" Line
___A regional nicotine treatment program
___Nicotine treatment services provided by me or my staff
___Other (please specify)_____

25. How effective do you feel the nicotine treatment services in #23 were in helping your patients to stop using tobacco? (please circle your answer)

Very Ineffective 1	Somewhat Ineffective 2	**Did not refer patients to nicotine treatment** 3	Somewhat Effective 4	Very Effective 5

26. How confident are you in your ability to… (please circle your answer)

	Not at all confident	Not very confident	Somewhat confident	Quite confident	Very confident
Prevent children from starting to use tobacco products.?	1	2	3	4	5
Motivate tobacco users to consider stopping?	1	2	3	4	5
Help tobacco users who are interested to stop?	1	2	3	4	5
Prescribe medications for patients trying to stop tobacco use?	1	2	3	4	5

Thank you very much for your time!

Please return this questionnaire to: _____

Source: www.healthcarepartnership.org

Tobacco Use Questionnaire

ALASKA NATIVE MEDICAL CENTER

Your Address:_____City:_____ State:___ Zip:_____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

Best time to contact you:_____(am pm) Best # to contact you: ❑Home # ❑ Work # ❑ Cell # Is it Okay to leave a message? ❑ Yes ❑ No

Birth Date: ___/___/___ Gender: ❑ Male ❑Female

Race: ❑ Alaska Native ❑ Native American ❑ Asian or Pacific Islander ❑ Black/African American ❑ Caucasian ❑ Hispanic or Latino ❑ Other

Name of provider:_____

Number of tobacco users in your home: _____

Please circle the highest school grade you have completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

What is your work status? Unemployed Retired Disabled Full time Part time Housewife or Househusband

Please tell us about the types of tobacco you use by filling out the table:

	Cigarettes	Chew (Like Copenhagen)	Tobacco & Ash	Pipe	Cigar
Have you ever used this product?	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
How much tobacco do you currently use?	____cigarette a day	_____cans per week _____ chew per/day	_____cans per/ week _____ chew per/day mix in mouth ❑Yes ❑No	_____times a day	_____times a day
How many years used?	_____years	_____years	_____years	_____years	_____years

1. Are you planning to stop using tobacco? (Please check only one)

a. ❑Yes, I've already stopped
b. ❑Yes, plan to stop today
c. ❑Yes, in the next 30 days.
d. ❑ Yes, within the next 6 months.
e. ❑ Not sure
f. ❑ No, I'm not planning to stop for good

Are you currently pregnant? ❑ No ❑ Yes If Yes, Please complete the following questions…

1. When is your baby due: _____/_____/_____
2. Why are you seeing a Nicotine Dependence Treatment Counselor? *(Check all that apply)*
   - ❑ I wanted to talk to someone about tobacco use ❑ My provider referred me to the Nicotine Dependence Treatment Program
   - ❑ My family wanted me to join the Nicotine Dependence Treatment Program ❑ Uncertain
3. What is your main concern about using tobacco during your pregnancy?
   - ❑ I am concerned that my baby will be born too early
   - ❑ I am concerned that my baby may be addicted to tobacco
   - ❑ I am concerned my baby will be underweight
   - ❑ I am concerned about having an unhealthy baby
   - ❑ I do not have any concern
4. After learning you were pregnant, have you changed the type of tobacco you use?
   - ❑Yes, I switched from cigarettes to commercial chew
   - ❑ Yes, I switched from cigarettes to Ash mixed with Tobacco (Iqmik, Blackbull, or Dediguss)
   - ❑ Yes, I switched from commercial chew to Ash mixed with Tobacco (Iqmik, Blackbull, or Dediguss)
   - ❑ Yes, I switched from chew to cigarettes
   - ❑ No, I did not make any changes in the type of tobacco I use
5. After learning you were pregnant, did you change how much tobacco you use?
   - ❑ Yes, I **increased** how many cigarettes or chews per day I use
   - ❑ Yes, I **decreased** how many cigarettes or chews per day I use
   - ❑ Yes, I **quit** using tobacco
   - ❑ Yes, I am **trying to quit** tobacco
   - ❑ No, I did not make any changes in how much tobacco I use
6. What kind of information would you like about tobacco use? *(Check all that apply)*
   - ❑ Tobacco use and Pregnancy ❑ Tobacco use and Children
   - ❑ Tobacco use and Breast Feeding ❑ General Information about Tobacco Addiction
   - ❑ I do not want any information
7. How would you like to receive this information? *(Check all that apply)*
   - ❑ Brochures ❑ Meet with a Nicotine Dependence Treatment Counselor
   - ❑ Video ❑ Phone Call ❑ I do not want to receive any information
8. Have you had other pregnancies?
   - ❑ Yes ❑ No If yes, did you use tobacco during the pregnancy? ❑ Yes ❑ No

Name:
Chart #:
DOB: Counselor Signature: Date:

Source: www.healthcarepartnership.org

2. Have you ever had or currently have any of the following? *(Check all that apply)*

❑ Seizures	❑ Peptic Ulcer Disease	❑ Peripheral vascular disease	❑ Mouth Sores
❑ Head injury	❑ Diabetes	❑ Coronary artery disease	❑ Shortness of breath
❑ Eating disorders	❑ Skin allergy or sensitivities	❑ Stroke	❑ Cancer
❑ Alcohol withdrawal	❑ Emphysema or chronic bronchitis	❑ Asthma	❑ High blood pressure
			❑ Cough

3. Do you have a history of depression? ❑ Yes ❑ No

4. Do you have a history of anxiety? ❑ Yes ❑ No

5. Have you ever used alcohol? ❑ Yes ❑ No
If Yes: Do you currently use Alcohol? ❑ Yes ❑ No
How many drinks per week on average do you have?
Drinks _____a **week** (one drink = one beer, one glass of wine, one shot alcohol)

6. Have you received treatment for alcohol or other drug dependency? ❑ Yes ❑ No
If Yes: Are you currently receiving treatment for this condition? ❑ Yes ❑ No
Have you been sober and/or drug free for a year or more? ❑ Yes ❑ No

7. Have you tried to stop using tobacco before today? ❑ Yes ❑ No... if "No" please go to question # 8

How many times have you tried to stop using tobacco? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 or more times
What is the longest you have gone without using tobacco? _____ *(days, weeks, months, or years)*
Which of these symptoms have you had when you've tried to stop using tobacco? *(Check all that apply)*

❑ Cravings for tobacco	❑ Anxiety	❑ Restlessness	❑ Eating more
❑ Trouble concentrating	❑ Depression	❑ Frustration	❑ Trouble sleeping
❑ Grouchiness/irritability	❑ None of these	❑ Other: _____	

When was the last time you tried to stop using tobacco?

❑ Less than 1 month ago	❑ 7 to 12 months ago	❑ More than 5 years ago
❑ 1 to 6 months ago	❑ More than 12 months ago	❑ More than 10 years ago

What made you start again? _____

How have you tried to stop in the past? *(Check all that apply)*

❑ Nicotine gum	❑ Nicotine patch	❑ Quitting "cold turkey"	❑ Group counseling
❑ Zyban/ Wellbutrin pills	❑ Nicotine lozenge	❑ Individual counseling	❑ Nicotine Nasal Spray
❑ Nicotine inhaler	❑ Hypnosis	❑ Being in jail	❑ Acupuncture
❑ Being in the hospital	❑ Herbals: Type _____	❑ Cutting down gradually	❑ Other: _____
	❑ Chantix		

If you used a nicotine replacement or Zyban, did you have side effects? ❑ Yes ❑ No
If yes, what product(s) and what side effect(s)? _____

8. What is your main reason for wanting to stop using tobacco? *(Check all that apply)*

❑ Health Reasons	❑ To Save Money	❑ To be a Positive Role Model
❑ Live Longer	❑ Protect the health of others	❑ Other(s):_____

9. When do you use tobacco? *(Check all that apply)*

❑ When feeling stressed	❑ When wanting to cheer up	❑ When drinking coffee, tea or soda
❑ When feeling anxious	❑ When bored	❑ When wanting something in your mouth
❑ After meals	❑ When At work	❑ When hunting or fishing
❑ When relaxing	❑ When drinking	❑ When around other users

10. Does anyone in your family have a tobacco-related disease? ❑ No ❑ Yes, what disease(s) _____

11. What is the biggest obstacle you face in stopping tobacco use?_____

12. Are you under a lot of stress now? ❑ Yes ❑ No
If yes, from what? _____

13. Where did you hear about our program? _____

Name:
Chart #:
DOB: **Counselor Signature:** **Date:**

Source: www.healthcarepartnership.org

(This shaded area to be completed by the Counselor)
Chart #_____

ou smoke cigarettes:

How soon after you wake up do you smoke your first cigarette?
- ☐ Within 5 minutes 3
- ☐ 6 to 30 minutes 2
- ☐ 31 to 60 minutes 1
- ☐ After 60 minutes 0

Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in public buildings?
- ☐ Yes 1
- ☐ No 0

Which cigarette would you hate most to give up?
- ☐ The first one in the morning 1
- ☐ Any other 0

How many cigarettes per day do you smoke?
- ☐ Less than 10 0
- ☐ 11 to 20 1
- ☐ 21 to 30 2
- ☐ More than 31 3

Do you smoke more frequently during the first hours after waking than during the rest of the day?
- ☐ Yes 1
- ☐ No 0

Do you smoke if you are so ill that you are in bed most of the day?
- ☐ Yes 1
- ☐ No 0

15. If you chew or use ash mixed with tobacco:

How soon after you wake up do you put in your first chew/ash mixed with tobacco?
- ☐ Within 5 minutes 3
- ☐ 6 to 30 minutes 2
- ☐ 31 to 60 minutes 1
- ☐ After 60 minutes 0

Do you intentionally swallow tobacco juices?
- ☐ Never 0 ☐ Sometimes 1 ☐ Always 2

Which chew/ash mixed with tobacco would you hate most to give up?
- ☐ The first one in the morning 1
- ☐ Any other 0

How many cans of chew/ash mixed with tobacco do you use a week?
- ☐ More than 3 3
- ☐ 2 – 3 2
- ☐ 1 – 2 1
- ☐ Less than 1 0

Do you chew more frequently during the first hours after waking than during the rest of the day?
- ☐ Yes 1
- ☐ No 0

Do you use chew when you are so ill that you are in bed most of the day?
- ☐ Yes 1
- ☐ No 0

Please give this questionnaire to the counselor

(This area is to be completed by the Counselor) **I =** **C =**

Chart #_____ ❑ **Self Referral** ❑ **Provider Referral** ❑ **Specialty Clinic**_____ ❑ **Other**_____

Target Quit Date:_____/_____/_____

Readiness Level: ❑ Pre-contemplator (>6mo) ❑ Contemplator (1-6mo) ❑ Preparation (<1mo) ❑ Action (qt1-6mo) ❑ Maintenance (qt 6mo+)

Fagerstrom score: _____ (SMOKE) _____ (CHEW/IQMIK) **Counselor:**_____ **CO level:**_____

(< 4 = nicotine dependent; > 6 = highly nicotine dependent)

Employer: ❑ ANTHC ❑ SCF ❑Other_____ **Type of Employee:** ❑ Beneficiary ❑ Non-Beneficiary

Employment Classifications: ❑ Direct Hire ❑ Commissioned Corp ❑ Civil Services

Employment Type: ❑ Regular Full-Time ❑ Regular Part-Time ❑ Part Time ❑Temporary ❑ Intermittent

Name:
Chart #:
DOB: **Counselor Signature:** **Date:**

Source: www.healthcarepartnership.org

Tobacco Treatment Follow-up Data Collection Form

Quit date: _____ ❑ Quit Date ❑ 1 Wk ❑ 2 Wk ❑ 3 Wk ❑ 6 Wk ❑ 12 Wk ❑ 26 Wk ❑ 52 Wk ❑ Other

Call	Call Time	Date	Counselor	Contact Type		No Contact	Refused service	Left Msg	No Answer or Busy	Disconnected or wrong #
				phone	In person					
1	am pm			☑	❑	❑	❑	☑	❑	❑
2	am pm			❑	❑	❑	❑	❑	❑	❑
3	am pm			❑	❑	❑	❑	❑	❑	❑
4	am pm			❑	❑	❑	❑	❑	❑	❑

(1) **Have you used tobacco since your quit date?** ❑Yes ❑No… *check the "No" on Q#4 and proceed*

(2) **If "Yes" what has been the frequency of use?** ❑One time ❑a few times ❑weekly ❑daily

(3) **If answered "daily" how many times a day are you currently using tobacco?** ("Can" means Copenhagen size can)

Cigarettes _____/day; Chew (Copenhagen type) _____cans/week; Tobacco/Ash _____cans/week; Other_____/day

(4) **Has client used ANY tobacco in the last seven days?** ❑Yes ❑No
(5) **Has the client used ANY tobacco in the last 30 days?** ❑Yes ❑No

❑No ⇩

If client is in action or maintenance stage:
(1) Compared to how you felt when you were using tobacco, how have you felt physically since quitting?

❑Much better ❑Better ❑Same ❑Worse ❑Much worse

(2) Withdrawal symptoms? *(Check all that apply)*
❑ Cravings ❑ Anxiety
❑ Restlessness ❑ Increased eating
❑ Difficulty concentrating ❑ Irritability
❑ Other _____
(3) Have you gained or lost weight? ❑ Gained ❑ Lost
(4) Amount_____ On a scale of 1–10 **how concerned** are you about weight gain? _____
(Check "Action" or "Maintenance" in Q#6 then ask Q#7)

❑Yes ⇩

If client is currently using tobacco:
On a scale of 1 – 10
(1) **How important** is it for you to quit? _____
(2) **How confident** are you that you **can** quit? _____
(3) When would you be seriously ready to set a quit date and start again?
❑ ASAP
❑ Next 7 days
❑ < 30 days
❑ In 1 to 6 months
❑ Not Sure

Restart Quit Date_____

Number of estimated relapses since initial quit date? _____

(6) **Readiness:** ❑Precontemplation (Ready in more than 6mos) ❑Contemplation (Ready in 1-6 mos) ❑Preparation (Ready in 30 days or less) ❑Action (Quitting 0-6mo) ❑Maintenance (quit for at least 6 months or more)

(7) **Have you used any medication or cessation aids?** ❑Yes (fill in box below) ❑No

Medications	Start date	Stop date	Dosage	Side effects	Details/ Medication Comments
❑ Bupropion SR			❑ 1x/day ❑ 2x/day	❑ Y ❑ N	
❑ Varenicline			❑ 1x/day ❑ 2x/day	❑ Y ❑ N	
❑ Nicotine Patch			❑ 7mg ❑ 14mg ❑ 21mg ❑____mg	❑ Y ❑ N	
❑ Lozenge			❑ 2mg _____/day =____mg	❑ Y ❑ N	
❑ Gum			❑ 2mg _____/day =____mg	❑ Y ❑ N	

(8) **On a scale of 1 to 10 how helpful has the use of these aides been to you?** _____
(9) **On a scale of 1 to 10 how helpful has this program been to you?** _____

❑ Contacted ❑ Inactive
❑ Not Contacted
❑ Re-activation request

Comments: _____

Patients Name:
Chart #:
DOB: Signature Date

Source: www.healthcarepartnership.org

you quit two quit

CLIENT IDENTIFICATION INFORMATION
CLIENT IDENTIFICATION INFORMATION
CLIENT IDENTIFICATION INFORMATION

PRENATAL FIVE As INTERVENTION RECORD

Date of First Visit: ____/____/_____

English-speaking clients: ASK client to choose the statement that best describes her smoking status

Write the letter in the box ☐

A. I have **NEVER** smoked or have smoked less than 100 cigarettes in my lifetime.
B. I stopped smoking **BEFORE** I found out I was pregnant and am not smoking now.
C. I stopped smoking **AFTER** I found out I was pregnant, and I am not smoking now.
D. I smoke some now, but have cut down since I found out I am pregnant.
E. I smoke about the same amount now as I did before I found out I was pregnant.

Spanish-speaking clients: ASK client to " Indique su situación actual con respecto a fumar:"

Write the letter in the box ☐

A. Yo **NUNCA** he fumado, o he fumado MENOS DE 100 cigarrillos en toda mi vida.
B. Yo dejé de fumar **ANTES** de dar cuenta que estaba embarazada, y no fumo ahora.
C. Yo dejé de fumar **DESPUES** de dar cuenta que estaba embarazada, y no fumo ahora.
D. Yo fumo un poco ahora, pero he reducido la cantidad de cigarrillos que fumo desde que me dio cuenta que estaba embarazada.
E. Yo fumo la misma cantidad que antes de dar cuenta que estaba embarazada.

ADVISE - Clear, strong, personalized advice to quit - Note benefits for woman & whole family – 1st Visit

Advised client to quit or stay quit ☐

ASSESS - Assess willingness to quit in next 30 days - check boxes and enter dates where appropriate

Enter date of visit	1st visit / /	2nd / /	3rd / /	4th / /	5th / /	6th / /	7th / /	8th / /	9th / /
NOT READY TO QUIT (If checked **CONTINUE to ARRANGE**)	☐	☐	☐	☐	☐	☐	☐	☐	☐
READY TO QUIT (DATE)	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Quit since last visit (DATE)		/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Still smoking		☐	☐	☐	☐	☐	☐	☐	☐
Relapsed		☐	☐	☐	☐	☐	☐	☐	☐
Stayed Quit		☐	☐	☐	☐	☐	☐	☐	☐

ASSIST - For those who are **ready to quit**, provide pregnancy-specific counseling and information

Used a problem-solving method (i.e. identify triggers/support systems)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Assessed social environment (with whom/where do they smoke?)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Provided pregnancy-specific materials	☐	☐	☐	☐	☐	☐	☐	☐	☐
Provided Quit Kit (give name and date to coordinator)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Referred to Quit Line (check box, fill out referral form and fax)	☐	☐	☐	☐	☐	☐	☐	☐	☐

ARRANGE - Inform client you will talk further about cessation/staying quit at next visit

Arranged (check box when complete)	☐	☐	☐	☐	☐	☐	☐	☐	☐

PROVIDER INITIALS: _____ _____ _____ _____ _____ _____ _____ _____ _____

NOTES:

Developed by Smoke-Free Families with the support of The Robert Wood Johnson Foundation

Source: http://youquittwoquit.com/

CLIENT IDENTIFICATION INFORMATION
CLIENT IDENTIFICATION INFORMATION
CLIENT IDENTIFICATION INFORMATION

you quit two quit

POST-PARTUM FIVE As INTERVENTION RECORD

DATE: ___/___/___

ASK client to choose the statement that best describes her smoking status (Indique su situación actual con respecto a fumar)

Write the letter in the box

A. I have **NEVER** smoked or have smoked less than 100 cigarettes in my lifetime.	Yo **NUNCA** he fumado o he fumado menos que 100 cigarrillos en todo de mi vida.
B. I stopped smoking **BEFORE** I found out I was pregnant and am not smoking now.	Yo dejé de fumar **ANTES** de que dió cuenta que estaba embarazada y todavia No Estoy fumando.
C. I stopped smoking **AFTER** I found out I was pregnant, and I am not smoking now.	Yo dejé de fumar **DESPUES** que dió cuenta que estaba embarazada y todavia No Estoy fumanda.
D. I stopped smoking during pregnancy, but I am smoking now.	Yo dejé de fumar durante mi embarazo pero estoy fumando ahora.
E. I smoked during pregnancy, and I am smoking now.	Yo fumé durante mi embarazo y continuo de fumar.

ASK client about second hand smoke

	Circle			Circle	
Mother (if the mother smokes)					
a. Does the child's mother currently smoke in the **home**?	**Y**	**N**	in the **car**?	**Y**	**N**
Father					
a. Does the child's father smoke?	**Y**	**N**			
b. Does the child's father currently smoke in the **home**?	**Y**	**N**	in the **car**?	**Y**	**N**
Others					
a. Is the child exposed to tobacco smoke on a regular basis (any exposure at least 1 time per week) from anyone other than the parents?				**Y**	**N**

ADVISE - Clear, strong, personalized advice to quit - Note benefits for woman & whole family

Advised client to quit or stay quit ☐

ASSESS - Assess willingness to quit in next 30 days - check boxes and enter dates where appropriate

NOT READY TO QUIT (If checked **CONTINUE to 5 Rs**)	☐
READY TO QUIT (ENTER PLANNED QUIT DATE)	/ /

ASSIST - For those who are **ready to quit**, provide parenting-specific counseling and information

Used a problem-solving method (i.e. identify triggers/support systems)	☐
Assessed social environment (with whom/where do they smoke?)	☐
Provided parent-specific materials (e.g. *You Quit, Two Quit* and *Oh Baby!* booklets)	☐
Provided Quit Kit	☐

ARRANGE – Arrange for follow-up via NC Quitline or healthcare provider

Referred to Quit Line **(check box, fill out referral form and fax)**	☐
Referred to provider for Rx or additional assistance	☐

5 Rs – Engage the 5 Rs with patients who are **not ready to quit**

Relevance: Encourage the patient to indicate why quitting could be personally relevant.	☐
Risks: Ask the patient to identify potential negative consequences of tobacco use	☐
Rewards: Ask the patient to identify potential benefits of stopping tobacco use	☐
Roadblocks: Ask the patient to identify barriers or impediments to quitting. Note elements of treatment (problem solving, pharmacotherapy) that could address barriers	☐
Repetition: If possible, repeat motivational approach next time you come into contact with patient	

Based on a form developed by Smoke-Free Families with support from The Robert Wood Johnson Foundation

Source: http://youquittwoquit.com/

Fagerstrom Test for Nicotine Dependence *

Is smoking "just a habit" or are you addicted? Take this test and find out your level of dependence on nicotine.

1. How soon after you wake up do you smoke your first cigarette?
- ♦ After 60 minutes (0)
- ♦ 31-60 minutes (1)
- ♦ 6-30 minutes (2)
- ♦ Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?
- ♦ No (0)
- ♦ Yes (1)

3. Which cigarette would you hate most to give up?
- ♦ The first in the morning (1)
- ♦ Any other (0)

4. How many cigarettes per day do you smoke?
- ♦ 10 or less (0)
- ♦ 11-20 (1)
- ♦ 21-30 (2)
- ♦ 31 or more (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?
- ♦ No (0)
- ♦ Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?
- ♦ No (0)
- ♦ Yes (1)

* Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom KO. The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. British Journal of Addictions 1991;86:1119-27

(continued on the following page)

Fagerstrom Test for Nicotine Dependence Score Sheet and Interpretation

Your score was:_____

Your level of dependence on nicotine is:

0-2 Very low dependence
3-4 Low dependence
5 Medium dependence
6-7 High dependence
8-10 Very high dependence

Scores under 5: "Your level of nicotine dependence is still low. You should act now before your level of dependence increases."

Score of 5: "Your level of nicotine dependence is moderate. If you don't quit soon, your level of dependence on nicotine will increase until you may be seriously addicted. Act now to end your dependence on nicotine."

Score over 7: "Your level of dependence is high. You aren't in control of your smoking– it is in control of you! When you make the decision to quit, you may want to talk with your doctor about nicotine replacement therapy or other medications to help you break your addiction."

Pharmacotherapy for Tobacco Cessation

Counseling and medication are effective when used by themselves for treating tobacco dependence; however, counseling and medication used together is more effective than either alone.[1] Several effective medications are available to help treat tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking–except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).[1]

Medication	Trade Name	Schedule	Side Effects	Length of Treatment	Cost	Additional Information
Nicotine-Based Agents						
Nicotine Patches	Over the counter (OTC)	21 mg first 4 weeks 14 mg for 2 weeks 7 mg last 2 weeks	-Local skin reactions -Insomnia -Vivid dreams	8-12 weeks	$35/14 patches	The largest patch (21 mg) equals ~3/4 pack of cigarettes per day. Depends on nicotine content of cigarette.
	Nicoderm CQ (OTC)	21 mg first 6 weeks 14 mg for 2 weeks 7mg last 2 weeks		8-12 weeks	$50/14 patches	
Nicotine Nasal Spray	Nicotrol NS (Prescription)	2 sprays = 1 mg (1/nost) = 1 dose 1-2 doses/hr max: 5 doses/hr 40 doses/day	-Nasal irritation	3-6 months	$45/10 ml bottle (10 mg in 10 ml)	Patients with nasal or sinus problems, allergies or asthma should avoid using this product.
Nicotine Gum	Nicorette 2mg (OTC)	1-24 cigarettes/day = 9-12 pieces/day (2 mg/piece) max 24	-Mouth soreness -Upset stomach	4-6 months	Brand: $54/100 $33/40 Generic: $39/110 $23/50	Each piece, 2 and 4 mg, delivers about 50% of its nicotine. White Ice Mint, Cinnamon Surge, Fruit Chill, Fresh Mint, Mint and Original
	Nicorette 4 mg (OTC)	>25 cigarettes/day = 9-12 pieces/day (4 mg/piece) max 24		4-6 months		
Nicotine Oral Inhaler	Nicotrol Inhaler (Prescription)	6-16 cartridges/day	-Local mouth & throat irritation	8-12 weeks	$45/42 cartridges ~$180/month	May assist patients with handling component.
Nicotine Lozenges	Nicorette (OTC)	One piece every: 1-2 hrs (weeks 1-5) 2-4 hrs (weeks 7-9) 4-8 hrs (weeks 10-12)	-Sore throat -Heartburn -Hiccups -Nausea	12 weeks	$41/72 $30/48	Time to first cigarette dosing: less than 30 minutes use 4 mg, greater than 30 minutes use 2 mg. Original, Mint and Cherry
Nicotine Mini Lozenges	Nicorette Mini Lozenges	Same as above	Same as above	Same as above	——	Breath mint-sized lozenges. Mint dissolves up to three times faster.
Non-Nicotine: First Line FDA Approved Agents						
Bupropion	Zyban/Wellbutrin (Prescription)	150 mg once daily in the AM for 3 days then twice daily with second dose 8 hrs after first	-Insomnia -Dry mouth	2-3 months	$70/month $36/34 tablets (Walmart)	Helps minimize withdrawal symptoms. Black Box Warning: mood change
Varenicline	Chantix (Prescription)	0.5 mg once daily for 3 days then 0.5 mg BID for 4 days, then 1 mg BID to end tx.	-Nausea	12 weeks + optional additional 12 weeks	$125/month	Quit date - Tx Day 8-35 Take with food to minimize nausea. Discuss: Cardiovascular Safety Black Box Warning: mood change
Non-Nicotine: Second Line Non-FDA Approved Agents						
Clonidine	Generic Catapress (Prescription)	0.15-0.75 mg per day	-Dry mouth -Dizziness -Sedation	3-10 weeks	~$15/month	Risk: rebound hypertension
Nortriptyline	Generic Pamelor (Prescription)	75-100 mg per day	-Sedation -Dry mouth	12 weeks	~$22/month	Risk: arrhythmias

[1] Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
[2] Koval P. Evidence Based Interventions for Smoking Cessation. Greensboro Area Health Education Center Pharmacy Updates, 2011. Available from: http://www.gahec.org/pharmupd/

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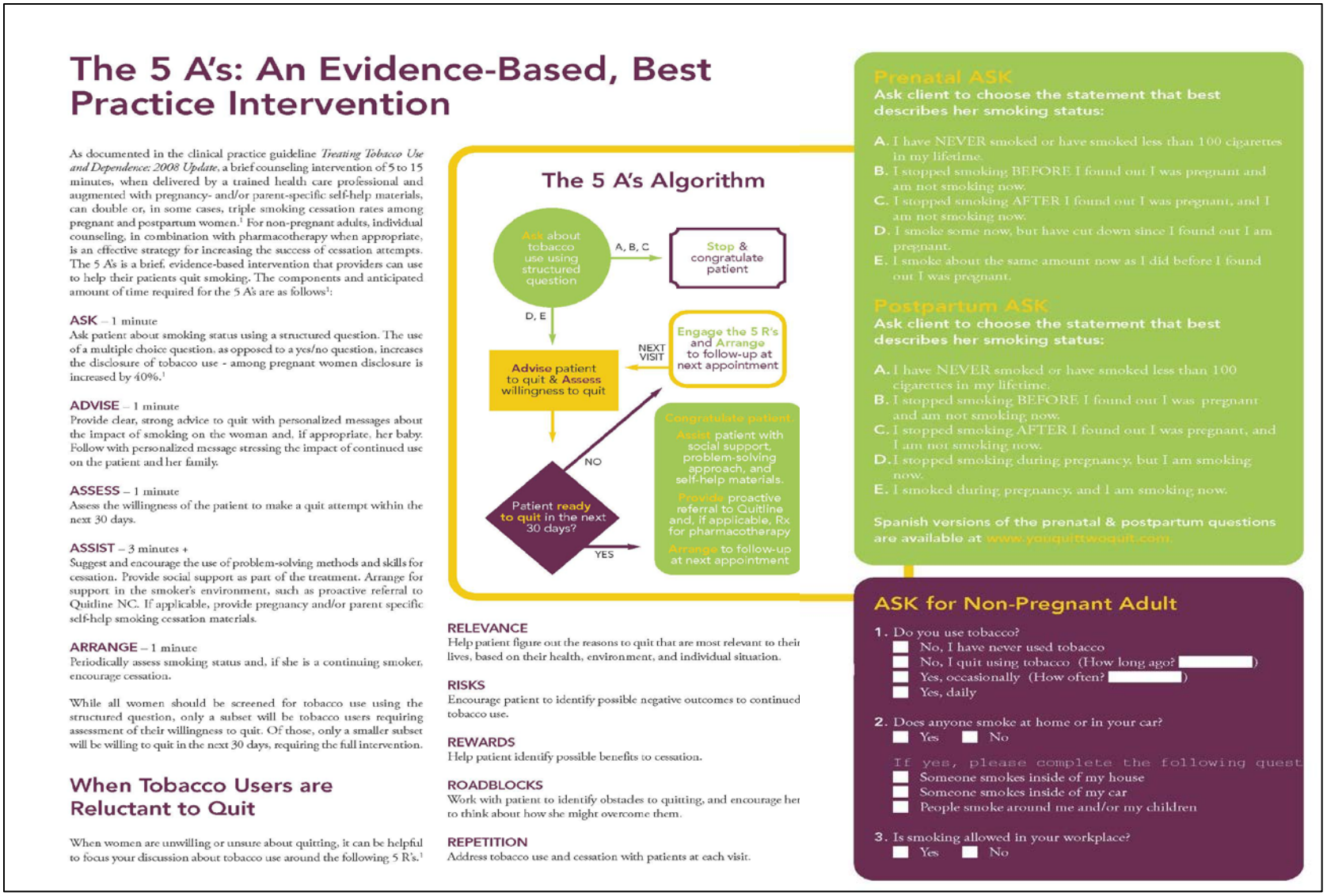

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