



Tobacco Cessation Treatment Guideline

All Team Members: Patient Self-Management Education & Support

For current smokers, quitting tobacco is the single most important action to reduce the risk of bad health outcomes. Although most smokers who attempt to quit are not successful the first time, interventions to promote tobacco cessation are among the most cost-effective in all of medicine.

The benefits of quitting smoking include reduced blood pressure and pulse, improved lung function, reduced risk of heart attacks and strokes, improved taste, reduced smoker's breath, improved circulation, reduced cough, reduced sinus symptoms and shortness of breath, and lower rates of lung and other cancers. Quitting also saves money and improves the health of those exposed to second hand smoke. (Handout: Discover the Benefits of Quitting Smoking)

Most smokers (70%) want to quit and make a quit attempt each year. Multiple quit attempts are often needed for long term success. From each attempt, smokers learn the key supportive factors and barriers to their efforts to quit. The more quit attempts, the higher the likelihood of success. Patients in addiction treatment who quit smoking have improved addiction treatment outcomes compared with those who do not quit, so cessation efforts should not be delayed.

Tobacco use should be assessed at each visit in current or former smokers.

All smokers should be offered the components of a quit plan, including education on the benefits of quitting, behavior change counseling, medication, and close follow up.

- I. All team members can perform elements of a brief intervention for tobacco cessation. Assistance with some parts of a quit plan may require follow up or coordination with other team members.
 - a. Elements of Brief Intervention for Tobacco Cessation
 - i. Ask smokers and recent former smokers about tobacco use at each visit
 - ii. Advice to quit or cut down



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1. Clear, strong, personalized, non-judgmental
 - iii. Assess readiness
 1. “Are you willing to try quitting/cutting down?”
 - iv. For those wanting to quit, Assist with medication and counseling
 - v. If not ready: Empathy, support for future change, telephone quit hotlines
 - vi. Arrange follow up – including close follow up for patients attempting to cut down or quit
- II. Behavior Change Counseling: While the above outlines the entire process of tobacco cessation, it doesn't include behavior change counseling that any team member can do. Specifically, all members of the team can be involved in improving motivation to quit smoking. This is sometimes called Motivational Interviewing. It is accomplished using one or more of the following strategies.
- a. Eliciting “Change Talk.” Behavior change is more likely if patients actually say out loud the good things about quitting and the bad things about smoking.
 - i. Asking “what are your concerns about smoking?” can open a discussion of the benefits of quitting based on the most important concerns of the patient.
 - ii. Following up with open-ended questions (“tell me more about that”), reflection (“so you are worried about...”), and probing (“do you have other concerns?”) can promote further change talk.
 - b. The “Importance” scale.
 - i. “On a scale of 0-10, how important do you think it is to change your...?”
 - ii. Following up with “why is it not less important?”
 - iii. Then using open-ended questions, reflection and probing further promotes change talk.
 - c. Rolling with Resistance. Effective behavior change counseling minimizes “Resistance Talk” by the patient.
 - i. If patients resist behavior change, do not to argue or educate. Instead communicate free choice (“it is up to you whether you quit”).
 - ii. It may be helpful to use gentle paradox (“maybe you will decide not to make a change even though it is costing you.”)
 - iii. Considering smaller changes (cutting down), identifying barriers to quitting, or shifting to a different topic or health issue may help to roll with resistance.

NP/PA

While Behavior Change Counseling can be performed by any team member, the NP should focus on the medication management component. All medications should be used in conjunction with counseling to strengthen the commitment to change behavior (see below). A stepped-care medication approach is recommended. Consider a higher step if a lower step intervention is not successful.

I. Medication Protocol

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- a. Assess level of dependence using the Fagerstrom Nicotine Dependence Scale (<http://www.globaladdiction.org/dldocs/GLOBALADDICTION-Scales-FagerstromNicotineDependenceScale.pdf>)
 - i. Scores of 7 or more should prompt a strong recommendation to use medication as part of a quit attempt.
 - ii. For patients with scores below 5, an attempt with behavior change counseling alone may be reasonable, though medication is still effective.
- b. Assess prior tobacco cessation medication usage and success, including whether a medication was used in conjunction with behavior change counseling or as a sole intervention.
 - i. Consider using nicotine replacement plus behavior change counseling if there was an unsuccessful cessation attempt with nicotine replacement alone.
- c. **Step One:** nicotine replacement therapy (NRT)
 - i. Consider gum alone in patients smoking $\frac{1}{2}$ PPD or less
 1. How to use gum:
 - a. “chew and park”: chew gum a little, and let it sit between the teeth and the inner cheek
 - b. mix with sugar free gum if taste is a problem
 - ii. Lozenges, inhaler and nasal spray are alternatives for low level smokers who cannot use gum
 - iii. Patches are recommended for over $\frac{1}{2}$ PPD or if patients prefer. Dosage depends on quantity of cigarettes.
 1. How to use patch:
 - a. put on at bedtime so it is active on awakening.
 - i. Many patients experience nightmares if they wear the patch to bed. If this occurs, then avoid use at night, and have it by the bedside for use upon awakening in the morning.
 - b. this is especially important in patients with high levels of dependence.
 - iv. Advantages: inexpensive and readily available. Extensive safety data, including for longer term use. No hurry to taper.
 - v. Disadvantages: Gum, lozenge, inhaler and nasal spray may be inadequate for patients with higher level dependence.
 - vi. Note on e-cigarettes: These are products that vaporize a nicotine-containing liquid that is inhaled through a cigarette-shaped device.
 1. There are multiple products, none of which are FDA approved and there are no supporting clinical trials.
 2. The purity of nicotine and contaminants are potential problems for these products, but if patients are having success with one, adding behavior change counseling is a reasonable approach.



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- d. Step Two: multiple nicotine replacement products used together. The patch is used along with gum, lozenge or nasal spray.
- e. Step Three: Combination of NRT and bupropion.
 - i. Bupropion SR is started at 150 mg daily for one week prior to a planned quit date, then increased to 150mg twice daily on the quit date.
 - 1. Take the second dose no later than 3:00 PM to avoid difficulty sleeping.
 - 2. Can also be used without NRT.
 - 3. Consider especially with co-occurring depression.
 - 4. Avoid bupropion if patient has a history of seizures, TBI, or is using cocaine or methamphetamine
 - ii. Advantages: clinical trials favor the combination over NRT alone. Associated with less weight gain.
 - iii. Disadvantages: jitteriness, insomnia.
- f. Step Four: Varenicline.
 - i. Start one week before the planned quit date at 0.5 mg daily for 3 days, then 0.5 mg twice daily for 4 days, then on the quit date, increase to 1 mg twice daily.
 - ii. Not used with the patch.
 - iii. Advantages: Better outcomes than with bupropion alone, but has not been compared with the combination of bupropion and NRT.
 - iv. Disadvantages: Case reports of severe behavioral problems triggered by Varenicline have been submitted, suggesting that Varenicline should be used with caution in patients with a history of severe mental health problems, especially if they are not stable from a mental health perspective.
- g. Step 5: Alternative: nortriptyline
 - i. Start 2-4 weeks before Quit Date at 25mg daily, and increase to dose of 75mg -100mg daily. Many studies used Nortriptyline blood levels to determine dose with a goal of 50-150 ng/mL.

CHW & NP

- I. Behavior Change Counseling (BCC)
 - A. BCC can be divided into two parts, 1) enhancing motivation to change and 2) strengthening commitment to change.
 - a. Enhancing motivation to change is an attempt to tip the balance toward change by encouraging the patient to express the good things about changing and the bad things about not changing. This part of BCC can be performed by any team member (see details above) for patients who want to quit or who are not yet ready to quit.
 - b. Strengthening commitment to change is the part of BCC that occurs after a patient has expressed commitment to quit smoking. It results in a well developed quit plan.

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B. Strengthening Commitment to Change

- a. Discuss a plan rather than reasons to change
 - i. “What will you need in order to quit?”
- b. Elicit the patient’s ideas
 - i. “How do you think you might do that?”
 - ii. “What do you think might help?”
- c. Reflect, summarize, ask whether you can offer other options

C. The Confidence Scale

- a. “On a scale of 0-10, how confident are you that you could make this change?”
- b. “Why are you not less confident?” encourages expression of self-efficacy and possible supports that the patient can use during a quit attempt.
- c. “Why are you not more confident” can identify important barriers to change. Common barriers are craving, mood and anxiety symptoms, weight gain, contact with smokers, and triggers to smoke.
- d. Another strategy to identify things that make quitting easier and barriers to quitting is to have the patient develop a list of the pros and cons of quitting smoking.

II. Elements of a Quit Plan.

- a. Set a quit date (ideally within 2 weeks) and try not to smoke at all from then on.
- b. Prepare by removing all cigarettes and ash trays from home, car and work.
- c. Get support by telling others of the quit attempt.
- d. Review helpful strategies from past quit attempts.
- e. Develop coping strategies to deal with past or expected barriers (see below)
- f. Medication
- g. Close follow up after quit date

III. Common Barriers to Quitting

- a. Craving
 - i. Keep yourself busy
 - ii. Distract yourself, especially with activities that move your body
 - iii. Learn a breathing or relaxation exercise
 - iv. Change your routines by adding non-smoking activities
 - v. Remind yourself of why you want to quit
 - vi. Cravings last only a few seconds and then recede – “surf” the craving
 - vii. Call a supportive person
- b. Mood and/or anxiety
 - i. Reduce stress: practice relaxation exercises
 - ii. Reward yourself often by planning something enjoyable every day
 - iii. Put the money saved by not buying cigarettes aside. Plan how you are going to use it.



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- c. Dealing with other smokers
 - i. Ask other smokers to help you quit by not giving you cigarettes or smoking around you
 - ii. Stay in non-smoking areas
- d. Weight Gain.
 - i. Weight gain is common with smoking cessation, but the health benefits of quitting far outweigh the risks of weight gain.
 - ii. Minimize weight gain by increasing activity, which also helps with craving.
 - iii. Eat smaller, more frequent meals, avoid sugar, eat slowly
 - iv. Consider bupropion use to limit weight gain.

IV. Triggers to Smoke

- a. Identify key triggers (Tobacco Use Log handout)
- b. Plan behavioral strategies to use when trigger arises (“what will you do?”).
 - i. Suggest possibilities, including going for a walk, calling someone for support, doing something fun or interesting.
- c. Change the thinking that triggers desire to smoke (“how can you think differently?”).
- d. Avoid places you associate with smoking
- e. Avoid alcohol or other drinks associated with smoking
- f. Other Tips
 - i. If you miss holding cigarettes, hold something else (pencil, coin, paper clip)
 - ii. If you miss something in your mouth, try a toothpick, cinnamon stick, gum

V. Patients who are not ready to quit: Strategies to cut down

- a. Keep a Tobacco Use Log (Handout) for at least a few days (weekday and weekend)
- b. Rate the need for each cigarette
- c. Cut out cigarettes with low need first
- d. Delay important cigarettes with high need ratings (e.g. first one in morning, after meals) by just a few minutes, then extend the delay time slowly.
- e. Smoke only outside, not in your home or car

VI. Follow Up

- a. Patients who have set a quit date should be called on that day to review the quit plan and check up on how it is going.
 - i. If the quit has not occurred, assess the barriers, problem-solve around those barriers, and develop a new plan (e.g. quit date or return to clinic for more discussion).



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- ii. If the quit has occurred, provide encouragement and call again in one week.

Question

How much do we engage with Quit Line resources? **I think they are helpful supplemental resources and we should encourage their use to the extent they exist locally. What do you currently do?**