



*VIRGINIA PREMIER HEALTH PLAN, INC.*

*Smoking Cessation*

*Clinical Practice Guidelines*

**2009**

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**Smoking Cessation Clinical Practice Guidelines**

The following guideline addresses the assessment and treatment of tobacco abuse and nicotine addiction in current clinical practice. The major recommendations for primary care clinicians are to use officewide systems to identify smokers, treat every smoker with a cessation or motivational intervention, offer nicotine replacement except in special circumstances, and schedule follow-up contact to occur after cessation. Major recommendations from smoking cessation specialists are to use multiple individual or group counseling sessions lasting at least 20 minutes each with sessions spanning multiple weeks, offer nicotine replacement or appropriate medications, and provide problem-solving and social support counseling. Major recommendations for health care administrators and insurers are that tobacco-user identification systems be used in all clinics and that smoking cessation treatment be supported through staff education and training, dedicated staff, changes in policies, and the provision of reimbursement for tobacco-dependency treatment.

Tobacco addiction presents a rare confluence of circumstances that mandates clinical intervention: (1) it is a highly significant health threat, (2) there is a disinclination among clinicians to intervene consistently, and (3) effective preventive interventions are now available. Smoking cessation treatment is preventive because if it is provided in a timely and effective manner, it greatly reduces the smokers risk of suffering from smoking related disease. Indeed, it is difficult to identify a condition that presents such a mix of lethality, prevalence, and neglect, and for which effective interventions are so readily available.

VPHP determined the need for clinical practice guidelines based on several factors including prevalence, related morbidity and mortality, the economic burden imposed by the condition and variations in clinical practice related to the condition. Tobacco abuse meets all of these requirements which proves the need for guidelines for the treatment of nicotine addiction. The guideline is specifically intended to help primary care physicians improve their treatment of patients with nicotine dependency.

The guideline offers a simple and flexible set of strategies designed to ensure that all patients who use tobacco are offered motivational interventions and effective treatments to overcome this powerful addiction. The guideline is intended to identify empirically based and validated assessments and treatments for tobacco dependence.

## **GUIDELINE RECOMMENDATIONS**

### **Primary Care Clinicians**

Primary care clinicians are uniquely poised to assist patients who smoke, as they have extraordinary access to this population. At least 70% of smokers see a physician each year. Moreover, 70% of smokers report that they want to quit and have made at least one serious attempt to quit. Finally, smokers cite a physician's advice to quit as an important motivator for attempting to stop.

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Unfortunately, clinicians are not capitalizing fully on this unique opportunity. Only about half of current smokers report having been asked about their smoking status or urged to quit. Fewer still have received specific advice on how to quit smoking successfully. Why don't clinicians consistently address tobacco use among their patients? Some clinicians' reluctance to intervene may be attributed, in part, to time constraints, a perceived lack of skills to be effective in this role, frustration due to low success rates, or even a belief that smoking cessation is not an important professional responsibility. Several changes have been proposed to increase clinicians' intervention with smokers:

- (1) Health care delivery practices must change so that smoking cessation interventions are institutionalized;
- (2) clinicians and their patients must be reimbursed by insurers for smoking cessation counseling and pharmacotherapy;
- (3) clinicians must adjust their goals so that motivational interventions are offered to smokers who are not yet committed to quitting, and
- (4) standards of health care delivery must reflect the health care systems obligation to intervene in a timely and appropriate manner with patients who smoke.

These recommendations are designed to be brief and to be consistent with those produced by the National Cancer Institute in *How To Help Your Patients Stop Smoking* and by the *American Medical Association Guidelines for the Diagnosis and Treatment of Nicotine Dependence: How to Help Your Patients Stop Smoking*, as well as others. The goals of these recommendations are clear – to change clinical culture and practice patterns to ensure that every patient who smokes is offered treatment. The recommendations revolve around a central theme: *It is essential to provide effective cessation intervention for all tobacco users at each clinical visit.*

First, institutional changes in clinical practice are necessary to ensure that all patients who smoke are identified. Second, although more intensive interventions produce greater success, the compelling time limitations on primary care clinicians demand brief interventions. Third, because many smokers are reluctant to enter into intensive cessation programs, they must receive treatment every time they visit a primary care clinician.

The Agency for Health Care Policy and Resources (AHCPR) *Guideline* recommendations for primary care clinicians emphasize the importance of systematically identifying all smokers, strongly advising all smokers to quit and determining patients' willingness to make a quit attempt. Those patients not willing to commit themselves to quitting should receive a motivational intervention to promote subsequent quit attempts. When patients are willing to make a quit attempt, primary care clinicians should assist the patients in their efforts by helping the patient set a quit date, preparing the patient for the quit date, recommending appropriate pharmacotherapy, providing self-help materials, and providing key advice including problem solving and social support. If the patient prefers a more intensive treatment or if the clinician believes more intensive treatment is appropriate, the patient should also be referred to an intensive program. All patients attempting to quit should have follow-up contact scheduled. The panel identified appropriate first-

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line pharmacotherapy to include the multiple forms of nicotine replacement therapy (patch, nasal spray, gum, inhaler) and sustained-release bupropion hydrochloride. The panel noted that clonidine and nortriptyline have also been found to be efficacious and may be considered as second-line therapy. Varenicline (chantix) is the newest agent available for smoking cessation and can be considered as first line therapy based on its efficacy and side-effect profile.

### **Health Care Administrators and Insurers**

Although clinical practice guidelines have traditionally focused on the role of the individual clinician, promoting smoking cessation requires a broader approach involving health care delivery administrators and insurers. Why broaden the scope of this document beyond individual clinician? Smoking cessation efforts directed solely at the individual clinician have yielded disappointing results. National data suggest that in a given visit with a clinician, most smokers are not advised and assisted with cessation. Factors that contribute to this problem include the failure to include smoking assessment and cessation in the performance expectations of clinicians and the failure to provide clinicians with an environment that supports systematic intervention with smokers. Without supportive systems, policies, and environmental prompts, the individual clinician cannot be counted on to assess and treat tobacco use reliably. In addition, an increasing number of Americans are receiving their health care in managed care settings. The structure of managed care environments provides new opportunities to identify and treat patients who smoke. These factors indicate that responsibility for smoking cessation treatment must be redistributed; just as every clinician has a professional responsibility to assess and treat tobacco users, health care administrators and insurers have a responsibility to craft policies, provide resources, and display leadership in fostering smoking cessation efforts.

Smoking cessation treatments (both pharmacotherapy and counseling) are not consistently provided as paid services for subscribers of health insurance packages. One survey demonstrated that only 11% of health plans provided coverage for the treatment of nicotine addiction. This lack of coverage is particularly surprising given that studies have shown that physician counseling against smoking is at least as cost-effective as several common preventive medical practices, including the treatment of mild or moderate hypertension and an elevated cholesterol level. These and other findings have recently led the Centers for Disease Control and Prevention to identify universal reimbursement for the treatment of nicotine addiction as an important national public health goal.

Health care delivery administrators and insurers can promote cessation of tobacco use through a systems approach. In addition, health care administrators and insurers must provide clinicians with assistance to ensure that institutional changes promoting smoking cessation interventions are universally and systematically implemented. Finally, performance indicators that are directed at both tobacco-use monitoring and treatment should be implemented to assess both health plan and provider performance. Implementation of a number of institutional policies would facilitate these outcomes:

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- Implement and monitor use of a tobacco-user identification system in every medical setting.
- Provide education, resources, and feedback to promote provider intervention.
- Dedicate staff to provide smoking cessation treatment identified as effective in this document and assess the delivery of this treatment in staff performance evaluations.
- Promote policies that support and provide smoking cessation services.
- Include smoking cessation treatment (both pharmacotherapy and counseling) identified as effective in this *Guideline* as paid services for all subscribers of health insurance packages.
- Reimburse fee-for-service clinicians for delivery of effective smoking cessation treatments and include these interventions among the defined duties of salaried clinicians.

## **GUIDELINE RECOMMENDATIONS OF GENERAL INTEREST**

### **1. Promoting the motivation to quit**

Despite receiving a clinician's advice to quit smoking, many patients are not willing to make a commitment to quit at the time of a health care visit. These patients may be uninformed, concerned about the effects of quitting, or demoralized due to previous failure. Such patients may respond to a motivational intervention. Motivational interventions that may help clinicians promote smoking cessation are characterized by the 4 R's: *relevance, risks, rewards, and repetition*.

*Panel Recommendation:* For patients not willing to initiate a quit attempt at the time of their health care visit, clinicians should engage in a brief intervention designed to promote motivation to quit (strength of evidence = C).

### **2. Relapse Prevention**

Because of the high rates of relapse after initial abstinence, clinicians must employ strategies to assist their patients in maintaining abstinence. While relapse prevention interventions may be used with any ex-smoker when judged appropriate by the clinician, it is vital that such interventions be delivered to any smoker who has stopped within the past 3 months. This is a period of high risk for relapse. Relapse prevention interventions can be delivered via either prearranged telephone calls, clinic visits or anytime the clinician encounters an ex-smoker. It is vital that a systematic, institutionalized mechanism be in place to identify ex-smokers, because that is a necessary first step in delivering relapse prevention messages. Relapse prevention interventions can be divided into 2 categories:

- **Minimal Practice** – These relapse prevention interventions should be part of every primary care encounter with a patient who has recently quit. Because most relapses occurs within the first 3 months after quitting, relapse prevention is especially appropriate during this period.

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- **Prescriptive interventions** – These individualized relapse prevention components are based upon information obtained regarding problems the patient has encountered in maintaining abstinence. More intensive relapse prevention interventions may be delivered via primary care or through a specialist or smoking cessation program.

*Panel Recommendation:* - When clinicians encounter a recent quitter, they should reinforce their patient's decision to quit, review the benefits of quitting, and assist the patient in resolving any residual problems arising from quitting (strength of evidence = C).

**3. Smoking Cessation during Pregnancy**

Smoking during pregnancy presents risks to both the woman and the fetus. Many women are motivated to quit during pregnancy, and health care professionals can take advantage of this motivation by reinforcing the fact that cessation will be best for the fetus, with postpartum benefits for both mother and child. A pregnant woman who still smokes should continue to be encouraged and helped to quit. Among women who stop smoking during pregnancy, there is a high rate of relapse in the postpartum period, even among women who have maintained total abstinence from tobacco for 6 or more months during pregnancy. Postpartum relapse may be decreased by continued emphasis on the relationship between maternal smoking and poor health outcomes (sudden infant death syndrome, respiratory infection, asthma, and middle ear disease) in infants and children.

**4. Smoking Cessation among Hospitalized Patients**

Hospitalization can be an ideal opportunity for a patient to stop smoking, and smoking cessation may promote the patient's medical recovery. Smoking negatively affects bone and wound healing. Clinicians should use hospitalization as an opportunity to promote smoking cessation. Smokers may experience nicotine withdrawal symptoms during hospitalization. Clinicians should consider providing temporary nicotine replacement therapy during a hospitalization to reduce such symptoms and should encourage the continued use of this therapy for patients desiring prolonged abstinence.

*Panel Recommendation:* For every hospitalized patient, the following steps should be taken: (1) Ask each patient on admission if he or she smokes and document the patient's smoking status; (2) for current smokers, list smoking status on the admissions problem list and as a discharge diagnosis; (3) assist all smokers with quitting during the hospitalization, using nicotine replacement therapy if appropriate; and (4) provide advice and assistance on how to remain abstinent after discharge (strength of evidence = C).

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## CONCLUSION

1. Clinicians should assess the smoking status of every patient and should offer each smoker an effective smoking cessation treatment. This should occur at every encounter.
2. Longer-duration, intense treatments are more effective than brief treatments. However, even brief treatments such as a physician's advice to stop smoking, can be efficacious in increasing long-term smoking cessation.
3. Nicotine replacement therapy with clinician-delivered social support can be an effective component of smoking cessation treatment.
4. Effective reduction of tobacco use requires that health care systems make institutional changes that result in the systematic identification of all tobacco users and that reimbursement be provided for clinicians' delivery of effective treatments.
5. Clinicians should (a) motivate all smokers to make a quit attempt and screen for barriers to cessation such as anxiety, other smokers in the household, fear of weight gain; (b) deliver relapse prevention interventions to all smokers who have recently quit; (c) encourage pregnant smokers to receive intensive smoking cessation counseling and possibly nicotine replacement therapy; (d) assist all hospitalized smokers to remain abstinent from tobacco during and after the period of hospitalization; (e) discuss with smokers the weight gain they may experience after quitting and recommend nicotine gum as a method to limit the weight gain; (f) offer smokeless tobacco users the same cessation counseling that is used with smokers; and (g) offer effective treatments listed in this *guideline* to all smokers regardless of sex, ethnicity, or socioeconomic status.
6. Smokers with respiratory symptoms may be offered pulmonary function testing or chest x-ray. This practice could detect pulmonary disease at an earlier stage and it may also help to motivate the patient to quit smoking.
7. Treatment of tobacco abuse may include the use of appropriate pharmacotherapy. First-line treatment options include bupropion sustained-release and varenicline (chantix). Patients should be screened carefully for contraindications when prescribing these medications. Contraindications for the use of bupropion include seizure disorder and history of eating disorder. Varenicline is contraindicated in patients with history of psychiatric illness. Clonidine or nortriptyline may be considered for use as second-line therapy.
8. Clinicians should recommend various types of support available to patients working on smoking cessation. Many hospitals, churches, community centers, etc offer support groups for smokers trying to quit. There are also numerous on-line resources for patients including [smokefree.gov](http://smokefree.gov) and [quitandstayquit.com](http://quitandstayquit.com).