

Treating  
**TOBACCO DEPENDENCE**  
**PRACTICE MANUAL**  
*a systems-change approach*



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS

**ASK AND ACT**  
A TOBACCO CESSATION PROGRAM

**MAKE SURE**

**every patient**

who uses tobacco is

identified, advised to quit,

**AND OFFERED**

**evidence-based treatment.**

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# Introduction

Tobacco use causes 480,000 deaths in the United States each year, making it the leading preventable cause of mortality.<sup>1</sup> On average, people who smoke die 10 years earlier than those who do not,<sup>2</sup> and 16 million people are living with a serious illness caused by smoking.<sup>2</sup> Of the estimated 42.1 million people in the United States who currently smoke, nearly 70 percent say that they would like to quit.<sup>3</sup> However, tobacco dependence is a chronic disease that often requires repeated intervention and multiple quit attempts. More than one in four office visits is made to a family physician, so family medicine practices have 240 million opportunities each year to make a significant impact on the tobacco use behaviors of Americans.<sup>5</sup>

The U.S. Public Health Service (USPHS) clinical practice guideline *Treating Tobacco Use and Dependence: 2008 Update* (hereafter referred to as “the Guideline”) calls on clinicians to change the clinical culture and practice patterns in their offices to ensure that every patient who uses tobacco is identified, advised to quit, and offered evidence-based treatments. Specifically, the Guideline recommends the following:<sup>4</sup>

- Implementing a system in every practice to identify patients who use tobacco
- Providing adequate training, resources, and feedback to ensure that health care professionals consistently deliver effective treatments
- Dedicating staff to provide tobacco dependence treatment and assessing the delivery of this treatment in staff performance evaluations

This practice manual provides solutions and suggestions for implementing a systems-change approach in your practice.

“Patients who have been advised to quit smoking by their doctors have a 66 percent higher rate of success.”

— Former US Surgeon General  
Regina Benjamin, MD, MBA

# Develop a culture that promotes tobacco cessation

Primary care practices are transforming from condition- and treatment-centered practices to patient-centered medical homes (PCMHs) and other emerging enhanced quality improvement models. The PCMH model of care delivery for primary care practices holds the promise of higher quality care, improved self-management by patients, and reduced costs. This model offers your practice a prime opportunity to improve your tobacco dependence interventions because it is based on a continuous relationship between the patient, the physician, and the health care team, and it requires the team to take collective responsibility for the patient's ongoing care. More information about the PCMH model is available at [www.aafp.org/pcmh](http://www.aafp.org/pcmh).

The Office Champions model for tobacco cessation incorporates the tools necessary to improve patient engagement and improve the health of a practice's patient population. This model incorporates evidence-based guidelines and is a great way to meet the requirements of enhanced quality improvement models, such as the PCMH model. By following the Office Champions model, practices can improve the quality of care provided to each patient, engage their patients in shared decision making, discuss the harms and benefits of any course of treatment, support patient self-management, help their patients access community resources, and encourage their patients to live healthier lives. In particular, the Office Champions model for tobacco cessation has served as the basis for the American Academy of Family Physicians' (AAFP's) successful Office Champions Tobacco Cessation Projects.<sup>6</sup> In these projects, training and materials provided to participating practices help them implement changes in their daily office routines that improve their ability to identify tobacco users and offer tobacco cessation assistance. More information about the AAFP's Office Champions project is available at [www.aafp.org/askandact/officechampions](http://www.aafp.org/askandact/officechampions).



There are numerous ways to develop and establish a tobacco-free culture in your family medicine practice. The most important aspect is to get the entire staff, as well as your patients, thinking and talking about being tobacco free. Examples of how to demonstrate your tobacco-free culture include the following:

- Making sure magazines in your exam rooms and waiting areas do not have tobacco ads
- Not allowing staff to smoke on clinic grounds or during work hours
- Placing visual cues, such as posters and brochures, throughout the office to encourage “quit now” and “be tobacco-free” (see page 20 for information on available resources)
- Educating all staff on an ongoing basis by offering training (e.g., lectures, workshops, in-service) on tobacco dependence treatments and providing continuing education (CE) credits and other incentives for participation

## Identify an Office Champion

Make one person in your practice a tobacco cessation office champion. An office champion plays a critical role in providing overall leadership for tobacco cessation efforts. The champion should be charged with recommending and implementing system changes to integrate tobacco dependence treatment into your practice's daily office routines.

Choose a champion who is passionate about helping staff and patients quit tobacco use so they can live healthier lives. Give your champion the time, power, and resources to institute real change. Make it a collaborative process, allowing all staff and clinicians to provide input into realigning processes. Your practice may want to form a committee to assist the champion in planning and implementing change, and measuring success.

“This project was a great incentive and a reminder about the value of documenting tobacco status and counseling as it is a significant component on the PCMH journey.”

— Office Champions Tobacco Cessation Project participant

# Evaluate your current system

This section will help you think about how your practice currently functions so you can identify small changes you can make to integrate tobacco cessation activities.

## Assess your practice environment and systems

Your practice can demonstrate a commitment to tobacco cessation and facilitate patient-centered conversations with a physical environment that supports tobacco cessation efforts.

Conduct a brief, informal assessment of your practice by answering these questions:

1. How does your practice currently identify and document tobacco use by patients? Whose responsibility is this?
2. How does your practice environment currently communicate to patients the importance of quitting and your ability to assist them? (Select all that apply.)
  - Signs at entrances stating that your practice is tobacco free
  - Posters in waiting areas
  - Posters in exam rooms
  - Self-help materials in waiting areas
  - Self-help materials in exam rooms
  - Lapel pins
  - Other \_\_\_\_\_
3. How does your practice currently help patients quit smoking? (Select all that apply.)
  - Distribute educational materials
  - Refer patients to a quitline
  - Refer patients to outside support groups or counseling options
  - Conduct tobacco cessation group visits
  - Counsel patients at visits
  - Prescribe medication at visits
  - Provide follow up for patients making a quit attempt
4. What systems do you have in place to make sure tobacco use is addressed at patient visits?
  - Prompts in electronic health record (EHR) system
  - Tobacco use status as part of vital signs
  - Registry of patients who use tobacco
  - Flags or stickers on paper charts
  - Feedback to clinicians on adherence to guidelines
  - Regular staff training
  - Other \_\_\_\_\_
5. Imagine that your practice is successfully doing everything possible to help patients quit tobacco use. How would that look?
6. What are some of the challenges you face in identifying patients who smoke/use tobacco to help them quit?
7. What has worked in terms of helping patients quit tobacco use? What has not worked?
8. Whose responsibility is it to advise patients to quit and to provide counseling and resources?
9. What resources are available in your community that your patients could access for help with their quit attempts?

## Evaluate patient flow

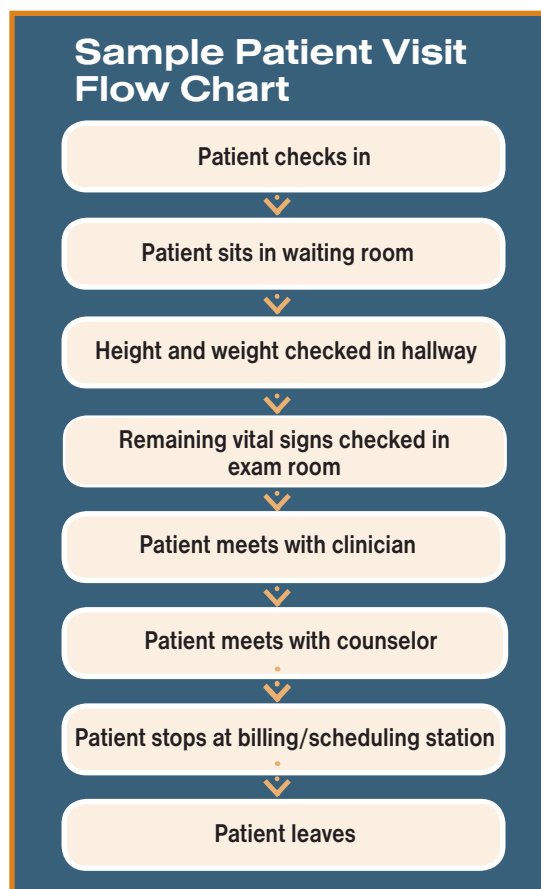
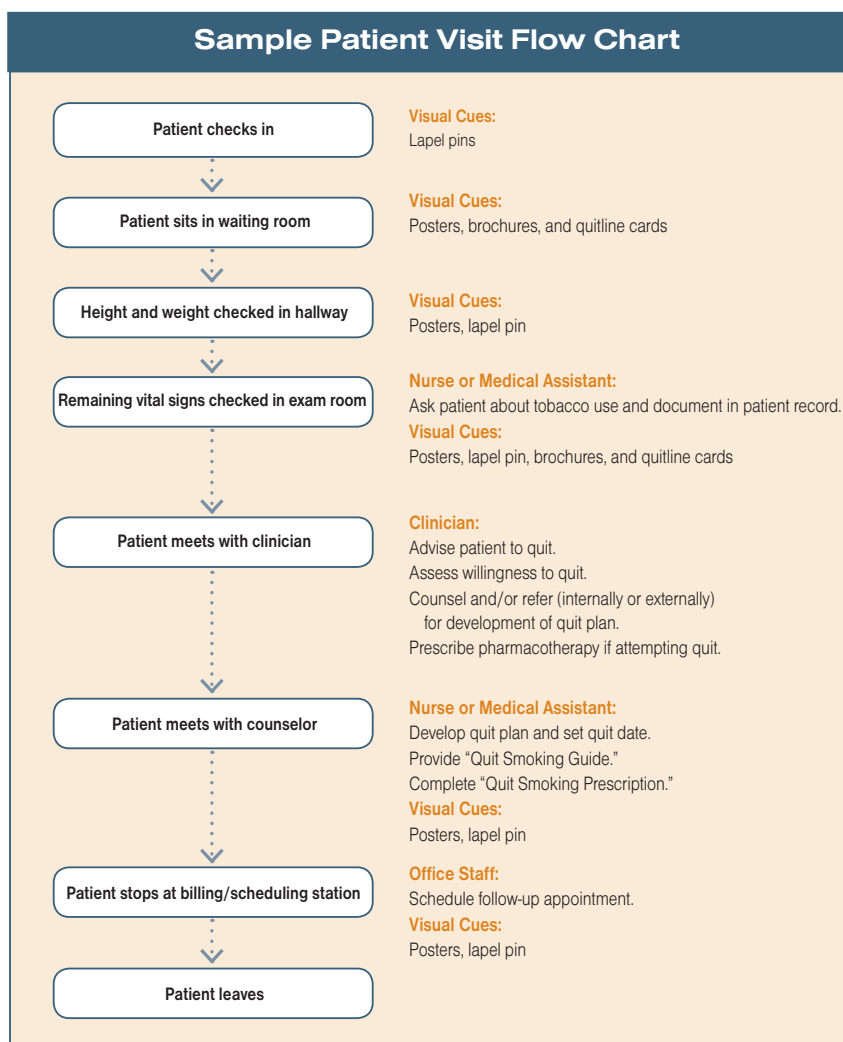
Take a moment to examine how patients flow through your office. This will help you identify opportunities to expose patients to tobacco cessation messages and offer adequate support from staff. Create a simple document that shows how patients advance through your system, from the time they enter until the time they leave.

Think about the following questions, relative to tobacco cessation, as you document your current patient flow.

1. Where do patients go when they enter the office? What do they see and do before they are called back for their visit?
2. Who do patients see before meeting the clinician?
3. What questions are asked when vital signs are measured?
4. What information is exchanged with patients before the patient-clinician encounter?
5. How do clinicians support tobacco cessation during the encounter?
6. How is tobacco cessation counseling and/or other treatment documented?
7. What reminder systems and prompts are in place to alert clinicians of opportunities to discuss tobacco cessation?
8. What path do patients take as they exit the office? Do they make any stops to speak with staff?

## Create a new patient flowchart

Based on your observations, create a new flowchart that shows how and where you will communicate with patients about quitting.



## Identify barriers

What challenges do you expect to experience as you make system changes to identify and treat patients who use tobacco? This manual provides solutions to those challenges.

A team meeting to identify potential barriers is a great place to begin your system redesign. Make a list. For many clinicians, common barriers to treatment of tobacco dependence include: the need for a better tobacco cessation model/system; lack of time; perceived lack of payment for intervention; and lack of experience/training.<sup>7</sup> Some practices may find it difficult to enforce no smoking policies with staff. Staff members who use tobacco may be uncomfortable assisting patients with quitting smoking.

Many family medicine practices lack systems to do the following:

- Track patients to determine who needs preventive services and remind them to get the services
- Prompt clinicians to deliver preventive services when they see patients
- Ensure services are delivered correctly and that appropriate referral and follow-up occur
- Confirm that patients understand what they need to do<sup>8</sup>

Another potential barrier is having inappropriate expectations about treating tobacco dependence. It should be considered a chronic condition, and it needs to be treated with the expectation that most patients will be helped through a series of relapses and remissions rather than immediately quitting on the first try.<sup>4</sup>

## Define a new system

Now that you have evaluated your current system, it is time to take steps to define and implement a system to ensure that tobacco use is systematically assessed and treated at every clinical encounter.

The AAFP's tobacco cessation program, "Ask and Act," encourages family physicians to ASK their patients about tobacco use, and then ACT to help them quit. This easy-to-remember approach provides the opportunity for every member of a practice team to intervene at every visit. Interventions can be tailored to a specific patient based on his or her willingness to quit, as well as to the structure of the practice and each team member's knowledge and skill level. More information about the program is available at [www.aafp.org/patient-care/public-health/tobacco-nicotine/ask-act.html](http://www.aafp.org/patient-care/public-health/tobacco-nicotine/ask-act.html).

As you think about how to systemize your interventions, consider the five A's recommended in the Guideline.

<b>ASK</b>	Identify and document the tobacco use status of every patient at every visit.
<b>ADVISE</b>	In a clear, strong, and personalized manner, urge every tobacco user to quit.
<b>ASSESS</b>	For the current tobacco user, is the user willing to make a quit attempt at this time? For the ex-tobacco user, how recently did he/she quit, and are there any challenges to remaining tobacco free?
<b>ASSIST</b>	For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional behavioral treatment to help the patient quit. For patients unwilling to quit at this time, provide interventions designed to increase future quit attempts. For the patient who recently quit and for the patient facing challenges to remaining tobacco free, provide relapse prevention.
<b>ARRANGE</b>	For the patient willing to make a quit attempt, arrange for follow-up contacts, beginning within the first week after the quit date. For the patient unwilling to make a quit attempt at this time, address tobacco dependence and willingness to quit at next clinic visit.



## Ask

The first step in your process redesign should be to make sure that tobacco use status is queried and documented for every patient at every office visit.

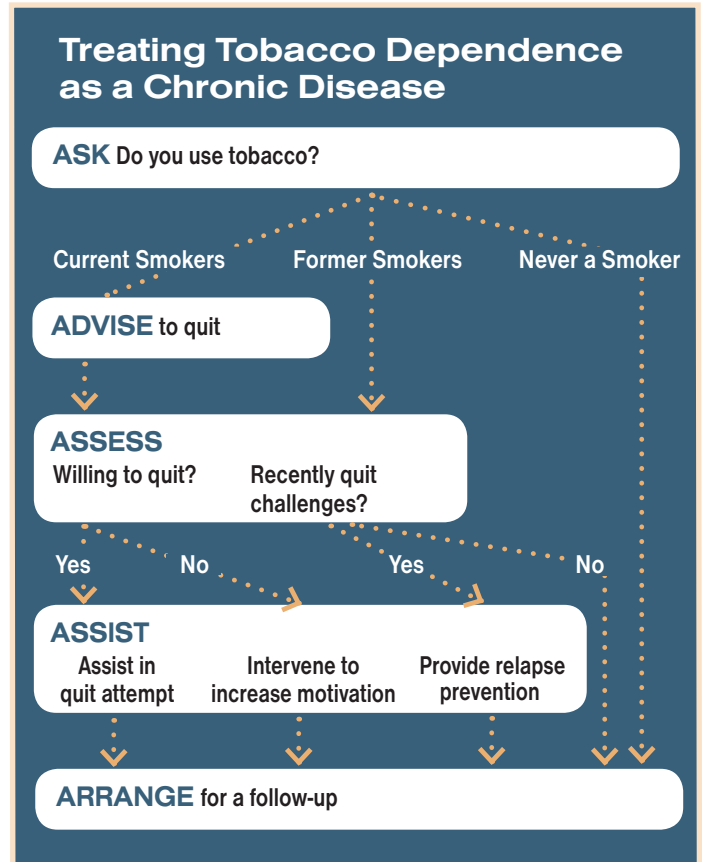
If you are using paper records, expand the vital signs to include tobacco use. Electronic health records (EHRs) allow for integration of the Guideline into the practice workflow, facilitating system-level changes to reduce tobacco use. Prompts on face sheets or summary screens can help you easily identify patients who smoke, similar to a chart sticker or flag. These prompts can be specific to tobacco use, with status embedded in the social history, or they can be generic chart reminders that your practice customizes. For example, many EHRs have pop-up reminders that could contain a query about smoking status. After the initial identification of the patient as a tobacco user, the EHR should then be programmed to remind the clinician to ask the patient about tobacco use at subsequent visits.

Weight	<input type="text"/>	Height	<input type="text"/>
Temperature	<input type="text"/>		
Pulse	<input type="text"/>		
Systolic	<input type="text"/>	Diastolic	<input type="text"/>
Respirations	<input type="text"/>		
Smoking	<input type="text"/>	Packs Per Day	<input type="text"/>
Pain Level	<input type="checkbox"/>	Current every day smoker	
Peak Flow	<input type="checkbox"/>	Current some day smoker	
Other	<input type="checkbox"/>	Former smoker	
	<input type="checkbox"/>	Never smoker	
	<input type="checkbox"/>	Smoker, current status unknown	
	<input type="checkbox"/>	Unknown if ever smoked	

A complementary field can document secondhand smoke exposure: current, former or never, and work, home, or social.

## Act

Once you have asked and found that a patient does use tobacco, it is important to take appropriate action, advising the patient to quit and assisting those who are willing to make a quit attempt. Tobacco cessation interventions do not have to be lengthy. The Guideline states that even brief counseling sessions may increase abstinence rates. Counseling combined with medication is the most effective treatment.<sup>4</sup>



## Teachable moments

One way to effectively help patients become interested in quitting is to recognize, create, and capitalize on “teachable moments.” A teachable moment is a point in a patient visit when you are able to reshape the conversation from advice giving into shared decision making. This opportunity often arises when patients are presented with information that requires them to pay attention to or process new information. Capitalize on teachable moments to discuss healthy lifestyle choices.

### Some key “teachable moment” opportunities include:

- New patient visits
- Annual physicals
- Well-child visits (e.g., discuss smoking in the home and car)
- Women’s wellness exams
- Problem-oriented office visits for the many diseases caused or affected by tobacco use and/or exposure to secondhand smoke (e.g., upper respiratory conditions, diabetes, hypertension, asthma)
- Follow-up visits after hospitalization for a tobacco-related illness or the birth of a child
- A recent health scare

You can build “teachable moment” reminders into flow sheets and EHR templates for annual exams and tobacco-affected conditions so that conversations about quitting become a routine part of clinical care. See the guide “Integrating Tobacco Cessation into Electronic Health Records” at [www.aafp.org/tobacco-tools](http://www.aafp.org/tobacco-tools).

A major component of any conversation should be assessment of patients’ attitudes toward and readiness to change. As you capitalize on teachable moments, actively engage patients in conversations to do the following:

- Start a dialogue.
- Motivate a desire for behavior change and eliminate resistance to change.
- Help patients set goals that are specific, measurable, attainable, realistic, and time-based (SMART).
- Improve continuity of care.

“This is a great program. We’ve been successful in helping several of our patients with their quit attempts.”

— Office Champions Tobacco Cessation Project Participant

## Stages of change

Through patient-centered conversations, you will identify your patients' current readiness to change and help them advance through the stages of changes,<sup>9</sup> with the ultimate goal of getting them to take action to quit using tobacco.

STAGE	DEFINITION	GOALS OF CONVERSATION	STRATEGIES	HELPFUL OFFICE CHAMPIONS RESOURCES
Precontemplation	Not interested in quitting	Increase awareness of need to change without criticizing	Personalize risks, but avoid scare tactics  Offer to help when they're ready to quit	Lapel pins  Posters  Quitline Referral Cards  Patient Education Brochures
Contemplation	Considering pros and cons of quitting, but not committed to taking action	Motivate and increase confidence	Discuss benefits of change and risks of not quitting  Explore concerns and fears (i.e., barriers)	Secondhand Smoke/Patient Education Brochures
Preparation	Making plans to change within the next month	Motivate patient to take action  Support desire for change  Confirm that quitting is possible	Help individualize a plan for quitting  Set realistic goals  Provide and have patient seek social support  Invite to group visit  Set quit date  Schedule follow up  Refer to quitline (1-800-QUIT-NOW)  Provide educational materials  Write prescription/discuss over-the-counter (OTC) meds for cessation	Quit Smoking Guide  Quitline Referral Cards  Prescription: Quit Smoking pad  Guide to Tobacco Cessation Group Visits  Pharmacologic Product Guide
Action	Taking action to change behavior	Reaffirm commitment and arm with strategies for success  Reduce risk of relapse	Identify triggers  Teach behavioral skills  Invite to group visit  Provide educational materials  Reinforce benefits  Celebrate success  Follow up  Refer to quitline (1-800-QUIT-NOW)	Quit Smoking Guide  Prescription: Quit Smoking pad  Quitline Referral Cards  Guide to Tobacco Cessation Group Visits
Maintenance	Change becomes way of life  Have quit for six months or more	Plan for potential difficulties  Use support network	Identify ongoing triggers  Reaffirm behavioral skills  Resolve problems  Invite to group visit	Guide to Tobacco Cessation Group Visits
Relapse	Resumption of old behaviors	Overcome shame and guilt  Use relapse as a learning experience	Reassure that relapse is a normal learning experience  Facilitate another quit attempt  Identify successful strategies and barriers	Quit Smoking Guide  Prescription: Quit Smoking pad  Quitline Referral Cards

## Motivational interviewing

Motivational interviewing is goal-directed counseling to motivate behavior change. Motivational interviewing uses the OARS technique to help patients move through the stages of change.

OARS is an acronym for:

- Open-ended questions
- Affirmations
- Reflective listening
- Summaries

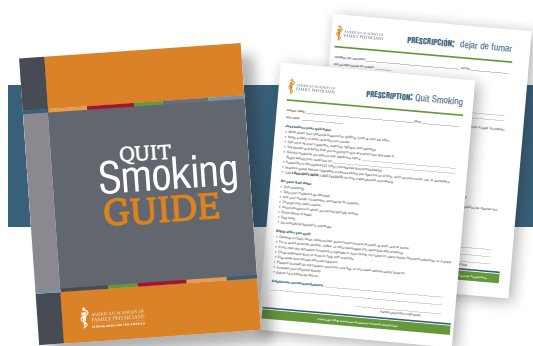
When using the OARS technique to talk to patients about their tobacco dependence, do the following:

- Express empathy—When patients think you are listening to them and understand their concerns, they will be less defensive and may be more likely to open up. As they talk, you can assess areas in which they need support.
- Support self-efficacy—Make your patients responsible for identifying the changes they want to make. Focus your attention on helping them believe that they can change.
- Point out previous successes they have had or how other patients have successfully quit.
- Roll with resistance—Don't challenge patients who resist change. Instead, ask them what their solution is for the problem they have identified.
- Develop discrepancy—Help patients see the discrepancy between where they are and where they want to be.<sup>10</sup>

More information about motivational interviewing is available at [www.motivationalinterviewing.org](http://www.motivationalinterviewing.org).

## Develop strategies for change

Patients who are motivated to quit will need help developing strategies for behavior change. In most instances, counseling should be combined with medication. Patients typically are more successful in their quit attempts if they receive counseling over multiple visits. Support can be provided by multiple clinicians, including quitline specialists. Practical counseling, which teaches problem-solving skills, is especially effective.



The AAFP's *Quit Smoking Guide* walks patients through the steps for getting ready to quit, quitting, and staying tobacco free. The guide helps patients identify potential triggers and develop coping skills to use in difficult situations.

When a patient leaves your office after setting a specific quit date, support the attempt with a prescription to quit smoking. This serves as a form of contract and also provides practical tips on what to do before, on, and after the quit date.

## Counseling + Medication Works Best

### Pharmacotherapy

Clinicians should encourage all patients attempting to quit smoking to use medication, unless otherwise contraindicated or in populations in which there is a lack of evidence.<sup>4</sup> As you develop new systems for ensuring patients receive appropriate treatment, be sure to designate at which point during visits patients will receive information about medication. Recent studies have shown that certain combinations of pharmacotherapy are generally more effective than monotherapy.<sup>4,11,12,13,14</sup>

### Medications Approved by the U.S. Food and Drug Administration (FDA) for Smoking Cessation:

- Nicotine gum
- Nicotine lozenge
- Nicotine transdermal patch
- Nicotine nasal spray
- Nicotine inhaler
- Bupropion SR
- Varenicline

Source: Rx for Change, Pharmacologic Product Guide. 2017

## Referrals

Providing support and follow up to patients motivated to quit is a challenging part of implementing a systematic approach to helping tobacco users quit.

Find out what types of referral resources are available in your community. Many health centers offer tobacco cessation support groups.

With assistance from the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC), all 50 states provide free quitline services. Your patients can access your state's quitline by calling **1-800-QUIT-NOW (1-800-784-8669)**. Quitline services are available seven days a week, from early in the morning to late in the evening in most states.

When your patients call 1-800-QUIT-NOW they will have the opportunity to talk to a trained counselor who will help them create a quit plan based on their situation and past experiences. In some states, callers to quitlines can have over-the-counter cessation medication mailed to their house. Many state quitlines also provide follow-up calls to patients.

Some state quitlines offer a fax referral system so that your office can fax in a patient's name and phone number. A quitline counselor will then call your patient and offer services. Some quitlines even provide feedback to your office, letting you know when they connect with your patients.

### ***E-Referrals to quitline***

In addition to fax referrals to quitlines, some health care systems are using e-referrals. To learn more about what types of referral programs are already offered by your state's quitline, go to <http://map.naquitline.org/>, select your state, and scroll down to the "Provider Referral Program" section. You may also contact the North American Quitline Consortium for additional information at [www.naquitline.org/](http://www.naquitline.org/).

### ***How to refer your patients to a quitline***

There are several successful strategies for referring a patient to a quitline:

- Provide a brief description of what services are available and address common misconceptions. For example, "This service has been shown to help people who smoke quit. It is staffed by people skilled at helping people quit. They will not try to make you feel guilty about smoking, and any information you supply will be kept confidential."



- Endorse the service and personalize it. For example, "I have referred many of my patients to the quitline, and they received assistance that helped them quit."
- Assess the patient's interest in getting help.
  - If the patient is unsure, explore his or her ambivalence.
  - If the patient is not interested, offer a quitline referral card and say, "If you ever change your mind, here is a number you can call to get support."
  - If the patient is interested, provide a referral (fax referral, if available, or brochure or card with number).
- Inquire at follow-up visits to find out whether the patient has called the quitline or check feedback from the quitline.

You can obtain wallet-sized referral cards with the quitline number at <https://nf.aafp.org/shop/tobacco-prevention-cessation>.

In addition to state-supported quitlines, some health plans and employers offer telephone-based cessation support to their members or employees.

## ADVANTAGES OF QUITLINES

- Accessible in all 50 states  
**1-800-QUIT-NOW (1-800-784-8669)**
- Confidential
- No cost to patient
- One-stop shop for resources
- Easy intervention
- Evidence-based

## Follow up

After a patient has set a quit date or started medication for smoking cessation, it is important to monitor progress. Patients often have side effects that can derail their cessation attempts.

When formulating a follow-up plan, consider the appropriate intervals and the contact method that will work for both clinician and patient.

- **When?** — Plan to follow up with patient on the quit date, a week later, and about a month later.
- **Who?** — Frequency of contact is a major determinant of success, but the contact need not be limited to direct, in-person visits with a physician. For example, dieticians, nurses, and health educators can maintain frequent contact with patients.
- **How?** — In addition to in-office follow-up visits, you can arrange for e-visits, telephone visits, or email communication.

Follow-up calls and/or visits should include discussions about the following:

- The benefits of quitting
- Potential side effects of medications

- How social support is working
- Withdrawal effects and ways to deal with these
- Positive achievements, such as creating a tobacco-free home and car
- How you and your team can help

Most people change behavior gradually. Patients cycle forward and backward through stages ranging from uninterested, unaware, or unwilling to make a change (precontemplation); to considering a change (contemplation); to deciding and preparing to make a change (preparation); to modifying behavior (action); to avoiding a relapse (maintenance).<sup>9</sup> Relapses of some sort are almost inevitable. An adequate, individualized plan for support and follow up will help your patient with his or her change efforts.

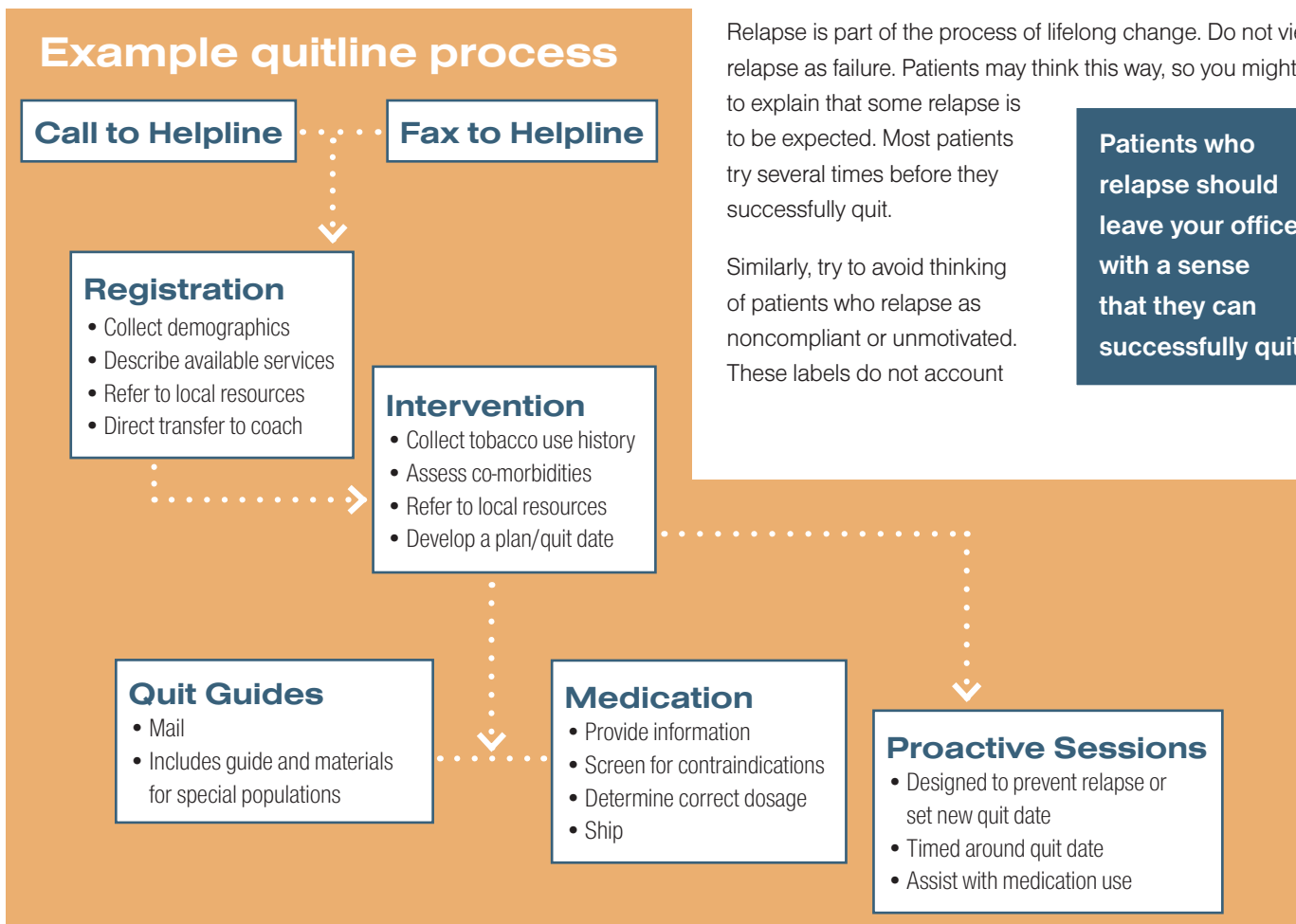
## Relapse

A relapse is generally considered to be a return to smoking that leads to a return to previous levels of tobacco intake. A slip, on the other hand, is just that: a cigarette or two that does not bring on a full-fledged return to the previous level of tobacco use. It is important that patients understand that a slip does not always lead to a full relapse.

Relapse is part of the process of lifelong change. Do not view relapse as failure. Patients may think this way, so you might want to explain that some relapse is to be expected. Most patients try several times before they successfully quit.

Similarly, try to avoid thinking of patients who relapse as noncompliant or unmotivated. These labels do not account

**Patients who relapse should leave your office with a sense that they can successfully quit.**



for the complex nature of behavioral change or the physiologic effects of nicotine dependence. Remember, you are helping your patient overcome a chronic condition.

When counseling a patient who has relapsed, begin by normalizing the situation and focusing on the positive. Explain to the patient that even though a relapse has occurred, he or she has learned something new about the process of changing behavior.

Ask what got in the way. Have the patient identify obstacles. Note that this is not a “why” question. If you assume that relapse is normal and expected, the why is already answered.

Acknowledge the difficulty of the behavior change and provide encouragement. Support patients and help them re-engage in the change process.

Help the patient focus on the details of the obstacles, which will help facilitate problem solving. Some situations are not changeable, so the patient will have to discover strategies to overcome these challenges.

Ask how the patient will deal with the same situation in the future. This conversation will help the patient shift the focus from failure to problem solving. Patients will be more vested in solutions if they come up with them. As part of this discussion, you can have the patient identify what worked previously.

Acknowledge the difficulty of the behavior change and provide encouragement. Support the patient and help him or her re-engage in the change process.

Have the patient make a new plan or modify the current one. Shorten the interval between repeat visits. Consider using phone calls or e-visits for patients who are having difficulty reaching their goals.

## Cultural considerations

It is likely that you see patients from a variety of cultural and ethnic backgrounds. As you encourage these patients to quit, be aware of traditions or ingrained social or cultural customs (for example, ceremonial tobacco use) that might pose barriers to successful cessation. Help patients see how the benefits of quitting outweigh any social benefits of smoking. Having patient-centered conversations will help ensure that goals and action plans are culturally and linguistically appropriate.

## Health literacy

Health literacy can be defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”<sup>15</sup> Nearly nine out of 10 adults may not possess the skills they need to assist them in managing their health and preventing disease.<sup>16</sup>

Patients with low health literacy may not comprehend drug labeling or medical instructions, with the result that they appear unwilling to follow recommendations. Patients may not understand health publications, may not give an adequate history, may be unable to provide truly informed consent, and may have difficulty completing medical and insurance forms.

You may want to assume that some of your patients have limited health literacy. Consider the following recommendations:

- Create an environment in which patients feel comfortable talking to you.
- Use plain language instead of medical jargon or technical language.
- Sit down to achieve eye-level communication.
- Use visual models to illustrate a procedure or condition.
- Have patients explain back to you the care instructions you gave them or demonstrate procedures you explained.

## Behavioral health

Rates of smoking are two to four times higher among people who have mental health disorders and substance use disorders than in the general population.<sup>17</sup>

All people who smoke and have a mental health disorder, including those who have a substance use disorder should be offered tobacco dependence treatment. However, consider offering treatment when mental health symptoms are not severe. Quitting smoking or nicotine withdrawal may exacerbate comorbid conditions. Treating tobacco dependence in individuals who have a mental health disorder is made more complex by the potential for multiple diagnoses and multiple medications.<sup>4</sup>

Patients who have a mental health disorder can successfully quit smoking. Counseling is critical to their success. These patients will likely need more and longer counseling sessions, and they may need more time to prepare for their quit attempt.



Using motivational interviewing and the Five R's system can also be effective. This system is targeted at patients who use tobacco, and are not yet ready to quit. It can motivate change by helping them understand the importance of quitting in personal terms.

## The Five R's

**Relevance.** Why is quitting relevant to this patient? For example, maybe he or she has had a personal health scare, such as a recent heart attack, or has a child who has asthma.

**Risk.** Ask the patient to list negative effects of their tobacco use. These may include short-term risks, long-term risks, and environmental damage.

**Rewards.** Ask the patient to list benefits of quitting. These may include being healthier, saving money, setting a good example, or having better self-esteem.

**Roadblocks.** Ask the patient to identify barriers to quitting. Then, talk about ways to address these barriers. For example, if a patient is worried about withdrawal symptoms, ease his or her fears by describing medication options that can help.

**Repetition.** The health care team should repeatedly follow up with the patient, keeping in mind that it may take repeated attempts to quit, especially for patients with a behavioral health disorder.<sup>4</sup>

To quit permanently, patients may need to rely on more than one method at a time. In addition to counseling, methods may

include step-by-step manuals, phone support, self-help classes, nicotine replacement therapies (NRT), and/or prescription medications. It is important for those who smoke and live with a mental health disorder to work with a health care professional to determine the most effective strategies.<sup>21</sup>

Patients who have a behavioral health disorder are often highly nicotine dependent. Most will need medication to manage withdrawal symptoms, which will likely be more severe than those in the general population. It is very important to customize pharmacotherapy for these patients. For example, for patients who have a history of inhaling drugs, nicotine nasal spray is not recommended. For patients who have schizophrenia, the nicotine patch has been shown to be highly effective.<sup>22,23</sup> Take into account a patient's current medications, previous quit attempts, access to affordable medication, and personal preferences.

In particular, physicians need to carefully monitor the dosage and effects of psychiatric medications during quit attempts by patients who have a behavioral health disorder. Because smoking increases the metabolism of some medications, quitting can increase their effects. In addition, because ongoing use of nicotine may modulate psychiatric symptoms and medication side effects, changes in a patient's smoking status require close follow up.

See the AAFP's Behavioral Health Smoking Cessation fact sheet for more information at [www.aafp.org/patient-care/public-health/tobacco-nicotine/office-champions/behavioral-health.html](http://www.aafp.org/patient-care/public-health/tobacco-nicotine/office-champions/behavioral-health.html).

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## Standardize the system

Now that you have a broad understanding of effective tobacco dependence treatment, it's time to standardize your office systems to ensure that every patient who uses tobacco is identified, advised to quit, and offered evidence-based treatments.

### Meaningful Use of EHRs

The Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA), provides incentives to eligible professionals (EP) and hospitals that adopt certified electronic health record (EHR) technology and can demonstrate that they are meaningful users of the technology. To qualify as a meaningful user, EPs must use EHRs to capture health data, track key clinical conditions, and coordinate care of those conditions.

EHRs allow for integration of the Guideline into the practice workflow, facilitating system-level changes to reduce tobacco use.

Beyond identifying smoking status, the EHR should include automatic prompts that remind clinicians to encourage quitting, give advice about smoke-free environments, and connect patients and families to appropriate cessation resources. To view a suggested template, see the "Integrating Tobacco Cessation into Electronic Health Records" at [www.aafp.org/tobacco-tools](http://www.aafp.org/tobacco-tools).



## Tobacco-use registries

A tobacco-use registry is a list of all your patients who use tobacco. The entire care team can use this list to keep track of which patients need services and to get a population-based view of how well your practice is meeting care guidelines. Registries make it easier for your practice to reach out to patients who do not seek the care they need.

A registry creates an opportunity to capture, organize, and analyze information about your patients who use tobacco. Ideally, you will want your registry to encompass your entire patient population, but you can start small and add data over time.

There are dozens of ways to create a registry. You can create a simple spreadsheet or use a standard database program. There are several registry applications you can download or use online for free. There are also robust applications you can buy. Newer EHR systems often have registry functionality built into the system.

While creation of a registry does not require the hiring of additional staff, you and your practice team will need to create a process for using the registry to prepare for and conduct patient visits, as well as to follow up with patients. It is important to clearly define who is responsible for each step in the process.

Registries give you the opportunity to monitor the performance of each member of the health care team and the team as a whole. Peer comparisons can be a great incentive for improved care.

**A registry creates an opportunity to capture, organize, and analyze information about your patients who use tobacco.**

## E-visits

Electronic medical appointments, or e-visits, take place online through a secure email system or patient portal. E-visits are generally initiated by a patient, who enters information about his or her medical condition. After the patient sends a request, it is triaged to a physician or a nurse practitioner who communicates treatment recommendations. The patient then receives an email notification to log back into the system to view the recommendations. E-visits are an efficient way to provide follow-up care to patients during their quit attempts.

## Group visits

Well-organized group visits provide better access to care at a lower cost. They can also provide an improved quality of care and a higher level of patient and physician satisfaction.

Group visits are ideal for patients who are trying to quit smoking. Group visits include a group educational session plus most components of an individual visit, including one-on-one medical evaluation conducted by a physician or nurse practitioner. Learn how to conduct group visits by reading “Guide to Tobacco Cessation Group Visit,” available at [www.aafp.org/tobacco-tools](http://www.aafp.org/tobacco-tools).

## Make assignments/team approach

As you implement your practice’s process of change, bring together your health care team. Led by your Office Champion, discuss how best to adapt tobacco cessation activities into your practice setting. The team must do the following:

- Select Office Champions resources to be used in the office and determine how they will be stored, distributed, and accessed.
- Choose who will discuss tobacco-related issues with the patient, how and when this will happen, and where the responses should be documented on the chart. Remember that the patient’s success increases in proportion to the number of staff involved in the process.
- Decide who will help the patient develop a quit plan. Physicians have a slightly higher success rate engaging patients in brief encounters, but interventions by non-physician clinicians are nearly as successful.
- Discuss how the team will provide follow-up care for patients in the cessation process and create mechanisms to ensure that this care is provided.

“I felt the project was beneficial, and we can build on this process, not just for smoking cessation but for other quality improvement projects, as well.”

— Office Champions Tobacco Cessation Project Participant

## Roles of multidisciplinary team members

Systematizing processes requires very clear guidelines on roles and responsibilities. Assignments may vary based on practice size and structure. As you define who will assume various roles in your practice's tobacco cessation process, consider the following options:

### Physicians

- Deliver strong personalized advice to quit smoking/using tobacco
- Assess readiness to quit
- Deliver brief interventions to patients who are ready to quit
- Review medication options and prescribe cessation pharmacotherapy or advise the use of over-the-counter (OTC) nicotine replacement therapy (NRT)
- Refer patients to other team members for supplemental counseling
- Perform follow-up counseling during quit attempts
- Keep current on research

### Nurses, physician assistants, and/or health educators

- Assess smoking status of patients and their readiness to quit
- Provide counseling, with a focus on identifying strategies to avoid triggers, cope with cravings, and get social support
- Perform follow-up counseling during quit attempts
- Support education from other clinicians about use of medications

### Receptionists/medical assistants

- Distribute health questionnaire and specific smoking cessation screening tools to identify smoking status of patients and/or collect information about smoking history and readiness to quit
- Ensure general information and self-help materials are in waiting areas and exam rooms
- Schedule follow-up appointments for smoking cessation visits
- Make follow-up calls to patients during quit attempts

### Administrators

- Ensure adequate human resource support for staff engaging patients with tobacco cessation interventions (e.g., the office champion's duties)
- Create no smoking policies
- Support integration of smoking cessation tools into the EHR
- Arrange for smoking cessation training opportunities for staff
- Implement quality audits and monitor quality of key implementation activities
- Ensure data are tracked for program evaluation
- Communicate outcomes to other members of the health care team

Be sure to communicate to each staff member about his or her responsibilities in the delivery of tobacco dependence treatment. Incorporate a discussion of these staff responsibilities into training of new staff.<sup>20</sup>

## Create staff/physician feedback mechanism

As with any quality improvement process, data are necessary and feedback is essential to system improvement. Formal, regular communication about how the tobacco cessation process is working should be integrated into the system. Several elements can be measured and reported, such as the following:

- The number and/or percentage of tobacco users in the patient population
- The number and/or percentage of patients advised to quit and assisted
- The number and/or percentage of quit attempts
- Success rates at one, six, and 12 months, etc.

Provide feedback to clinicians and staff about their performance, drawing on data from chart audits, electronic medical records, and computerized patient databases. Evaluate the degree to which your practice is identifying, documenting, and treating patients who use tobacco.

Physicians will be interested in data on the use of pharmacotherapy and short- and long-term success rates of medications. It may also be helpful to note the number of patients who quit spontaneously without much assistance.

**Formal, regular communication about how the tobacco cessation process is working should be integrated into the system.**

Set benchmarks or target goals. Use a few minutes in regular staff meetings to share information about the tobacco cessation process. Include unblinded data in internal practice communications. Reinforcing the importance of tobacco cessation efforts and continuously creating ways to improve the system are crucial to success.

## Payment

As you adjust your systems, be sure to involve those who do your medical billing. Patient visit forms and electronic claims systems may need to be modified to include tobacco treatment codes. Clinicians will also need to be educated on appropriately documenting treatment to ensure payment for services.

# CODING REFERENCE

## Tobacco Use Prevention and Cessation Counseling

In 2014, the Patient Protection and Affordable Care Act (ACA) began requiring insurance plans to cover many clinical preventive services. Two of the covered preventive services include:

- Tobacco use screening for adults and adolescents
- Tobacco cessation counseling for adults and adolescents who use tobacco, and expanded counseling for pregnant women

### Medicare

Medicare Part B covers two levels of tobacco cessation counseling for symptomatic and asymptomatic patients: intermediate and intensive.

Two cessation attempts are covered per 12-month period. Each attempt may include a maximum of four intermediate or intensive counseling sessions. Therefore, the total annual benefit covers up to eight smoking cessation counseling sessions in a 12-month period.

The patient may receive another eight counseling sessions during a second or subsequent year once 11 full months have passed since the first Medicare-covered cessation counseling session took place. For counseling to qualify for Medicare payment, the following criteria must be met at the time of service:

- Patients must be competent and alert at the time the counseling is provided.
- Counseling must be provided by a physician or other Medicare-recognized health care professional.

Medicare no longer differentiates between symptomatic and asymptomatic patients as of October 1, 2016. Codes G0436 and G04037 were deleted that represented asymptomatic cessation counseling. According to the Medicare Preventive Services guide, Medicare suggests the use of codes 99406 and 99407.

Both symptomatic and asymptomatic patients are covered for care if they:

- Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Are competent and alert at the time of counseling

- Receive counseling furnished by a qualified physician or other Medicare-recognized practitioner

A notable change as of October 1, 2016 is that the copayment/coinsurance as well as the deductible for 99406 and 99407 are now waived. The Medicare beneficiary has a zero dollar out-of-pocket liability.

HCPCS/CPT Code	Type of Counseling	Description
99406	Intermediate	Smoking and tobacco use cessation counseling visit is greater than three minutes, but not more than 10 minutes
99407	Intensive	Smoking and tobacco use cessation counseling visit is greater than 10 minutes

ICD-10 CM Diagnosis Code	Description
F17.200	Nicotine dependence, unspecified, uncomplicated
F17.201	Nicotine dependence, unspecified, in remission
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
T65.211A	Toxic effect of chewing tobacco, accidental (unintentional)
T65.212A	Toxic effect of chewing tobacco, intentional self-harm
T65.213A	Toxic effect of chewing tobacco, assault
T65.214A	Toxic effect of chewing tobacco, undetermined
T65.221A	Toxic effect of tobacco cigarettes, accidental (unintentional)
T65.222A	Toxic effect of tobacco cigarettes, intentional self-harm
T65.223A	Toxic effect of tobacco cigarettes, assault
T65.224A	Toxic effect of tobacco cigarettes, undetermined
T65.291A	Toxic effect of other tobacco and nicotine, accidental (unintentional)
T65.292A	Toxic effect of other tobacco and nicotine, intentional self-harm
T65.293A	Toxic effect of other tobacco and nicotine, assault
T65.294A	Toxic effect of other tobacco and nicotine, undetermined
T87.891	Personal history of nicotine dependence

*continued*

### Medicaid

Many states offer some payment for individual cessation and treatment counseling for Medicaid patients. For example, the ACA requires states to expand Medicaid coverage of cessation services for pregnant women. You are encouraged to contact your state Medicaid office for coverage information in your specific state.

The Centers for Medicare and Medicaid Services encourage state partners to support smoking cessation by ensuring coverage of all FDA-approved smoking cessation medication (prescription and over-the-counter [OTC]) without a copayment requirement or other financial barrier.

### Private/Commercial Insurance Carriers

Private insurers are required to provide evidence-based tobacco cessation counseling and interventions to all adults and pregnant women. Private payer benefits are subject to specific plan policies. Check with individual insurance plans to determine what specific interventions are included and the extent to which these interventions are covered.

HCPCS/CPT Code	Type of Counseling	Description
99406	Intermediate	Smoking and tobacco use cessation counseling visit is greater than three minutes, but not more than 10 minutes
99407	Intensive	Smoking and tobacco use cessation counseling visit is greater than 10 minutes
S9453	Smoking cessation classes	Non-physician provider, per session
99381-99397	Preventive medicine services	Comprehensive, preventive evaluation based on age and gender to include appropriate history, examination, counseling/anticipatory guidance, risk factor reduction interventions, and related plan of care
99078	Physician educational services	Group setting (e.g., prenatal, obesity, diabetes)

ICD-10 CM Diagnosis Code	Description
F17.200	Nicotine dependence, unspecified, uncomplicated
F17.201	Nicotine dependence, unspecified, in remission
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
T65.211A	Toxic effect of chewing tobacco, accidental (unintentional)
T65.212A	Toxic effect of chewing tobacco, intentional self-harm
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T65.214A	Toxic effect of chewing tobacco, undetermined
T65.221A	Toxic effect of tobacco cigarettes, accidental (unintentional)
T65.222A	Toxic effect of tobacco cigarettes, intentional self-harm
T65.223A	Toxic effect of tobacco cigarettes, assault
T65.224A	Toxic effect of tobacco cigarettes, undetermined
T65.291A	Toxic effect of other tobacco and nicotine, accidental (unintentional)
T65.292A	Toxic effect of other tobacco and nicotine, intentional self-harm
T65.293A	Toxic effect of other tobacco and nicotine, assault
T65.294A	Toxic effect of other tobacco and nicotine, undetermined
T87.891	Personal history of nicotine dependence

### Self-pay Patients and Uninsured Patients

The following resources are for patients who do not have insurance, or who have limited insurance coverage:

- Quitline: 1-800-QUIT-NOW (1-800-784-8669)
- Flexible spending accounts, if smoking cessation is an allowable expense
- Employee assistance programs (EAPs), in some cases
- Community resources and support groups
- Out-of-pocket spending
- Online resources
  - Centers for Disease Control and Prevention
    - ◆ How to Quit: [www.cdc.gov/tobacco/quit\\_smoking/how\\_to\\_quit/](http://www.cdc.gov/tobacco/quit_smoking/how_to_quit/)
    - ◆ Tips From Former Smokers: [www.cdc.gov/tobacco/campaign/tips/](http://www.cdc.gov/tobacco/campaign/tips/)
    - ◆ Quit Smoking: [www.cdc.gov/tobacco/quit\\_smoking/](http://www.cdc.gov/tobacco/quit_smoking/)
  - U.S. Department of Health and Human Services
    - ◆ Smokefree.gov: <http://smokefree.gov/>
    - ◆ SmokefreeTXT: <http://smokefree.gov/smokefreetxt>

# Prevent and overcome staff resistance to change

In any organization or group, including a medical office, change can be threatening, even if new ideas or processes lead to improvement. No matter how well changes are communicated prior to their implementation, some people will resist.

It is very important for the tobacco cessation office champion, supported by a physician champion, to anticipate resistance and plan strategies for dealing with it. This applies not only when the change is introduced, but also over the long term. Clear communication is imperative. For example, the office champion should spell out how changes will affect the office, how patient care will be improved, and how roles and responsibilities are defined.

Office leadership needs to present changes in a united, positive way, creating opportunities for communication, staff input, feedback and improvement in the new system, and shared goals for both operations and improved patient care outcomes.

Your office clinicians and staff will be more willing to accept change if they:

- Like the way the change is communicated and feel included in the process
- Like and respect the source of the change
- Understand the motivation and goals for the change
- Feel a sense of challenge and satisfaction
- Are allowed to help put the new plan into place, as opposed to having it forced on them

## Your implementation plan

Put your new ideas into action. Use this worksheet to develop a plan for systems change. This is intended to provide a basic checklist and should not limit the development of a system for your office.

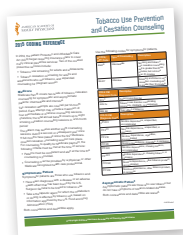
TASK	PERSON RESPONSIBLE	DATE TO BE COMPLETED	CHECK WHEN COMPLETE
Conduct initial meeting with staff			
Create tobacco-free atmosphere <ul style="list-style-type: none"> <li>• Hang posters in waiting areas</li> <li>• Hang posters in exam rooms</li> <li>• Display self-help materials and quitline cards in waiting areas/exam rooms</li> <li>• Distribute lapel pins to staff</li> <li>• Check magazines for tobacco ads</li> <li>• Enforce a tobacco-free policy</li> <li>• Other _____</li> </ul>			
Flow chart the patient experience and highlight opportunities for tobacco interventions			
Update vital signs (if needed)			
Create EHR or paper flags, prompts and templates			
Formalize treatment protocol (identification of smokers, counseling, medication, follow-up)			
Provide staff training			
Update billing process to ensure payment			
Define services of state quitline			
Create list of community resources			
Create patient registry			
Plan for group visit			
Create and implement system to track and communicate success			
Make staff assignments. What is the role of: <ul style="list-style-type: none"> <li>• Physician(s)</li> <li>• Nurse(s)</li> <li>• Health educator(s)</li> <li>• Medical assistant(s)</li> <li>• Administrator(s)</li> <li>• Receptionist(s)</li> </ul>			



# American Academy of Family Physicians (AAFP) Resources

The following tobacco cessation resources are available from the AAFP to help you change your practice system. The Tobacco Control Toolkit is available at [www.aafp.org/tobacco-tools](http://www.aafp.org/tobacco-tools).

**Coding Reference – Tobacco Use Prevention and Cessation Counseling** – List of HCPCS, CPT, and ICD-9 CM/ICD-10 CM codes related to tobacco cessation counseling.



**Integrating Tobacco Cessation into Electronic Health Records** – Recommendations for creating a template to ensure tobacco use is addressed with patients and treatment is adequately documented.



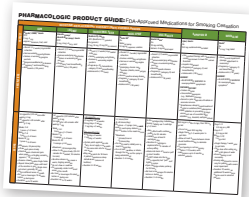
**Guide to Tobacco Cessation Group Visits** – A step-by-step guide to conducting group visits to help your patients quit smoking.



**Lapel pins** – Prompt your patients to ask for assistance with their quit attempts by wearing a lapel pin that says “Quit now. Ask me how. Be tobacco free.”



**Pharmacologic Product Guide** – Information on the seven FDA-approved medications for smoking cessation.



**Prescription: Quit Smoking pad\*** – Prescribe healthy habits by giving these “prescriptions” to patients who are ready to quit so they will know what to do before, during, and after the quit date.

**Quitline Referral Cards\*** – Refer patients to 1-800-QUIT-NOW (1-800-784-8669), which will route patients to your state’s quitline to receive counseling and resources.

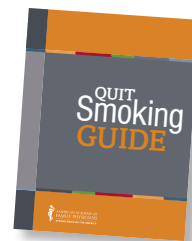


**Steps to Help You Quit Smoking patient education brochures\*** – These easy-to-read brochures provide an overview of how and why to quit smoking. Display them in your reception area and exam rooms.



**Wall posters\*** – Encourage your patients to ask for help with their smoking cessation efforts by displaying this full-color 16” x 20” wall poster.

**Quit Smoking Guide\*** – This booklet walks patients through the steps for getting ready to quit, quitting, and staying tobacco free.



**RECOGNIZED  
for EXCELLENCE  
in tobacco cessation**

This wordmark, as noted in the recognition certificate and poster, signifies exemplary tobacco cessation efforts.

*\*Also available in Spanish*

## Additional training

This manual provides a broad overview of the treatment of tobacco dependence. If you or members of your practice team are looking for evidence-based continuing education, check out the following resources:

**AAFP Tobacco and Nicotine Prevention and Control webpage:** The AAFP offers evidence-based strategies for the treatment of tobacco dependence at [www.aafp.org/tobacco](http://www.aafp.org/tobacco).

**American Academy of Pediatrics (AAP) Julius B. Richmond Center of Excellence:** The AAP offers training and continuing medical education (CME) courses on tobacco use and secondhand smoke exposure at [www2.aap.org/richmondcenter/](http://www2.aap.org/richmondcenter/).

**American Congress of Obstetricians and Gynecologists (ACOG):** Online training entitled “Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic” is available at [www.smokingcessationandpregnancy.org](http://www.smokingcessationandpregnancy.org).

**Association for the Treatment of Tobacco Use and Dependence (ATTUD):** This association’s website includes a list of organizations that offer tobacco treatment specialist training at [www.attud.org](http://www.attud.org).

## Additional resources

**American Lung Association’s Affordable Care Act Tobacco Cessation Guidance Toolkit:** Materials, template letters, and resources to explain the new guidance on insurance coverage of tobacco cessation can be found at <http://www.lung.org/our-initiatives/tobacco/cessation-and-prevention/affordable-care-act-tobacco.html>.

**Centers for Disease Control and Prevention (CDC):** [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco)

**CDC’s Tips From Former Smokers:** [www.cdc.gov/tobacco/campaign/tips](http://www.cdc.gov/tobacco/campaign/tips)

**Smoking Cessation Leadership Center:** This organization’s website contains a variety of resources for health care professionals at <https://smokingcessationleadership.ucsf.edu/>.

**AAFP’s Tar Wars:** A tobacco-free education program for fourth- and fifth-grade students is available at [www.tarwars.org](http://www.tarwars.org).

**U.S. Public Health Service’s Treating Tobacco Use and Dependence: 2008 Update:** <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html>

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