Clinical Practice Guideline: **Tobacco Cessation Counseling**

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Table of Contents

GUIDELINES

American Specialty Health – Specialty (ASH) clinical committees determined that in the context of best practices and for the population of all patients, the evaluation of tobacco/nicotine use is necessary. In this same context, a brief intervention for the population of tobacco users is recommended. An example of a brief intervention would be what is recommended by the United States Preventive Services Task Force (USPSTF) for tobacco users. Lastly, ASH clinical committees concluded in the same context of best practices for the population of tobacco users, a direct intervention or referral, depending upon the expertise and scope of the practitioner, for appropriate tobacco/nicotine cessation intervention is necessary.

INTRODUCTION

An office visit with a health care practitioner can provide an opportunity to talk with patients about their tobacco/nicotine use. Given the health effects associated with chronic tobacco use, the office visit provides a "teachable moment" during which a qualified healthcare professional can relate current health problems to tobacco use, provide brief counseling, or set an appropriate referral for patients who use tobacco products.

Tobacco contains nicotine, an addictive substance. Addiction to nicotine can happen after the first exposure so prevention is a key intervention to reducing smoking in the population. Tobacco use is the leading preventable cause of death in the U.S. This is more than the combined total from AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires. The association between tobacco use and premature death is one of the best documented in the epidemiological literature, beginning with Doll's study of over 40,000 male physicians in 1951; this study then continued, following participants for 50 years. These studies showed that cigarette smokers had twice the death rate ratio as nonsmokers (42% to 24%) for premature death (at ages 35-69). Cigarette smoking was found to be highly correlated with all causes of death, as was number of cigarettes smoked, which demonstrates a strong dose-response effect.

Smoking is known to cause cancer, heart disease, stroke, lung diseases such as COPD, and diabetes. Tobacco use in any form can also lead to health issues including various cancers, pregnancy complications, lung diseases, gum disease, and vision problems. Some studies suggest that tobacco use may be a risk factor for low back pain and may contribute to poorer outcomes in people with musculoskeletal back pain, including outcomes of rehabilitation care. Secondhand smoke exposure contributes to an estimated 40,000 deaths among non-smoking adults and 400 deaths of infants every year. Besides the health impact, smoking also increases health care utilization, health care costs, and absenteeism from work.

Electronic cigarettes (vapes) usually contain nicotine and are an emerging issue in tobacco use and cessation. According to the Centers for Disease Control, in 2022, more than 2.55 million U.S. middle and high school students had used e-cigarettes in the past 30 days. This includes 14.1% of high school students and 3.3% of middle school students. The Food and Drug Administration reported that e-cigarette use, from 2017 to 2018, increased 78% among high school students and 48% among middle school students. Additionally, 4.5% of adults aged 18 or older are e-cigarette users, with highest use among those between 18-24 years of age. Adults who are between the ages of 18-44 are more likely to smoke both cigarettes and vape in comparison with adults 45 years of age or older (Kramarow & Elgaddal, 2023).

E-cigarettes are not currently approved by the FDA as a quit-smoking aid. The U.S. Preventive Services Task Force, has concluded that evidence is insufficient to "assess the balance of benefits and harms of e-cigarettes for tobacco cessation in adults, including pregnant persons." The USPSTF (2021) recommends that clinicians direct patients who use tobacco to other tobacco cessation interventions with proven effectiveness and established safety. Based on evolving evidence, ASH does not currently support e-cigarettes as a viable method of tobacco cessation or nicotine replacement.

SCREENING RECOMMENDATIONS

The 2008 clinical practice guideline by the U.S. Department of Health and Human Services advises that healthcare providers should inquire about tobacco use among all patients and consistently document this information in their medical records (Fiore et al., 2008).

The inclusion of tobacco use status has been recommended in patient intake forms and clinic screening systems as a fifth vital sign.

The strength of evidence for this recommendation was designated as Level A, meaning that "multiple well-designed randomized clinical trials, directly relevant to the recommendation, yielded a consistent pattern of findings." In a meta-analysis of nine studies, it was found that including patient report of tobacco use status in patient records through the use of screening systems significantly increased the rate of clinician intervention. However, a meta-analysis showed that use of a clinic system to identify and track patients' tobacco use status, alone, did not significantly increase rates of cessation.

In addition, the USPSTF (2021) provided the following recommendations for adults:

Grade A Recommendation: Clinicians should ask all adults about tobacco use, advise them to stop using tobacco and provide behavioral interventions and US Food and Drug Administration (FDA) approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.

Grade A Recommendation: Clinicians should ask all pregnant persons about tobacco use, advise them to stop using tobacco and provide behavioral interventions for cessation to pregnant persons who use tobacco.

Documentation Requirements to Substantiate Medical Necessity

CPT® Code	CPT® Code Description
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than three (3) minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

The 5As comprise a framework frequently used in clinical practice to guide behavioral interventions. Within the following 5 As are examples of how each step can be applied to tobacco cessation.

1) **Ask:**
   - Ask every patient about tobacco use at each visit.
   - Record the response in the patient's chart.

2) **Advise:**
- Provide the patient with a clear, non-judgmental statement about how important it is to stop smoking.
- Discuss the increased risk of tobacco use to the patient's health.
- Discuss benefits of quitting for health, family, and economics (e.g., cost savings).

3) **Assess:**
- Ask the patient about their willingness to quit.
- Provide interventions to a patient not yet willing to quit. Explore why they are not motivated to quit at this time. What are the advantages and disadvantages of smoking? Identify the patient's core values and how they are related to tobacco use.
- If they are willing to quit, offer brief intervention, referral sources, schedule follow up plan.
- Assess for any medical and/or psychological condition(s) which may contraindicate or complicate tobacco cessation (e.g., COPD, schizophrenia). Consultation with the primary care physician in such circumstances should be obtained prior to cessation of tobacco use.

4) **Assist:**
- Help the patient make a quit plan. Set a date, ideally within 2 weeks.
- Help the patient change their environment (e.g., cleaning ash trays out of the home).
- Assist patient with establishing a social support system for help with quitting.
- Identify and plan for dealing with tobacco triggers or other challenges before or after quitting tobacco (e.g., co-workers who smoke, stress).
- Discuss relapse prevention; Develop coping skills to maintain a desire to quit.
- Ask about the patient's interest in medications and refer if medications are desired.
- Provide supplemental self-help materials and referrals information such as quit lines.
- Assess for environmental barriers (e.g., others smoking at home).
- Discuss previous quit attempts (successes and/or barriers).
- Given alcohol's relation to relapse, consider limiting use while quitting.
- Discuss nicotine withdrawal symptoms.
- Discuss steps taken prior to quitting, such as removing all tobacco products from the patient's environment and avoiding using tobacco/nicotine products in places where the patient spends the majority of their time.
- Discuss making home smoke-free.
- Provide support to address family and friends who use tobacco.
- Provide encouragement and support to quit.

5) **Arrange:**
   - Follow up within the first week after quit date and again within the first month.
   - Follow-up can be by phone, texting, in person or by e-mail.
   - Congratulate successes.
   - Provide out of office visit clinician support to maintain quitting (e.g., email, phone, texting, walk-in).
   - Encourage and support a prolonged quitting.
   - Relapse prevention/intervention to support long term tobacco cessation.
   - Reinforce the positive health benefits immediately following quitting and for prolonged cessation.
   - Records should indicate that patients participating in a tobacco cessation program are asked about their tobacco use at every visit (prior, during, and after quitting).

According to the USPSTF, there is a dose-response relationship between quit rates and the intensity of counseling (that is, more or longer sessions improve quit rates). Quit rates appear to plateau after 90 minutes of total counseling contact time. Combination therapy with counseling and medications is more effective at increasing cessation rates than either component alone.

EFFECTIVE INTERVENTIONS

The practitioner should carry out an assessment to determine the most appropriate course of tobacco cessation treatment for the patient. Figure 1 (below) provides a guideline (adapted from Hughes, 2013) that the practitioner can utilize for the assessment and management of tobacco cessation treatment. If the counseling and/or medication interventions are outside of the expertise and scope of practice of the practitioner, then it is helpful to educate the patient that counseling and medication can be effective and refer the patient to an appropriate health care professional for further assistance.

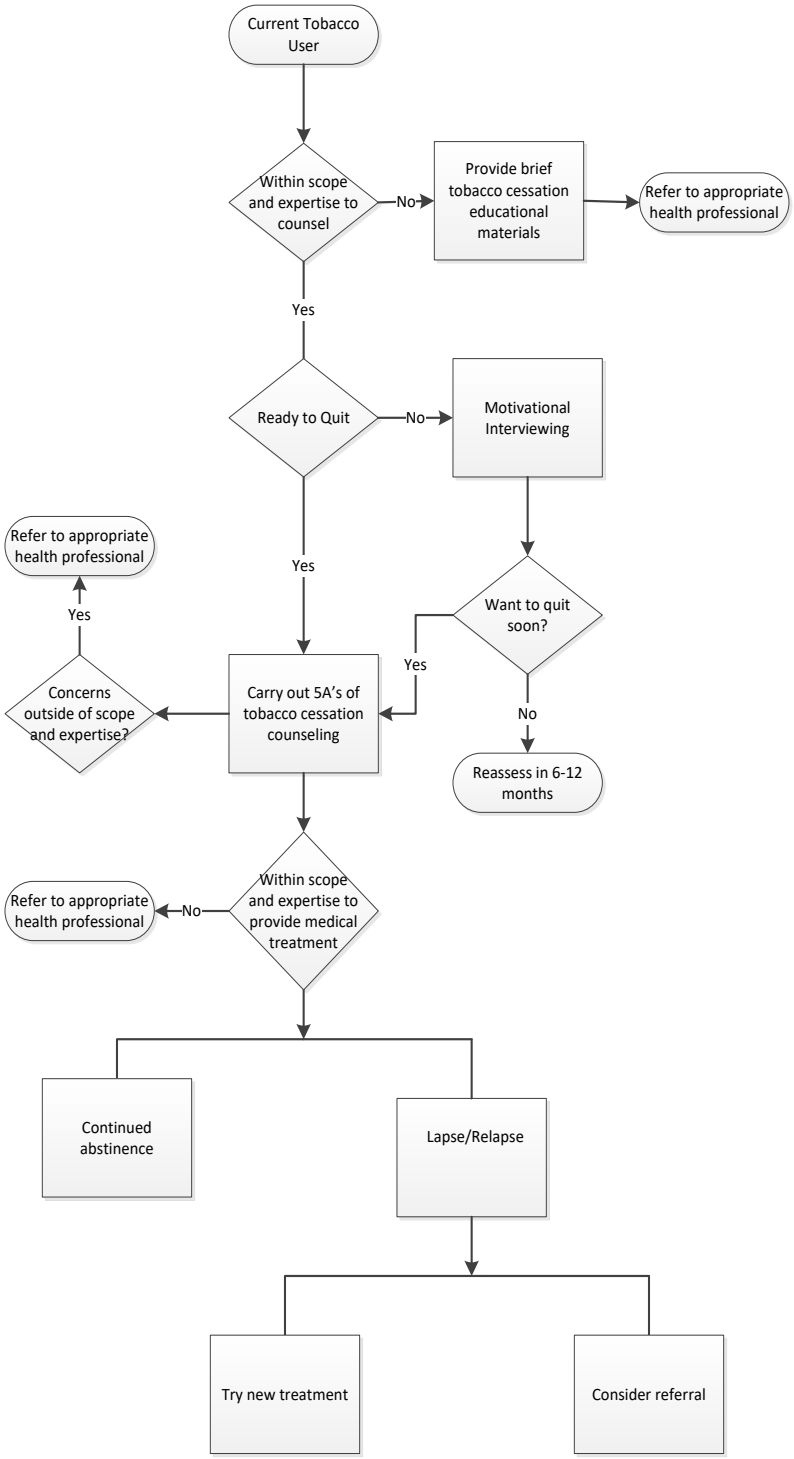

Figure 1: Tobacco Cessation Intervention Assessment Algorithm (adapted from Hughes, 2013)

Counseling

Community-based tobacco-control programs have been effective, judging by the decline in adult smoking prevalence in the U.S. from 20.9% in 2005 to 11.5% in 2021 (Centers for Disease Control and Prevention, 2023). At the individual level, it has been documented that personalized advice from their doctor influences patients to quit, when compared to patients not advised to quit. Brief counseling of 3 minutes or less by a physician has been shown to be effective in achieving prolonged abstinence, compared to no intervention. Higher-intensity counseling sessions >10 minutes have achieved abstinence rates of 22.1%, nearly twice those of brief counseling of <3 minutes, 13.4%. Use of state quit lines for telephone counseling has been shown to be effective compared to no counseling or self-help only.

Evidence-Based Behavior Modification Techniques

A recommendation published by the Department of Health and Human Services (Fiore et al., 2008) reported that 2 types of counseling and behavioral therapies result in higher abstinence rates: (a) providing smokers with practical counseling (problem-solving skills/skills training), and (b) providing support and encouragement as part of treatment. The panel recommended that these types of counseling elements should be included in smoking cessation interventions. Examples of these include:

- **Problem solving/ skills training:** Recognize danger situations – Identify events, internal states, or activities that increase the risk of smoking or relapse.
- **Develop coping skills:** Identify and practice coping or problem-solving skills. Typically, these skills are intended to cope with danger situations.
- **Provide basic information:** Provide basic information about smoking and successful quitting.

According to a meta-analysis by Hartmann-Boyce et al. (2021), smoking cessation rates can be increased at 6 months or longer through behavioral support without evidence that suggests that there is increased harm. This is true whether psychopharmacotherapy is also provided, although this effect is slightly more pronounced when the latter is absent. In fact, evidence of benefits is strongest when counseling of any kind is employed and guaranteed financial incentives. There might also be benefit from interventions that are more individually tailored; delivered by text message, email, or audio recording; delivered by a lay health advisor; and content with motivational components, as well as a focus on how to quit.

Counseling can be effective when used alone, however the combination of counseling and medication is more effective than either strategy used on its own (Stead et al., 2012). The use of medications is effective in combination with counseling, except for situations in which it may be contraindicated, or with populations in which medication use has not been found to be effective.

Medications

In addition to counseling, all smokers making a quit attempt may be offered medications, or referrals for medication evaluations as appropriate.

Though evidence and guidelines suggest medication, practitioners must consult within their scope of licensure. This guideline does not suggest communication about medication if such activity is outside the practitioner's scope of practice.

Over-the-counter products include nicotine gum, patches, and lozenges. It is important to thoroughly review the directions prior to use. Prescription nicotine replacement products include nasal and oral inhalers. Oral prescription medications for tobacco cessation that do not contain nicotine include bupropion and varenicline.

Electronic cigarettes (e-cigarettes or electronic nicotine delivery systems) are a group of products that generally provide aerosolized nicotine without the use of tobacco. They are readily available to the public and are touted as an aid to tobacco cessation or as a replacement for cigarettes where smoking is prohibited (Grana, 2014). The short- and long-term efficacy and comparative efficacy with approved tobacco cessation products is not yet fully known. A systematic review showed good results with smoking abstinence at one month, but abstinence at 3 and 6 months was the same as placebo (McRobbie et al., 2014). The toxicity of e-cigarettes is not yet clear and further research is needed to evaluate their safety for the direct user and those with second-hand exposure (Hartmann-Boyce et al., 2021). When used as a therapeutic intervention, the use of e-cigarettes may have a negative effect on nicotine abstinence in comparison to nicotine replacement therapies. This is, most smokers who quit smoking cigarettes with the help of e-cigarettes continued using e-cigarettes until the end of random controlled trials (Hanewinkel et al., 2022).

Nicotine withdrawal symptoms include irritability, cravings, depression, anxiety, cognitive and attention deficits, sleep disturbances, and increased appetite. These symptoms may begin within a few hours after the last cigarette, quickly driving people back to tobacco use. Symptoms peak within the first few days of smoking cessation and may subside within a few weeks. For some people, however, symptoms may persist for months. The former tobacco user should receive recognition of any success made during a quit attempt and receive strong encouragement to remain abstinent. Relapse is most likely to occur soon after quitting, but the risk for relapse can continue for months, or even years. All very recent quitters should be given assistance; therefore, it is important to regularly ask those who have quit if they are facing any challenges, such as temptations to smoke, close calls for slips and relapses, or serious thoughts about starting again. Former tobacco users who report such challenges should be given additional tobacco cessation assistance.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a patient only if they are trained to competency, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the patient to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a patient's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is essential for the practitioner to refer the patient for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

PRACTITIONER RESOURCES

One way to assist patients with tobacco cessation is by using a tear sheet. The tear sheet can allow clinicians to individualize an intervention and can be given to patients as a takeaway.

- Tear Sheet for Use with Patients – English (http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/tearsheets/tearsheet.pdf)
- Quick Reference Guide for Clinicians (https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/tobaqrg.pdf)
- Material Links for Clinical Websites and Blogs (http://www.smokefree.gov/)

Spanish Language

- Tear Sheet for Use with Patients - Spanish (http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/tearsheets/tearsheetsp.html)
- Material links for Clinical Websites and Blogs – Spanish (https://espanol.smokefree.gov/)

MEMBER RESOURCES

Educating patients about tobacco cessation options and available resources can assist the patient. Publicly available resources can be found at:

- Tobacco Cessation – What You Need to Know About Smoking (http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/pdfs/what-you-need-to-know.pdf)
- Tools to Help You Quit (https://www.smokefree.gov/)

Federal resources are available to patients to assist in quitting tobacco products:

- Visit https://smokefree.gov/
- Visit the CDC's website on how to quit smoking (with links to Spanish content as well): https://www.cdc.gov/tobacco/campaign/tips/quit-smoking/index.html
- Talk to a Smoking Cessation Counselor
    - Call 1-800-QUITNOW (1-800-784-8669), a national portal to a network of state quitlines
    - American Lung Association: Lung Helpline and Tobacco Quitline:
        - 1-800-LUNG-USA (1-800-586-4872) & for the hearing impaired TTY 1-800-501-1068
- Get Instant Messaging Live Help (https://livehelp.cancer.gov/app/chat/chat_launch)
- Approved Smoking Cessation Products (http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm198176.htm)

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