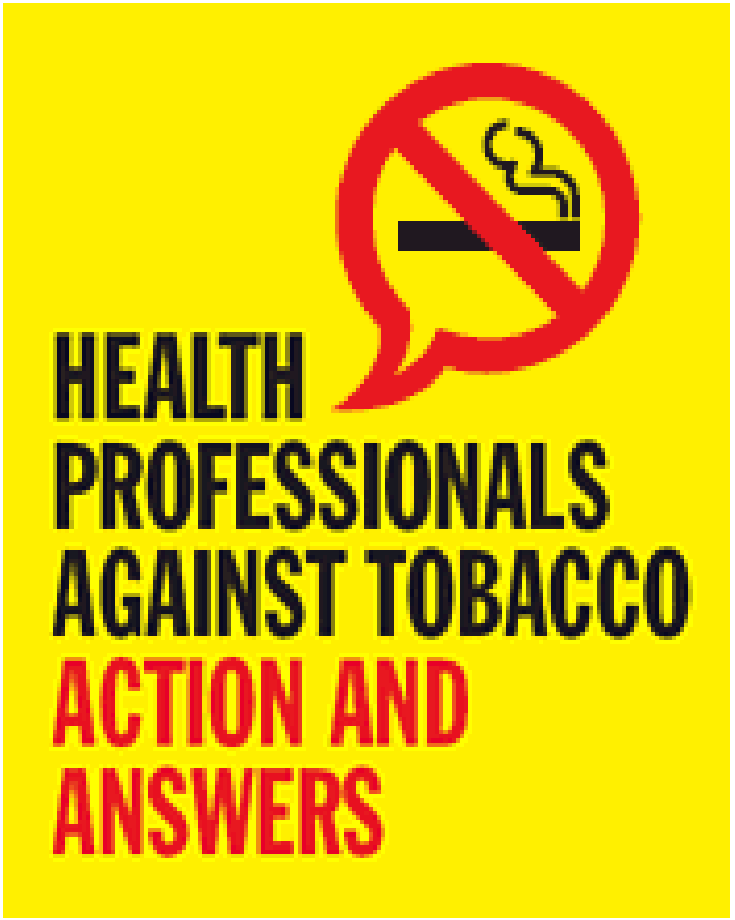
Part III- Module 1-A

The role of health professionals in tobacco control and tobacco dependence treatment

WNTD Theme in 2005 – Health professionals against tobacco

Doctors, nurses, midwives, dentists, pharmacists, chiropractors, psychologists and all other professionals dedicated to health can help people change their behaviour. They are on the frontline of the tobacco epidemic and collectively speak to millions of people.

Dr LEE Jong-wook, former Director-General,
World Heath Organization (2005)



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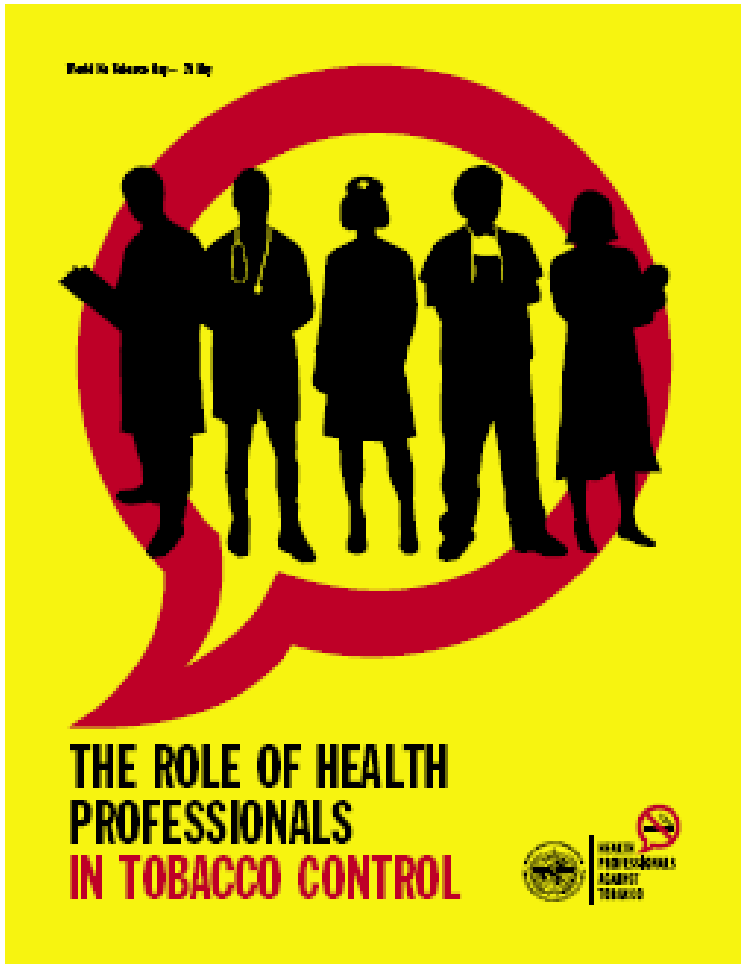
Brainstorming

What is the role of health professionals in tobacco control and tobacco dependence treatment?

The role of health professionals in tobacco control

- Role model
- Clinician
- Educator
- Scientist
- Leader
- Opinion-builder
- Alliance-builder
- Watching out for tobacco industry activities



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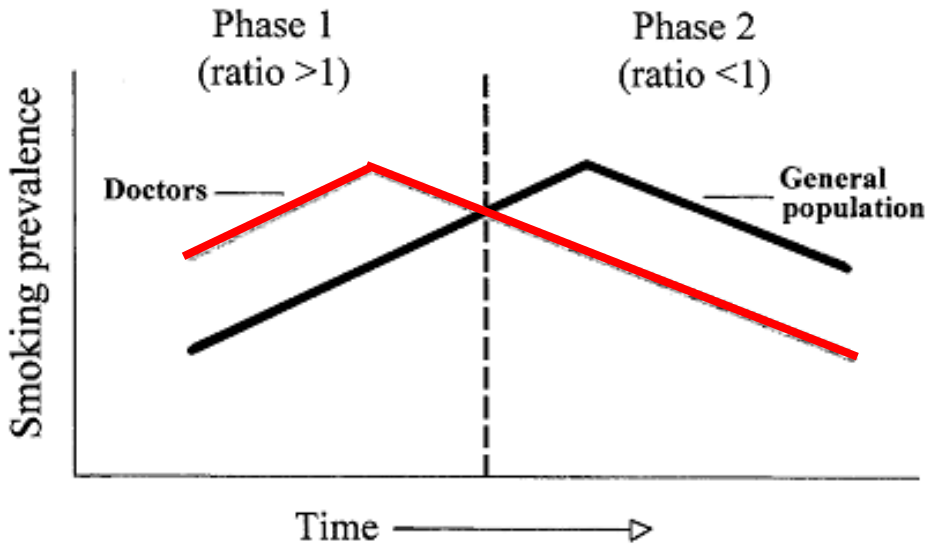
Role model

- Health professionals are the most knowledgeable in health matters and they are expected to be tobacco-free role models for the rest of population

- Professionally respected and popularly revered, they could lead the decline of smoking prevalence in general population



Source: When doctors smoke. Tobacco control. 1993;2:187-188

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Role model

- However, in many countries smoking prevalence among health professionals is similar to that of the general public

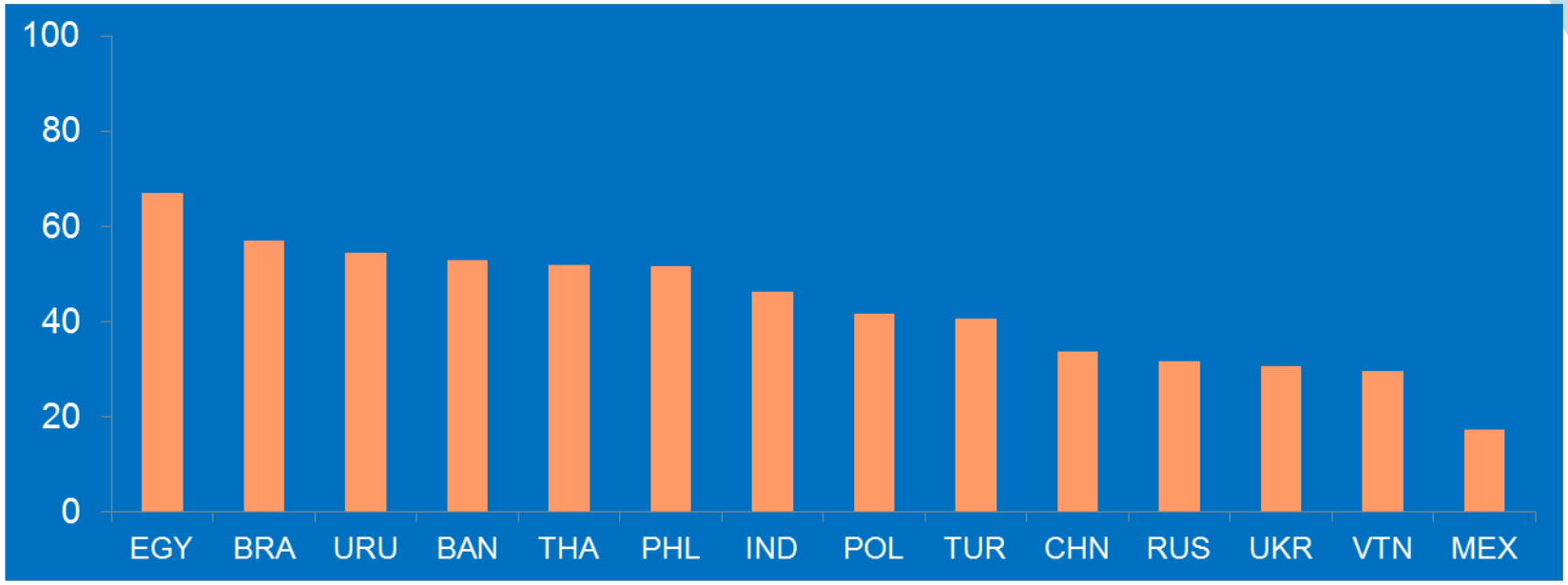
		Health professionals	General population
China	Males	40%	52.9%
	Females		2.4%

- Smoking status will affect health professionals' other roles in tobacco control:
  - Less likely to promote smoking cessation or engage in tobacco control
  - Damage their image and credibility as spokesperson on tobacco control

Source: Global Adult Tobacco Survey 2010

Clinician

- All health professionals need to:
  - Address tobacco dependence as part of their standard of care practice
  - Assess exposure to secondhand smoke and provide information about avoiding all exposure
- Current level of provision – Smokers advised to quit by a health care provider in the past 12 months



Source: Global Adult Tobacco Survey 2008-2010

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Educator

- Health professionals play an important role in preparing new generations of health professionals
- However, tobacco control content, both theoretical and practical, in health professional schools is inadequate
  - Less than 33% of the health professions students have received formal training in patient counseling
- Good news: 90% of students have desire to receive formal training in patient counseling

Source: GHPSS data

Scientist

- All health professionals should be encouraged to do research to find facts and evidence:
  - It was medical professions who first noticed an increase in lung cancer in 1930s and began to identify smoking as a leading cause of the increase in lung cancer rate by 1950s.
- All health professionals should be aware of evidence on effective tobacco control measures
- Health professionals have a duty to mobilize funding resources for research in addressing the tobacco epidemic

Source: The beginner's guide to tobacco control 2009

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Leader

- Many health professionals have leadership positions at different levels:
  - Local leader/employer
  - National political health authority
- Activities health professionals can take in the positions of leadership:
  - Getting involved in policy-making process to support comprehensive tobacco control measures
  - Supporting tobacco control measures at their own workplace
  - supporting the implementation of the Code of Practice on Tobacco Control for Health Professional Organizations

Code of Practice on Tobacco Control for Health Professional Organizations

Preamble: In order to contribute actively to the reduction of tobacco consumption and include tobacco control in the public health agenda at national, regional and global levels, it is hereby agreed that health professional organizations will:

1. Encourage and support their members to be role models by not using tobacco and by promoting a tobacco-free culture.
2. Assess and address the tobacco consumption patterns and tobacco-control attitudes of their members through surveys and the introduction of appropriate policies.
3. Make their own organizations' premises and events tobacco-free and encourage their members to do the same.
4. Include tobacco control in the agenda of all relevant health-related congresses and conferences.
5. Advise their members to routinely ask patients and clients about tobacco consumption and exposure to tobacco smoke, using evidence-based approaches and best practices, give advice on how to quit smoking and ensure appropriate follow-up of their cessation goals.
6. Influence health institutions and educational centres to include tobacco control in their health professionals' curricula, through continued education and other training programmes.
7. Actively participate in World No Tobacco Day every 31 May.
8. Refrain from accepting any kind of tobacco industry support–financial or otherwise-and from investing in the tobacco industry, and encourage their members to do the same.
9. Ensure that their organization has a stated policy on any commercial or other kind of relationship with partners who interact with or have interests in the tobacco industry through a declaration of interest.
10. Prohibit the sale or promotion of tobacco products on their premises, and encourage their members to do the same.
11. Actively support governments in the process leading to signature, ratification and implementation of the WHO Framework Convention on Tobacco Control.
12. Dedicate financial and/or other resources to tobacco control-including dedicating resources to the implementation of this code of practice.
13. Participate in the tobacco-control activities of health professional networks.
14. Support campaigns for tobacco-free public places.

Leader

"No country in the world has made significant progress in curbing the tobacco epidemic without its doctors … take a leadership role in advocating for comprehensive tobacco control laws."

- **Example: Doctors speak out on behalf of patients**
  - In the United Kingdom, the British Medical Association (BMA) has been calling for legislation to ban smoking in enclosed public places since1986.
  - In November 2004, they appealed to their role as leaders in calling on the United Kingdom's Health Secretary to set a date for banning smoking in public places.

Source: 1. Tobacco control strategy planning: 2.The role of health professionals in tobacco control 2005

Opinion-builder

- Health professionals have great potential to build opinion in support of tobacco control
  - Express clearly the magnitude of the tobacco issue
  - Becoming political active or supporting the champions
  - Assisting in disseminating scientific information

Country	Time	Event	Immediate reduction in cigarette consumption
UK	**1962**	**1st report of the Royal College of Physician**	**5%**
The US	**1964**	**1st Surgeon General Report**	**1-2%**

Source: Kenkel and Chen, 2000

Alliance-builder

- Health professionals should always consider in cooperation with other groups because tobacco control is no one's domain but everyone's business

- Forming alliances between societies and organizations can have a much greater impact and the benefits.

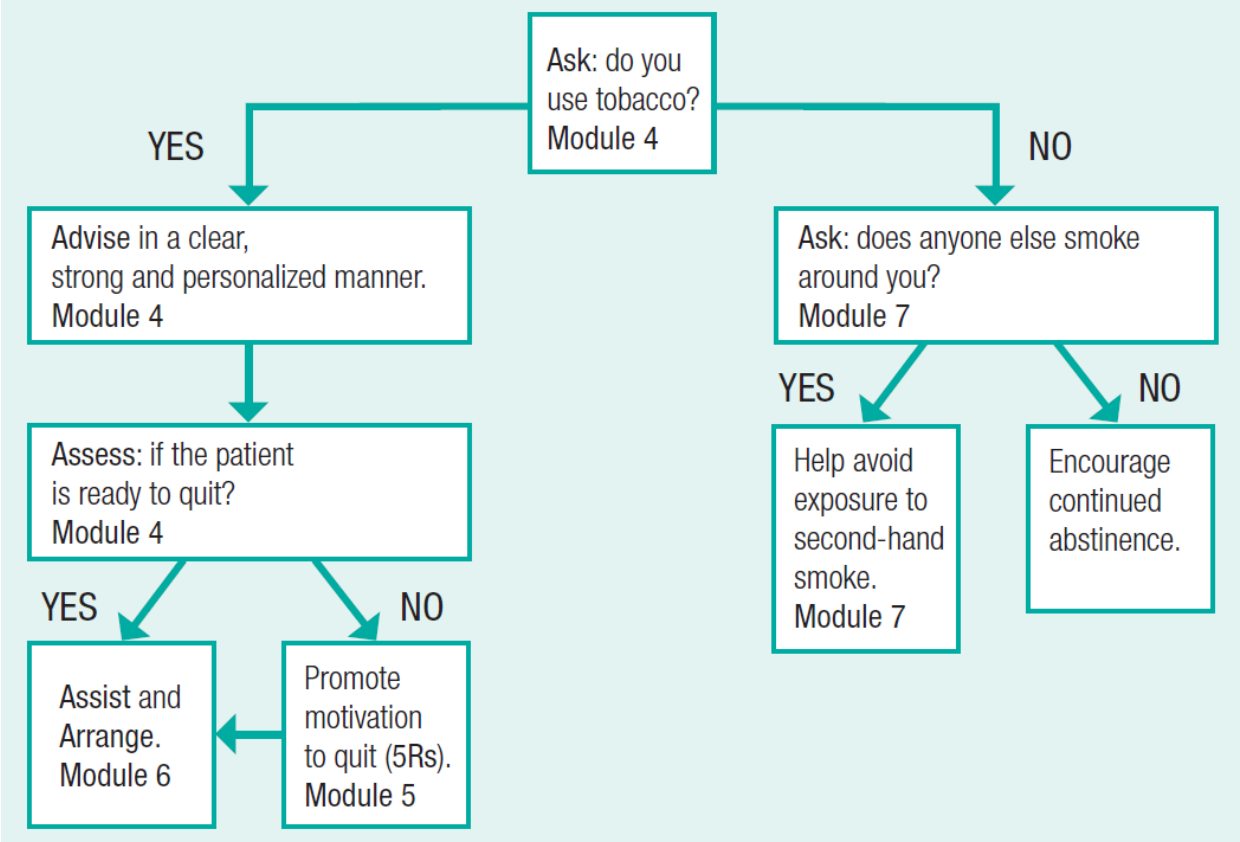
Watching out for tobacco industry activities

- **Health professionals, as individuals or associations have a duty to denounce tobacco industry strategies, which may include**
  - Using public relations to present itself in positive ways
  - Using money to fund political events
  - Giving money to various organizations
  - Employing well-connected lobbyists

- **Health professionals need to take a stand against the negative influence of tobacco industry money in many aspects of our society**
  - Refusing to accept funding from the tobacco industry
  - Regulating interaction with the tobacco industry
  - Raising awareness of the tobacco industry influence

Summary

This training will focus on their role as clinician to address tobacco dependence and secondhand smoke exposure as part of their standard care practice using the algorithm below:



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Part III- Module 1-B

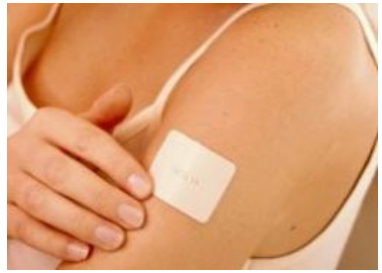
Effective tobacco dependence treatment methods

Brainstorming

What tobacco dependence treatment methods can you use to help tobacco users?

Effective tobacco dependence treatment methods

- **Behavioral interventions:**
  - Self-help interventions
  - Physician advice
  - Nursing intervention
  - Individual behavioral counseling
  - Group behavioral therapy
  - Telephone counseling (quitlines)
  - Quit and Win competitions
- **Pharmacologic interventions:**
  - Nicotine replacement therapy (NRT)
  - Bupropion
  - Varenicline
  - Cytisine
  - Clonidine
  - Nortriptyline



More intensive or longer lasting treatments are more likely to help tobacco users quit successfully

Level of contact	Number of arms	Estimated odds ratio (95% C.I.)	Estimated abstinence rate (95% C.I.)
No contact	30	1.0	10.9
Minimal counseling (< 3 minutes)	19	**1.3 (1.01-1.6)**	**13.4 (10.9-16.1)**
Low intensity counseling (3-10 minutes)	16	1.6 (1.2-2.0)	16.0 (12.8-19.2)
Higher intensity counseling (> 10 minutes)	55	2.3 (2.0- 2.7)	22.1 (19.4-24.7)

Source: Fiore MC et al. Treating tobacco use and dependence: 2008 update.

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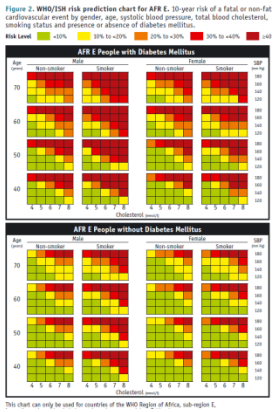
Brief advice

- **Definition in the WHO FCTC Article 14 Guidelines**:
  - Advice to stop using tobacco, usually taking only a few minutes, given to all tobacco users, usually during the course of a routine consultation or interaction.
  - Used interchangeably with brief intervention.

- Brief advice (5As, 5Rs) in clinical setting are
  - Feasible: an opportunistic intervention, can be done within 3-5 minutes
  - Effective: 40% will make a quit attempt, increase quit rate by 30%
  - Efficient: a “good buy” with the potential to reach more than 80% of the general population at least once per year



Source: 1. WHO FCTC Article 14 Guidelines; 2.West et al 2000； 3. Fiore MC et al 2000; 4.WHO NCD report 2011; 5. WHO 2007 Pocket guidelines for assessment and management of cardiovascular risk.

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Part III- Module 1-C

Activities by primary care providers to assist tobacco users to quit within 3 to 5 minutes

5A's brief tobacco interventions

Ask — Ask all patients if they smoke.

Advise — Advise tobacco users that they need to quit.

Assess — Assess ‘readiness’ to quit.

Assist — Assist the patient with a quit plan or provide information on specialist support.

Arrange — Arrange follow up contacts or a referral to specialist support.

Part III- Module 2-A

The impact of tobacco use on tobacco users and others

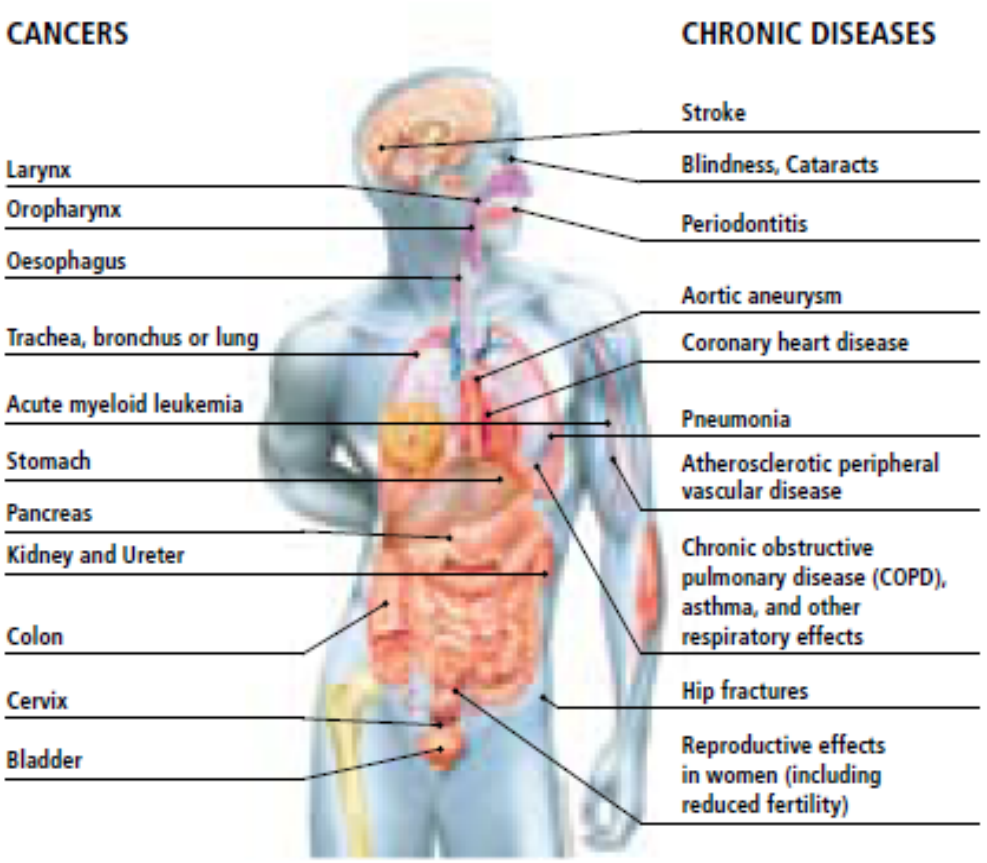
Brainstorming

What is the impact of tobacco use on tobacco users and others?

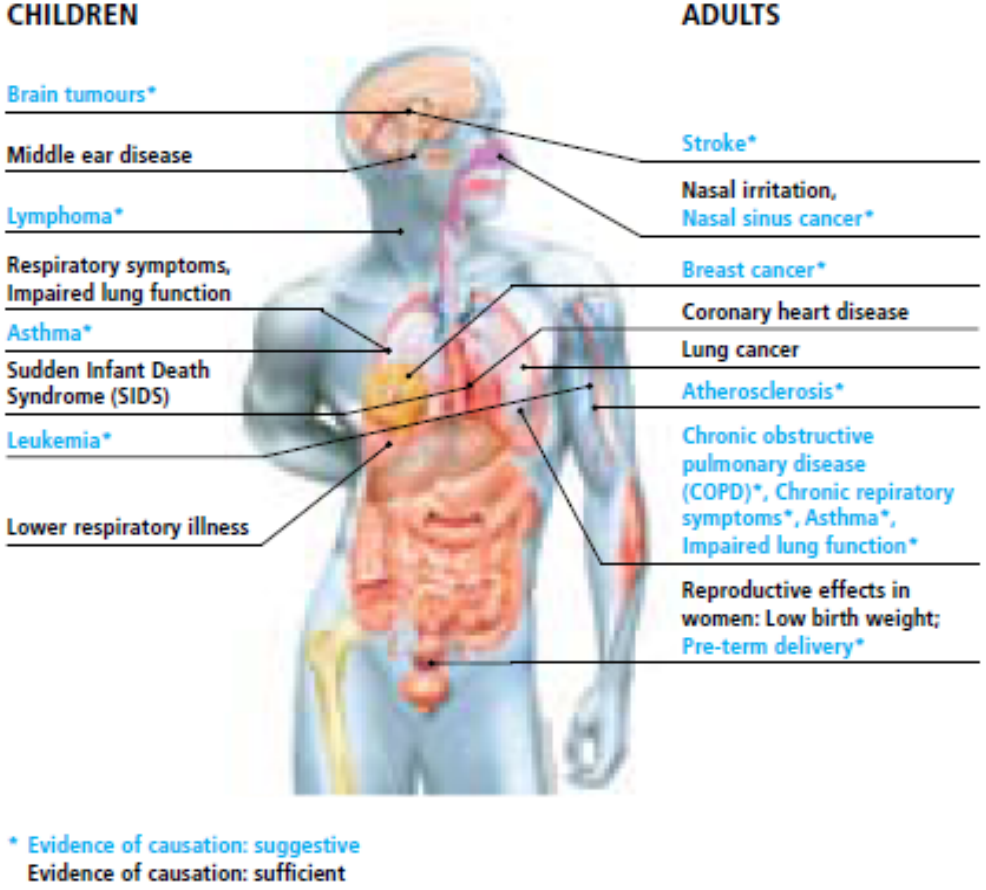
Health impact

Tobacco use and second-hand smoke damage every part of the body

DISEASES CAUSED BY SMOKING



DISEASES CAUSED BY SECOND-HAND SMOKE



* Evidence of causation: suggestive
Evidence of causation: sufficient

Source: WHO Report on the Global Tobacco Epidemic 2008.

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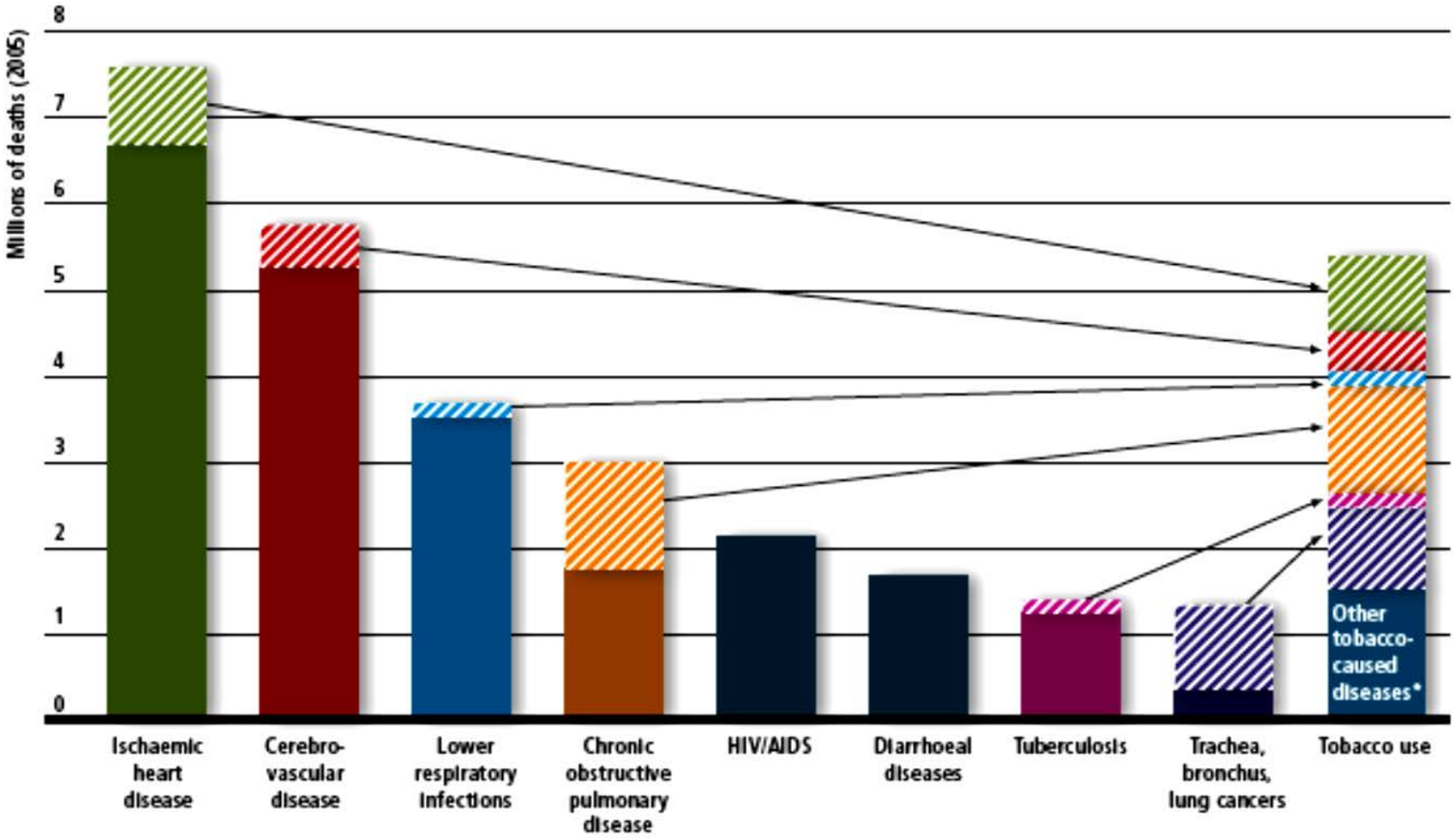
A risk factor for six of eight leading causes of death in the world



Source: WHO Report on the Global Tobacco Epidemic 2008.

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Tobacco kills up to half of its users

- **The tobacco epidemic kills nearly** 6 million people **each year, of whom**:
  - more than 5 million are users and ex users
  - more than 600 000 are nonsmokers exposed to secondhand smoke

Source: WHO Report on the Global Tobacco Epidemic 2011.

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The dangers of smokeless tobacco

- Cancer of the head and neck, esophagus and pancreas, as well as oral diseases
- Heart disease
- Low-birth-weight babies

Source: WHO Report on the Global Tobacco Epidemic 2008.

World Health Organization

More than 4000 chemicals have been identified in tobacco smoke

CHEMICALS CONTAINED IN SECOND-HAND TOBACCO SMOKE (PARTIAL LIST)

- At least 250 of which are known to be harmful
- More than 50 of which are known to cause cancer

Source: WHO Report on the Global Tobacco Epidemic 2011.

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Common misconceptions about health effects of tobacco held by tobacco users

- Light, "ultra-light". "low tar" or "mild" cigarettes are less harmful?
- Are 'rollies' safe to smoke?
- Will cutting down the number of cigarettes I smoke reduce my health risks?
- Only old people get ill from smoking don't they?
- Does everyone who quits smoking put on weight?

Economic impact of tobacco use

Costs to the society

Cost* attributable to tobacco use (2007 or latest available data)	
The United States	167.00 billion
Japan	62.39 billion
Germany	23.75 billion
Canada	17.00 billion
France	15.30 billion
China	5.00 billion
Egypt	1.25 billion

*:Direct health care costs plus indirect costs, including productivity losses, absenteeism and other socioeconomic costs.

Source: Tobacco Atlas online- Cost to economy

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Costs to families and individuals

- **Tobacco products are expensive. The price of 20 Marlboro cigarettes could buy**:
  - a dozen eggs in Panama
  - one kilogram of fish in France
  - four pairs of cotton socks in China
  - 6 kilograms of rice in Bangladesh

- **Tobacco use is costly with 5-15% of tobacco user's disposable income is spent on tobacco**

Source: WHO The tobacco atlas, first version

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Benefits of quitting tobacco use

Brainstorming

The benefits of quitting tobacco use?

Health benefits

Time since quitting	Beneficial health changes that take place
Within 20 minutes	Your heart rate and blood pressure drop.
12 hours	**The carbon monoxide level in your blood drops to normal.**
2-12 weeks	**Your circulation improves and your lung function increases.**
1-9 months	**Coughing and shortness of breath decrease.**
1 year	**Your risk of coronary heart disease is about half that of a smoker.**
5 years	**Your stroke risk is reduced to that of a non-smoker 5 to 15 years after quitting.**
10 years	**Your risk of lung cancer falls to about half that of a smoker and your risk of cancer of the mouth, throat, esophagus, bladder, cervix, and pancreas decreases.**
15 years	**The risk of coronary heart disease is that of a non-smoker's**

Exercise: quit & save

- How much money you can save if you quit?
  - Total money spent on tobacco per day
  - The amount of money spent per year
  - The amount of money spent in ten years
  - You can buy many things with the money saved:

$2

$730

$7300





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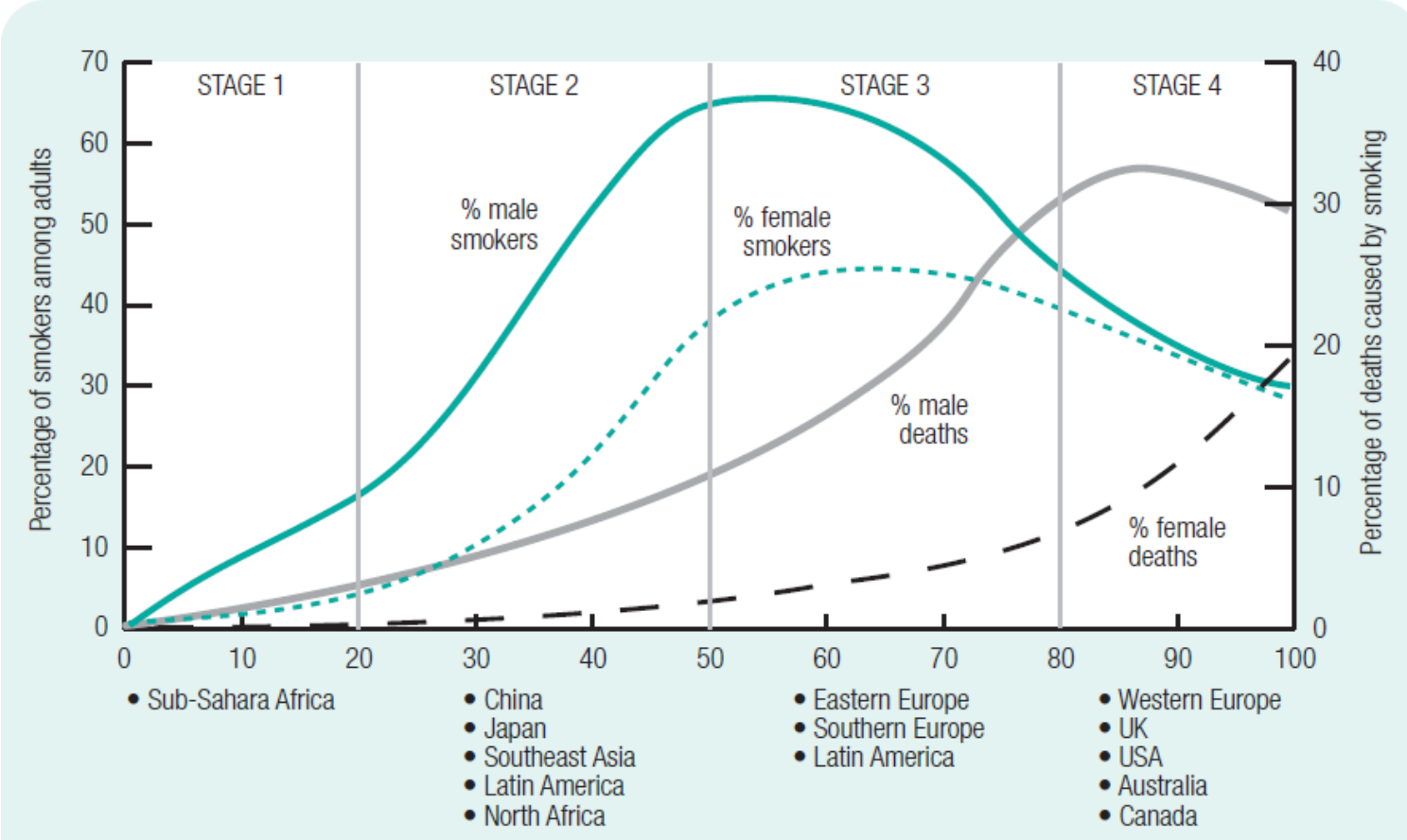
Part Ⅲ- Module 2-B

Overview of local, national, worldwide patterns of tobacco use

Different countries are at different stages in tobacco epidemic

- There are more than one billion smokers in the world. Nearly 80% of them live in low- and middle-income countries



Source: Lopez AD, Collishaw NE, and Piha T. (1994). A descriptive model of the cigarette epidemic in developed countries. Tobacco Control 3: 242-247.

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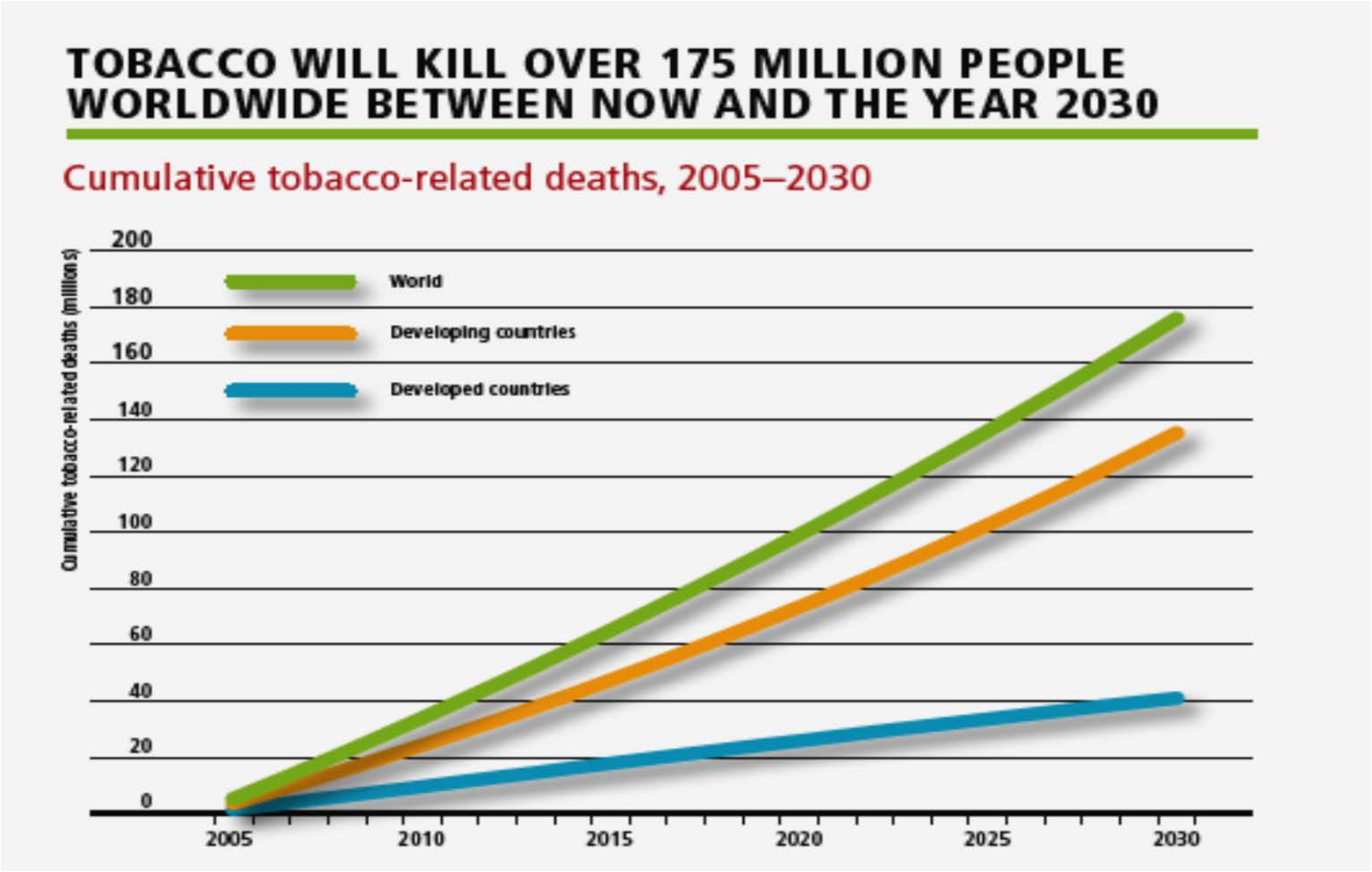
Tobacco is growing fastest in developing countries



Source: the WHO Report on the Global Tobacco Epidemic, 2008

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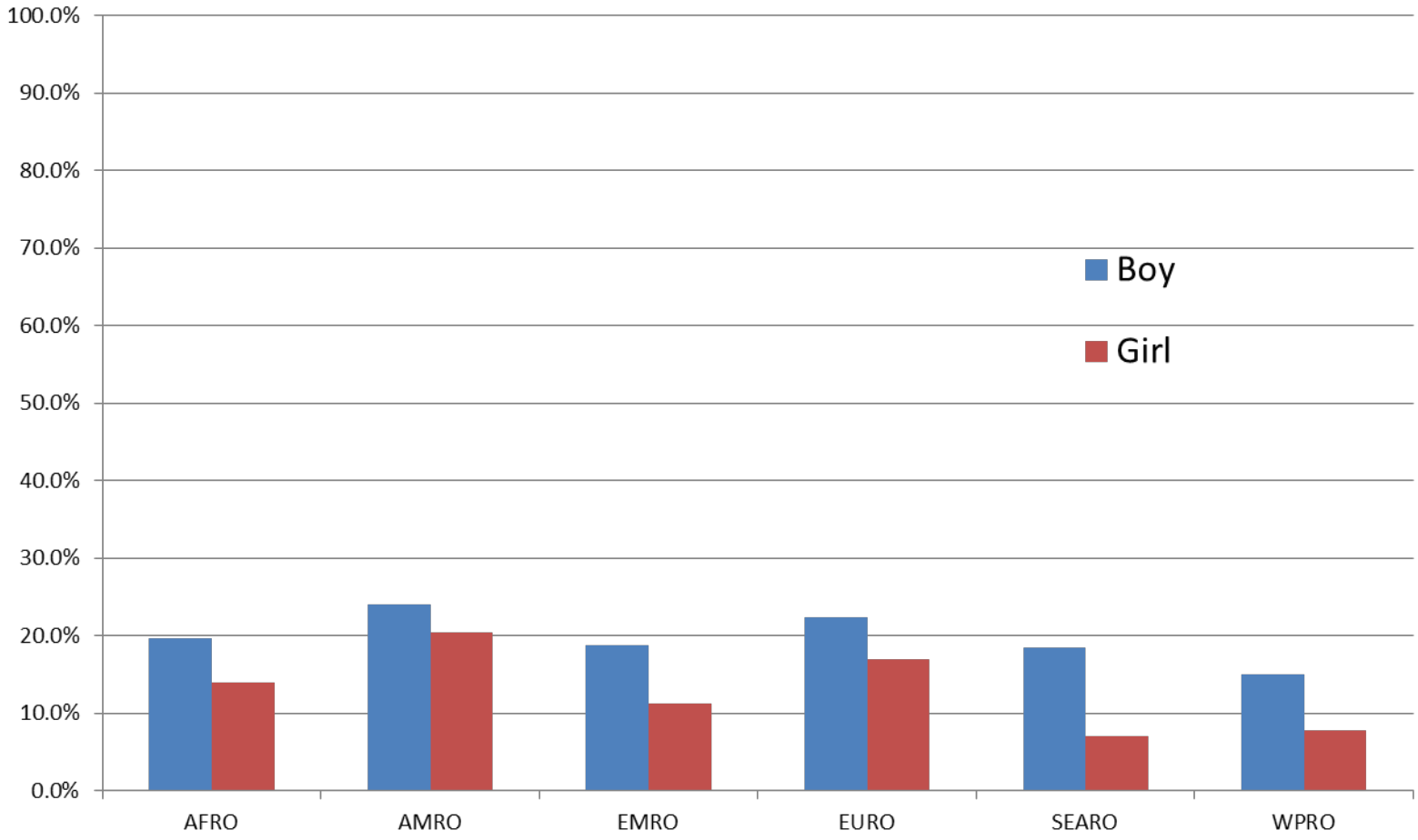
Tobacco use is rising among younger females

GYTS measures of tobacco use, by sex and WHO region 1999-2005



Source: Warren CW, et al. The Lancet 2006

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Local and national patterns of tobacco use

- To be added for each specific country based on:
  - The WHO tobacco control country profiles http://www.who.int/tobacco/surveillance/policy/country_profile/en/index.html
  - National and local data

Part Ⅲ- Module 2-C

Why people smoke but do not quit?

Brainstorming

Why do people smoke?

Understanding why people smoke

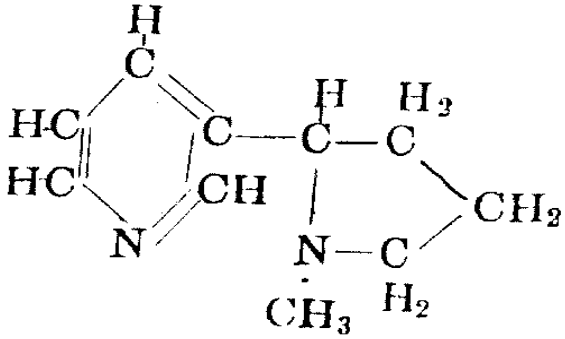
- **People smoke for many reasons**
  - **Addiction**
  - **Social activity**
  - **Stress relief**
  - **Emotional support**
  - **Boredom/filling in time**
  - **Everyone does it**
  - **Sharing of cigarettes**
  - **Bonding/acceptance**

Understanding smoking behaviour

- **Tobacco addiction is made up of three parts:**
  - **Physical/physiological dependence**
  - **Emotional/psychological connection**
  - **Habitual and social connection**

Physical addiction

- **A major factor that maintains a smoking habit over time is addiction to nicotine**



- **Nicotine has been shown to have effects on brain dopamine systems similar to those of drugs such as heroin and cocaine.**
  - It gradually increase the number of nicotinic receptors in the brain
  - Smokers need greater amounts of tobacco to bind to the growing number of nicotinic receptors in order to achieve the same levels of satisfaction.

Physical addiction

- **Nicotine**
  - **Not a carcinogen**
  - **Liquid in its native state**
  - **Distilled from burning tobacco and carried on tar droplets**
  - **Only free (unprotonated) nicotine crosses biological membranes**
  - **Inhalation: peak arterial concentration 2-4 X venous concentrations**
  - **Half-life 120 minutes**

Inhalation is the quickest way For nicotine to reach the brain

Nicotine

↓ Lung

Arterial bloodstream

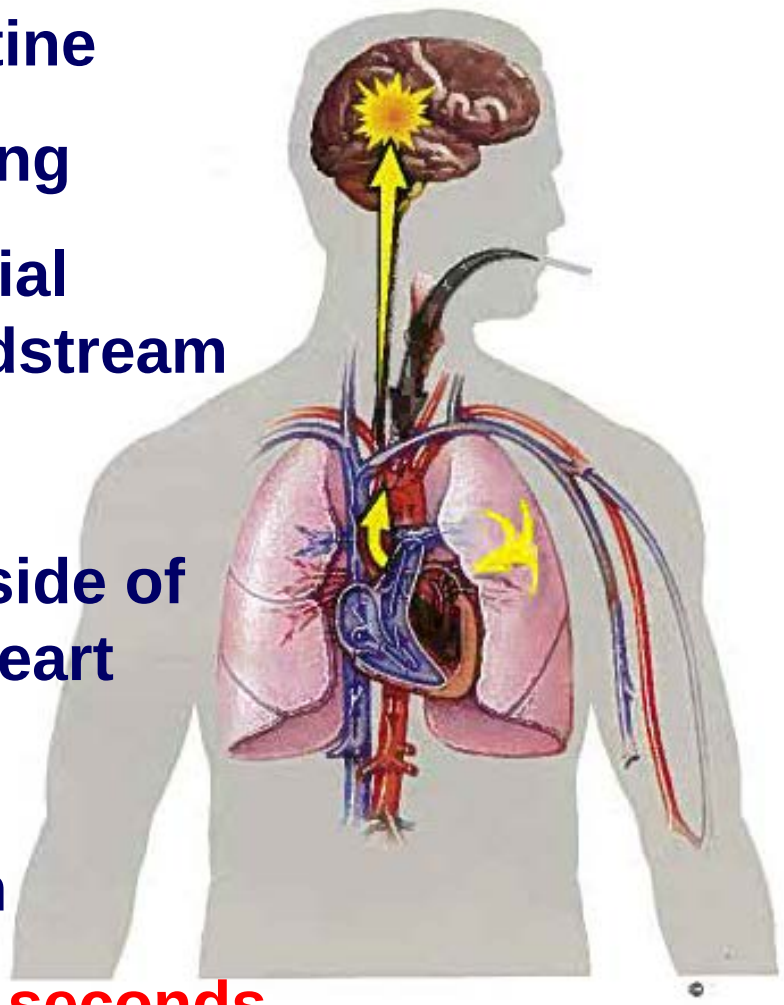
↓

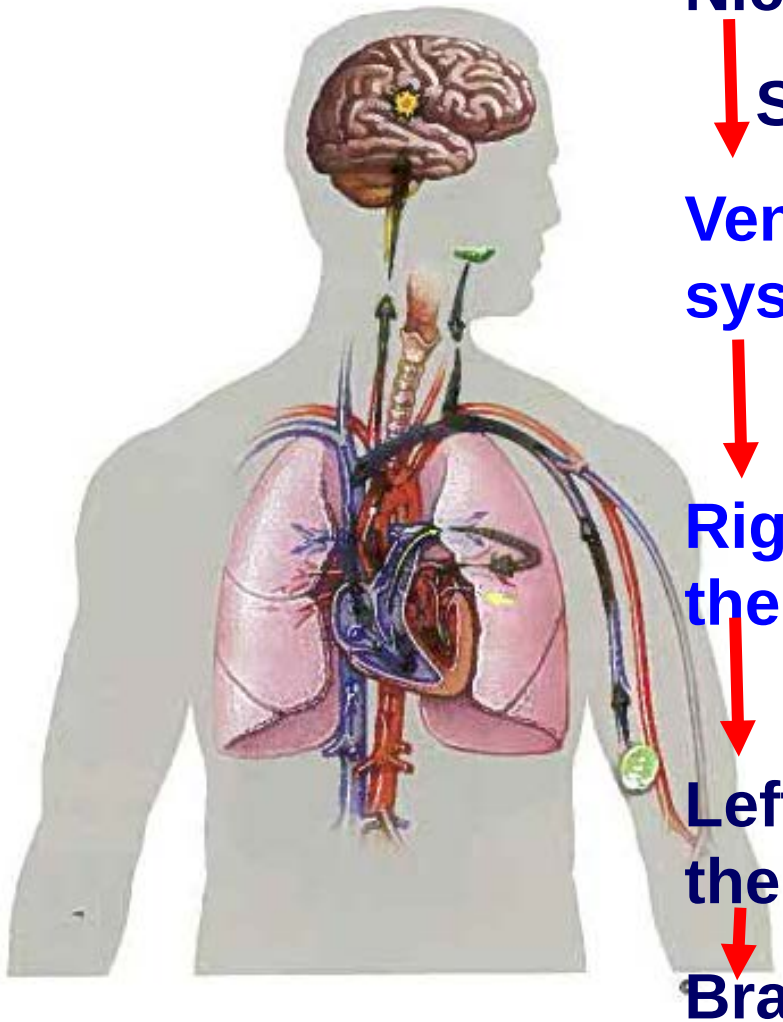
Left side of the heart

↓

Brain

7 -10 seconds





Nicotine

↓ Skin

Venous system

↓

Right side of the heart

↓

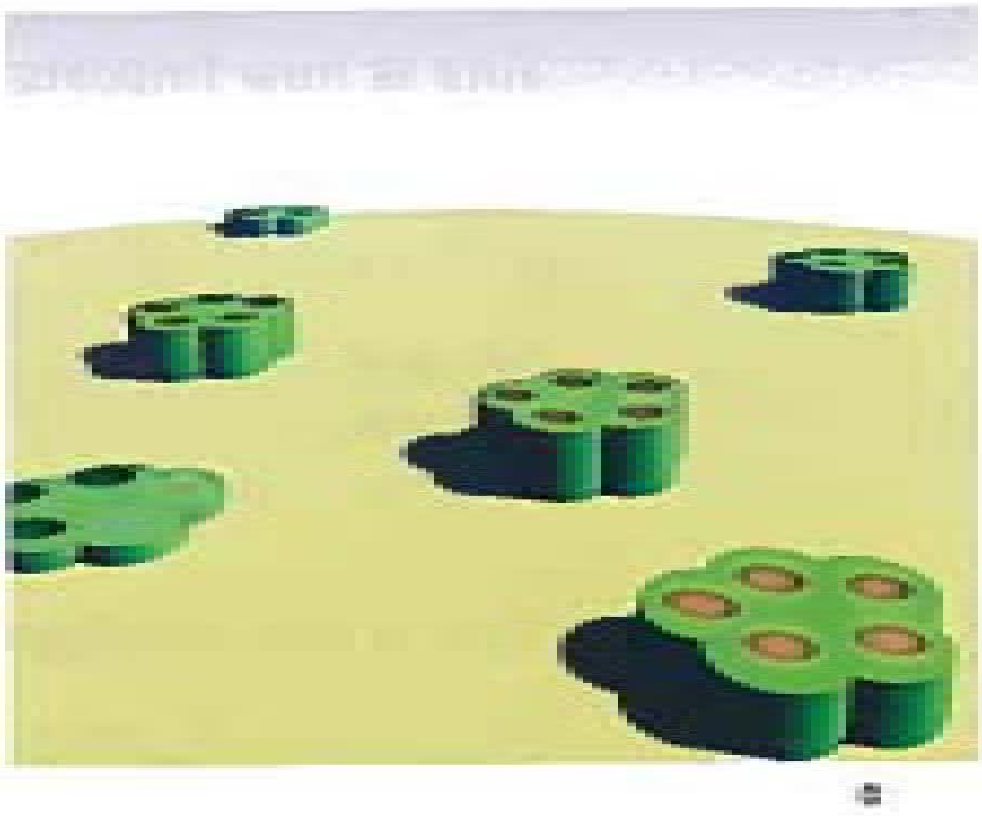
Left side of the heart

↓

Brain

Nicotine Withdrawal

- Nicotine increases the number of nicotinic receptors in the brain
- When receptors are empty, they make you feel uncomfortable and increase your urge to smoke



Nicotine Withdrawal

- **Withdrawal is your body's response to no more nicotine/the adjustment of the body to living without nicotine**
- **Withdrawal symptoms are a product of your body's physical or psychological adaptation, positively referred to as recovery symptoms**
- **Withdrawal symptoms are normally temporary (2- 4 weeks)**
- **Most smokers know about withdrawal symptoms, through hearsay or from direct experience. They can be a major barrier against staying quit, or even attempting to quit in the first place.**

Nicotine Withdrawal

- **Common withdrawal symptoms :**
  - **Headaches**
  - **Coughing**
  - **Cravings**
  - **Increased appetite or weight gain**
  - **Mood changes (sadness, irritability, frustration, or anger)**
  - **Restlessness**
  - **Decreased heart rate**
  - **Difficulty concentrating**
  - **Flu-like symptoms**
  - **Insomnia**

Video from Mayo Clinic: Stop Smoking- Why is it so hard to quit

Emotional/psychological connection

- **Smokers link feelings with cigarettes via the process of withdrawal and 'operant conditioning'**
- **Some of the emotional connections that may be associated with smoking:**
  - Stressed → craving → cigarette
  - Happy → craving → cigarette
  - Sad → craving → cigarette
  - Angry → craving → cigarette
- **Your cognitions (i.e. – thoughts and beliefs) have effect on smoking too.**

Smoking Cognitions – Some Pro's

World Health Organization

Smoking Cognitions – Some Con's

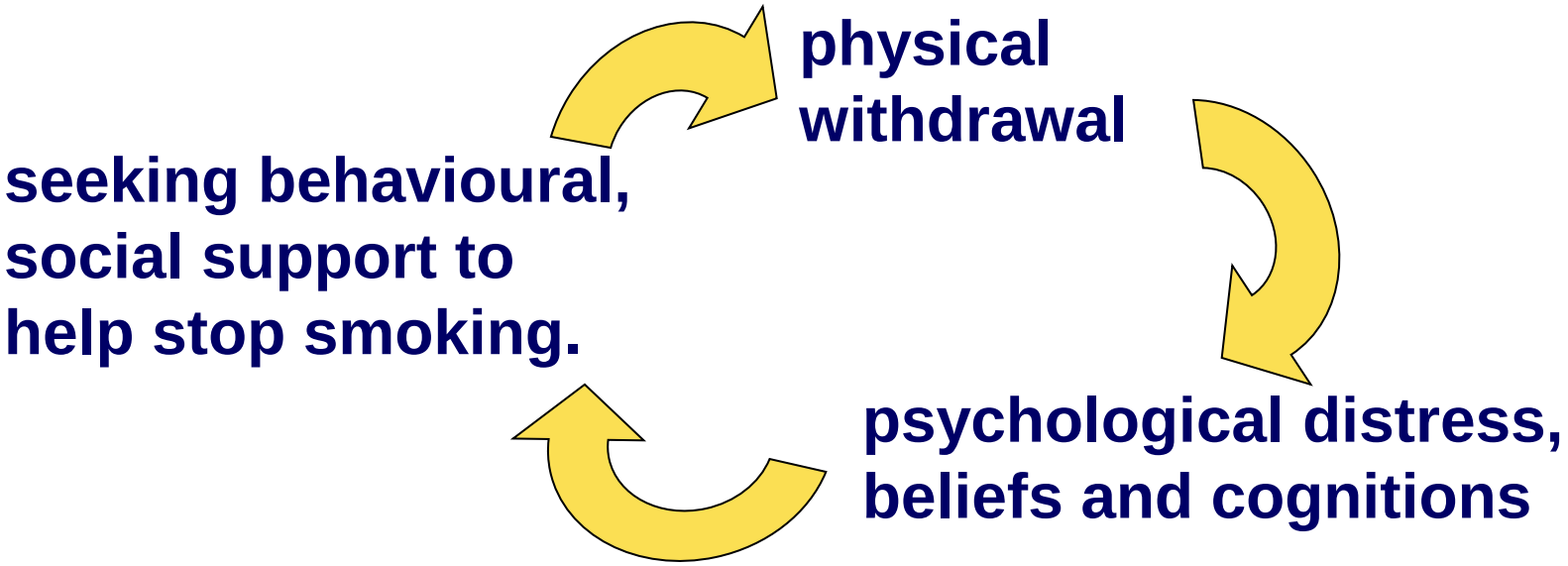
World Health Organization

Habitual and social connection

- **Smokers link behavior with cigarettes via the process of 'operant conditioning'. Some of the habits that may be associated with smoking:**
  - Coffee → craving → cigarette
  - The end of meal → craving → cigarette
  - phone → craving → cigarette
  - Watching TV → craving → cigarette
- **Smoking is also prone to social influences:**
  - These processes start early! Children are more likely to start smoking if their parents smoke
  - Later on in life we smoke with friends – it's a social thing to do.

Interactions between Factors

The physical, psychological and social influences are not independent of each other.



All three types of factors influencing smoking need to be explored and referred to in stop smoking support programmes.

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Part Ⅲ- Module 3-A

The purpose, impact and delivery models of brief tobacco interventions

Purpose

- **The primary purpose of a brief tobacco intervention is to help the patient:**
  - understand risk of tobacco use and the benefits of quitting
  - motivate them to make a quit attempt

- **Brief tobacco interventions can also be used to encourage those heavy tobacco users to seek or accept a referral to more intensive treatments within their community**

The population impact

- **The success of a service is measured by its:**
  - **Reach** (number of people who receive the service/intervention)
  - **Effectiveness** (percentage of people who change their behavior as a result of the service/intervention) and
  - **Cost** per person to deliver.

- **Brief tobacco interventions – even small effect sizes –can have significant population impact if they are delivered routinely and widely across a healthcare system:**
  - **Reach**: In the developed world, **85%** of the population visit a primary care clinician at least once per year
  - **Effectiveness**: **40%** of case will make a quit attempt; quit rate of **2%**
  - **Cost**: **very low** (a few minutes opportunistic intervention as part of primary care providers' routine practice).

Effective delivery models

5A's for patients who are ready to quit

Ask - Ask all patients if they smoke

↓

Advise - Advise smokers that they need to quit

↓

Assess - Assess 'readiness' to quit

↓

Assist - Assist the patient with a quit plan or provide information on specialist support

↓

Arrange - Arrange follow up contacts or a referral to specialist support

5R's for patients not ready to quit

Relevance - How is quitting most personally relevant to you?

↓

Risks - What do you know about the risks of smoking in that regard?

↓

Rewards - What would be the benefits of quitting in that regard?

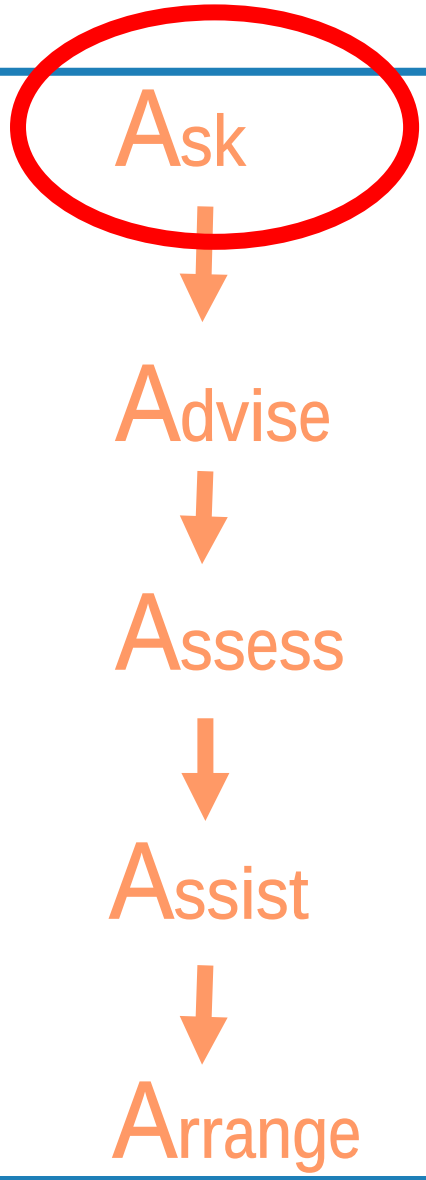
↓

Roadblocks - What would be difficult about quitting for you?

↓

Repetition - Repeat assessment of readiness to quit – if still not ready to quit repeat intervention at a later date.

Overview of the 5A's model

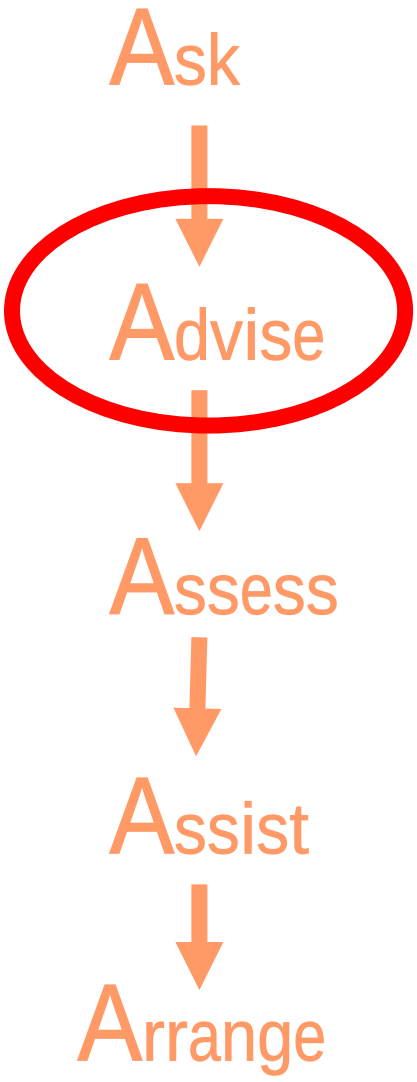


We need to be asking ALL of our patients if they smoke…making it part of our routine.

Only then do we start to make a real difference to the smoking rates around us.

Smoking should be asked about in a friendly way – it's not an accusation!

Overview of the 5A's model

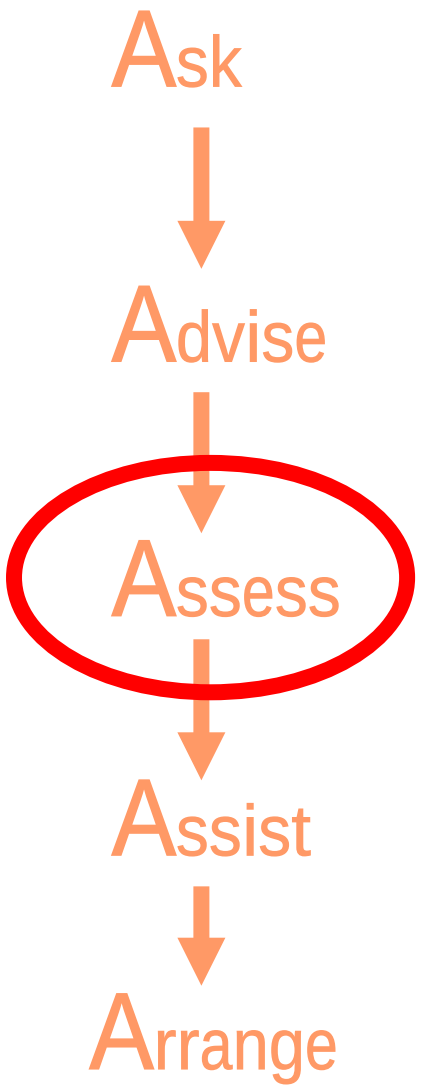


Advice should be clear and positive.

It should also be tailored to the particular patient's characteristics or circumstances

More on tailoring advice later!

Overview of the 5A's model

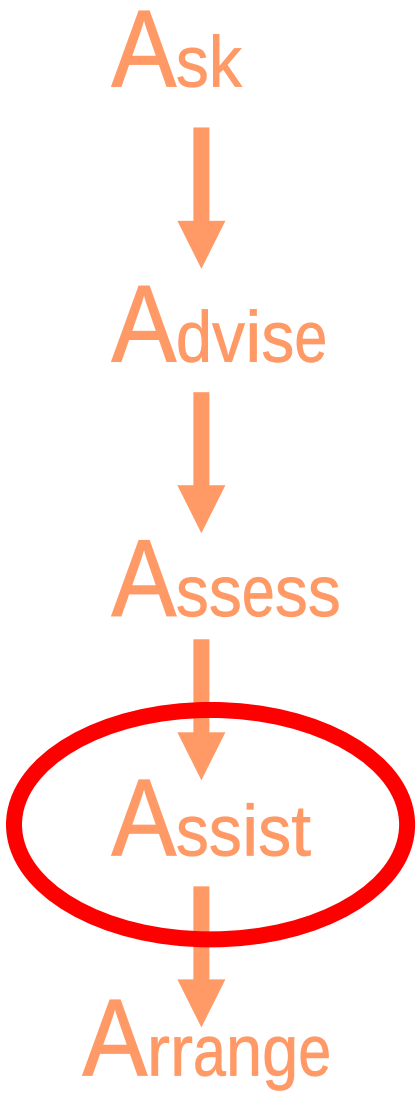


After giving advice we need to assess the patient's 'readiness to quit'.

This will be determined whether they want to be a non-smoker, and by if they think they have any chance of quitting successfully.

More on the 'assess' stage later!

Overview of the 5A's model

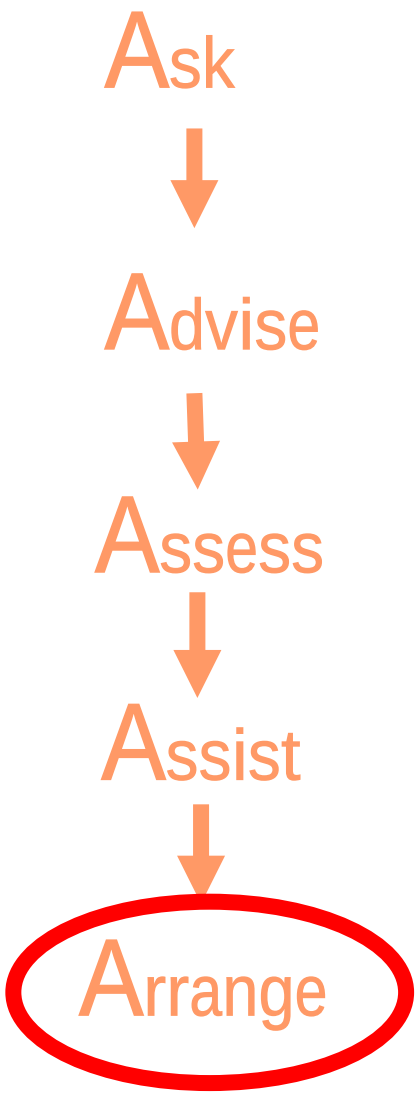


If the patient is ready to quit then they'll need some help from us.

We need to assist tobacco users in developing a quit plan or to tell them about the specialist support if that is available.

The support needs to be described positively but realistically. More on this later.

Overview of the 5A's model



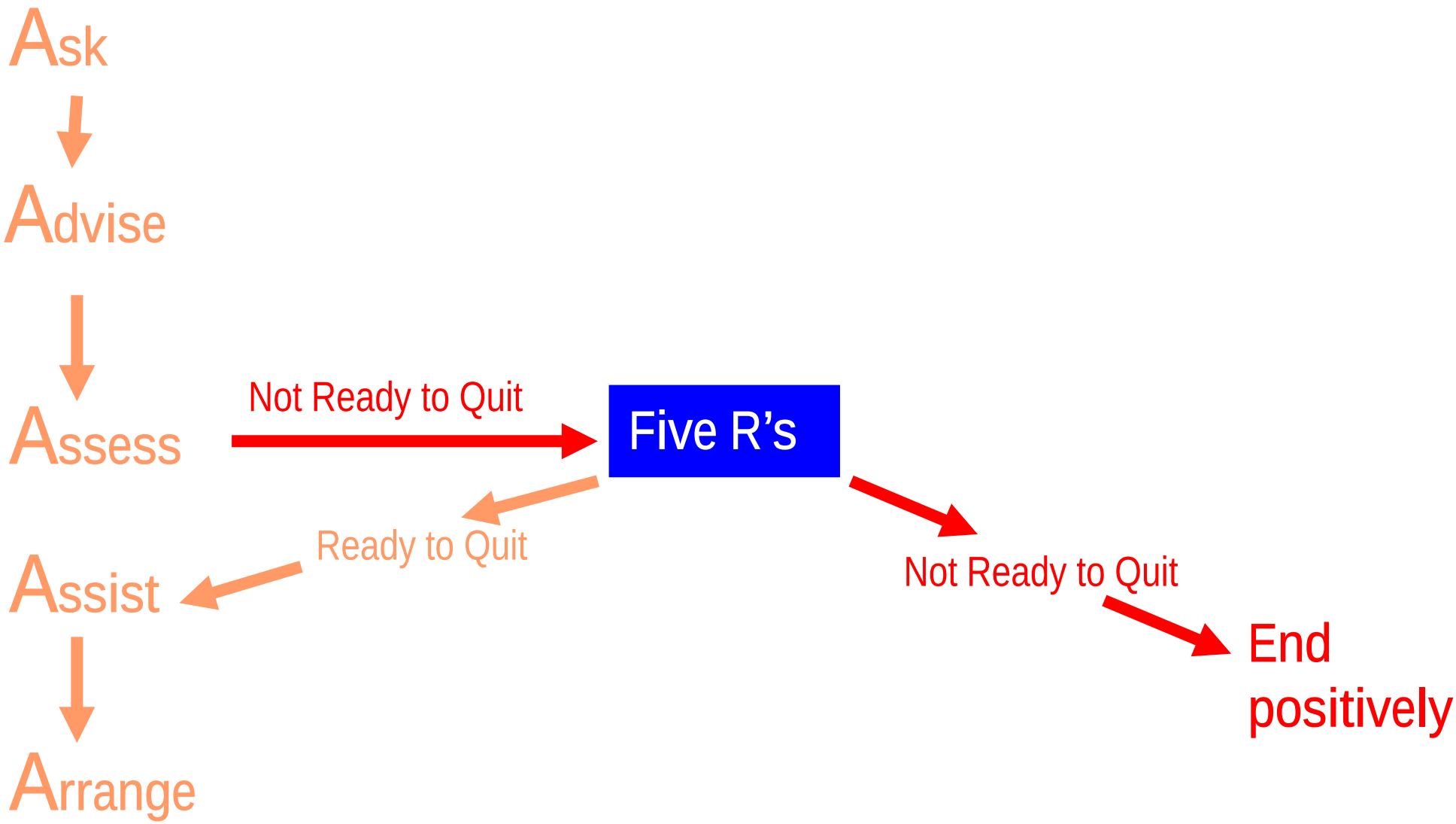
If the patient is willing to make a quit attempt we should arrange follow-up around 1 week after the quit attempt, or arrange referrals to the specialist support.

More on arranging later.

Patients not Ready to Quit?

- **Often, the patient will not be ready to quit. They may not want to be a non-smoker, or be certain that they could not quit.**
- **In these cases we will deliver a brief motivational intervention before ending the consultation. The intervention is called the 5R's**
- **This will occur after the Assess stage. Once completed we can re-assess readiness to quit and complete the 5A's if appropriate)…**

Patients not Ready to Quit?



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Other models of Brief Interventions

If specialist support (quitlines, cessation clinics) is available, other models can be used

1.AAA

Assess Assist Arrange

Ask → Advise → ACT on patient's response

build confidence, give information, refer, prescribe; succeed with local Stop Smoking Services

2.AAR

Ask → Advise → Refer

to quitlines and to local cessation programs

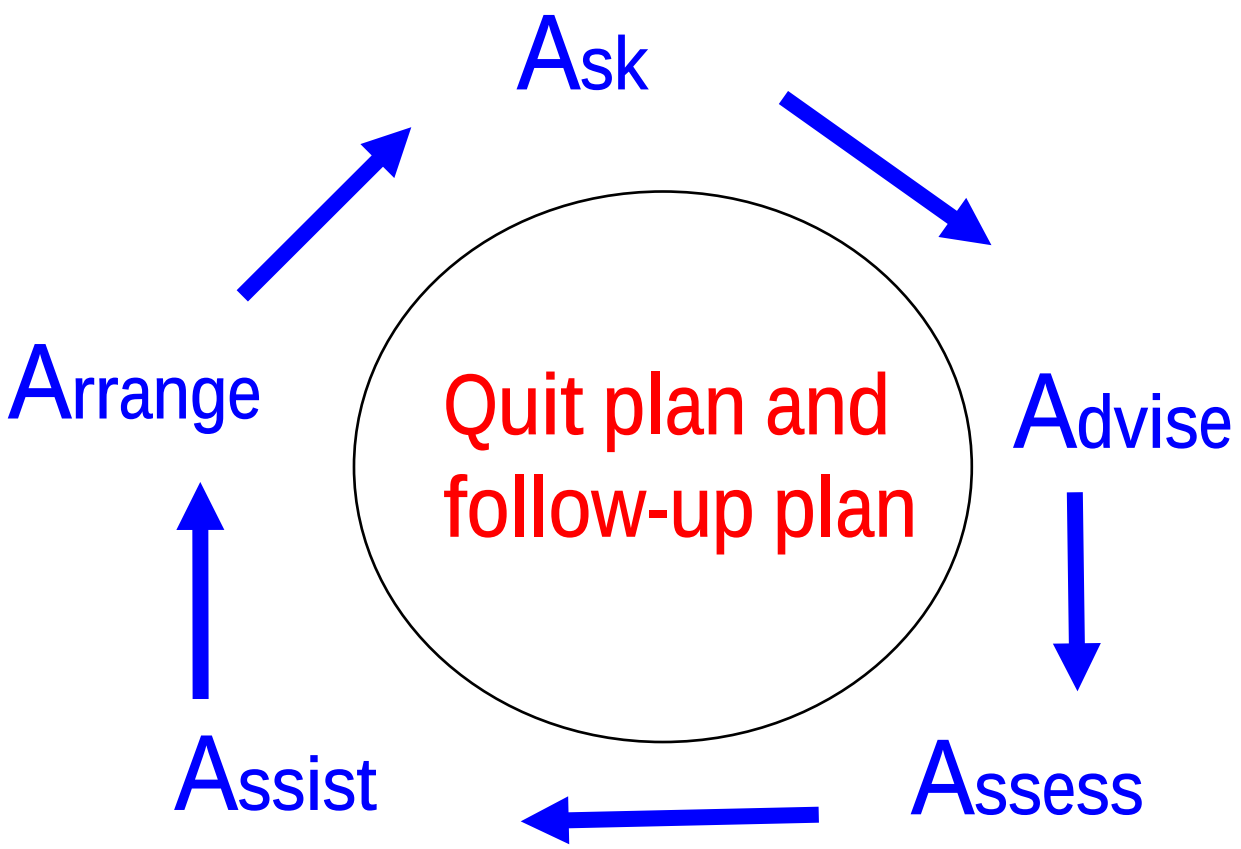
3.ABC

Ask → Brief advise → Cessation

Make referral to the Quitline or cessation services
Provide cessation support and medication
Arrange follow-up within a week

Summary

- **The 5As (Ask, Advise, Assess, Assist, Arrange) summarize all the activities that a primary care provider can do to help a tobacco user within 3 to 5 minutes in primary care settings**
- **You can start and stop at any step as indicated in the diagram**



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Part Ⅲ- Module 4-A

How to ask about tobacco use?

Ask

- **Ask about tobacco use at EVERY encounter.**
- Keep it simple:
  - Do you use tobacco?
  - Does anyone else smoke around you?
- For health facilities: to include tobacco use as a "vital sign"
  - Tobacco use (circle one): Current Former Never

Part Ⅲ- Module 4-B

How to tailor advice for a particular patient?

Advise to Quit

Advise to quit in clear, strong and personalised manner!

- **Clear**—"It is important that you quit smoking (or using chewing tobacco) now, and I can help you."
- **Strong**—"As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you."
- **Personalized**—Tie tobacco use to *demographics*, *health concerns* and *social factors*.

Examples of personalized Advice

- **Demographics:** For example, women may be more likely to be interested in the effects of smoking on fertility than men.
- **Health:** Asthma sufferers may need to hear about the effect of smoking on respiratory function, while those with gum disease may be interested in the effects of smoking on oral health.
- **Social Factors:** People with young children may be motivated by information on the effects of second hand smoke, while a person struggling with money may want to consider the financial costs of smoking.

Evidence shows that providing tailored information on smoking is more effective than providing standardised information.

Source: Lancaster & Stead , 2005

Tailoring Advice

- **In a brief intervention:**
  - There are a number of factors that a practitioner may think about when give personalized advice
  - It would be impossible to tell patients about every possible effect of tobacco use because the effects of tobacco use are very wide ranging, including a variety of health effects (see Module 2)
- **When how to tailor advice for a particular patient is not obvious, a useful strategy may be to ask the patient:**
  - "What do you not like about being a smoker?"
  - The patient's answer to this question can be built upon by the practitioner with more detailed information on the issue raised…

Tailoring Advice

Example:

Doctor: "What do you not like about being a smoker?"

Patient: "I suppose I don't like the way it makes me cough"

Doctor: "Yes. Smoking does effect lung function, and it will get worse over time if you continue to smoke."

Example:

Doctor: "What do you not like about being a smoker?"

Patient: "Well, I don't like how much I spend on tobacco."

Doctor: "Yes, it does build up. Let's work out how much you spend each month. Then we can think about what you could buy instead!"

Part Ⅲ- Module 4-C

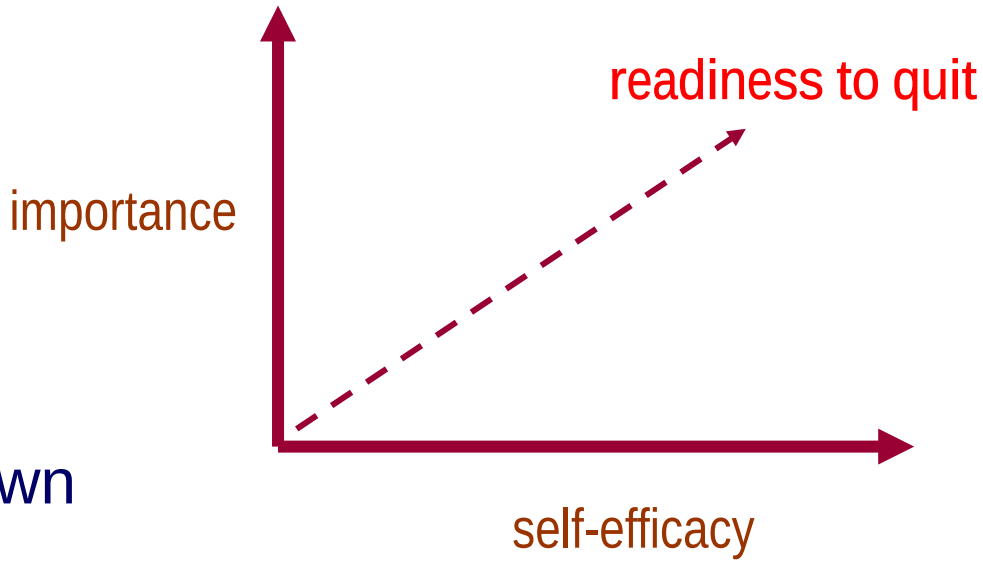
How to assess readiness to quit?

Brainstorming

How can we tell if someone is ready to quit?

When is someone ready to quit?

- **To be ready to quit we need to:**
  - Believe "quitting is important"
  - Feel confident that we could quit successfully (i.e. have high self-efficacy in relation to quitting).



- **Self-efficacy:**
  - Relates to confidence in one's own ability to succeed in something.
  - Person's belief about his or her ability and capacity to accomplish a task or to deal with the challenges of life

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When is someone ready to quit?

- **If a tobacco user believes "quitting is important" and has high level of confidence in their ability to quit, he or she is more likely to say:**
  1. “I want to be a non- tobacco user” (a desire to be non-tobacco user)
  2. “I have a chance of quitting successfully” (high level of confidence in his or her ability to quit)

Assessing Readiness to Quit

- **Method 1: asking two questions related to importance and self-efficacy:**
  1. "Would you like to be a non-user?"
  2. "Do you think you have a chance of quitting successfully?"

  In relation to the first question – someone needs to be quite sure that they want to be a non-tobacco user. Only a 'Yes' will do!

  In relation to the second question– there is room for some doubt. It is OK to be unsure – but a definite 'No' indicates a problem.

Assessing Readiness to Quit

Any answer in the shaded area indicates that the smoker is NOT ready to quit.

Would you like to be a non-tobacco user?	Yes	Unsure / No
Do you think you have a chance of quitting successfully?	Yes	Unsure / No

In these cases we should deliver the 5R's intervention.

Assessing Readiness to Quit

- **Method 2: asking just one question:**

  "Would you like to quit tobacco within the next 30 days?"

  If the answer is "No" indciates that the tobacco user is NOT ready to quit and we should deliver the 5R's intervention.

Part Ⅲ- Module 5-A

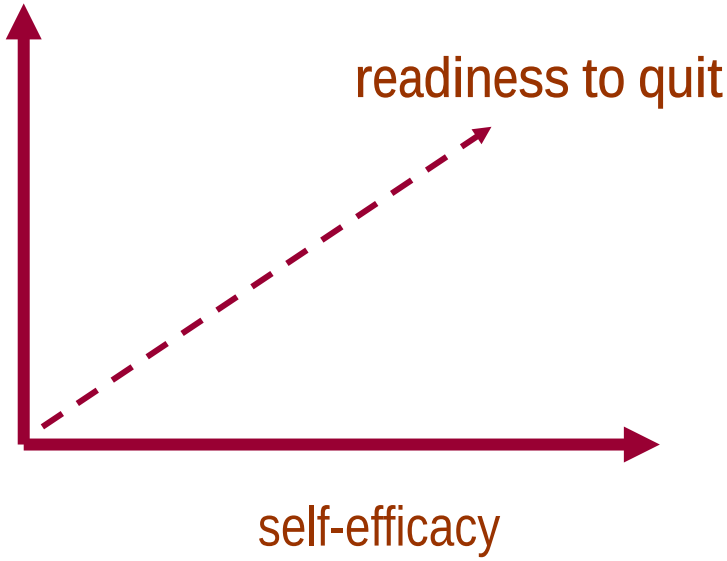
Definition of motivation

Brainstorming

What is motivation?

What is a motivation?

- **"Motivation" here refers to "intrinsic motivation", the key predictor of behaviour change.**
  - According to the behavioural scientists, "intrinsic motivation" is an internal state that activates, directs and maintains behaviour towards goals.
  - In this training, we define it as the state of readiness to change, which relates to importance of change and confidence in one's ability to change.



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Brainstorming

Any experiences of dealing with tobacco users who are not willing to quit?

Part Ⅲ- Module 5-B

Overview of 5R's model

The 5R's model

- **The 5R's model is a brief motivational intervention that is based on principles of Motivational Interviewing (MI), a directive, patient-centred counselling approach**
- **Principles of MI are:**
  - Express empathy
  - Develop discrepancy
  - Roll with resistance
  - Support self-efficacy
- **It is aimed at making people (who, when assessed, do not indicate that they are ready to quit) more ready to quit. This may be because:**
  - they do not want to be a non-smoker, or
  - they feel that they do not have a chance of quitting successfully.

MI: a new way of being with people

Traditional Method

Practitioner centered

- Persuade, manipulate
- Information giving
- Teach

Saves the patient

Resistance is bad

New Method

- **Patient centered**
  - Engage
  - Information exchange
  - Learn
- **Patient saves self**
- **Resistance is information**

Because

- People tend to resist that which is forced upon them
- People tend to support that which they helped to create

Motivational Interviewing (MI)

- **Stems from working with people who had problems with drinking alcohol.**
  - **1980's-William Miller, PhD & Stephen Rollnick, PhD**
- **Definition:**
  - **A directive, patient-centered counseling style that enhance motivation for change by helping patients clarify and resolve ambivalence about behavior change**
- **Goal of MI:**
  - **To increase the person's intrinsic motivation based on the person's own personal goals and values.**

Principles of MI

- **Express Empathy**
- **Develop Discrepancy**
- **Rolling with Resistance**
- **Support Self-efficacy**

How do you express empathy?

- Understanding without judging, criticizing or blaming

  "What might happen if you quit?"

- Willingness to accept "where" a patient is (his/her place of readiness)

  "I hear you saying you are not ready to quit smoking right now. I'm here to help when you are ready."

- A desire to understand the patient's perspectives (does not mean that you agree)

  "So you think smoking helps you maintain your weight."

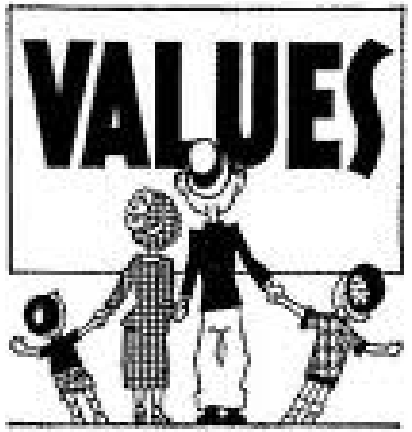
How do you develop discrepancy?

- Discrepancy
  - Change is motivated by a perceived discrepancy between present behaviours and personal goals or values
  - Use strategies to assist patient in identifying discrepancy and move forward change

How do you develop discrepancy?

- Put aside the "how to do it", ask patients about their vision/goal
  - Let's put aside the "how to do it", for right now, and just talk about what are some of the goals or values you hold?

Patient: "*I want to be a good role model for my children*"
Counselor: *" How does smoking fit in with this goal"*



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Rolling with resistance

- **Resistance is an interpersonal phenomenon**
  - How we respond matters
- **"Yeah, but…" syndrome**
  - I can't afford the medications
  - I am afraid I will gain weight.
  - I don't smoke nearly as much as some other people that I know

Rolling with resistance

- **Causes**
  - Misjudge readiness/ jumping ahead
  - Arguing/lecturing
  - Taking away control

strategies

- Re-assess readiness
- Reflective listening
- Emphasize personal choice and control

Support self-efficacy

- **People develop self-efficacy from four main sources:**
  - Mastery experience
  - Observation of others' performance
  - Verbal/social persuasion
  - Emotional and Physiological arousal

What we can do:

- Actual practice of quitting
- Observation of modeled behaviors
- Encouragement, convince them success is result of self
  - "I have tried sixteen times to quit smoking."
  - "Wow, you've already showed your commitment to trying to stop smoking several times. That's great! More importantly you're willing to try again"
- Relaxation techniques, minimize stress and elevate mood

Overview of the Five R's

Relevance	How is quitting most personally relevant to you?
Risks	What do you know about the risks of smoking in that regard?
Rewards	What would be the benefits of quitting in that regard?
Roadblocks	What would be difficult about quitting for you?
Repeat	Repeat assessment of readiness to quit – if still not ready to quit repeat intervention at a later date.

Example of the Five R's

Relevance

Risks

Rewards

Roadblocks

Repeat

"How is quitting most personally relevant to you?"

"I suppose smoking is bad for my health."

Example of the Five R's

"What do you know about the risks of smoking to your health. What particularly worries you?"

"I know it causes cancer. That must be awful."

"That's right – the risk of cancer is many times higher among smokers."

Example of the Five R's

"Do you know how stopping smoking would affect your risk of cancer?"

"I guess it would be lower if I quit."

"Yes, and it doesn't take long for the risk to decrease. But it's important to quit as soon as possible."

Example of the Five R's

"So what would be difficult about quitting for you?"

"Cravings – they would be awful!"

"We can help with that. We can give you nicotine replacement therapy (NRT) that can reduce the cravings."

"Does that really work?"

"You still need will power – but yes, NRT can double your chances of quitting successfully."

Example of the Five R's

"So, now we've had a chat, let's see if you feel differently. Can you answer these questions again…?

Go back to Assess stage of 5A's. If ready to quit then proceed with 5A's. If not ready to quit, end intervention positively.

When do we deliver the 5R's?

We deliver the 5R's following the Assess stage in the 5A's – that is, after we have asked the following questions…

Would you like to be a non-tobacco user?	Yes	Unsure	No
Do you think you have a chance of quitting successfully?	Yes	Unsure	No

Any answer in the shaded area indicates that the smoker is NOT ready to quit and we should deliver the 5R's intervention.

When do we deliver the 5R's?

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Tips for implementing the Five R's

- **Let the patient do the talking. Don't give lectures!!!**
- **If patient doesn't want to be non-smoker – focus more time on 'Risks' and 'Rewards'.**
- **If they do want to be a non-smoker but don't think they can quit – focus more time on 'Roadblocks'.**
- **Even if patient remains not ready to quit – end positively with an invite for them to come back to you if they change their mind.**

Part Ⅲ- Module 5-C

Motivational tools

Tools for motivating tobacco users

- **Cost calculators**
  - **Cost of smoking Calculator**
  - **Personal Savings Calculator**
- **Photos of tobacco-related diseases, smoking-exacerbated facial ageing**

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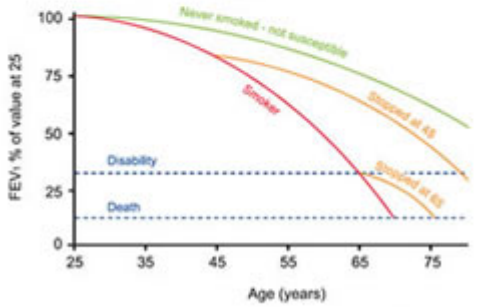
Tools for motivating tobacco users

- **Visual motivational tools:**
  - Carbon Monoxide Monitor
  - Pulmonary Function Testing (Spirometry)
  - "Lung Age" Indicator (graphically show the age of the average healthy person who has an FEV1 equal to that of the patient)



Fletcher C Peto R (1977).The natural history of chronic airflow obstruction. British Medical Journal.I 1645-1648

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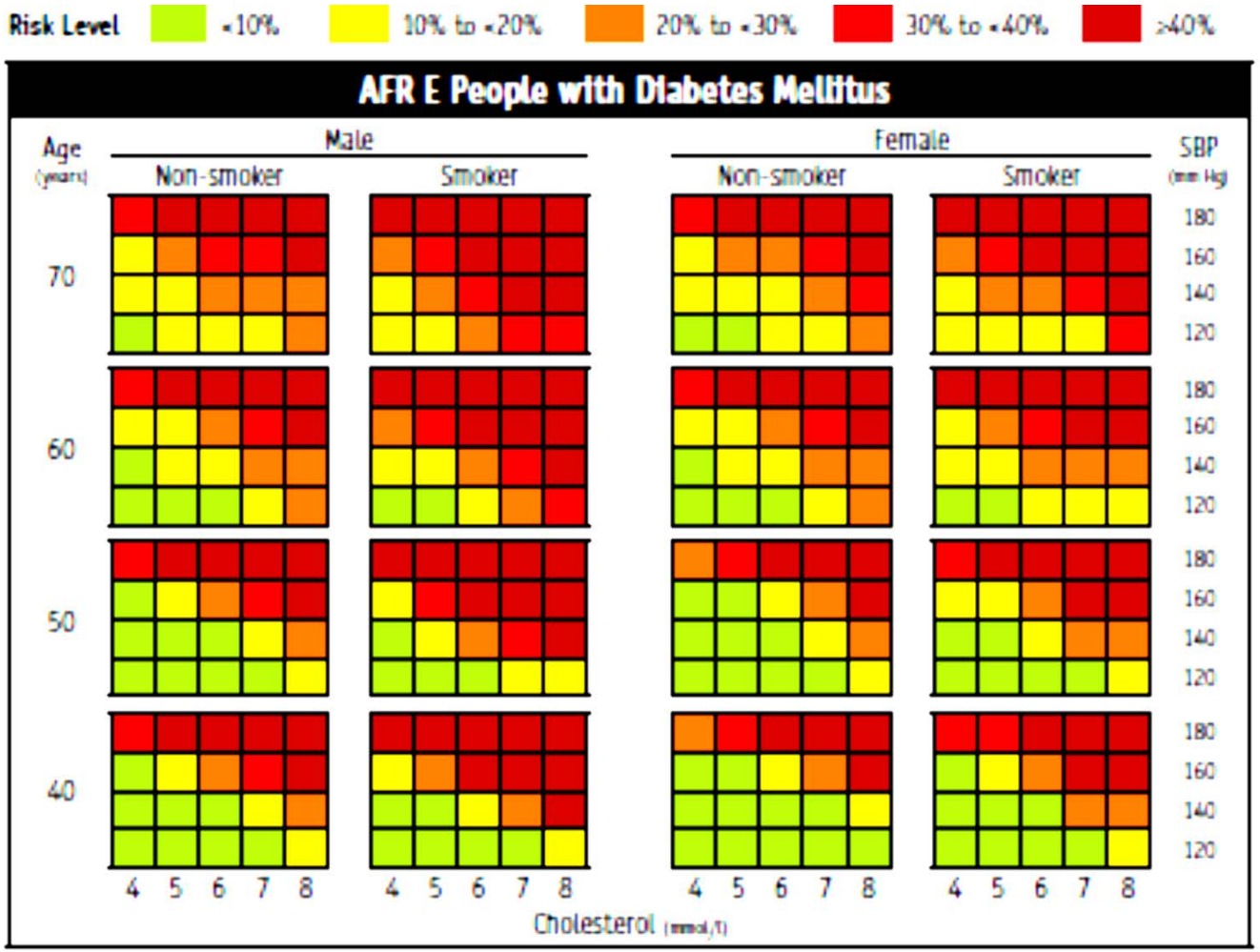
Tools for motivating tobacco users

- **Risk Charts**

  (facilitate physician-patient discussion about disease risk)

  – WHO/ISH risk prediction charts



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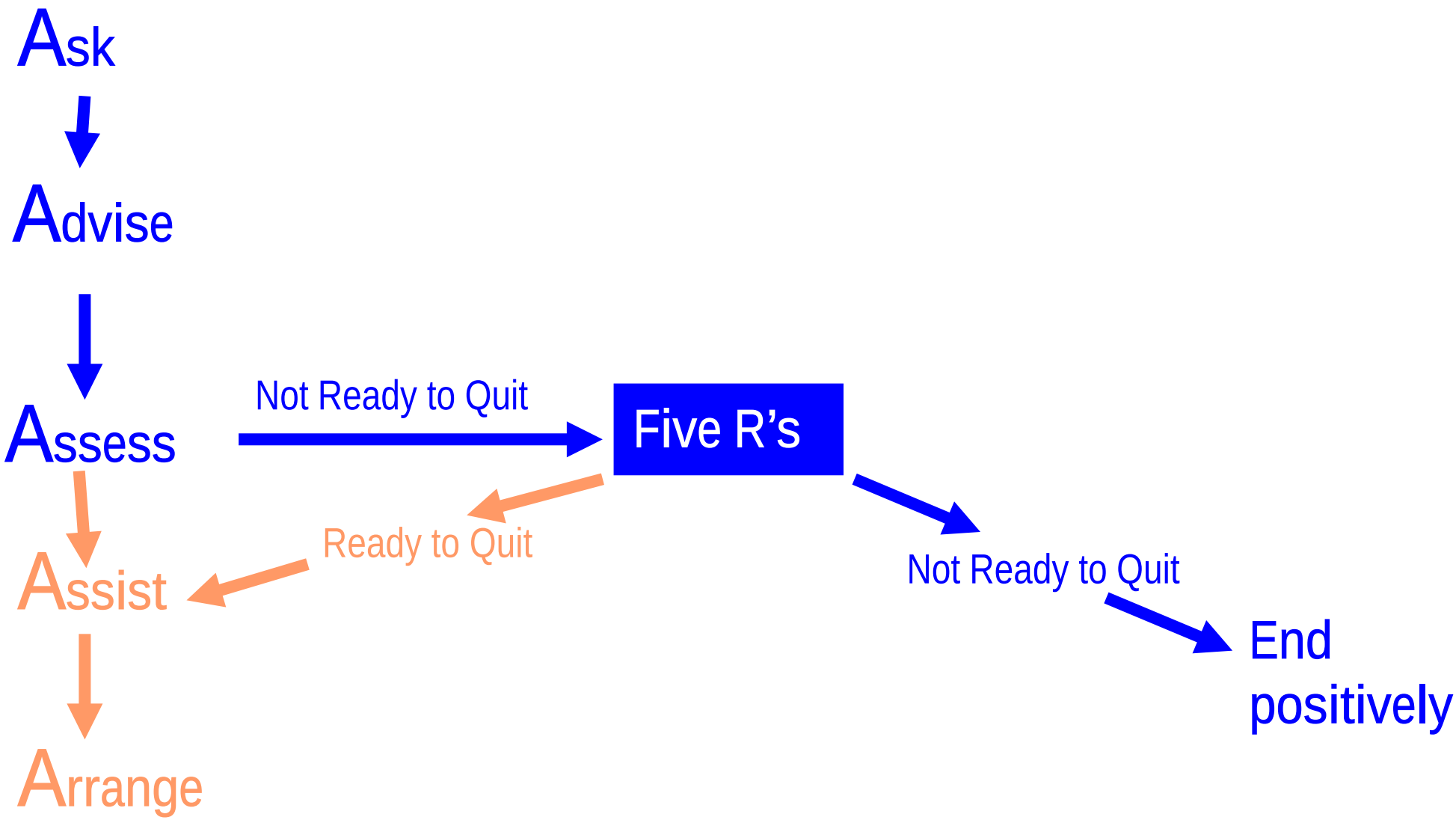
Part Ⅲ- Module 6-A

How to assist patients in making a quit attempt?

Where are we now?



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Brainstorming

If you were a smoker, what kind of assistance you will need from the doctor to make a quit attempt?

Assist

For the patient willing to quit, the following actions can be taken to aid the patient in quitting

- Help develop a quit plan
- Provide practical counseling (will be discussed later)
- Provide intra-treatment social support
- Help patient obtain extra-treatment social support
- Recommend pharmacotherapy if appropriate
- Provide supplementary materials

Source: Fiore MC et al. Treating tobacco use and dependence ,2008

Developing a quit plan-STAR

- **S**et a quit date- within 2 weeks
- **T**ell family, friends, and coworkers about quitting, and request understanding and support
- **A**nticipate challenges to the upcoming quit attempt
- **R**emove tobacco products from your environment, make your home smoke-free.

Source: Fiore MC et al. Treating tobacco use and dependence ,2008

Provide intra-treatment social support

Supportive treatment component	Examples
Encourage the patient in the quit attempt.	• Note that effective tobacco dependence treatments are now available. • Note that one-half of all people who have ever smoked have now quit. • Communicate belief in patient's ability to quit.
Communicate caring and concern.	• Ask how patient feels about quitting. • Directly express concern and willingness to help as often as needed. • Ask about the patient's fears and ambivalence regarding quitting.
Encourage the patient to talk about the quitting process.	Ask about: • Reasons the patient wants to quit. • Concerns or worries about quitting. • Success the patient has achieved. • Difficulties encountered while quitting.

Source: Fiore MC et al. Treating tobacco use and dependence ,2008

Assist exercise

- Please answer the following questions asked by patients who are willing to quit:

1. “What if I still have cravings?”

2.“What if I smoke after quitting?”

Part Ⅲ- Module 6-B

How to arrange follow up contacts for the patient?

Arrange

- **When- timing is everything!**
  - The majority of relapse occurs in the first two weeks after quitting
  - First contact -within one week after the quit date
  - Second –within the first month
- **How- use practical methods**
  - Telephone
  - Personal visit
  - Mail/ E-mail
- **What- actions during follow up contacts**

Actions during follow-up contact

For all patients	• Identify problems already encountered and anticipate challenges • Remind patients of available extra-treatment social support • Assess medication use and problems • Schedule next follow-up contact
For patients who are abstinent	• Congratulate them on their success
For patients who has used tobacco again	• Remind them to view relapse as a learning experience • Review circumstances and elicit recommitment • Link to more intensive treatment if available

Source: Fiore MC et al. Treating tobacco use and dependence ,2008

Tips for Follow-up

- Keep it brief!
- Stick to the topic
- Avoid getting into problem-solving discussions
- Use reminder tools to remind you who and when to follow-up.
- Know the cessation services and cessation providers in your community.

Part Ⅲ- Module 6-C

Reviewing each stage of the brief tobacco intervention

Reviewing each stage of the brief intervention

Ask — Ask all patients if they smoke.

↓

Advise — Advise smokers that they need to quit.

↓

Assess — Assess ‘readiness’ to quit.

↓

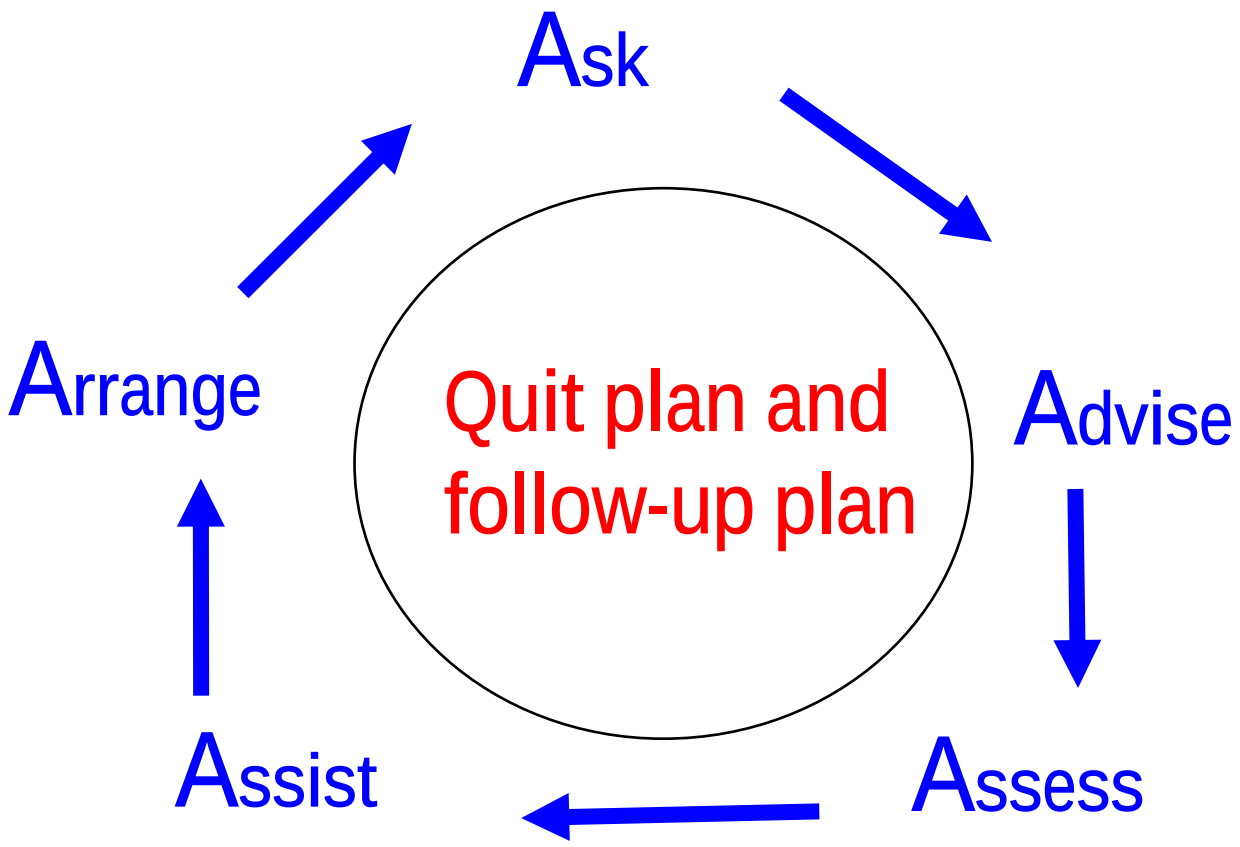
Assist — Assist the patient with a quit plan or provide information on specialist support.

↓

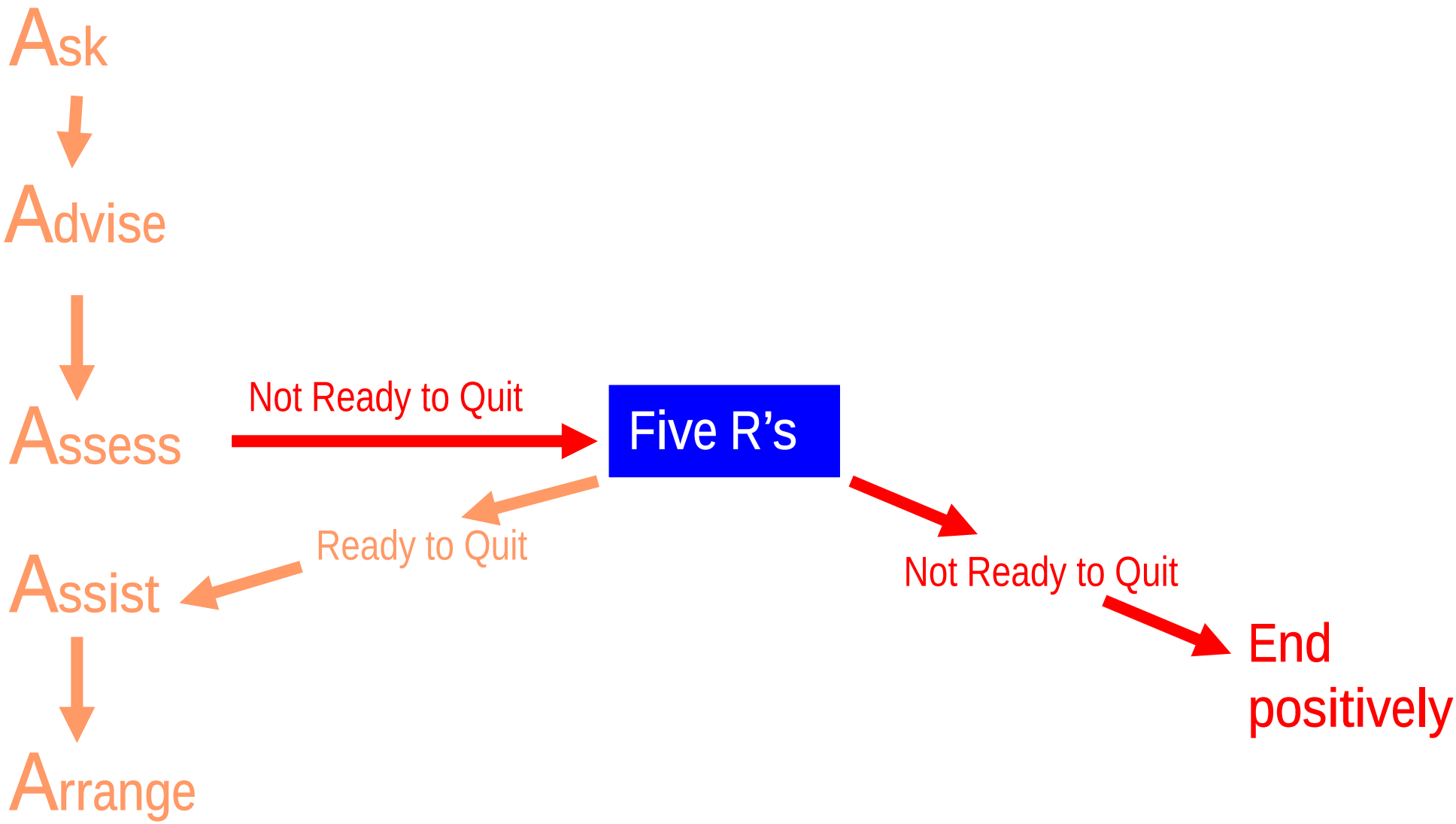
Arrange — Arrange follow up contacts or a referral to specialist support.

Reviewing each stage of the brief intervention

You can start and stop at any step as indicated in the following diagram



Reviewing each stage of the brief intervention



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Reviewing each stage of the brief intervention

Relevance	How is quitting most personally relevant to you?
Risks	What do you know about the risks of smoking in that regard?
Rewards	What would be the benefits of quitting in that regard?
Roadblocks	What would be difficult about quitting for you?
Repeat	Repeat assessment of readiness to quit – if still not ready to quit repeat intervention at a later date.

Part Ⅲ- Module 7-A

Addressing non-smokers' exposure to secondhand smoke

Brainstorming

What is secondhand smoke?

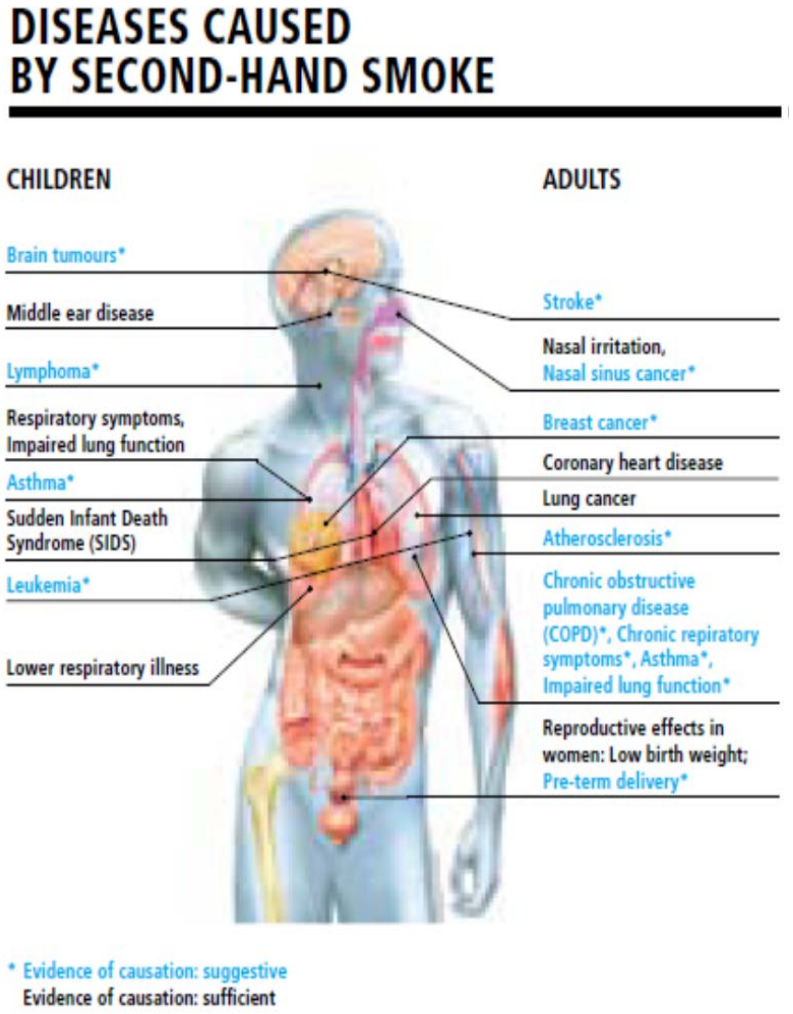
What disease are known to be caused by secondhand smoke?

Definition of secondhand smoke

- **Secondhand smoke (also called environmental tobacco smoke or passive smoking) is made up of:**
  - mainstream smoke, the smoke that is exhaled by the smoker
  - side-stream smoke, the smoke that comes from the burning end of a cigarette or other tobacco products (pipe, cigar)

Health effects of secondhand smoke

- **There is no safe level of exposure**
- **Secondhand smoke causes 600 000 premature deaths per year**
- **Diseases in children**
  - Sudden Infant Death Syndrome
  - Acute respiratory illnesses
  - Middle ear disease
  - Chronic respiratory symptoms
- **Diseases in adults**
  - Coronary heart disease
  - nasal irritation
  - Lung cancer
  - Reproductive effects in women: low birth weight



Source: WHO Report on the Global Tobacco Epidemic 2008, 2011.

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5A's brief intervention model for addressing exposure to secondhand smoke

Ask - systematically identify no-smoking patients who are exposed to secondhand smoke at every visit

Advise - advise the patient to avoid exposure secondhand smoke

Assess - determine the patient's willingness to reduce exposure to secondhand smoke

Assist - assist the patient in making an attempt to make their daily life environment smoke-free

Arrange - schedule follow-up contacts.

Assist patients in avoiding secondhand smoke exposure

For the patient willing to reduce their exposure to secondhand smoke, the following actions(MAD-TEA) can be taken to aid the patient

- **M**eet friends at spaces in the community that are smoke-free.
- **A**sk family members and visitors to smoke outside.
- **D**eclare their home and personal spaces to be smoke-free.
- **T**alk to family members and workmates about the risks of second-hand smoke.
- **E**ncourage family members, friends and workmates who smoke to stop.
- **A**dvocate comprehensive smoke-free laws or regulations in workplaces and public places.

Source: The truth about second-hand smoke. Edmonton, Alberta Health Services

Part Ⅲ- Module 8-A

Effective tobacco cessation medications

Brainstorming

What effective tobacco cessation products are currently available for tobacco users in your country?

Effective tobacco cessation medications

- **Pharmacologic interventions:**
  - Nicotine replacement therapy (NRT)
    - Nicotine gum
    - Nicotine patches
    - Nicotine nasal spray
    - Nicotine inhaler
    - Nicotine lozenge/Sublingual tablet
  - Bupropion
  - Varenicline
  - Clonidine
  - Nortriptyline
  - Cytisine

First line

On WHO Model List of Essential Medicines

Summary of effectiveness data for pharmacological treatments

Intervention (source)	Comparator	Odd ratio (95% confidence interval)
Nicotine replacement therapy	Placebo or non-NRT	1.58(1.50-1.66)
Bupropion	Placebo	1.69(1.53 to 1.85)
Varenicline	Placebo	2.27 (2.02 to 2.55)
Cytisine	Placebo	3.98 (2.01 to 7.87)
Clonidine	Placebo	1.63 (1.22 to 2.18)
Nortriptyline	Placebo	2.03 (1.48 to 2.78)

Source: The latest Cochrane Systematic Reviews

Part Ⅲ- Module 8-B

Description of NRT products, bupropion and varenicline

Nicotine replacement therapy

What is NRT

- **NRT is the remedial administration of nicotine** to the body by means other than tobacco, for quitting tobacco use.
- **Common forms of NRT and available dosage**

Forms	How it works	Available dosage
Nicotine gum	Delivers nicotine through the lining of the mouth	2mg, 4 mg
Nicotine patch	Delivers nicotine through skin	• 24 hour delivery systems 7mg, 14mg, 21mg • 16 hour delivery systems 5mg, 10mg, 15mg
Nicotine lozenge	Delivers nicotine through the lining of the mouth	2mg, 4 mg
Nicotine nasal spray	Delivers nicotine through the lining of the nose	0.5 mg nicotine in 50 µl aqueous nicotine solution
Nicotine inhaler	Delivers nicotine to the oral mucosa, not the lung	10 mg catridge delivers 4mg inhaled nicotine vapor

What is NRT

All forms of NRT better than no treatment

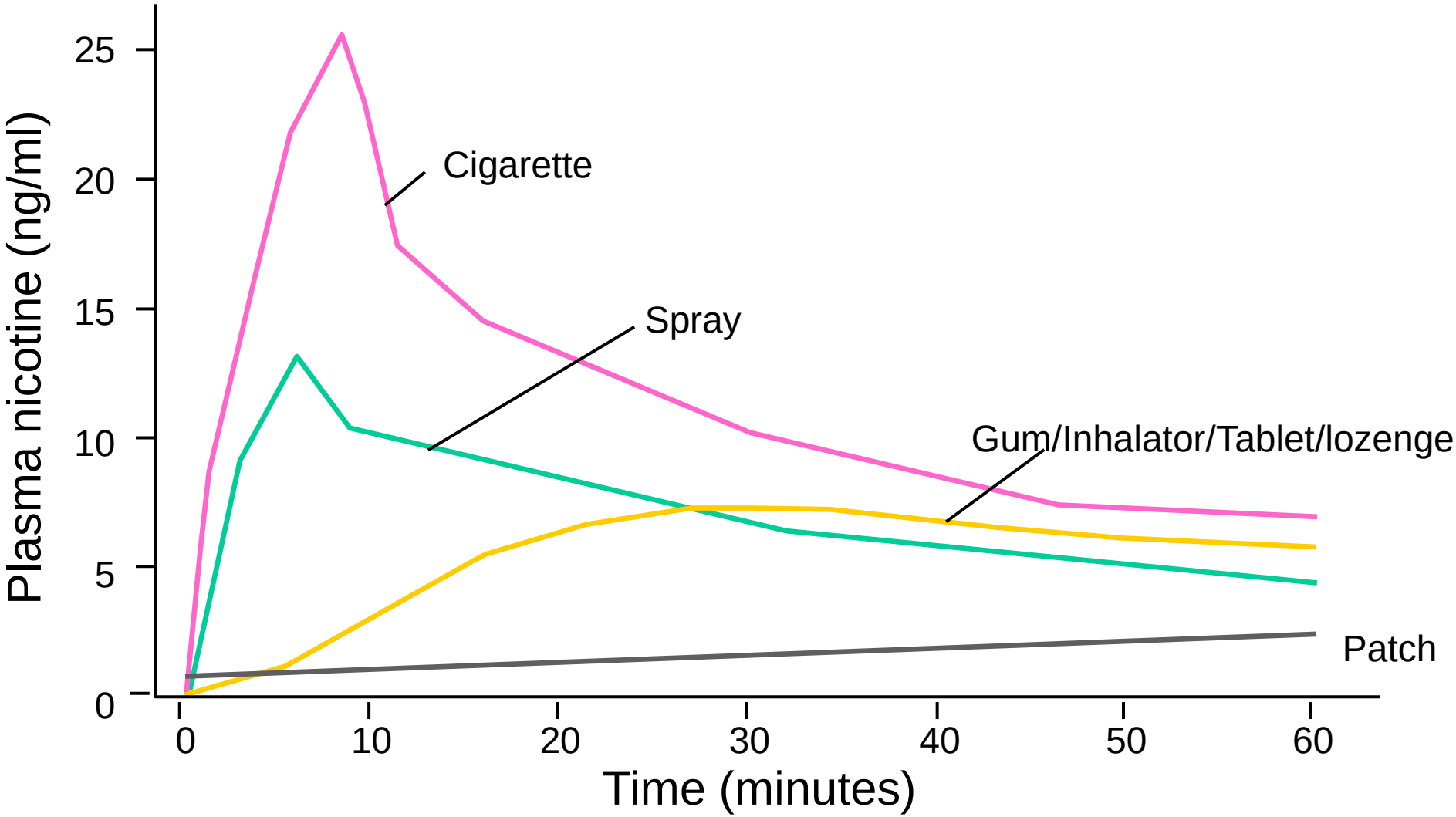
	Odds Ratio	Number of trails
Gum	1.43	53
Patches	1.66	41
Oral tablets/lozenges	2.00	6
Nasal spray	2.02	4
Inhaler	1.90	4

Source: Stead LF, et al. Nicotine replacement therapy for smoking cessation. Cochrane Database of Systematic Reviews 2008

What is NRT

- Using NRT is a safe alternative to cigarettes, will take in less nicotine and at a much slower rate than when smoking:
  - No high concentration arterial bolus of nicotine characteristic of cigarette smoking
  - Over-all nicotine dose ~ 1/3 to ½ in cigarettes
  - NO toxic tar and gas phase

Plasma nicotine levels – contrast between cigarettes and NRT



Adapted from: Tobacco Advisory Group of the Royal College of Physicians 2000.

World Health Organization

The purpose of using NRT?

- Stop smoking
- Reduces severity of withdrawal symptoms
- Reduces desire to smoke
- Delays weight gain
- Provides a coping behaviour

Who can use NRT ?

- Smokers 18 years and over
- Smokers with severe heart and circulation problems, should start NRT under medical supervision
- Pregnant or breastfeeding women if they cannot stop without NRT

Who can use NRT ?
-Common contraindications

- Pregnancy*
- Breastfeeding*
- Under 18's*
- Acute MI
- Unstable Angina
- Severe Cardiac Arrythmias
- Recent Cerebrovascular Accident

* Some doctors may prescribe to these groups with caution

Who can use NRT ?

-Common cautions

- Diabetes Mellitus
- Hyperthyroidism
- Peripheral Vascular Disease
- Hypertension
- Stable Angina
- Coronary Heart Disease
- Renal or Hepatic impairment
- Ca Adrenal Glands

Bupropion

What is Buproprion

- **Bupropion SR (sustained release) Originally used as anti depressant, can also be used to help adults quit smoking**
- **It can**
  - **affect the levels of neurotransmitters affecting the urge to smoke**
  - **lessen some withdrawal symptoms (anxiety irritability and depression)**
- **Available dosage:** 150 mg sustained release tablet

The purpose of using Bupropion SR

It helps smokers to:

- **Stop smoking**
- **Reduce withdrawal symptoms (anxiety irritability and depression)**

How to and who can use Bupropion SR

How to use

Tablet taken at least 7 weeks to 12 weeks

- Day 1- 3, 150mg (1 tablet) daily
- Day 4-6, 150mg twice daily
- Day 7 (quit day) – 150mg twice daily for 12 weeks

Who can use

All adult smokers except those

- pregnant or breastfeeding
- concomitant with medications or medical conditions known to lower the seizure threshold
- Severe hepatic cirrhosis

Side effects and warnings

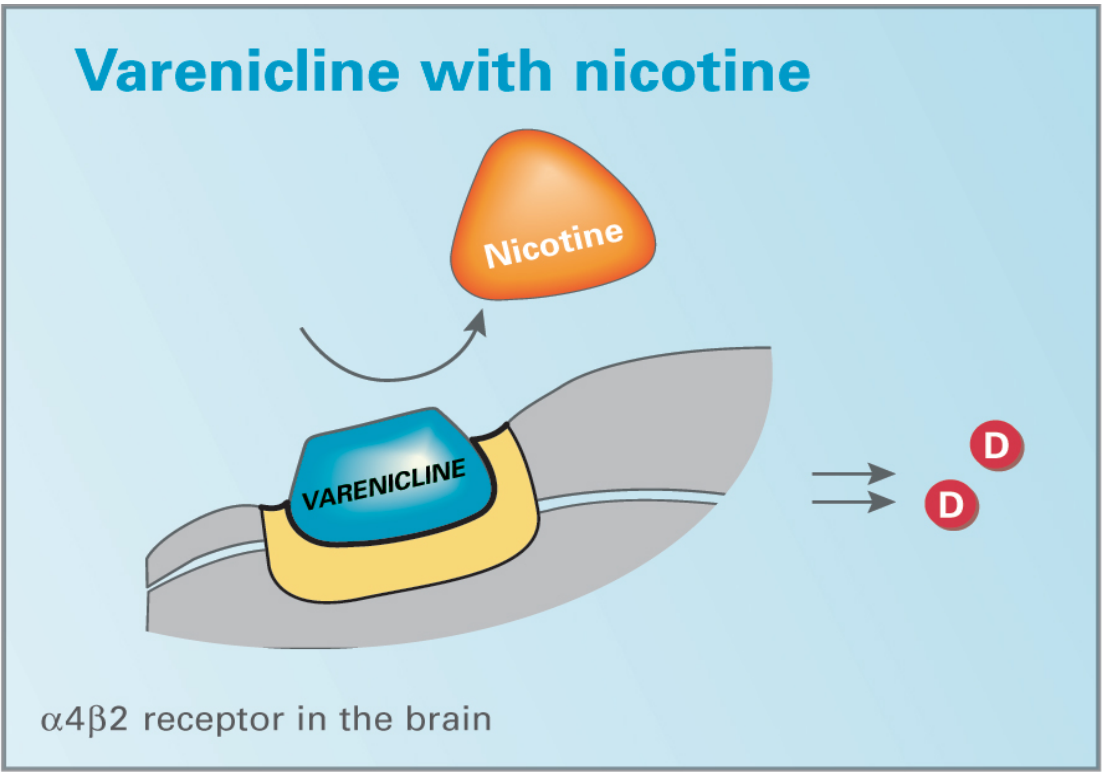
- Insomnia, dry mouth, nausea**,** nervousness/difficulty concentrating, rash, headache, dizziness, seizures,
- There have been reports of serious neuropsychiatric symptoms have been reported in patients taking bupropion for smoking cessation

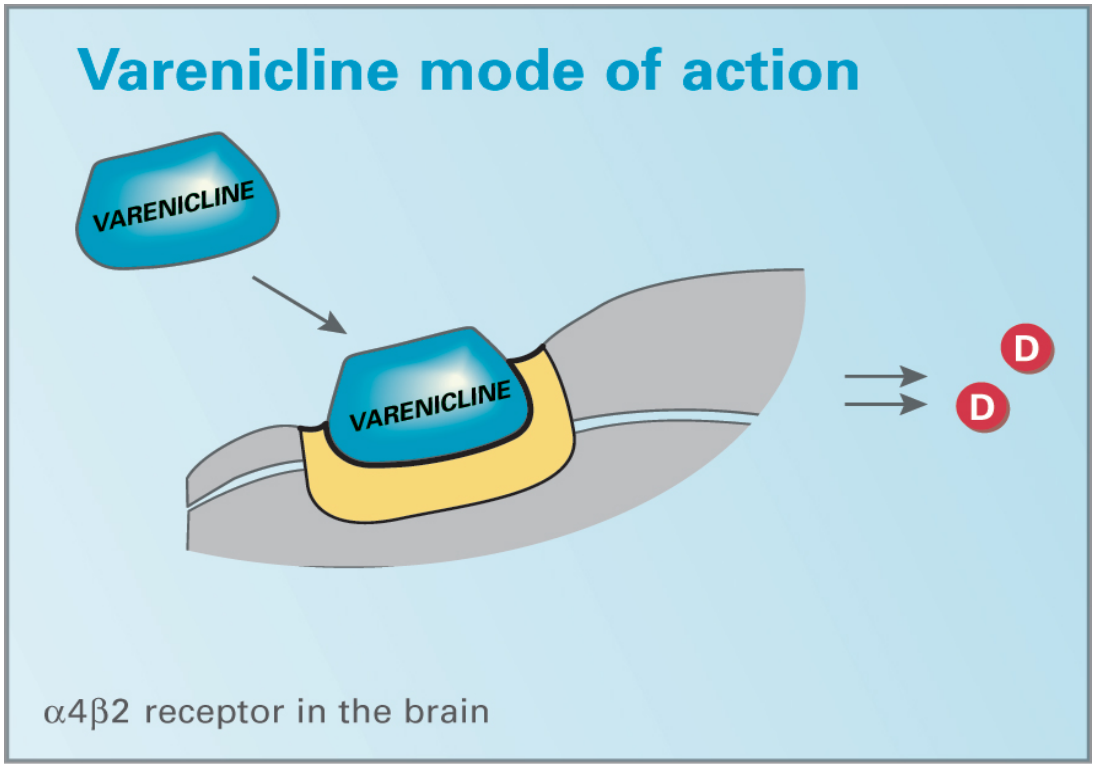
Varenicline

What is Varenicline

- **A new drug developed specifically for smoking cessation**
- **Partial nicotine agonist attaches to nicotinic receptors**
  - **Partially blocking nicotine:**
    - To reduce the pleasurable effects of nicotine
    - To reduce the risk of full relapse
  - **Partially stimulating the receptors:**
    - To relieve craving and withdrawal symptoms
- **Available dosage:** 0.5mg, 1 mg tablet

What is Varenicline
- partial nicotine agonist





Part blocking
Reduces the pleasurable effects of smoking and potentially the risk of full relapse after a temporary lapse[1-4]

Part Stimulating
Relieves craving and withdrawal symptoms[1-3]

Sources: 1. Coe JW. J Med Chem 2005; 48:3474-3477. 2. Gonzales D et al. JAMA 2006; 296:47-55.
3. Jorenby DE et al. JAMA 2006; 296:56-63. 4. Foulds J. Int J Clin Pract 2006; 60:571-576.

World Health Organization

The purpose of using Varenicline

It helps smokers to:

- **Stop smoking**
- **Reduce withdrawal symptoms**
- **Reduce smoking satisfaction**
- **Prevent relapse**

How to and who can use Varenicline

How to use

Tablet taken over 12 weeks

- Day 1-3 , 0.5mg (1 tab) daily
- Day 4-7, 0.5mg (1 tab) twice daily
- Day 8 (quit date) – end of week 12 , 1mg (1 tab) twice daily

Who can use

All adult smokers except those

- With severe renal impairment
- pregnant or breastfeeding

Side effects and warnings

- Nausea, sleep disturbances (insomnia, abnormal dreams), constipation, flatulence, vomiting
- There have been reports of depressed mood, agitation, changes in behaviour, suicidal ideation and suicide in Varenicline users

Part III- Module 8-C

Assessing tobacco users' levels of tobacco dependence

Brainstorming

- **What is the purpose of assessing tobacco users' level of nicotine dependence?**

How to do it?

- **Method 1: the Fagerström Test for Nicotine Dependence**
  - **It is a standard instrument for assessing the intensity of physical addiction to nicotine**
  - **It can be done in a few minutes**
  - **Scoring:**
    - 0-2 Very low dependence
    - 3-4 Low dependence
    - 5 Medium dependence
    - 6-7 High dependence
    - 8-10 Very high dependence
  - **Result:** level of dependence is **high** or **very high** will be considered to use NRT

Items and scoring for Fagerström Test for nicotine dependence

1. How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	3
	6-30 minutes	2
	31-60 minutes	1
	After 60 minutes	0
2. Do you find it difficult to refrain from smoking in places where it is forbidden e.g. in church, at the library, in cinema, etc.?	Yes	1
	No	0
3. Which cigarette would you hate most to give up?	The first one in the morning	1
	All others	0
4. How many cigarettes/day do you smoke?	10 or less	0
	11-20	1
	21-30	2
	30 or more	3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes	1
	No	0
6. Do you smoke if you are so ill that you are in bed most of the day?	Yes	1
	No	0

Source: Heatherton TF et al. British Journal of Addiction 1991.

How to do it?

- **Method 2: Asking two simple questions:**
  - **How many cigarettes do you smoke per day?**
    A. <10 cpd
    B. 10-20 cpd
    C. 21-39 cpd
    D. ≥40 cpd
  - **At what time do you smoke first cigarette in the morning?**
    A. ≤ 30 minutes after waking up
    B. > 30 minutes after waking up

Part Ⅲ- Module 8-D

Recommendations for use of NRT

Guidelines for using nicotine gum

Directions for use	Chew gum slowly until you notice a “peppery” taste. Then stop chewing and move gum between cheek and gum. Chew one piece every 1-2 hours.
Dosing Recommendations based on level of dependence	Based on cigarettes/day (cpd) • >20 cpd: 4 mg gum • ≤20 cpd: 2 mg gum Based on time to first cigarette of the day: • ≤30 minutes = 4 mg • >30 minutes = 2 mg Initial dosing is 1-2 pieces every 1-2 hours (10-12 pieces/day). Taper as tolerated.
Duration	Up to 12 weeks with no more than 24 pieces to be used per day
Side effects	Hiccups, sore mouth jaw ache, stomach irritation

Guidelines for using nicotine patch

Directions for use	One patch each day. Place a new patch on a part of the body between the neck and waist. Choose a new spot each day to lessen skin irritation.
Dosing Recommendations based on level of dependence	**Dosing (24 hour patch)** • >40 cpd = 42 mg/day • 21-39 cpd = 28-35 mg/day • 10-20 cpd = 14-21 mg/day • <10 cpd = 14 mg/day Adjust based on withdrawal symptoms, urges, and comfort. After 4 weeks of abstinence, taper every 2 weeks in 7-14 mg steps as tolerated.
Duration	8-12 weeks
Side effects	Skin irritation, allergy, vivid dreams and sleep disturbances

Guidelines for using nicotine lozenge

Directions for use	The lozenge should be allowed to dissolve in the mouth rather than chewing or swallowing it.
Dosing Recommendations based on level of dependence	Based on time to first cigarette of the day: • ≤30 minutes = 4 mg • >30 minutes = 2 mg Based on cigarettes/day (cpd) • >20 cpd: 4 mg • ≤20 cpd: 2 mg Initial dosing: 1-2 lozenges every 1-2 hours (minimum of 9/day) in the first 6 weeks. Taper as tolerated: 1 lozenge very 2-4 hours during the weeks 7-9; 1 every 4-8 hours during the weeks 10-12
Duration	Up to 12 weeks with no more than 20 lozenges to be used per day
Side effects	Irritation of mouth, nausea, hiccups, heartburn

Part III- Module 9-A

Opportunities for delivering brief tobacco interventions in the community

Brainstorming

- **What are the opportunities to deliver brief tobacco interventions in patients' homes and in the community?**

The community outreach activities for delivering brief tobacco interventions

- **Home visits to pregnant women, children and old people;**
- **Home visits to patients with severe chronic diseases;**
- **Home visits for family planning;**
- **Community health education;**
- **Environmental sanitation;**
- **Health screening;**
- **Data collection or survey in the community;**
- **Community public campaigns** (such as World No Tobacco Day).

Part Ⅲ- Module 9-B

Community referral resources

Community referral resources to support primary care providers in delivering brief tobacco interventions

- Tobacco quit lines
- Specialist services in cessation clinics
- Local tobacco cessation classes and support groups
- Smoker's web-based assistance
- Free self-help materials

AAR brief tobacco intervention model

A	**Ask** about tobacco use and document in medical record.
A	**Advise** patients who use tobacco to quit. 'Quitting is one of the best things you can do for your health.'
R	**Refer** to trusted resources. • For patients who are ready to quit, provide referral to resources that can provide assistance and follow up. • For patients who are not ready to quit, provide referral to self-help materials, and let the patient know you are available to help when they are ready.

Thank you for your attention