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Introduction

Many factors contribute to this focus on quitting including the smoke free hospital environment, decreased wound healing in smokers, and the multitude of health concerns that are directly or indirectly attributable to smoking. To maximize this teachable moment, each patient admitted to the hospital should be asked about his or her tobacco use status and that status should be documented. All tobacco users should be advised to quit, and offered assistance with pharmacotherapy and counseling. Those patients that do not want to make a quit attempt should be offered pharmacotherapy for withdrawal symptom relief to alleviate discomfort during their hospitalization.

This packet of information is designed to assist hospitals to successfully integrate smoking cessation interventions into every hospitalization for every patient admitted who smokes. Successful integration of a comprehensive tobacco cessation program for hospitals includes the following steps:

- Assemble a multidisciplinary team to develop program.
- Recruit a physician champion.
- Assess the current level of interventions and set measurable smoking cessation goals.
- Appoint a cessation counselor or counseling team.
- Add tobacco status to initial vital sign assessment.
- Include cessation pharmacotherapies in hospital formulary.
- Acquire hospital-wide approval and integration of standing orders for cessation counseling and pharmacotherapy.
- Provide department specific in-services for staff to detail tobacco cessation procedures including resources available to staff, patients and visitors.

Each of these steps is important to ensure the successful integration of services. Each hospital endeavoring to initiate cessation services may have resources and barriers unique to their setting. For that reason, this packet offers a variety of methods of incorporating these steps. This packet also acknowledges that a hospital may not integrate all of the steps simultaneously.

A system for **ASKING** about tobacco use, **ADVISING** all patients who smoke to quit, and **ASSESSING** willingness to make a quit attempt should be initiated for **EVERY** patient being evaluated in the emergency room and/or admitted. Those patients interested in making a quit attempt should be **ASSISTED** in their quit attempt by providing counseling and pharmacotherapy. Those not interested in making a quit attempt should be offered pharmacotherapy for relief of withdrawal symptoms during the hospitalization. A system should also be initiated for those

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patients that cannot receive a counseling visit for various reasons such as short length of stay. These patients should receive information on the Tobacco Quit Line, a copy of the self-help brochure "You Can Quit Smoking" or other resources available in this manual. **ARRANGING** follow-up should also be systematically integrated into the hospital cessation services.

Counseling services may be reimbursed using inpatient consultation codes (99251-99255). The primary or secondary diagnostic codes for this service are "ICD-9 Codes 305.1 Tobacco use disorder" or "V158.2 Personal history of tobacco use". Applying the model described in this packet, the designated consultant will make at least one visit to the patient during the hospitalization.

The goals of this Hospital Tobacco Cessation Program are to encourage all hospitalized smokers to quit, provide information about pharmacotherapy for cessation, and provide resources to continue or initiate a quit attempt after discharge.

PHS Clinical Practice Guideline Steps for Addressing Smoking Among Hospitalized Patients

This manual "Treating Tobacco Use and Dependence in Hospitalized Smokers" is based upon the findings of The Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence* that was published in June 2000. This Guideline is the result of an extraordinary partnership among Federal Government and nonprofit organizations. It is the product of a two year effort by tobacco dependence experts, representatives from the sponsoring organizations, and professional staff. The panel employed an explicit methodology and expert clinical judgment to develop scientific recommendations on the successful treatment of tobacco use and dependence. The Guideline identified hospitalization as a uniquely effective time to assist smokers to successfully quit. To achieve this goal the PHS Guideline outlines strategies for integrating and promoting hospital policies that support and provide tobacco dependence services.

Action

Provide tobacco dependence treatment to all tobacco users admitted to a hospital. Implement a system to identify and document the tobacco-use status of all hospitalized patients.

Strategies for implementation

- Implement a system to identify and document the tobacco-use status of all hospitalized patients.
- Identify a clinician(s) to deliver tobacco dependence in-patient consultation services for every hospital.
- Offer tobacco dependence treatment to all hospitalized patients who use tobacco.
- Reimburse providers for tobacco dependence in-patient consultation services.
- Expand hospital formularies to include FDA-approved tobacco dependence pharmacotherapies.
- Ensure compliance with JCAHO regulations mandating that all sections of the hospital be entirely smoke-free.
- Educate hospital staff that first-line medications may be used to reduce nicotine withdrawal symptoms even if the patient is not intending to quit.

Specific Steps for Developing a Successful Hospital-wide Smoking Cessation Program

Hospital systems that have successfully integrated smoking cessation treatment programs into the routine care provided to smokers have found that the following common practices were integral to their achievement. These practices are summarized in the following 8 steps:

- Assign a multidisciplinary team to develop the program.
- Recruit physician champion.
- Assess current level of interventions and set measurable smoking cessation goals.
- Appoint cessation counselor or counseling team.
- Add tobacco status to initial vital sign assessment.
- Include cessation pharmacotherapy in hospital formulary.
- Acquire hospital-wide approval and integration of standing orders for cessation counseling and pharmacotherapy.
- Provide department specific in-services for staff to detail tobacco cessation procedures including resources available to staff, patients and visitors.

The following pages give more detailed information on completing each of these steps as well as examples on how hospitals have successfully instituted the procedures.

STEP 1: *Assign multidisciplinary team to develop program*

The formation of a multidisciplinary team to define program goals, implementation plan, and evaluation methodologies can be an excellent initial step in initiating a successful tobacco cessation program in hospitals. This team may consist of a variety of disciplines including ER physicians, cardiologists, hospitalists, physical therapists, pharmacists, nurses, respiratory therapists and other professionals. It is also important to include members of the quality improvement and staff education teams.

EXAMPLE: A 120-bed East Coast hospital began to develop a smoking cessation program when a respiratory therapist became interested in smoking cessation. Through discussions with her colleagues in the respiratory therapy department, hospital cardiologists, rehabilitation specialists and nurse educators, she developed hospital-wide interest in smoking cessation programming. A multidisciplinary team was developed that included physicians, nursing, respiratory therapy, rehabilitation therapy, and quality improvement staff. The team began meeting weekly and started the process of developing protocol for the tobacco cessation programming.

STEP 2: *Recruit a physician champion*

One of the first tasks of the multidisciplinary team is to identify a physician committed to leading the hospital-wide effort. Physician buy-in is important to the successful integration of tobacco cessation activities. Successful hospital based smoking cessation programs have found that a physician champion who promotes cessation activities can enhance successful integration.

EXAMPLE: A 450-bed Midwest hospital's chief medical officer has been the champion for the hospital-wide efforts to integrate smoking cessation activities. She serves as the chairperson for the multidisciplinary team entrusted with the job of designing the smoking cessation program. After the multidisciplinary team was formed, this team, headed by the physician champion, began the process of initiating smoking cessation programming by presenting data on smoking and health along with a carefully prepared proposal to the hospital's Medical Executive Committee. This committee determined that this issue was important to address and they supported the plan as the best way to begin the process. In addition to the smoking cessation multidisciplinary team, the physician champion serves as liaison to several committees, and therefore is able to advocate the importance of smoking cessation programming in that capacity.

STEP 3: *Assess current level of interventions and set measurable smoking cessation goals*

Quality improvement measures can be established and documented by designing a measurable system of tobacco dependence treatment and completing the steps of tobacco cessation: **ASK, ADVISE, ASSESS, ASSIST** and **ARRANGE**. Hospitals should also develop methods to carefully document **ADVICE** to quit, and **ASSESS**ment of willingness to make a quit attempt. **ASSIST**ance with quitting can be assessed by documenting the proportion of patients who smoke who receive visits for counseling and who receive pharmacotherapy orders. Integral to the success of these quality improvement mechanisms and measurement is a systematic record-keeping structure that clearly and easily records and monitors smoking cessation interventions at each of the phases.

EXAMPLE: One Midwest hospital began their smoking cessation program by measuring the number of patients whose tobacco use is documented. Although the intake form, completed by the admitting nurse, included information about smoking history it was only completed 52% of the time. This hospital set a goal of 100% documentation of tobacco use. One of the first endeavors of the program was to train all nursing staff in the implications of smoking for patients, with an emphasis on accurate record keeping. This training program increased documentation of smoking to 96% of patient records within the first year.

STEP 4: *Appoint cessation counselor or counseling team*

The multidisciplinary team designing the cessation program protocol should designate a department or individual available to counsel each patient identified as a tobacco user. For example, Physician Assistants, Nurse Practitioners, Clinical Psychologists, or Clinical Social Workers, Respiratory Therapists, Pharmacists or other designated departments or staff may be assigned this important consultant task. Assigning the responsibility of the tobacco cessation consult visit to a single staff member or department can ensure uniformity in the cessation message as well as consistency with the referral process. Counseling should include at least one visit during the hospitalization.

EXAMPLE: A small rural 80-bed hospital developed a program in which the hospital social worker provides counseling visits for patients identified as smokers who wish to make a quit attempt. When a patient is identified as a smoker, the attending physician discusses pharmacotherapy for smoking cessation with the patient and orders a consult visit by a social worker to offer information on quitting, provide motivation, and offer information on the state-wide quit line. The hospital has developed a pro-active fax program to the state's quit line. The social worker faxes information on the patient making the quit attempt upon the patients' discharge from the hospital. The quit line staff initiates a call to the patient within three days after hospital discharge to offer support for the quit attempt.

STEP 5: *Add tobacco status to initial vital sign assessment*

Tobacco users should be identified upon admission to any hospital setting including emergency room and the admitting office. The initial hospital intake process should include information about tobacco use status. Patients' interest in quitting tobacco use should be ascertained and if interested, a referral for counseling services should be initiated. These steps should all be documented clearly in the patients' chart.

EXAMPLE: A city-based 740-bed hospital instituted a plan in which patients who use tobacco are identified in both the physician and the nurse admission history and physical. The RN H&P is computerized and generates the patient record including all forms appropriate for that patient. For patients identified as smokers, a standing order form for smoking cessation is included in the patients' chart. Computer prompts also remind the RN to show the patient an education video and give the patient a self-help quit brochure developed by the hospital.

STEP 6: *Include cessation pharmacotherapy in hospital formulary*

Hospital pharmacists are key members of the tobacco cessation team. Cessation pharmacotherapies must be included on hospital formularies to ensure that pharmacotherapeutic agents for cessation are readily available to patients. The six FDA approved pharmacotherapies for the treating of tobacco dependence are bupropion SR, nicotine patch, nicotine gum, nicotine inhaler, nicotine nasal spray and nicotine lozenge.

EXAMPLE: A large Midwest university-based hospital began a hospital wide smoking cessation program. Led by a physician champion, the multidisciplinary team initiated a hospital-wide program that included referral to a psychologist for counseling for each patient interested in making a quit attempt. For patients that were documented in the admission record as smokers and not willing to make a quit attempt at this time, an informational pamphlet was provided to the patient. To ensure that patients receive FDA approved pharmacotherapies for smoking cessation, the multidisciplinary committee approached the hospital Pharmacy and Therapeutics Committee for inclusion of the pharmacotherapies found to be effective in treating tobacco dependence. The hospital formulary now includes bupropion, the nicotine patch and the nicotine inhaler.

STEP 7: *Acquire hospital-wide approval and integration of standing orders for cessation counseling and pharmacotherapy*

Systematically integrating standing orders for tobacco cessation treatments can facilitate implementation and efficiency. These orders work best when they are added to the new patient chart as soon as the patient is admitted and the chart assembled. This should then lead the admitting physician to complete the orders including requesting a smoking cessation consult and initiating pharmacotherapy for tobacco cessation or managing withdrawal symptoms during the hospitalization. Included in this packet is a sample of standing orders for tobacco cessation under "Sample Forms".

EXAMPLE: A small Midwest hospital began a smoking cessation program by training all nursing staff to intervene with patients who smoke. One nurse on each unit was designated as the smoking cessation coordinator for that unit and smoking cessation coordinators meet monthly to discuss hospital-wide procedures and policies. One of their successful policy development initiatives was the integration of standing orders for

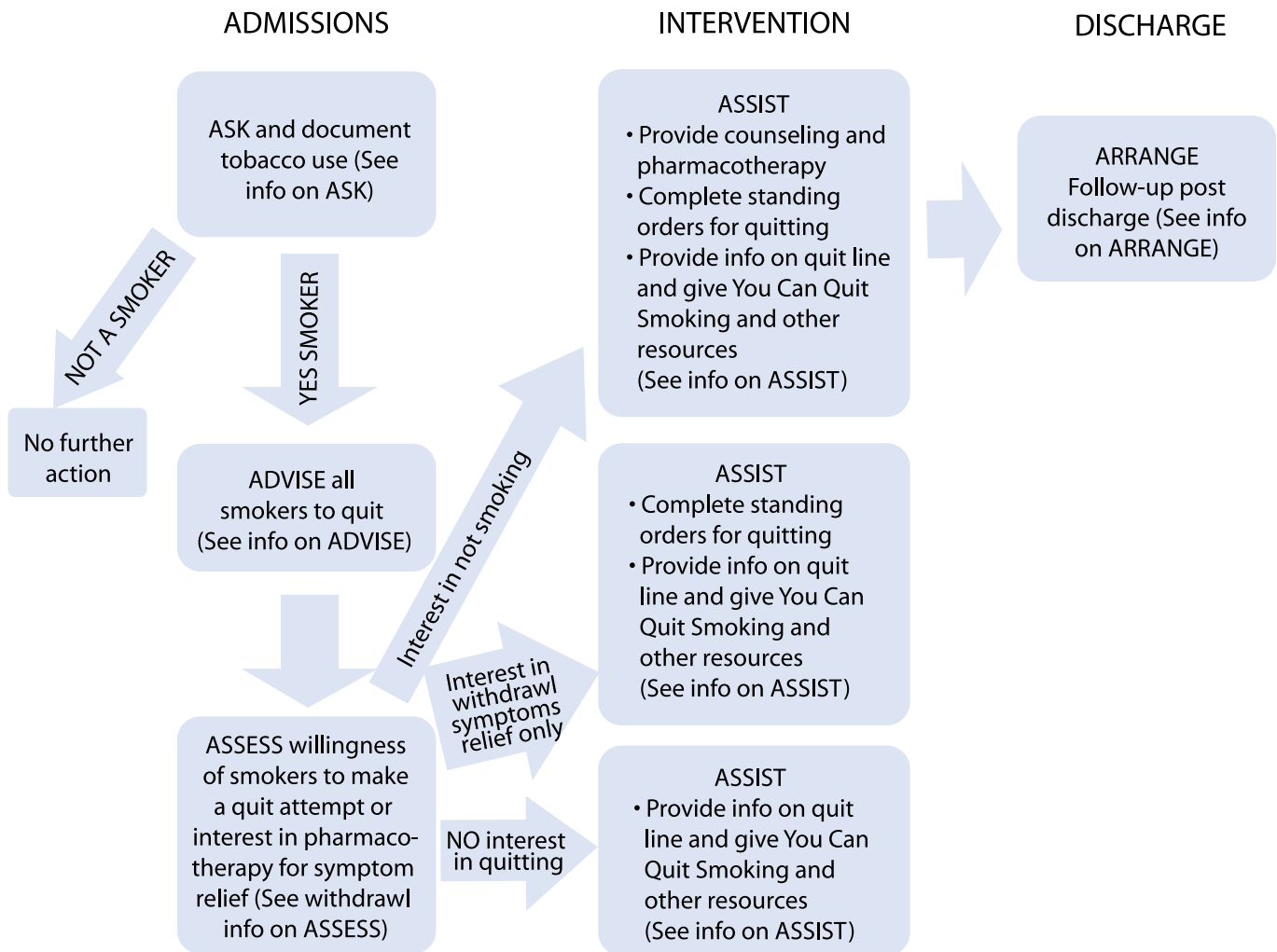
tobacco cessation. The admitting nurse documents tobacco use and if the patient is a smoker, the unit clerk includes standing orders for smoking cessation in the patients' chart. The smoking cessation coordinator for each unit visits the patient, asks if they are interested in making a quit attempt at that time and documents the patients response and interest in pharmacotherapy on the standing order form. The attending physician then has the opportunity to enact the orders and discuss the quit attempt at her next visit with the patient.

STEP 8: *Provide department specific in-services for staff to detail tobacco cessation procedures including resources available to staff, patients and visitors*

The multidisciplinary implementation of tobacco cessation stipulates that hospital staff receive training in tobacco cessation interventions. Physicians, nurses, therapists, quality improvement professionals and allied health professionals should all understand the importance of repeated, consistent messages. Training in tobacco interventions is available online at www.cme.uwisc.org. Other training materials and resources are also available and are presented in this packet under "Resources".

EXAMPLE: A 120-bed Midwest hospital offers training in the area of smoking cessation in all orientation programs for nurses, respiratory therapists and social workers. Smoking cessation efforts are reviewed on an ongoing basis by sharing the QI quarterly report with all staff involved in the cessation programming. This hospital provides a one-hour course yearly with updates on smoking cessation counseling and pharmacotherapy offered by their education department. Information on smoking cessation, including videos, guidelines, and books are also available in the hospital library.

Algorithm For Treating Tobacco Use and Dependence in Hospitals



JCAHO and Smoking Cessation

In addition to helping your patients improve their health, providing tobacco dependence treatment to your in-patients who smoke may assist your hospital with obtaining JCAHO certification.

In 1992 the Joint Commission's Tobacco Control standards resulted in the nation's first industry-wide ban of work place smoking. These standards have been instrumental in making the hospital a smoke free environment for patients. For most patients, this means that they cannot smoke for the duration of their hospitalization. This results in a unique opportunity to provide effective tobacco dependence treatments to your patients who smoke.

Recently, the Joint Commission has established several sets of standardized health care performance measures. These standardized performance measures, referred to as core measures, were grouped into sets by disease condition. These performance measures may be assessed during JCAHO Accreditation visits. The first four sets introduced were acute myocardial infarction (AMI), heart failure; community acquired pneumonia (CAP), and pregnancy and related conditions. Accredited hospitals recently began collecting data on those core measures beginning with July 2002 discharges. The AMI, heart failure, and CAP measure sets each include a measure that addresses the provision of smoking cessation counseling for patients.

As a result of this new JCAHO policy, providing tobacco dependence treatments to all patients who smoke will assist with the JCAHO accreditation while improving your patient's health. For the purposes of meeting these measurement criteria outlined by the Joint Commission, smoking cessation advice/counseling may include:

- Direct discussion with a patient or caregiver about stopping smoking.
- Prescription of smoking cessation aid (Habitrol, NicoDerm, Nicorette, Nicotrol Prostep, Zyban) during hospital stay or at discharge.
- Prescription of Wellbutrin/bupropion during hospital stay or at discharge, if prescribed as smoking cessation aid.
- Smoking cessation brochures/handouts/video.
- Referral to smoking cessation class/program.

The base population of each measure includes all patients within the disease condition, 18 years of age or older, who are identified as cigarette smokers during the past 12 months. Patients who are transferred to another hospital, transferred to a hospice, left against medical advise or died during the hospital stay are excluded from the population since the hospital may not have the opportunity to provide these patients with counseling.

For more information please visit the web site: <http://www.jcaho.org/pms/core+measures>

The Impact of Smoking on Hospitalized Patients

The detrimental effects of tobacco use, on the health of hospitalized patients have been well documented. For patients who smoke, these effects include:

- Delayed wound healing, including adverse effects on bone mineral density and the dynamics of bone healing.
- Wound infections after all types of surgery including post-mastectomy wound infection, skin flap necrosis, and epidermolysis.
- Cardiopulmonary complications.
- Increased requirement for postoperative intensive care.
- Poor surgical results.
- Heightened risk of second heart attacks.
- Increased risk for second primary tumors (SPTs) in patients with lung, head, and neck cancers.

No smoking policies are now mandated in all U.S. hospitals. As a result, every hospitalized smoker is temporarily housed in a smoke-free environment affording physicians and other clinicians the opportunity to help their patients quit. Research indicates that hospitalized patients who receive nicotine replacement therapy (NRT) to relieve nicotine withdrawal symptoms have both better outcomes and an increased likelihood of continuing tobacco abstinence post-discharge.

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Consultation Guidelines and Billing Codes for Treating Tobacco Dependence in Hospitals

Smoking cessation treatments are not only clinically effective, but they also reduce health costs and increase productivity. It is vital that health care providers recognize that smoking cessation treatments ranging from clinician advice to pharmacotherapy to specialist-delivered intensive programs are highly cost-effective.

Diagnostic Codes for Tobacco Dependence

For the in-hospital setting, tobacco use is usually listed as a secondary diagnosis. The clinician should list tobacco use on the discharge summary using one of the following diagnostic codes: *305.1 Tobacco use disorder* or *V158.2 Personal history of tobacco use*.

Billing for Consultation Visits for Tobacco Cessation

If a physician provides a consult on a patient during an inpatient hospital stay and all the requirements are met for a consultation, the provider can bill for these services and would use the appropriate inpatient consultation codes (99251-99255). Medicare Carriers Manual (MCM) section 15506 regarding consultations needs to be adhered to. The following is the first section of the MCM 15506: A. Consultation versus visit: Pay for a consultation when all of the criteria for the use of a consultation code are met:

- (1) Specifically, a consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).
- (2) A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.
- (3) After the consultation is provided, the consultant prepares a written report of his or her findings and provides it to the referring physician.

MCM Section 15505.1 F states, "Advise physicians that if they participate in the care of a patient but are not the admitting physician of record, they should bill the inpatient evaluation and management services codes that describe their participation in the patient's care (i.e., subsequent hospital visit or inpatient consultation)."

MCM Section 2020 E states "Concurrent care exists where services more extensive than consultative services are rendered by more than one physician during a period of time. The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services."

Reimbursement Guidelines for Non-physician Clinicians Providing Tobacco Dependence Treatments

Non-physician clinicians in the hospital setting often provide tobacco dependence consulting and treatments. Some payers, primarily Medicare and Medicaid recognize and accept billings by certain types of non-physician providers in their own name provided they are enrolled with the payer as a credentialed provider. Reimbursement rates vary but usually range from 65% to 85% of a physician's typical reimbursement. In particular, Medicare and Medicaid enroll Physician Assistants, Nurse Practitioners, Clinical Psychologists, Certified Nurse Midwives and Clinical Social Workers. Commercial insurance companies vary in their certification for non-physician providers.

Wisconsin Medicaid Reimbursement for Tobacco Dependence in the Hospital and Post-Discharge

Inpatient pharmacological products that require a written prescription and are prescribed by a physician are covered under Medicaid.

Patients should be encouraged to continue to use pharmacotherapeutic agents prescribed for tobacco cessation after they are discharged. Please see "Summary Table for Smoking Cessation Pharmacotherapy" for current costs for pharmacotherapy (page 23).

Medicaid covers the following for outpatients:

- Pharmacological products that by law require a written prescription and are prescribed by a medical provider for smoking cessation.
- Products covered include bupropion and prescribed nicotine patches, spray or inhaler.
- An office visit for counseling and to obtain a prescription.
- FFS patients are required to pay a \$1 co-pay per prescription medication with a monthly maximum of \$5 paid to any one pharmacy.

Medicare Reimbursement in the Hospital for Tobacco Dependence Treatments

Pharmacological products that require a written prescription and are prescribed by a physician are covered under Medicare part A in the hospital setting. Medicare does not cover any outpatient smoking cessation products. Independent Medicare supplemental policies may cover outpatient medications or counseling.

All State of Wisconsin Employees (regardless of insurer)

- Pharmacological products that require a written prescription and are prescribed by a plan provider for the purposes of achieving smoking cessation.
- Products covered include bupropion, nicotine patch, inhaler or spray.
- One office visit for counseling and to obtain the prescription.
- Products are subject to prescription drug co-payment and annual out-of-pocket maximum.
- Coverage is limited to one course of treatment per calendar year.

Asking, Advising and Assessing— Admission to the Hospital

Successful intervention begins with identifying users and identifying appropriate interventions based upon the patients' willingness to quit. The five major steps to intervention are the "5 A's", **Ask, Advise, Assess, Assist, and Arrange**. **ASKING** a patient about tobacco use should be integrated into the admission process as a "5th vital sign" with the blood pressure, pulse, and respirations. This step can be completed in the admitting office or by the admitting clinician.

ADVISE to quit and **ASSESSMENT** of willingness to make a quit attempt can be completed by the admitting clinician. A sample form for completing these three steps **ASK, ADVISE** and **ASSESS** are included in this packet in the sample forms section and titled:

Admission/Preadmission Questions for Treating Tobacco Use and Dependence in Hospitals.

ASK

Implement a hospital-wide system that ensures that, for EVERY patient who is admitted, tobacco use is queried and documented. This can be accomplished by expanding vital signs to include tobacco use. Alternatives to expanding the vital signs are to place a tobacco use status sticker on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.

ADVISE

Once tobacco use status has been identified and documented, advise all tobacco users to quit. Even brief advice to quit results in greater quit rates. Advice should be: **clear, strong, and personalized**. "As your health care provider, I must tell you that the most important thing you can do to improve your health is to stop smoking."

ASSESS

Ask every tobacco user if he or she is willing to make a quit attempt at this time. If the patient is willing to make a quit attempt, a counseling visit should be arranged (see information on Assisting, page 18). If the patient is unwilling to make a quit attempt, he or she should receive brief motivating information (**the 5 R's**) and/or pharmacotherapy for relief of nicotine withdrawal symptoms (see Managing Hospitalized Patients Who Are Not Ready to Quit Smoking, page 25).

INTEGRATING "ASK, ADVISE and ASSESS" INTO THE HOSPITAL SETTING

Tobacco users should be identified upon admission to any hospital setting including the emergency room and the admitting office. All patients should be **ASKED** about their tobacco use, **ADVISED** to quit, and **ASSESSED** regarding their interest in making a quit attempt at that time. Hospitals should design methods of integrating these three steps to meet the unique needs of their setting. Hospitals that have successfully integrated tobacco cessation have used the following methods:

- Include a question about tobacco use, a statement with advice to quit and a question on willingness to make a quit attempt in the preadmission form completed by the patient prior to admission. A sample of questions is included in the "Sample Forms" section of this manual. It is important when using this method that a clinician review the answers to the questions with the patient, and that the clinician strongly **ADVISES** the patient to quit. For example, the admitting physician may review the information when completing the preadmission work or the admitting nurse may review and discuss the questions.
- Clinicians admitting patients should **ASK** about tobacco use, **ADVISE** the patient to quit and **ASSESS** willingness to quit. This should be documented in the patient record.

If the patient is a tobacco user, and wishes to make a quit attempt at the time of admission, a consult visit should be initiated by completing standing orders for tobacco cessation counseling and/or notification to the attending physician. A sample of a Standing Order Form titled "Smoking Cessation Standing Orders" is included in the Sample Forms section of this manual.

Smokers Interested in Withdrawal Symptoms Relief Only

If the patient does not wish to make a quit attempt but is interested in relieving the symptoms of withdrawal to nicotine, the same form "Smoking Cessation Standing Orders" can be completed using only the section for pharmacotherapy. For each smoker, information should be available on the Tobacco Quit Line, a copy of the self-help brochure "You Can Quit Smoking" or other resources available in this manual.

ASSISTING — The Consult Visit

Once a tobacco user has been identified, advised to quit and assessed for willingness to make a quit attempt, a systematic method for providing counseling and pharmacotherapy for cessation or pharmacotherapy for relief of the symptoms of nicotine withdrawal should be implemented.

Prepare for the Consult Visit by the following two steps:

- 1. Generate Standing Orders for Tobacco Cessation:** Records indicating patients willing to make a quit attempt or wishing relief of withdrawal symptoms during hospitalization should prompt a "Standing Order" form for tobacco cessation.
 - These standing orders work best when they are added to the new patient chart as soon as the patient is admitted and the chart assembled. This should then lead the admitting physician to complete the orders including calling for a smoking cessation consult and initiating pharmacotherapy for tobacco cessation or managing withdrawal symptoms during the hospitalization. Included in this packet is a sample of standing orders for tobacco cessation under "Sample Forms".
 - For those patients willing to make a quit attempt and those patients interested in relief of withdrawal symptoms, the attending physician should complete the standing order form, tailoring it to the individual needs of the patient. The standing order form should include:
 - A consult visit and pharmacotherapy for all patients willing to make a quit attempt during hospitalization.
 - Pharmacotherapy for relief of the symptoms of nicotine withdrawal for patients not willing to make a quit attempt if appropriate.
 - Patients not willing to make a quit attempt nor wishing to receive pharmacotherapy for relief of symptoms of nicotine withdrawal should receive information on the Tobacco Quit Line, the brochure "You Can Quit Smoking" and other resources available in this manual.
- 2. Schedule a Consult Visit:** The consult visit should consist of at least a five minute counseling visit.
 - The consult visit should be completed by the designated staff member or department that may include Physician Assistants, Nurse Practitioners, Clinical Psychologists, Clinical Social Workers, Respiratory Therapists, Pharmacists or other designated departments or staff.

- This clinician should assist the patient in setting up a quit plan. *The form "You Can Quit Smoking" tear sheet can assist a clinician to personalize a short 3-5 minute intervention.* This personalized plan can be given to the patient as a take away. The front of the tear sheet offers motivational messages and specific advice on how to quit successfully. The back of the tear sheet offers five key steps that embody the key recommendations from the PHS Guideline.

Cessation Tear Sheets can be ordered from the Agency for Healthcare Research and Quality (AHRQ) by calling 800-358-9295. They can also be downloaded from the University of Wisconsin Medical School Center for Tobacco Research and Intervention website at www.ctri.wisc.edu.

The Consult Visit should consist of the following 6 steps:

- 1. Assist the Patient to Get Ready:** Discuss past quit attempts. Discuss what worked and what didn't work.
- 2. Assist the Patient to Get Support and Encouragement:** Patients should discuss their quit attempt with family and friends, talk to health care providers, and/or call the local quitline or the National Cancer Institute Smoking Quitline toll free at **1-877-444-QUIT**.
- 3. Assist the Patient to Learn New Skills and Behaviors:** Hospitalization offers an opportunity to break routines. If possible, family or friends should remove tobacco products from the patient's home before discharge. Stress should be avoided. Patients should be encouraged to drink a lot of water and other fluids.
- 4. Discuss Pharmacotherapy:** Discuss with a patient which medication will work best for him/her. By using the pharmacotherapies found to be effective in the PHS Guideline, a clinician can double or triple a patients' chances of abstinence. Discussion should include continuation of medication after discharge.
- 5. Prepare Patient for Relapse or Difficult Situations:** Hospitalization offers unique stressors as well as opportunities for tobacco cessation. Clinicians should give patients the opportunity to discuss barriers and assist them to come up with solutions. See "Counseling Patients to Quit", page 21 in this manual for further information on effective counseling advice.
- 6. Schedule Follow-up Contact: Arranging Follow-up:** It is important that patients who have made a quit attempt during hospitalization be offered support to continue to remain abstinent. Follow-up can be arranged during the initial consult visit or at a second consult visit (see Discharge Plan in Sample Forms section of this manual). Additionally, discharge planners in the hospital setting can assist in arranging follow-up for patients as they may have

knowledge of resources available in the community to assist patients to maintain abstinence. Patients and families can minimize barriers to abstinence by ensuring that exposure to tobacco and tobacco products are limited after discharge. In addition, alcohol consumption should be limited as most relapses to tobacco occur with alcohol present. A hospitalization (even a brief hospitalization) often represents a break in a person's daily routine and discharge may offer an opportunity to establish new and healthier patterns.

Systematic follow-up to each patient's quit attempt should be established. Planning for follow-up can be discussed with a patient during the consult visit and the hospital cessation team has a variety of options for the provision of the follow-up services:

- Follow-up counseling session by attending physician at next clinic visit. This visit should be scheduled within one week after hospital discharge.
- Follow-up telephone call by designated hospital staff.
- Referral to the local quit line or to the National Cancer Institute's Smoking Quitline **1-877-444-QUIT**.
- Referral to community or health plan cessation counseling.

There is a strong dose-response relation between the session length of person-to-person contact and successful treatment outcomes. Intensive interventions are more effective than less intensive interventions and should be used whenever possible. The more time that the clinician can spend in counseling and assisting the patient in the quit attempt, the more successful the attempt. It is also important that other health care staff working with the patient making a quit attempt offer support during the hospitalization.

Counseling Patients to Quit

Counseling patients to quit should include assisting patients to develop problem-solving skills, supporting patients within the hospital environment and assisting the patient to find assistance in their home and environment. The PHS Guideline lists the following as important aspects of counseling patients to quit.

Practical counseling (problem-solving/skills training) treatment component	Examples
Recognize danger situations – Identify events, internal states, or activities that increase the risk of smoking or relapse.	<ul style="list-style-type: none"> • Negative affect • Being around other smokers • Drinking alcohol • Experiencing urges • Being under time pressure
Develop coping skills – Identify and practice coping or problem-solving skills. Typically, these skills are intended to cope with danger situations.	<ul style="list-style-type: none"> • Learning to anticipate and avoid temptation • Learning cognitive strategies that will reduce negative moods • Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure • Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention)
Provide basic information – Provide basic information about smoking and successful quitting.	<ul style="list-style-type: none"> • The fact that any smoking (even a single puff) increases the likelihood of full relapse • Withdrawal typically peaks within 1-3 weeks after quitting • Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating • The addictive nature of smoking

Common elements of intra-treatment supportive interventions

Supportive treatment component	Examples
Encourage the patient in the quit attempt.	<ul style="list-style-type: none"> • Note that effective tobacco dependence treatments are now available • Note that half of all people who have ever smoked have now quit • Communicate belief in patient's ability to quit
Communicate caring and concern.	<ul style="list-style-type: none"> • Ask how patient feels about quitting • Directly express concern and willingness to help • Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings
Encourage the patient to talk about the quitting process.	<p>Ask about:</p> <ul style="list-style-type: none"> • Reasons the patient wants to quit • Concerns or worries about quitting • Success the patient has achieved • Difficulties encountered while quitting
Train patient in support solicitation skills	<ul style="list-style-type: none"> • Show videotapes that model support skills • Practice requesting social support from family, friends, and co-workers • Aid patient in establishing a smoke-free home
Prompt support seeking	<ul style="list-style-type: none"> • Help patient identify supportive others • Call the patient to remind him/her to seek support • Inform patients of community resources such as hotlines/helplines
Clinician arranges outside support	<ul style="list-style-type: none"> • Mail letters to supportive others • Call supportive others • Invite others to cessation sessions • Assign patients to be “buddies” for one another

Treating Tobacco Use and Dependence: In Hospitalized Smokers

Summary Table for Smoking Cessation Pharmacotherapy – 2003

**Those who have had significant withdrawal symptoms and been unable to quit with a single therapy may be considered for combination therapy.

	Bupropion SR	Patch	Gum	Inhaler	Nasal Spray
Treatment Period	<ul style="list-style-type: none"> • 7-12 weeks • Take for 1-2 weeks before quitting smoking • May use for maintenance for up to 6 months 	<ul style="list-style-type: none"> • 6-8 weeks 	<ul style="list-style-type: none"> • Up to 12 weeks • May use for longer time as needed 	<ul style="list-style-type: none"> • 3-6 months • Taper use over last few weeks 	<ul style="list-style-type: none"> • 3-6 months • Taper use over last few weeks
Dosage	<ul style="list-style-type: none"> • Days 1-3: 150 mg tablet each am • Days 4-end: 150 mg tablet am and pm 	<ul style="list-style-type: none"> • One patch each day • Taper dose if using 21 mg: 21 mg for 4 wks 14 mg for 2 weeks 7 mg for 2 weeks • No taper if using 15 mg: 15 mg for 8 wks • Light smokers (less than 10 cigarettes /day) can start with lower dose 	<ul style="list-style-type: none"> • 2 mg • 4mg (heavy smokers) • Chew one piece every 1-2 hours (10-15 pieces/day) • Many people don't use enough gum – chew gum whenever you need! 	<ul style="list-style-type: none"> • 6-16 cartridges each day • Need to inhale about 80 times to use up cartridge • Can use part of cartridge and save the rest for later that day 	<ul style="list-style-type: none"> • One dose equals one squirt to each nostril • Dose 1-2 times each hour as needed • Minimum = 8 doses/day • Maximum = 40 doses/day • Up to 12 weeks
Pros	<ul style="list-style-type: none"> • Easy to use • Reduces urges to smoke 	<ul style="list-style-type: none"> • Easy to use • Steady dose of nicotine 	<ul style="list-style-type: none"> • Can control your own dose • Helps with predictable urges (e.g., after meals) • Keeps mouth busy 	<ul style="list-style-type: none"> • Can control your own dose • Helps with predictable urges • Keeps hands and mouth busy 	<ul style="list-style-type: none"> • Can control your own dose • Fastest acting for relief of urges
Cons	<ul style="list-style-type: none"> • May disturb sleep • May cause dry mouth 	<ul style="list-style-type: none"> • May irritate skin • May disturb sleep • Can't adjust amount of nicotine in response to urges • Nasal irritation 	<ul style="list-style-type: none"> • Need to chew correctly – "chew and park" • May stick to dentures • Should not drink acidic beverages while chewing gum 	<ul style="list-style-type: none"> • May irritate mouth and throat (improves with use) • Does not work well below 40 degrees • Should not drink acidic beverages while using inhaler • 3-6 months 	<ul style="list-style-type: none"> • Need to use correctly (DO NOT inhale it!) • May irritate nose (improves with use) • May cause dependence
Caution	<ul style="list-style-type: none"> • Do not use if you have a seizure disorder, an eating disorder, or are already taking a monoamine oxidase inhibitor 	<ul style="list-style-type: none"> • Do not use if you have severe uncontrolled eczema or psoriasis 	<ul style="list-style-type: none"> • Caution with dentures 		<ul style="list-style-type: none"> • Do not use if you have severe reactive airway disease (asthma)
Availability	Prescription only	Over the counter - OR - Prescription (Legend)	Over the counter - (regular/mint/orange flavors)	Prescription only	Prescription only
Cost for average use (based on Aug. 2003 chain pharmacy)	\$139.00 (60) (\$4.60 per day)	Brand name: \$50.00 (14) (\$3.60 per day) Store brand: \$37.00 (14) (\$2.65 per day)	Brand name: 2 mg - \$30.00 (48) 4 mg - \$32.00 (48) Store Brand: 2 mg - \$23.00 (48) 4 mg - \$25.00 (48)	\$47.00 (42)	\$28.80 (12 doses) Nasal spray

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Summary Table for Nicotine Lozenge – Commit Lozenge, GlaxoSmithKline Inc.

	Nicotine Lozenge
Treatment Period	<ul style="list-style-type: none"> • 12 weeks • Stop using lozenges at the end of 12 weeks. If still feel the need to use nicotine lozenges, talk to doctor.
Dosage	<ul style="list-style-type: none"> • 2mg • 4mg (if smoke less than 30 minutes after waking) • Weeks 1-6: 1 lozenge every 1-2 hours • Weeks 7-9: 1 lozenge every 2-4 hours • Weeks 10-12: 1 lozenge every 4-8 hours • Use lozenges on a regular schedule, using at least 9 lozenges per day during the first 6 weeks.
Pros	<ul style="list-style-type: none"> • Can control own dose • Helps with predictable urges (ie: after meals) • Keeps mouth busy
Cons	<ul style="list-style-type: none"> • May cause insomnia (reported in less than 5% of users) • May cause nausea, hiccups, coughing, heartburn, headache and flatulence (The side effects seen in users are generally moderate and transient)
Caution	<ul style="list-style-type: none"> • Do not eat or drink 15 minutes before using, or while the lozenge is in your mouth • Do not use more than one lozenge at a time or continuously use one lozenge after the other • Do not use more than 5 lozenges in 6 hours, or more than 20 lozenges total per day
Availability	<ul style="list-style-type: none"> • Over the counter
Cost for average use (based on Aug. 2003 chain pharmacy)	<ul style="list-style-type: none"> • 2mg \$43.00 (72) • 4mg \$43.00 (72)

Managing Hospitalized Patients Who Are Not Ready to Quit Smoking

No-smoking policies are now mandated in all U.S. hospitals. Hospitalized smokers are required to temporarily abstain from smoking, which may precipitate nicotine withdrawal in these patients. Physical symptoms of withdrawal from nicotine can occur within a few hours of the last cigarette and can lead to:

- Increased anxiety and discomfort.
- Heightened cravings for cigarettes.
- Violations of hospital smoking bans.

Patients who continue to smoke during hospitalization have poorer recovery outcomes than nonsmokers. Patients who abstain from smoking during hospitalization have an increased likelihood of continued abstinence after discharge. Physical withdrawal to nicotine can occur within one hour after the last cigarette. Nicotine replacement therapy (NRT) may temporarily relieve withdrawal symptoms. Patients who do not wish to make a quit attempt during hospitalization but are interested in relieving the symptoms of nicotine withdrawal should receive pharmacotherapy found to be effective to relieve these symptoms.

In addition, patients who are not ready to make a quit attempt may respond to a motivational intervention based on the 5 Rs: Relevance, Risks, Rewards, Roadblocks, and Repetition.

- **Relevance:** Encourage patients to examine why quitting may be personally relevant.
- **Risks:** Ask patients to identify potential negative consequences of tobacco use.
- **Rewards:** Ask patients to identify potential benefits of stopping tobacco use.
- **Roadblocks:** Have patients list potential barriers or impediments to quitting.
- **Repetition:** Motivational interventions should be repeated each time clinicians interact with their patients who smoke. Patients should be informed that most smokers make repeated attempts before successfully quitting smoking.

References

- Fiore, M.C., Bailey, W.C., Cohen, S.J., Dorfman, S.F., Goldstein, M.G., Gritz, E.R., et al. (2000). Clinical Practice Guideline: *Treating Tobacco Use and Dependence*. (pp. 31) Washington, DC: U.S. Department of Health and Human Services.
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- Rigotti, N.A., Arnsten, J.H., McKool, K.M., Wood-Reid, K.M., Singer, D.E., Pasternak, R.C. (1999). The use of nicotine replacement therapy by hospitalized smokers. *American Journal of Preventive Medicine*, 17 (4), 255-259.

Treating Tobacco Use and Dependence: A Web Based Continuing Medical Education Program

for Physicians, Nurse Practitioners Physician Assistants, Pharmacists and
Allied Health Professionals

<http://www.cme.uwisc.org/>

Program Objectives

At the end of this session, the participant should understand:

1. The rationale for treating tobacco dependence.
2. Tobacco dependence as a chronic disease.
3. Clinical interventions for tobacco users willing to quit.
4. Clinical interventions to prevent relapse.
5. Clinical interventions for tobacco users not willing to make a quit attempt.

Your Faculty

Michael C. Fiore, M.D., M.P.H.

Michael C. Fiore founded and has served as Director of the University of Wisconsin Center for Tobacco Research and Intervention (UW-CTRI) since 1992. He joined the faculty of the University of Wisconsin in 1988 and is currently a Professor of Medicine. He is clinically active treating patients both in internal medicine and for tobacco dependence. Dr. Fiore is a nationally recognized expert on tobacco, providing perspectives to audiences ranging from Good Morning America to the United States Senate. He has written numerous articles, chapters, and books on cigarette smoking and chaired the U.S. Public Health Service panel that published the Clinical Practice Guideline: *Treating Tobacco Use and Dependence*.

CME Accreditation

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the University of Wisconsin Medical School and the Center for Tobacco Research and Intervention. The University of Wisconsin Medical School is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation Statement

The University of Wisconsin Medical School designates this educational activity for a maximum of 1 hour in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

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Pharmacy CE Credit

Pharmacists may earn 1.0 hours (0.10 CEUs) of pharmacy CE credit for participation in and successful completion of this web-based CE program entitled “Treating Tobacco Use and Dependence.” Successful completion is based on studying the materials as well as completion of all evaluation exercises to include: Post-test (minimum score of 70% is required); exam may be repeated once; General Evaluation. Upon completion of these evaluation exercises, a printed Statement of CE Credit will be mailed to you.

Accreditation

Extension Services in Pharmacy is accredited by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education. This program is approved for 1.0 hours (0.10 CEUs) of continuing education credit. A Statement of Credit will be mailed to those who successfully complete this program (all evaluation exercises including a minimum score of 70% on the post-test).

ACPE# 073-000-02-112-H01 Expiration Date: September 31, 2004

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It is the policy of the University of Wisconsin Medical School that the faculty and sponsor disclose real or apparent conflict of interest relating to the topics of this educational activity and also disclose discussions of unlabeled/unapproved uses of drugs or devices during their presentation(s). The University of Wisconsin Medical School fully complies with the legal requirements of the ADA and rules and regulations thereof. The University of Wisconsin provides equal opportunities in employment and programming, including Title IX requirements.

Sponsored by: University of Wisconsin Medical School, Office of Continuing Medical Education and the UW Center for Tobacco Research and Intervention

Five On-line, Web based modules offer information and specific approaches to implement the U.S. Department of Health and Human Services, Public Health Service, Clinical Practice Guideline: *Treating Tobacco Use and Dependence*.

This program has been funded by unrestricted educational grants provided to the University of Wisconsin Medical School by GlaxoSmithKline, GlaxoSmithKline ConsumerHealthcare, and Pharmacia Consumer Healthcare. Additional funds to support this program were provided by Agency for Healthcare Research and Quality and Blue Cross Blue Shield of Minnesota.

SAMPLE FORMS

Admission/Preadmission Questions for Treating Tobacco Use and Dependence in Hospitals

1. Please indicate your tobacco use status:

- Never smoker Former smoker Current smoker Current other tobacco use

If you currently use tobacco, we strongly urge you to consider quitting at this time. While you are in the hospital you will be unable to smoke. We can assist you with your quit attempt. NOW IS A GREAT TIME TO QUIT!

2. Are you willing to make a quit attempt while you are in the hospital? Y N

3. If you are not willing to make a quit attempt at this time, would you be interested in relief of symptoms of nicotine withdrawal while you are hospitalized and unable to smoke?
(Symptoms may include negative mood, urges to smoke, and difficulty concentrating.)

Y N

Smoking Cessation Physician Orders

All admitted patients who use tobacco should be encouraged to use this hospitalization to quit tobacco. Those interested in quitting should be provided with evidence-based assistance. Such assistance includes the following:

_____ Smoking cessation bedside consultation service

_____ Nicotine gum 2mg

- Chewed and “parked” over 15-30 minutes as needed for smoking urge.
- Gum should be chewed slowly until a “peppery” taste emerges, then “parked” between the cheek and gum to facilitate nicotine absorption.
- Avoid eating or drinking anything for 15 minutes before and during chewing nicotine gum.
- Acidic beverages (coffee, juices, soft drinks) will interfere with absorption of nicotine.

_____ Nicotine Patch

check one:

- 20 or more cigarettes/day-21mg
- 10-19 cigarettes/day-14 mg
- <10 cigarettes/day-7 mg

- Apply to relatively hairless location between neck and waist.
- May treat local skin reaction with 1% hydrocortisone cream.
- Consider using nicotine gum for breakthrough nicotine withdrawal symptoms.

_____ Bupropion SR 150 mg PO every am for 3 days, then increase to bupropion SR 150 mg PO BID.

- Approximately one week is needed to achieve a steady blood level.
- Ideally treatment should be initiated while patient is still smoking and a quit date set for one week later.
- Separate doses by at least 8 hours.
- Give second daily dose at suppertime to reduce or avoid nighttime insomnia.
- Contraindicated if history of seizure disorder or increased risk of seizures, concurrent use of MAOI, or prior diagnosis of anorexia or bulimia.
- May use in conjunction with nicotine replacement therapy.

Physician Signature _____

Date/Time _____

Treating Tobacco Use and Dependence: In Hospitalized Smokers

CONSULTATION REPORT

Patient: _____

ID number: _____

Referred by: _____

Treatment plan:

Quit date: _____

Consult visit date: _____

Consult report:

Medications recommended:

Follow-up date: _____

Signature: _____

Date: _____

Treating Tobacco Use and Dependence: In Hospitalized Smokers

DISCHARGE PLAN

Patient: _____

ID number: _____

Referred by: _____

Discharge plan:

Quit date: _____

Consult visit date: _____

Comments: _____

Medications prescribed:

Follow-up plan:

Signature: _____

Date: _____

RESOURCES

Guideline Availability

This guideline is available in several formats suitable for health care practitioners, the scientific community, educators, and consumers.

The Clinical Practice Guideline presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references.

The Quick Reference Guide is a distilled version of the Clinical Practice Guideline, with summary points for ready reference on a day-to-day basis.

The Consumer Guide is an information booklet for the general public to increase consumer knowledge and involvement in health care decision making.

The full text of the Guideline documents and the meta-analysis references for online retrieval are available on the Surgeon General's Web site (<http://www.surgeongeneral.gov/tobacco/default.htm>).

Single copies of these Guideline products and further information on the availability of other derivative products can be obtained by calling any of the following Public Health Service clearinghouse's toll-free numbers:

Agency for Healthcare Research and Quality (AHRQ): 800-358-9295

Centers for Disease Control and Prevention (CDC): 800-CDC-1311

National Cancer Institute (NCI): 800-4-CANCER

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