Winnipeg Regional Health Authority Office régional de la santé de Winnipeg
Caring for Health   À l'écoute de notre santé

1.0   INTENT

- To support all Primary Care Providers in adopting a consistent implementation approach to use in a primary care clinic setting that is aligned with the WRHA Management of Tobacco Use and Dependence Regional Clinical Practice Guideline. [1]

- To support the provision of Patient counselling for tobacco cessation from a harm reduction perspective. To provide tips and tools to support clinicians to help patients to quit or reduce tobacco use.

- To promote initial and ongoing education for all Primary Care Providers regarding the WRHA Management of Tobacco Use and Dependence Regional Clinical Practice Guideline. Primary Care clinical teams will receive education and supportive learning opportunities in the following areas:

1.1   Safe medication prescribing practices.
1.2   Essential counselling strategies using a harm reduction approach, including the Health Behaviour Change, Stages of Change (Transtheoretical Model of Change), and Motivational Interviewing approaches and strategies to support patient self-management.

EDUCATIONAL RESOURCES:

Educational Areas:	Professional Development - Fundamentals	Professional Development - Advanced Practice
Safe Medication Prescribing Practices	e Health Learning Module System (LMS) - in development	CAMH TEACH 5-week online core course Canadian Pharmaceutical Association QUIT Prospectus
Health Behaviour Change & Motivational Interviewing through the use of adjunctive therapies to support self-management and smoking specific counseling content and relapse prevention	WRHA Health Behaviour Change Website for LMS sign up details: Part 1: The Fundamentals Part 2: In-person Practical Workshop	CAMH TEACH 5-week online core course (Consider 1-2 Champions at each site)
Commit to Quit A Facilitator training session (4-6 hour) is available for health care providers who are interested in offering individual or groups consultations (need a minimum of 6 participants to run the training).		(Consider 1-2 Champions at each site)

- To regularly review the EMR Practice Efficiency (Indicator Cluster Reports by Clinic, by Primary Care Provider) to support clinic practice reflection. Both Indicator Cluster Reports will assist with clinic and patient strategies (i.e., implementation of Commit to Quit Groups, Group visits).   The EMR Practice Efficiency (Indicator Cluster Report by Primary Care Provider) for Smoking Cessation provides the percentage of core patients 12 years of age and over who are smokers and have been given smoking cessation advice in the past 24 months. See Quality

Measurement Primary Care Quality Indicators for more information on primary care quality indicators and data extracts.

- To provide consistent documentation and emphasize the value of completing of the Smoking Primary Care Quality indicator and the Smoking lifestyle band (examples include, used tobacco in past 6 months, most recent quit attempt, patient advised to quit (yes/no); date) will assist the patient and the clinic team to monitor patient and overall clinic progress. Appendix C (separate attachment): Tobacco Reduction Cessation Entry into the EMR.

- Biannually the Family Medicine Primary Care program will collate on behalf of the WRHA Direct Operational sites through EMR Indicator Cluster Reports by Clinic, by Provider. Both the Primary Care Professional Practice Council and the Primary Care Quality Team will analyze and evaluate how the guideline is being utilized into practice, identify areas in which additional support and strategic opportunities may be needed to further primary care networks and overall system improvements. The Indicator Cluster Reports by Clinic, by Provider and any recommendations from these committees will be forwarded to the Tobacco Dependence Leadership Network team for review and planning purposes.

DEFINITIONS:

According to Health Canada (2012) Canadian Tobacco Use Monitoring Survey (CTUMS) terminology, "Smoking status has been defined to be consistent with the definitions used in other national Health Canada surveys that collect data on tobacco use.

- **Tobacco Current User: includes daily tobacco and non-daily tobacco user (also known as occasional tobacco users) who have not quit.**

- **Tobacco - Former User -** In the **EMR 'Lifestyle band' "Tobacco – Former User"** This captures patients who have quit using tobacco however, had previously used tobacco at least 100 times in their lifetime.

- **Tobacco - Never a User (Less than 100 times over their lifetime) -** In the **EMR 'Lifestyle band' "Tobacco Never a User (Less than 100 times over their lifetime)"** this captures patients who have used tobacco less than 100 times in the patient's lifetime."

- Health Behaviour Change (HBC) counselling is an evidence-based method shown to increase the likelihood that patients will initiate and sustain health producing behaviours over time. HBC methods are shown to be more effective than simple advice-giving, both in brief interventions of three to five minutes and in longer discussions of personal health behaviours. This patient consultation method shows results across a wide range of health behaviours three of these areas being to quit or reduce tobacco use and managing addictions and taking medications as directed. [2,4,5]

- Stages of Change model assesses the readiness to change and are Pre-contemplation, Contemplation, Preparation, Action and Maintenance. [5, 6]

- Primary Care Provider (PCP) is inclusive of the following providers (i.e. Physicians, Nurse Practitioners)

- Primary Care Clinicians (PCC) is inclusive of the following providers (i.e., Physician Assistants, Midwives, Nurses, Home Care Antenatal Nurses, Dietitians, Social Worker and Shared Care Counsellors).

- Primary Care Clinic Support is inclusive of the following team members (i.e., Primary Care Assistants).

GUIDELINE:

- The below refers to the WRHA Management of Tobacco Use and Dependence Clinical Practice Guideline related to the use of the 5 A's Stages of Change See Appendix A.

3.1 ASK

3.1.1 Tobacco use status should be updated, for all patients by all PCP/PCC's on a regular basis (regional clinical practice guideline recommends at every visit). However, with the understanding if the same PCP or PCC sees the patient multiple times per month than asking once per month is acceptable.

3.1.2 Online tools can also assess a patient's health, sets goals, take action and tracks their progress (includes Tobacco as one of the behaviours). This flags targeted areas which includes patients who are or may be considering to quit or reduce tobacco. The clinic team would then be able to support the patient in the development and tracking of goals.

3.2 ADVISE

3.2.1 All PCP/PCC's are to complete the Primary Care Quality Indicator "Smoker (Yes or No)" and add the date of the Smoking Cessation Advice. It is expected that all clinical PCP's will routinely complete and update these fields (as well as all other sections of the primary care indicators) in order to fully optimize the electronic medical record.

3.2.2 Relapse- All PCP/PCC's to consider if relapse occurs the patients should be advised the only thing that will fail is the treatment plan not that they failed. Tobacco cessation is a long-term process –fluctuations and setbacks along the journey are normal and create opportunities to reflect on relapse and how to strengthen the quit plan with the next quit attempt See Appendix D Relapse section of the Tobacco Assessment.

3.3 ASSESS

3.3.1 PCP should assess the willingness of patients to begin treatment to achieve abstinence/cessation and/or reduce tobacco use this can include assessing stages of change with Health Behaviour Change and Motivational Interviewing skills. By adopting these models and a consulting style that is curious, supportive, non-judgmental to increases the odds that someone will move ahead in the stages of change and communicates the evidence about benefit and risk in an unbiased way.[6]

3.4 ASSIST - Every tobacco user who expresses the willingness to begin treatment to quit or reduce should be offered assistance.

3.4.1 Offering appropriate messages to facilitate tobacco cessation/reduction (using the stages of Change model, Health Behaviour Change and Motivational Interviewing skills) can increase the likelihood the patient will progress in readiness to reduce or develop a target quit date. Discovering

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why a patient is stuck at a particular stage may provide an opportunity for progress to the next stage. The use of decisional aides as homework for the patient could be explored web-based patient resources.

3.4.2 Minimal interventions, of 1-3 minutes, are effective and should be offered to every tobacco user. To help patients and their families negotiate these stages, discussion should be stage-matched. However, there is a strong dose-response relationship between the session length and successful treatment, and so intensive interventions should be used whenever possible (may include referral to other resources).

3.4.2 Counseling by a variety or combination of delivery formats (self-help, individual, group, helpline, web-based) is effective and should be used to assist patients/clients who express a willingness to quit or reduce. Refer to self-help, individual, group, helpline and full listing of web-based patient resources and Appendix E for Quick Reference Web Based Resources to Help Quit Smoking.

3.4.3 Multiple counseling sessions increase the chances of prolonged abstinence. Patients who receive **four or more counseling sessions from the health care team substantially increase the likelihood of sustainable success (*may include referral to other resources).* See Appendix D – Tobacco Assessment and PC PG #16 Appendix B Spirometry Screening Tool & Patient Handout

3.4.4 Combining counseling and smoking cessation medication is more effective than either alone, therefore both should be provided to patients/clients trying to quit /reduce smoking where feasible. Refer to WRHA Medication Recommendations in the Management of Tobacco Use and Dependence.

3.4.5 Two types of counseling and behavioural therapies yield significantly higher abstinence rates and should be included in smoking cessation treatment: 1) providing practical consultation on problem solving skills or skill training and 2) providing support as part of treatment.

   Notes: Acupuncture - Available evidence shows no difference in effectiveness between active acupuncture and control acupuncture, suggesting any positive effect of acupuncture may be due to other factors such as expectations that the procedure will aid the cessation process.
Hypnosis, Laser Therapy – Available evidence is inadequate to determine effectiveness of these treatments.

Electronic cigarettes information can be found on the World Health Organization Statement on Electronic cigarettes and Health Canada advised Canadians to not use Electronic cigarettes.

3.5 ARRANGE

3.5.1 Schedule or prompt regular follow-up appointments to assess response to treatment, provide support and modify treatment as necessary.

3.5.2 Are encouraged to refer patients to relevant resources as part of the provision of treatment, where appropriate. These may include Nursing and Allied Health professionals located in the clinic (Nursing and Allied Health may wish to refer to Appendix B –Tobacco Assessment and PCPG#16 Appendix B Spirometry Screening Tool & Patient Handout. Any PCP or PCC may refer patients to outside resources, (i.e., Smokers' Helpline referral form and providing the patient toolkit and list of resources embedded in the macro).

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3.5.3 The use of group education or group visits is encouraged for increased resource efficiency and patient support. Healthy Together Now identifies smoking as of the three major risk factors. Clinics who are wishing to develop programs and activities to address the risk factors affecting their community are to contact the local Community Facilitator/Developer in your community area. See Appendix F Community Health Agency Program Descriptions of Tobacco Cessation Delivery Interventions Individual and Group Services

3.6 DOCUMENTATION

3.6.1 Key to the success of optimizing the EMR is to track and evaluate patient clinical outcomes for the PCP to complete and continually update both the Smoking lifestyle band and primary care quality indicator. See optimizing the Lifestyle band section See Appendix C (separate attachment): Tobacco Reduction Cessation Entry into the EMR.

3.6.2 Tobacco Assessment / Treatment planning and Spirometry Screening is available in the EMR to assist with documentation and to help guide practice, with links to evidenced-based resources for both patient and Primary Care clinic teams (See Appendix C (separate attachment) Tobacco Reduction Cessation Entry into the EMR and Appendix D – Tobacco Assessment and PC PG#16 Spirometry Screening and Patient Handout.

> 3.6.2.1 **The PCQI indicator will trigger "yes" in the application by selecting Tobacco Current User:** includes daily tobacco and non-daily tobacco user (also known as occasional tobacco users) **who have not** quit.
>
> 3.6.2.2 **The PCQI indicator will trigger "no" in the application by selecting Tobacco - Former User -** In the *EMR 'Lifestyle band' "Tobacco – Former User"* This captures patients who have quit using tobacco however, had previously used tobacco at least 100 times in their lifetime.
>
> 3.6.2.3 **The PCQI indicator will trigger "no" in the application by selecting Tobacco - Never a User (Less than 100 times over their lifetime) -** In the *EMR 'Lifestyle band' "Tobacco Never a User (Less than 100 times over their lifetime)"* this captures patients who have used tobacco less than 100 times in the patient's lifetime."
>
> 3.6.2.4 **The PCQI indicator will not be prompted in the application: nothing selected**
>
> 3.6.3.5 **The Advice box is already mapped in the application** (other than manually adding to the PCQI). When saving the smoking handout to the patient chart the date is populated in the worksheet. That is, if we continue with the current patient handout section. The current smoking handout in the EMR that is provided to patients will be revised by the Primary Care working group.

3.7 EVALUATION

3.7.1 Clinic teams are encouraged to regularly review the EMR Practice Efficiency (Indicator Cluster Reports by Clinic, by Primary Care Provider) to support practice reflection. Both Indicator Cluster Reports will assist with clinic strategies (i.e., implementation of Commit to Quit Groups). The Smoking lifestyle band (examples include, used tobacco in past 6 months, most recent quit attempt, patient advised to quit (yes/no); date will assist the patient and the clinic team to monitor progress in the EMR Appendix C (separate attachment): Tobacco Reduction Cessation Entry into the EMR.
3.7.2 The Family Medicine Primary Care program will collate through EMR Indicator Cluster Reports by Clinic, by Provider. These reports will be analyzed by both the Primary Care Professional Practice Council and the Quality Team to look for strategic opportunities to further system

improvements. The Indicator Cluster Reports by Clinic, by Provider and any recommendations from these committees will be forwarded to the Tobacco Dependence Leadership Network team for review and planning purposes.

APPENDICES:

- Better Breathing Survey
- Appendix A - Stages of Change to Quit or Reduce Smoking
- Appendix B - Terms used in the Lifestyle Band
- Appendix C - Tobacco Reduction Cessation Entry into EMR
- Appendix D - Tobacco Assessment and Management
- Appendix E - Tobacco Reduction Resources
- Appendix F - CHA Program Descriptions
- Tobacco Cessation Tips, Tools, Techniques
- 5A's 5R's Table WHO
- Tobacco Cessation in Primary Care - Cessation Medications
- Smoking Cessation - Reduction Medication Dosing Fact Sheet
- Algorithm for Tailoring Pharmacotherapy in Primary Care Setting

SOURCE/REFERENCES:

1. References for the WRHA Management of Tobacco Use and Dependence reviewed for changes (February 2014).
2. Canadian Tobacco Use Management Survey (CTUMS) (2012) Terminology http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/index-eng.php
3. Goldstein, MG, Whitlock, EP, DePue, J. Multiple Behavioral Risk Factor Interventions in Primary Care. American Journal of Preventative Medicine 2004. 27(2S): 61-79.
4. Jepson, R.G., Harris, F.M., Platt, S., & Tannahill, C. Effectiveness of interventions to change six behaviours: a review of reviews. BMC Public Health, 2010. 1:538. http://www.biomedcentral.com/1471-2458/10/538
5. Tobacco Treatment Dependence Toolkit http://tobaccodependence.chestnet.org/ (2009-2010) American Collegue of Chest Physicians.
6. DiClemente, CC, Prochaska, JO. Self change and therapy change of smoking behaviour: a comparison of processes of cessation and maintenance. Addict Behav 1982;7:133–42.
7. Making Shared Decision-Making A Reality No Decision about me without me The King's Fund (2011) http://www.kingsfund.org.uk/sites/files/kf/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf

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SCOPE: Applicable to all WRHA Primary Care Direct Operations Clinics and Quick Care Clinics Appendix C may exclude some Fee for Service Staff who aren't using Accuro