Regional Smoking Cessation Best Practice Working Group (SCBPWG)

The following list identifies SCBPWG members who contributed to the development of this Clinical Practice Guideline, according to their position at the time of their contribution.

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Background

Tobacco use continues to be a leading cause of death and disability in the Winnipeg Health Region (WHR). According to the Canadian Tobacco Use Monitoring Survey (CTUMS), 20.5% of Manitobans aged 15 years and older are current tobacco users[1]. According to the Winnipeg Regional Health Authority (WRHA) Community Health Assessment in 2009-10, 22.1% of our population aged 12 years and over are current smokers.[2] Half of long-term smokers will die from their tobacco use. This equates to approximately 1,400 deaths per year in Manitoba.[3]

Tobacco use is an even larger concern in a number of sub-populations, including people with mental health problems, people with low income/education, and people from First Nations, Inuit and Métis communities. People with mental health problems smoke at approximately 2.7 times the rate of the general population[4,5], and consume close to half of the cigarettes smoked.[4] Canadians with less than high school education smoke at twice the rate of university graduates.[6] The First Nations and Inuit Health Branch of Health Canada reports that 59% of on-reserve First Nations people smoke.[7] A 2010 Manitoba Centre for Health Policy report, produced in collaboration with the Manitoba Métis Federation, found that the Métis population has a higher percentage of people who use tobacco (33.3%) compared to all other Manitobans (21.7%); this difference was found specifically among Winnipeg RHA residents as well (Metis-35.4%; all other WRHA residents-21.3%).[8]

In Manitoba, the annual economic burden of smoking is estimated to have been $526 million in 2008 ($170 million in direct costs – costs associated with health care; $356 million in indirect costs – costs associated with morbidity and premature mortality).[9] In light of these high costs, it is important to recognize the cost effectiveness of tobacco use interventions. Numerous authors have identified that the reduction in costs of treating tobacco-related illness more than offsets the cost of cessation interventions,[9-12] with one study showing a better than 3-to-1 return on investment over a 16 year period.[9] Researchers have also demonstrated that cessation interventions are more cost-effective than other routinely used preventive interventions,[10, 13] such as treatment of hyperlipidemia in primary prevention of chronic disease and treatment of moderate to severe hypertension.[12]

In January 2011, an interprofessional, intersectoral WRHA Smoking Cessation Best Practice Working Group was established. The purpose of this group was:

- To facilitate the development and sustainable implementation of a WRHA-wide smoking cessation system that will promote consistent identification and effective intervention with people who use tobacco
- To effect practice change throughout acute care, long-term care, and community-based care so that a consistent level of quality in smoking cessation services is provided as a part of day-to-day services

A primary output of this Working Group was this ***Management of Tobacco Use and Dependence Regional Clinical Practice Guideline.***