Implementing Smoking Cessation Guidelines in Clinical Practice

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Disclosures

- Previous funds from Schering Canada to provide buprenorphine training (2000)

- Paid consultant and advisory board member- Pfizer consumer health care Canada, Pfizer Inc, Canada, Sanofi-Synthelabo, Canada, GSK, Canada. Genpharm and Prempharm, Canada, CTI.

- Industry-related grants: Pfizer Inc. (manufacturer of varenicline); Johnson and Johnson (manufacturer of NRT); Biovail (manufacturer of bupropion).

- Grants: Health Canada, SFO, CIHR, and provincial governments/health agencies

- NO TOBACCO INDUSTRY FUNDS
Learning Objectives

- Learn about the dynamic practice-informed development of the first Canadian clinical practice guideline (CPG) for smoking cessation
- Develop skills to incorporate the CPG into practice
- Understand how to overcome potential barriers to implementation while taking into account diverse settings and resources
Overview

- What is CAN-ADAPTT?
- Implementation: Barriers, Challenges, Opportunities
- Breakout groups: Overcoming challenges of implementing guideline into practice
- Report back and Wrap up
**Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment**

Informing the development of a Canadian clinical practice guideline for smoking cessation

Funding provided by Drugs & Tobacco Initiatives Program, Health Canada
“There are therefore 2 major disconnects between research and practice: research may not translate expeditiously to everyday practice, and clinical problems encountered in everyday practice are often under-investigated.” (Tierney et al., 2007)

**Solution**

Address this gap by:

**Developing a dynamic guideline**

- Incorporate practitioner input
Utility of Guidelines

- Guidelines are not consistently used.

Challenges with guidelines:

1. Don’t reflect local or current circumstances
2. Are quickly out of date
3. Reflect large gaps between the perspectives of experts and the day-to-day experiences of practitioners
4. Lack of dissemination and implementation efforts to support uptake
<table>
<thead>
<tr>
<th>Traditional Guidelines</th>
<th>Dynamic Guideline</th>
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<tbody>
<tr>
<td>Arbitrarily scheduled review date (often every 5-10 years)</td>
<td>Guideline is updated with experience from the ‘field’</td>
</tr>
<tr>
<td>Wasted resources if full update done in a slowly evolving field</td>
<td>Outdated recommendations can easily and quickly be removed or modified</td>
</tr>
<tr>
<td>Guidelines quickly out of date in rapidly evolving field</td>
<td>Timely &amp; readily useable to those in position to help smokers</td>
</tr>
<tr>
<td>Costly to assemble GDG for revision and to disseminate guidelines</td>
<td>Cost efficient, easy access to guidelines</td>
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</table>
Dissemination & Engagement
- Stakeholders
- Professional Advisory Groups

Knowledge Translation
- Seed grants
- Discussion board

Practice-informed Research Agenda
- Seed grants
- Discussion board
- AGM

National Network
- Practitioners
- Researchers
- Policy-makers

Canadian Clinical Practice Guideline
CAN-ADAPTT’s Guideline Development Process
Clinical
1. Medication
2. Counseling & Psychosocial

Population Level Approaches

Specific Populations
1. Pregnancy and Breastfeeding
2. Youth
3. Mental Health
4. Hospital Based
5. Aboriginal
Guideline Development Process

- Review **existing smoking cessation** CPGs (internationally and across disciplines)
- CPGs rated using the AGREE instrument
- **Highest-scoring CPGs were used**
- Sections subject to ongoing input by CAN-ADAPTT network (PBRN, partners etc.)
Appraisal: AGREE
4 independent reviewers (practicing physicians)
All formally trained on AGREE instrument

Appraisal: AGREE Plus
8 Additional questions developed by CAN-ADAPTT to understand the applicability of the recommendations in the Canadian context

Highest scoring CPG’s included
6 Guidelines Included

Initial LITERATURE REVIEW
for existing Clinical Practice Guidelines
5 Guidelines Included

COMPREHENSIVE LITERATURE SEARCH
87 Guidelines Found

U.S. Department of Health and Human Services Public Health Service: Treating Tobacco Use and Dependence (2008 Update),
New Zealand Smoking Cessation Guidelines (August 2007),
Registered Nurses Association of Ontario: Integrating Smoking Cessation into Daily Nursing Practice (March 2007),
Registered Nurses Association of Ontario: Integrating Smoking Cessation into Daily Nursing Practice (October 2003),
Institute for Clinical Systems Improvement. Tobacco use prevention and cessation for infants, children and adolescents (June 2004),
Institute for Clinical Systems Improvement Tobacco use prevention and cessation for adults and mature adolescents (June 2004).

The CAN-ADAPTT program engaged the Guidelines Advisory Committee

Version 1.0
February 2009
Clinical Approaches
• 7 clinical sections discussed
• Workshop held: November 1, 2009
  • 100 CAN-ADAPTT members attended and provided feedback
  • The Guideline Development Group (GDG) reviewed the section notes and determined revisions to the summary statements.

Population Level approaches
Sections: Population level approaches to tobacco cessation in Canada
Workshop/AGM: Oct 1st, 2010

Levels of Evidence
• Attributed level of evidence and grades of recommendation to each summary statements based on GRADE principles

Version 2.0
Currently Posted
Input from CAN-ADAPTT Network
Spring – Winter 2010

Version 3.0
Release Date January 2011
Network Input
Practice-informed Approach

Input obtained from CAN-ADAPTT practice-based research network (PBRN) to:

• Develop research agenda
• Revise and identify gaps in guideline

Member input is collected via:

• Discussion board
• Seed grants
• Guideline revision workshops
• Teleconferences/Webcasts
• Member surveys
Benefits of the PBRN

This Practice-Based Research Network:

1. Includes healthcare professionals, researchers, and decision-makers devoted to the treatment of smokers.
2. Contributes input in using and developing CAN-ADAPTT’s guideline.
3. Encourages a cross-Canada, multidisciplinary community to collaborate on advancing smoking cessation treatment.
Web-based Engagement

- Online discussion board
- Wiki-based guideline
- Guideline accessible via website
- News, events, and email updates
- Research-based information-sharing (eg. “Transdisciplinary Tobacco Rounds” webcast)
Version 2.0 Launch

- Sections Launched Oct. 1, 2010
  - Counselling
  - Hospital based populations
  - Youth
  - Pregnant and Breastfeeding Women
  - Mental Health and Addictions
  - Aboriginal Populations

- Upcoming Launch
  - Pharmacotherapy
Structure of Guideline Sections

Background and Evidence Overview
- Context of research and practice in the area

Summary Statements
- Summary of advised practice

Clinical Considerations
- Issues to consider in implementation

Tools and Resources
- Helpful tips/material

Future Research
- Research/knowledge gaps
Levels of Evidence/Grade of Recommendations

- Summary statements are rated based on the GRADE system
- Required consensus of the Guideline Development Group

**GRADE system of Ratings**

<table>
<thead>
<tr>
<th>Grade of Recommendation</th>
<th>Levels of Evidence</th>
</tr>
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<tbody>
<tr>
<td>High</td>
<td>Strong</td>
</tr>
<tr>
<td>1A</td>
<td>2A</td>
</tr>
<tr>
<td>1B</td>
<td>2B</td>
</tr>
<tr>
<td>1C</td>
<td>2C</td>
</tr>
<tr>
<td>Low</td>
<td>Weak</td>
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</table>
Implementing CAN-ADAPTT’s Guideline in Your Practice
Importance of Family Physician Role

- Ideally suited to deliver tobacco use cessation treatment through education, motivation & follow up visits
- Experts in: health promotion, disease prevention, behaviour modification
- Ongoing relationship with patient/client
- Opportunity to provide team based care or referrals
Tobacco Cessation and Family Physicians (or Primary Care Team)

Discussion Point

How many of you currently:

- Ask about tobacco use with your patients/clients?
- Know that tobacco status is consistently asked by other members of the team?
- Work in settings where tobacco status is documented?
- Work in a setting that provides tobacco cessation resources for patients/clients wanting to quit?
### Effect of Intervention Time

<table>
<thead>
<tr>
<th>Total Contact Time</th>
<th>Estimated Abstinence Rate</th>
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<tbody>
<tr>
<td>None</td>
<td>11.0%</td>
</tr>
<tr>
<td>1-3 minutes</td>
<td>14.4%</td>
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<tr>
<td>4-30 minutes</td>
<td>18.8%</td>
</tr>
<tr>
<td>31-90 minutes</td>
<td>26.5%</td>
</tr>
<tr>
<td>90-300 minutes</td>
<td>28.4%</td>
</tr>
<tr>
<td>&gt;300 minutes</td>
<td>25.5%</td>
</tr>
</tbody>
</table>

Slide from TEACH (Fiore et al., 2008)
Counselling

1. ASK: Tobacco use status should be updated, for all patients/clients, by all health care providers on a regular basis. (1, A)

2. ADVISE: Health care providers should clearly advise patients/clients to quit. (1, C)

3. ASSESS: Health care providers should assess the willingness of patients/clients to begin treatment to achieve abstinence (quitting). (1, C)

4. ASSIST: Every tobacco user who expresses the willingness to begin treatment (to quit) should be offered assistance. (1, A)
4a. Minimal interventions, of 1-3 minutes, are effective and should be offered to every tobacco user. However, there is a strong dose-response relationship between the session length and successful treatment, and so intensive interventions should be used whenever possible. (1, A)

4b) Counselling in a variety or combination of formats is effective and should be used to assist patients/clients that express a willingness to quit. (1, A)

4c) Multiple counselling sessions increase the chances of a successful quit and health care providers should recommend four or more sessions where possible. (1, A)

4d) Combining counselling and smoking cessation medication is more effective than either alone, therefore both should be provided to patients/clients trying to stop smoking where feasible. (1, A)
4e) Motivational interviewing is encouraged to support a patient’s/client’s willingness to engage in treatment now and in the future. (1, B)

4f) Types of counselling and behavioural therapies: Statement under review.

5. **ARRANGE**: Health care providers:
   
   a) should conduct regular follow-up to assess response, provide support and modify treatment as necessary. (1, C)
   
   b) are encouraged to refer patients/clients to relevant cessation resources as part of the provision of treatment, where appropriate. (1, A)
Aboriginal Peoples

1. Tobacco misuse status should be updated for all Aboriginal peoples by all health care providers on a regular basis. (1, A)

2. All health care providers should offer assistance to Aboriginal peoples who misuse tobacco with specific emphasis on culturally appropriate methods. (1, C)

3. All health care providers should be familiar with available cessation support services for Aboriginal peoples. (1, C)

4. All individuals working with Aboriginal peoples should seek appropriate training in providing evidence-based smoking cessation support. (1C)
### Pregnant & Breastfeeding

1. Smoking cessation should be encouraged for all pregnant, breastfeeding and postpartum women. (1,A)

2. During pregnancy and breastfeeding, counselling is recommended as a first line treatment for smoking cessation. (1,A)

3. If counselling is found ineffective, intermittent dosing nicotine replacement therapies (such as lozenges, gum) are preferred over continuous dosing of the patch after a risk-benefit analysis. (1,C, *under review*)
4. Partners, friends and family members should also be offered smoking cessation interventions. (2,B, under review)

5. A smoke-free home environment should be encouraged for pregnant and breastfeeding women to avoid exposure to second-hand smoke. (1,B, under review)
Youth (Children & Adolescents)

1. Health care providers, who work with youth (children and adolescents) should obtain information about tobacco use (cigarettes, cigarillos, waterpipe, etc.) on a regular basis. (1,A)

2. Health care providers are encouraged to provide counselling that supports abstinence from tobacco and/or cessation to youth (children and adolescents) that use tobacco. (2,C, under review)

3. Health care providers in paediatric health care settings should counsel parents/guardians about the potential harmful effects of second-hand smoke on the health of their children. (Under review)
1. All patients should be made aware of hospital smoke-free policies. (1, C)

2. All elective patients who smoke should be directed to resources to assist them to quit smoking prior to hospital admission or surgery, where possible. (1, B)

3. All hospitals should have systems in place to:
   a) identify all smokers (1,A)
   b) manage nicotine withdrawal during hospitalization (1,C)
   c) promote attempts toward long-term cessation; and (1,A)
   d) provide patients with follow up support post hospitalization. (1,A)
Hospital-based cont’d

4. Pharmacotherapy should be considered:  
   a) to assist patients to manage nicotine withdrawal in hospital  
      (1,C)  
   b) for use in-hospital and post-hospitalization to promote long  
      term cessation. (1,B)
Mental Health

1. Health care providers should screen persons with mental illness and/or addictions for tobacco use. (1,A)

2. Health care providers should offer counselling and pharmacotherapy treatment to persons who smoke and have a mental illness and/or addiction to other substances. (1,A)

3. While reducing smoking or abstaining (quitting), health care providers should monitor the patients/clients psychiatric condition(s) (mental health status and/or addiction(s)). Medication dosage should be monitored and adjusted as necessary. (1,A)
Let’s work with the guideline:
Counselling Section

Counselling

CAN-ADAPTT’s Clinical Practice Guideline Development Group with
Section Lead: Gerry Brosky, MD, CCFP

- Overview of Evidence
- CAN-ADAPTT Summary Statements
- Clinical Considerations
- Tools/Resources
- Research Gaps
The 5 As - at a glance

<table>
<thead>
<tr>
<th>ASK</th>
<th>1. Ask – do you smoke? Initiate the conversation</th>
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<tbody>
<tr>
<td>ADVISE</td>
<td>2. Advise – encourage to quit or reduce</td>
</tr>
<tr>
<td>ASSESS</td>
<td>3. Assess – evaluate smoking status</td>
</tr>
<tr>
<td>ASSIST</td>
<td>4. Assist – help to quit or reduce</td>
</tr>
<tr>
<td>ARRANGE</td>
<td>5. Arrange/Advocate – follow up support, policy advocacy</td>
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Slide from TEACH
CAN-ADAPTT Summary Statement:

- Tobacco use status should be updated for all patients/clients, by all health care providers on a regular basis.(1A)

*CAN-ADAPTT Guideline v.2.0, launched Oct. 1, 2010*
‘How’ to Ask

- “Have you used any form of tobacco in the past six months?”

- “How much do you smoke?
  0 - ___ cigarettes per day (cpd)? (one large pack = 25 cpd, one small pack = 20 cpd)

- Systematic approach is the best
  - Use chart reminders/stickers
  - Medical questionnaire and updates

*CAN-ADAPTT Guideline v.2.0, launched Oct. 1, 2010*
Advise

CAN-ADAPTT Summary Statement:

- Health care providers should clearly advise patients/clients to quit.(1C)

*CAN-ADAPTT Guideline v.2.0, launched Oct. 1, 2010
‘How’ to Advise

- Advise in a clear, strong and personalized statement
  
i.e.: “Mr. Packaday, I am concerned about your tobacco use, and advise you to quit. Would you like my help?”
Assess CAN-ADAPTT Summary Statement:

- Health care providers should assess the willingness of patients/clients to begin treatment to achieve abstinence (quitting). (1C)

*CAN-ADAPTT Guideline v.2.0, launched Oct. 1, 2010
‘How’ to Assess

Asking about willingness to quit:

- Given everything going on in your life, on a scale of 0-10, where 0 is lowest…
- How important is it for you to quit smoking?
- How confident are you that you can quit smoking?

*CAN-ADAPTT Guideline v.2.0, launched Oct. 1, 2010*
‘How’ to Assess

“Are you interested in quitting? In the next 6 months?”

Stages of Change

No: Precontemplation stage
- Leave the door open
- Education
- Patience
- Establish incongruence

Yes, but not in next 6 months: Contemplation stage
- Offer to help when ready
- Non-judgemental, slow progress
- Teachable moments to establish incongruence between thinking and behaviors

Yes
- Preparation & Action
Planning the Intervention

When did you last use tobacco?

- Within last 7 days

Interested in quitting

- Yes
- No

Interested in Cutting Down

- No
- Yes

R.E.D.U.C.E.
- Ration
- Exercise
- Delay
- Use Medication
- Conscious Smoking
- Environment – Smoke-free

S.T.O.P.
- Strategize
- Take Action
- Options to not smoking
- Prevent Relapse

Motivational Interviewing
- 5 Rs

Slide from TEACH TOBACCO CESSATION
Summary Statement:

- Every tobacco user who expresses the willingness to begin treatment (to quit) should be offered assistance. (1A)
‘How’ to Assist

Levels of Intervention

- Self help books
- Brief Intervention < 3 min
- Intensive intervention Multi-session
- Inpatient

(Fiore et al., 2009; Pbert et al., 2008; USDHHS, 2008)
‘How’ to Assist

- Pharmacotherapy
  - Over the counter: Patch, gum, lozenge, inhaler
  - Under the counter: Zyban, Champix
- Counselling
- Telephone quitline
- Self-help materials
- Refer to other HCPs who can provide more specialized support
‘How’ to Assist

A quit attempt within 1 month

- Review decisional balance
- Explore fears, barriers, high-risk situations
- Plan quit day
  - Maybe try a ‘trial’ quit day
  - Structured quit day is often helpful
- Discuss medications, counselling options
### ‘How’ to Assist

**Assisting with a quit – what to do up to 6 months**
- Reinforce success – encourage rewards
- “Process – not an event”
- Plan for slips or relapses
- Ongoing review of medications and supports

**Assisting with maintenance – a quit for over 6 months**
- Review accomplishments
- Talk about ongoing high-risk situations and barriers
- Relapse prevention
Health care providers:

a) should conduct regular follow-up to assess response, provide support and modify treatment as necessary. (1C)

b) are encouraged to refer patients/clients to relevant cessation resources as part of the provision of treatment, where appropriate. (1A)

*CAN-ADAPTT Guideline v.2.0, launched Oct. 1, 2010
Referral can be to:

- Smokers Helpline fax referral
- Local smoking cessation services, etc.

Practice Point:

- Identify available resources and services in the community or other practice settings.

*CAN-ADAPTT Guideline v.2.0, launched Oct. 1, 2010*
How to Arrange Primary Care and Quit Lines

Q: Do cessation supports enhance the practice of primary care physicians?

A: Yes.
The combination of in-office discussion and fax/quitline referral increased the frequency of cessation support for smokers (difference of 12.5% between both groups).

3 As + fax referral to Quitline vs. only 3 As
Summary Videos:
“Bad Doc” vs. “Good Doc”

Video by TEACH Project
Available online: http://www.youtube.com/user/teachproject
Breakout Groups
Discussion: The 5 As

- Do the summary statements accurately reflect your practice/clinical experience?

- What kind of tools/resources exist (or should exist) to support the summary statements?

- From your clinical experience, what do you think needs to happen for health practitioners to adopt and use this section of the guideline?
Breakout Group Instructions:

1. Discuss the questions as they relate to your practice
2. Record your answers on the given handout
3. Nominate a recorder/representative to speak for your group
4. Recap & report back to the group
How we are disseminating the CPG

Efforts for engagement and uptake of guideline

In person:
- Workshops
- Conferences
- Partnerships with practitioner organizations

Via web 2.0:
- Webconferences
- Network opportunities
Get involved...

1. Join the Network
2. Review the current version of the guidelines and research agenda
3. Provide feedback on the discussion board
Hand in your worksheets

1. Provide your name & e-mail if you want to join the CAN-ADAPTT Network

2. Please return your completed handout before you leave!
Resources and Links

- CAN-ADAPTT: www.can-adaptt.net
- TEACH Project: www.teachproject.net
- Smokers Helpline: www.smokershelpline.ca 1 877 513-5333
- Canadian Cancer Society: www.cancer.ca
- My Last Dip: www.mylastdip.com (web based smokeless tobacco cessation project)
Contact Information

CAN-ADAPTT
Centre for Addiction and Mental Health
175 College St. Toronto, ON
(416) 535-8501 ext. 7427
can_adaptt@camh.net
www.can-adaptt.net
Additional slides you may want to use....

- PETER, use the following slides?
SCENARIO #1

25 yr old female has just learned she is pregnant. She is worried about the effects of her cigarette smoking on her unborn child. She has decided to quit in the next several weeks and is seeking information on how to do this.
51 yr old male who has recently retired. He was admitted from the ER for an asthma exacerbation. He has quit smoking in the past month but is having difficulty coping with all the changes in his life.
66 yr old male with diagnosed COPD X 5 years. He continues to smoke despite increased SOB with activity and a regular productive cough. He states, “I can’t quit and the harm has already been done to my lungs.”
SCENARIO #4

49 yr old female diagnosed with mild COPD in the past year. She realizes that her smoking is contributing to her lung disease and she is thinking about quitting in the next 6 months, but is concerned about weight gain.