

TEACH Educational Rounds

Smoking Cessation with Respiratory Co-Morbidities in Family Practice

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1) *Is your Family Practice using the Ottawa Model?*

Our Family Health Team does use the Ottawa Model. I have completed all the Ottawa Model Training. They have some great resources!

2) *How often would you suggest trying to call a client who hasn't returned to follow up? I.e. if you leave a message, should you try again?*

Yes! Yes! Yes! The second time I leave a message and just say call me either way, I just want to hear from you. Quite often, even if they decide the time is not right for total cessation, or something in their life has come up, you can still touch bases with them and leave that Open Invitation for the future. After that, these are the people that show up at the door without an appointment later on and say "I'm ready now." We always want to leave an Open invitation and show no judgement. Secondly, with family practice, you will also see them again when they come in for something else (refills/physicals/illness). In six years, I have never been chastised by a patient for phoning them and seeing how things are going. It is an investment in our clients and supporting them in their Relapses, which are part of the Cessation process.

3) *What is the best strategy to use on clients that refuse to quit or are return smokers?*

Remember the Stages of Change: Your question refers to the Stage of Precontemplation (not thinking of quitting in the next 6 months). The Smoking question can just easily be asked by telling them you are just updating Preventatives & Lifestyle on the chart. This way they feel it is a question everyone is asked. In this case I always leave the door open when they are ready. I usually tell them quickly about the STOP Program and the 26 weeks of free NRT with counselling. Secondly, I squeeze in a little Smoking Education based on the client's responses. I am patient and let the client know they may not be ready now, but may be later in the year and that they are welcome at any time to come back if they require help. Last try to establish incongruence (the matching of experience with awareness). We want the client to feel they are heard and we understand. Remember in the Stages of Change that people do not move in a linear fashion through the cessation process. We must not just diagnose clients at a certain level and be rigid. Listen to the client and take their lead.

4) *How would I enroll in the MI course online?*

Through the Ontario Lung Association Provider Education Program website; this has information on MI workshops and modules that can be used for practice. It can be found at <http://olapep.ca/motivational-interviewing/>

5) In your case study, the patient was in the hospital for how many days? Would she not have already gone through withdrawal?

She was in the hospital for 7 days/intubated for 4 days. She remembers waking up in the ICU and all she wanted was a cigarette. It was her first and only thought! She clearly said to me not only was she craving but she felt she was withdrawing. This lady was incredibly addicted to cigarettes based in her pack years and number of cigarettes per day. The ICU nurse said to her, "you will be fine, you have a nicotine patch on." It was a 7 mg patch. She said the craving/withdrawals seemed insurmountable. It is always good to remember that what the patient says and how they feel always take precedent over what the textbook may say about withdrawal/cravings.

6) Just wondering about the 7 mg patch. Think that would be too low. And no follow up schedule. But was wondering what level you would have started her on?

Remember first I could have three clients who smoked the same number of cigarettes for the same number of years and their Nicotine Replacement Therapy would all be different based on their needs/beliefs/past quit attempts, etc. That is why Motivational Interviewing is important. We want to emphasize that we are dancing with the patient (with them leading) and not arm wrestling with them. As far as reliable literature: The Ottawa Model has the most amazing Quit Plan Consult Form (mine is laminated) that contains a chart on NRT. It is based on cigarettes per day: <10 cigs/day; 10-19 cigs/day; 20-29 cigs/day 30-39 cigs/day and 40+ cigs/day and recommended patch dosing. The chart then adds a subsection on "if time to first cigarette is <30 minutes of waking, consider higher dose NRT (basically adds 7 mg more of NRT in each section noted above. The last column is adding the Short Acting NRT (Inhaler/Gum/Lozenge). I love this chart and use it every day. Based on that we started this client on 28mg patch + 7mg patch for smoking first cigarette < 30 minutes of waking for a total of 35mg patch and SA NRT Inhaler of her choice, which was the SA NRT Inhaler because of her hand/mouth addiction and it made her feel like she was smoking something. We actually had to go up to 42mg patch with SA NRT Inhaler for a couple of weeks, and then titrated down to Quit. I want to stress this is off label, but the joy of working in a Family Practice setting with a Doctor who can supervise those changes and off label needs is priceless. Secondly, the TEACH Core Course also has great charts of applying the right amount of NRT to the patients smoking history and current cpd. As well, the STOP Program has Medical Directives for NRT adjustments if you are working under that process.