As the #1 trusted profession in the U.S., according to an annual Gallup poll, NURSES are in the perfect position to treat the #1 preventable cause of death, illness, and suffering in California—tobacco use.

When health care providers provide brief, simple advice about quitting smoking they increase the likelihood that patients will quit and remain quit a year later. Health systems can support the role of health professionals in tobacco cessation by promoting, providing coverage for, and supporting delivery of treatment, quit attempts, and successful quitting.

Unfortunately, this is one area where California is lagging behind the rest of the United States. Between 2001 and 2007, California patients who smoke were no more likely to be advised to quit by a health care provider than they were between 1992 and 1999, and were less likely to be advised to quit than their counterparts elsewhere in the United States. This suggests that provider advice is a significant area for improvement in efforts to promote cessation in California.
The landmark 1988 California Tobacco Tax and Health Promotion Act (Proposition 99) made California the first state to implement a comprehensive tobacco control program. Since its inception 20 years ago, the California Tobacco Control Program has been charged with reducing tobacco use across the state and with decreasing tobacco-related disease and death by protecting Californians from secondhand smoke.

According to the Treating Tobacco Use and Dependence Clinical Practice Guideline, 2008 Update, “tobacco use presents a rare confluence of circumstances.”

Significant progress has been made since 1988 as tobacco consumption has dramatically decreased and health outcomes have improved. Even lung and bronchial cancers have declined much faster in California than in the rest of the United States. Yet despite this progress, over 3.6 million Californians still smoke, and prevalence is still high in certain groups.

According to the Treating Tobacco Use and Dependence Clinical Practice Guideline, 2008 Update, “tobacco use presents a rare confluence of circumstances:

1. a highly significant health threat;
2. a disinclination among clinicians to intervene consistently; and
3. the presence of effective interventions.

This last point is buttressed by evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the smoker’s risk of suffering from smoking-related disease. Indeed, it is difficult to identify any other condition that presents such a mix of lethality, prevalence, and neglect, despite effective and readily available interventions.”

We challenge every nurse, health professional, and health system throughout California to devise, implement, and support a system for identifying, documenting, and treating every tobacco user who wants to quit. This guide is part of a series of webinars and resources designed to provide the evidence-based tools and resources necessary to do so.

We hope you will join with the California Tobacco Control Program, the California Smokers’ Helpline, and the Center for Tobacco Cessation to achieve a Tobacco-Free California. For more information, please visit Nurse.com/NoButts.
TOBACCO USE AND CESSATION
IN CALIFORNIA

Prevalence and Consumption

California has made significant progress in reducing tobacco use. The prevalence of smoking among adults fell from 26.7 percent in 1985 to 12 percent in 2011.ii

The Healthy People 2020 goal for adult smoking prevalence is at or below 12 percent. California is one of two states that have already met that goal.

Per capita consumption fell from 123 packs per adult per year to 34 packs in 2011, representing a drop of more than 72 percent.iii

Californians who use tobacco today are more likely to be light or non-daily consumers, which has tremendous implications for cessation messaging and treatment. For example, medications are not recommended for this group, and they may not even consider themselves to be “real” smokers if they smoke on a non-daily basis.iv Also, certain demographic groups, most notably Latinos, are more likely than others to be light or non-daily smokers.v

The reduction in prevalence and consumption has been accompanied by an ethnic shift. In 1990, nearly 65 percent of smokers were white, whereas in 2008 only 52 percent were white. Latinos, on the other hand, increased their share of the smokers from 18 to 31 percent over the same period, mainly due to faster population growth.vi

Despite the trend toward lower smoking prevalence and increased low-rate smoking, the following groups’ prevalence and/or consumption rates are much higher than the average:

- African Americans;
- American Indians/Alaska Natives;
- Asian men;
- White men;

![Smoking Prevalence Among California Adults 1984-2011](image)

![Ethnicity of Smokers in California 1990-2008](image)
Enlisted military personnel;
Lesbian/gay/bisexual/transgender individuals;
Rural residents;
Individuals of low SES;
People with mental health and substance use disorders.

But the greatest changes have taken place in communities consisting largely of higher SES, white, heterosexual civilians with relatively little mental illness or substance abuse, and this is where the rates of tobacco use are now lowest. In some communities, cultural norms still support and even encourage smoking. Tobacco users are now much likelier to belong to one or more of the groups listed above, so the associated cultural differences should be addressed in efforts to help smokers quit.

**Quitting Activity**

In 1990, about 50 percent of smokers had made a quit attempt in the past year. By 1999, it had increased to about 60 percent. Unfortunately, since then the percentage has stopped rising. Healthy People 2020 sets a goal of 80 percent of adults making a quit attempt per year.

Quit attempts are vitally important in population-based cessation, because most tobacco users must try repeatedly to quit before they succeed. Every percentage point increase means an additional 36,000 smokers trying to quit each year. Fortunately, the percentage of smokers who say they want to quit is approximately 70 percent, indicating a basic receptivity to advice to quit.

**Environmental Factors that Support Quitting**

Smoking bans, whether in public or private places, improve quitting success by making it more difficult to smoke and communicating that nonsmoking is the norm. The percentage of Californians that have implemented a household smoking ban has tripled, from about 20 percent of households in 1992-93 to about 60 percent in 2006-07. All ethnic groups have increased the prevalence of household smoking bans, with Hispanic and Asian households consistently the most likely to put one in place.

Encouraging public and private smoking bans for all groups should help promote cessation, as people who were smoking a year ago are twice as likely to be a nonsmoker today if they have a smoking ban at home or
Aided Versus Unaided Quitting

For many, the term “cessation” is short-hand for cessation treatment. Because the success rate for unaided quitting is so low, and because various treatments have been proven to increase the rate of success, the population benefits of unaided quitting may be easily overlooked. Yet the great majority of smokers who quit successfully do so on their own, without medications or counseling. This is not to say that tobacco users do not need help, but rather that a complete view of population-based cessation must encompass unaided quitting.

Quality versus Quantity

On the population level, tobacco cessation is the product of three factors:

» The percentage of tobacco users attempting to quit
» The number of quit attempts they make
» The average success rate per quit attempt.

For example, in a given year if 60% of tobacco users make an average of 1.5 attempts each, and 7% of those attempts are successful, the annual cessation rate will be about 6%.

The proportion attempting to quit and the number of attempts can be considered “quantity”, and the average success rate can be considered “quality”. Both at work (ten percent versus five percent). Those with a smoking ban both at home and at work are even more likely to be a nonsmoker today (13 percent). Many hospitals and medical groups have implemented tobacco-free campus-wide policies to protect their patients, patients’ families and staff from second-hand smoke, as well as to communicate their commitment to promoting tobacco-free living.

Use of Cessation Assistance by California Smokers Trying to Quit

Current Nonsmokers Among Californians Who were Smoking 12 months Ago, By Smoking Bans

<table>
<thead>
<tr>
<th>Smoking Bans</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace and Household</td>
<td>13%</td>
</tr>
<tr>
<td>Workplace OR Household</td>
<td>10.5%</td>
</tr>
<tr>
<td>Neither Ban</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Quality versus Quantity

On the population level, tobacco cessation is the product of three factors:
the quantity and quality of quit attempts can be improved through intervention. Quality can be improved by creating easy access to effective treatments, including counseling and medications, and by increasing their use. Quantity can be improved by motivating tobacco users to try quitting, and to keep trying till they succeed.

Which is more important - quality or quantity? California survey data show that it takes an average of 14 attempts for those who do not use a cessation aid to quit for good, compared to 12 attempts for those who do use an aid. This suggests that, on a population level, quantity is more critical than quality. Quantity is also more susceptible to intervention: because the great majority of quit attempts are unaided, it is much harder to increase the success rate than to get more people to make more attempts.

While cessation treatment providers necessarily strive for high quit rates among program participants, health professionals need to focus on boosting overall quitting activity, both aided and unaided, in the whole population. In other words, they have to increase quit attempts. Promoting use of treatment can be an important part of this effort, but care should be taken to avoid conveying the message that tobacco users will be unsuccessful if they try to quit cold turkey.

While cessation treatment providers necessarily strive for high quit rates among program participants, health professionals need to focus on boosting overall quitting activity, both aided and unaided, in the whole population.

A “Quit Machine”
The process by which tobacco users cycle through quitting and relapsing until they finally quit for good can be conceptualized as a “Quit Machine”, as shown in the figure below. Daily smokers either quit altogether and become former smokers, or in some cases reduce their smoking to the point that they are low-rate or non-daily smokers. Low-rate smoking is often a jumping-off point for quitting altogether. Among recent former smokers, relapse is common. They may relapse to non-daily smoking or go all the way back to daily smoking. Their desire...
to quit usually remains, leading them to cycle through the process again and again, till they become former smokers long enough to be less vulnerable to relapse.

From a public health perspective, the goal should be to get all tobacco users onto the Quit Machine and to help them cycle through it as expeditiously as possible, till they have successfully quit. The focus should be on normalizing quit attempts, just as the overall tobacco control movement has been successful at de-normalizing tobacco use. Anything that can speed up the machine, motivating relapsed smokers to make fresh quit attempts, will result in increased cessation rates. Efforts should be designed to increase the desirability of quitting, to increase the sense of urgency about quitting earlier in life, and to reach all groups of tobacco users.

Fortunately, many population-based strategies have the potential to motivate quit attempts including increasing the price of tobacco products, imposing restrictions on when and where tobacco can be used, and promoting quitting through media campaigns. Health care providers can impact the population cessation rate by providing consistent health care provider advice to quit, reducing barriers to cessation aids, and making smokers feel more hopeful about their chances of quitting successfully.\textsuperscript{xii}

THE ROLE OF HEALTH CARE PROVIDERS IN TOBACCO USE TREATMENT

Why Tobacco Use Treatment Should be a Priority
Seventy percent of smokers visit a physician at least once a year. Tobacco users who receive advice and resources to quit from their provider have higher satisfaction rates. Yet, only 33% of tobacco users report being advised to quit and referred to a program by a doctor during the past 12 months.

According to the \textit{Treating Tobacco Use and Dependence: Clinical Practice Guideline, 2008 Update}, “busy clinical teams should make the treatment of tobacco use a priority based on the compelling evidence:

1. Clinicians can make a difference with even a minimal (less than 3 minutes) intervention;
2. A relation exists between the intensity of intervention and tobacco cessation outcome;
3. Even when patients are not willing to make a quit attempt at this time, clinician-delivered brief interventions enhance motivation and increase the likelihood of future quit attempts;
4. Tobacco users are being primed to consider quitting by a wide range of societal and environmental factors;
5. There is growing evidence that smokers who receive clinician advice and assistance with quitting report greater satisfaction with their health care than those who do not;
6. Tobacco use interventions are highly cost effective; and
7. Tobacco use has a high case fatality rate (up to 50% of long-term smokers will die of a smoking-caused disease).”
The Gold Standard for Tobacco Use Intervention

Asking and advising patients to quit are not just good patient care, but can actually double the chance a smoker will make a quit attempt. According to the Clinical Practice Guideline, the gold standard for tobacco use intervention by health care providers is the “5 A’s” intervention: Ask, Advise, Assess, Assist, and Arrange.

A Team Approach to Tobacco Use Intervention

Providers have not broadly implemented the 5 A’s due to a pervasive belief that they take too much time. Many clinician groups now promote a streamlined version of the intervention, such as “Ask-Advise-Refer.” The goal of the alternate approaches is to increase the likelihood of clinicians intervening by simplifying their task: they Ask and Advise, then hand the patient off to a quitline or other cessation service provider to Assess, Assist, and Arrange. Such efforts have been successful both in changing health care provider behavior and in generating referrals for cessation treatment providers.

An Illustrative Example of Health Care Provider Training:
Rx for Change

A more basic reason for providers' failure to intervene on tobacco use is a lack of training. One effort to address this need is Rx for Change. Originally designed as a state-of-the-art training program for use in pharmacy schools, Rx for Change has since been expanded for use in other schools and as continuing medical education
for a range of health professions. It is intended as a turn key program, and all materials, including instructor tools, are available online. Rx for Change has been adapted for:

- Cancer care providers
- Surgical care providers
- Cardiologists
- Psychiatrists
- Mental health peer counselors

THE ROLE OF HEALTH SYSTEMS IN TOBACCO USE TREATMENT

Systems Strategies for Treating Tobacco Dependence

The role of health systems in tobacco cessation is to promote, provide coverage for, and support delivery of treatment, quit attempts, and successful quitting. There is evidence that institutional or systems support facilitate provider treatment of tobacco dependences. According to the Clinical Practice Guideline, health care systems should therefore institute the following institutional policies:

- Implement a tobacco user identification system in every clinic;
- Provide adequate training, resources and feedback to ensure that providers consistently deliver effective treatments;
- Dedicate staff to provide tobacco dependence treatment and assess the delivery of this treatment in staff performance evaluations;
- Promote hospital policies that support and provide tobacco dependence services; and
- Include effective tobacco dependence treatments as paid or covered services for all subscribers or members of health insurance packages.

In addition to the Guidelines, performance and quality-based measures have been expanded to more thoroughly address tobacco cessation. These include the Health Resources and Services Administration 2011 Uniform Data System Clinical and Quality of Care Measures, the Centers for Medicare and Medicaid Services Meaningful Use Criteria, and the Joint Commission tobacco measures. The Joint Commission has updated its tobacco measures, which no longer target a specific diagnosis and are now broadly applicable to all hospitalized inpatients 18 years of age and older. The new measures address:
Assessment – all adult patients will be assessed for tobacco use.
Treatment – tobacco users will be offered evidence-based counseling to help them quit and FDA-approved quitting aids during their hospital stay, unless contraindicated.
Treatment at discharge – current tobacco users will be referred to evidence-based outpatient counseling and offered a prescription for quitting aids upon discharge.
Treatment follow-up – current tobacco users will receive a follow-up call within two weeks after hospital discharge to ascertain their tobacco use status.

An Illustrative Example of Systems Change: Kaiser Permanente Northern California

One industry leader, Kaiser Permanente Northern California (KPNC), has identified tobacco cessation as a quality goal. KPNC measures performance and provides physician feedback, fostering healthy competition and offering incentives for good performance in this area. The organization has instituted a comprehensive systems approach that includes:

- Smoke-free medical campuses;
- Clinical practice guideline development;
- Practice tools and staff training;
- Benefits enhancements including Food and Drug Administration approved pharmacotherapies; and
- Behavioral support such as group classes, individual counseling, and an online program.

Beyond the systems changes, KPNC has institutionalized cessation even further with these additional approaches:

- Expert consultation and collaboration with health agencies; and
- Community benefits and legislation support.

The results of KPNC’s investment in cessation have been remarkable. The adult smoking prevalence among its members decreased by a third in just a few years, from 12.2 percent in 2002 to 9.2 percent in 2005. In 2007, 82.7 percent of patients were assessed for smoking and, if smokers, were advised to quit. KPNC has received the highest rating reported by the California Cooperative Healthcare Reporting Initiative, a collaborative of health care purchasers, plans, and providers whose mission is to collect and report comparable, reliable performance data on all commercial plans in California.

The results of KPNC’s investment in cessation have been remarkable.

In pursuing such an objective, KPNC enjoys the advantage of being a closed system, fully integrating insurance and patient care. Other health plans and systems in California generally have control over just one or the other. But they can all implement at least some of the measures listed above. It is important that they do so, because these proactive measures accelerate quit attempts and reduce relapse. Plans and systems that reduce the smoking prevalence of their patient population not only improve their health outcomes, but also reduce their costs.

TOBACCO-FREE CALIFORNIA: A Guide for Health Systems and Health Care Providers

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Acknowledgments

Some of the content in this publication was adapted from


Endnotes


ii. Behavioral Risk Factor Surveillance System (BRFSS) 1984-2011. The data are weighted to the 2000 California population. State BRFSS data are weighted to 2000 national populations based on each states population. Note and adjustment was made to address the change of smoking definition in 1996 that included more occasional smokers. Prepared by: California Department of Public Health, Tobacco Control Program, March 2012


vii. California Tobacco Surveys (CTS). A serious quit attempt is defined as one lasting at least 24 hours. Prepared by: University of California San Diego, December 2012


xii. Zhu, S.H. 2006. World Conference on Tobacco or Health


California Smokers’ Helpline

According to the Clinical Practice Guideline, “Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, both clinicians and health care delivery systems should ensure patient access to quitlines and promote quitline use.” In August 1992, the California Smokers’ Helpline, also known as 1-800-NO-BUTTS, became the first quitline in the nation to offer free, statewide services for tobacco users wanting to quit smoking. The Helpline, a proven service that doubles a person’s chance of successfully quitting, has served as a model for the rest of the country. Quitline services are now available in all 50 states.

“Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, both clinicians and health care delivery systems should ensure patient access to quitlines and promote quitline use.”

Since its debut, the Helpline has provided free, personalized and confidential services to more than 600,000 Californians from diverse communities throughout the state. Quitting assistance is available in six languages and specialized counseling services are available for pregnant smokers, tobacco chewers, and teens. The Helpline is funded by the California Department of Public Health and by First 5 California.

With funding from the Centers for Medicare and Medicaid Services under the Medicaid Incentives for Prevention of Chronic Diseases program, adult Medi-Cal members (18 and older) who smoke and want to quit may be eligible to receive a financial incentive from the Medi-Cal Incentives to Quit Smoking (MIQS) Project. The MIQS Project seeks to motivate smoking cessation by offering a $20 gift card to members who call the Helpline and enroll in its free telephone-based support services.

Information about the California Smokers’ Helpline is available at www.NoButts.org or by calling:

» 1-800-NO-BUTTS (English)
» 1-800-45-NO-FUME (Spanish)
» 1-800-556-5564 (Korean)
» 1-800-838-8917 (Cantonese and Mandarin)
» 1-800-778-8440 (Vietnamese)

The Center for Tobacco Cessation

The Clinical Practice Guideline recommends that health care administrators provide adequate training, resources, and feedback to ensure that providers consistently deliver effective treatments.

The Center for Tobacco Cessation (CTC), funded by the California Department of Public Health, offers technical assistance, resources, and both web-based and in-person trainings to health professionals on topics such as: Top 10 Tips to Help Smokers Quit, Pharmacotherapy 101, Tobacco and Chronic Disease, Treating Tobacco Use in Smokers with Mental Health or Substance Use Disorders, and How Child Health Providers can Help Family Members Quit Tobacco.

For more information, please visit www.CenterForCessation.org or call toll-free 1-866-610-2482.
Tobacco-Free California Educational Series
The California Smokers’ Helpline and the Center for Tobacco cessation are pleased to offer the Tobacco-Free California Educational Series. From February through July 2013, we will be offering a series of webinars, e-books, and other resources to help health systems and health care providers to achieve a Tobacco-Free California. For more information or to access the archived materials, please visit the campaign website at Nurse.com/NoButts.
SMOKING IS A DISEASE.
TREAT IT.
YOUR PATIENTS TRUST YOU.
Talk to them about quitting smoking.
Refer smokers to 1-800-NO-BUTTS for a free plan to quit smoking.
For free patient materials, training and resources, visit www.NoButts.org.
This material was made possible by funds received from the California Department of Public Health.