Information on Smoking Cessation for the Clinician

Getting Started: Ten Key Guideline Recommendations

The overarching goal of these recommendations is that clinicians strongly recommend the use of effective tobacco dependence counseling and medication treatments to their patients who use tobacco, and that health systems, insurers, and purchasers assist clinicians in making such effective treatments available.	
1	Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist that can significantly increase rates of long-term abstinence.
2	It is essential that clinicians and health care delivery systems consistently identify and document tobacco-use status and treat every tobacco user seen in a health care setting.
3	Tobacco dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in the 2008 Tobacco Guideline (see reference).
4	Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in this guideline.
5	Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt: • Practical counseling (problem solving/skills training) • Social support delivered as part of treatment

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Information on Smoking Cessation for the Clinician

Getting Started: Ten Key Guideline Recommendations

6	Numerous effective medications are available for tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (ie, pregnant women, smokeless tobacco users, light smokers, and adolescents). • Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates: – Bupropion SR – Nicotine gum – Nicotine inhaler – Nicotine lozenge – Nicotine nasal spray – Nicotine patch – Varenicline • Clinicians also should consider the use of certain combinations of medications. Effective combination medications are: – Long-term (> 14 weeks) nicotine patch + other NRT (gum and spray) – The nicotine patch + the nicotine inhaler – The nicotine patch + bupropion SR (Strength of Evidence = A) **Only the patch + bupropion combination has been approved by the FDA for smoking cessation.**
7	Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication is more effective than either alone. Clinicians should encourage all individuals making a quit attempt to use both counseling and medication.
8	Telephone quitline counseling is effective with diverse populations and has broad reach. Both clinicians and health care delivery systems should ensure patient access to quitlines and promote quitline use.
9	If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivational treatments (shown in "Promoting the Motivation to Quit") to be effective in increasing future quit attempts.
10	Tobacco dependence treatments are both clinically effective and highly cost-effective relative to interventions for other clinical disorders. Providing insurance coverage for these treatments increases quit rates. Insurers and purchasers should make sure that all insurance plans include the counseling and medications identified as effective in this Guideline as covered benefits. See covered benefits in full text of the Guideline.

Adapted from Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

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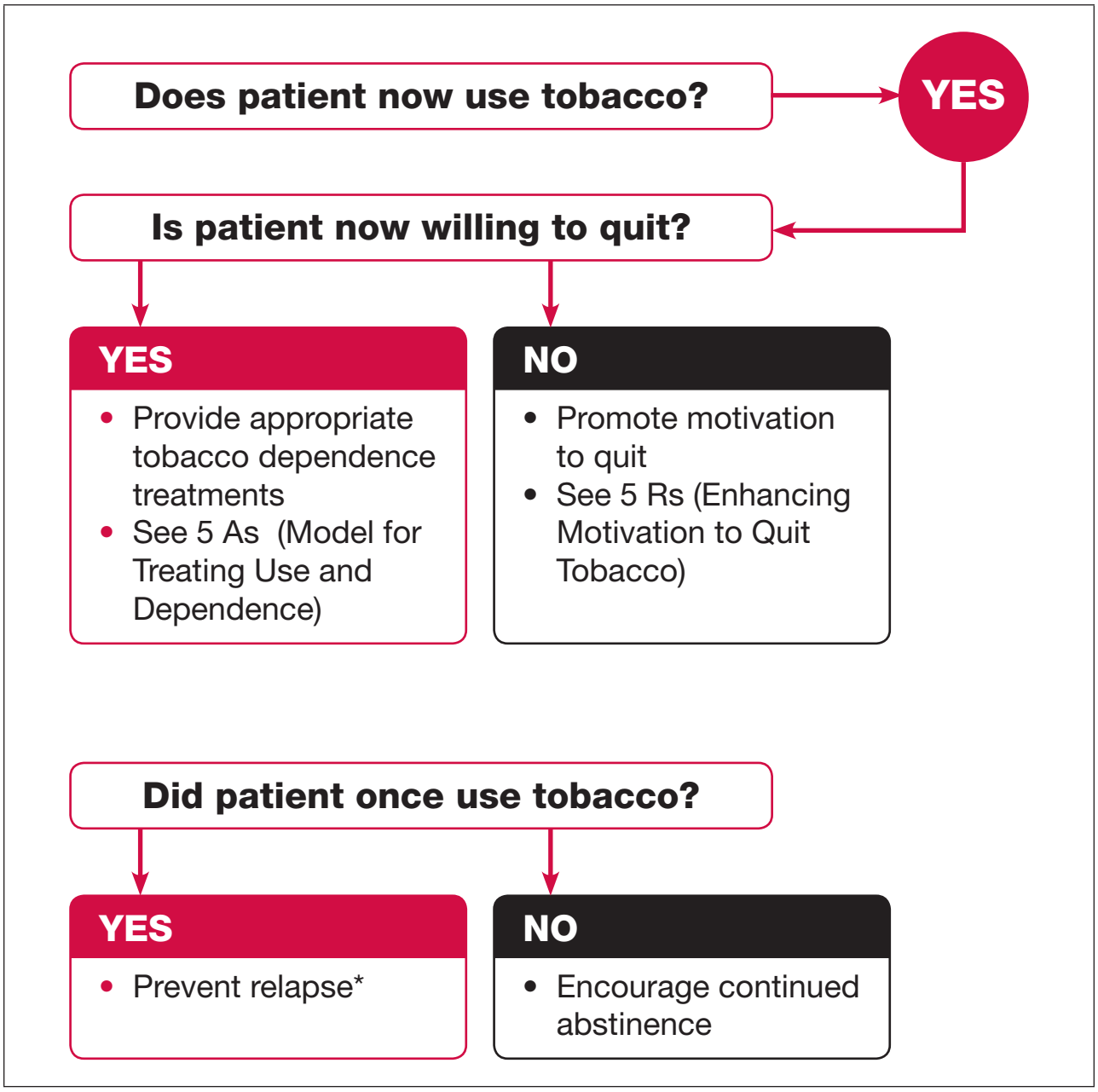
Information on Smoking Cessation for the Clinician

Always Identify and Assess Tobacco Users in Your Practice



*Relapse prevention interventions are unnecessary for the adult who has not used tobacco in many years.

Adapted from Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

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Information on Smoking Cessation for the Clinician

The 5As Model for Treating Tobacco Use and Dependence

Ask about tobacco use.	Identify and document tobacco use status for every patient at every visit. (Strategy A1)
Advise to quit.	In a clear, strong, and personalized manner, urge every tobacco user to quit. (Strategy A2)
Assess willingness to make a quit attempt.	Is the tobacco user willing to make a quit attempt at this time? (Strategy A3)
Assist in quit attempt.	For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional treatment to help the patient quit. (Strategy A4) For patients unwilling to quit at the time, provide interventions designed to increase future quit attempts. (Strategies B1 and B2)
Arrange follow-up.	For the patient willing to make a quit attempt, arrange for follow-up contacts, beginning within the first week after the quit date. (Strategy A5) For patients unwilling to make a quit attempt at the time, address tobacco dependence and willingness to quit at next clinic visit.

Adapted from Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

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Information on Smoking Cessation for the Clinician

For the Patient Willing To Quit

Strategy A1. Ask — Systematically identify all tobacco users at every visit		
Action	**Strategies for implementation**	
Implement an officewide system that ensures that, for every patient at every clinic visit, tobacco use status is queried and documented.[a]	Expand the vital signs to include tobacco use, or use an alternative universal identification system.[b]	
	VITAL SIGNS	
	Blood Pressure	
	Pulse	
	Weight	
	Temperature	
	Respiratory Rate	
	Tobacco Use (circle one)	Current Former Never

[a] Repeated assessment is not necessary in the case of the adult who has never used tobacco or has not used tobacco for many years and for whom this information is clearly documented in the medical record.

[b] Alternatives to expanding the vital signs include using tobacco-use status stickers on all patient charts or indicating tobacco-use status via electronic medical records or computerized reminder systems.

Strategy A2. Advise — Strongly urge all tobacco users to quit	
Action	**Strategies for implementation**
In a clear, strong, and personalized manner, urge every tobacco user to quit.	Advice should be: • **Clear—**"It is important that you quit smoking (or using chewing tobacco) now, and I can help you." "Cutting down while you are ill is not enough." "Occasional or light smoking is still dangerous." • **Strong—**"As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you." • **Personalized—**Tie tobacco use to current symptoms and health concerns, and/or its social and economic costs, and/ or the impact of tobacco use on children and others in the household. "Continuing to smoke makes your asthma worse, and quitting may dramatically improve your health." "Quitting smoking may reduce the number of ear infections your child has."

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Information on Smoking Cessation for the Clinician

For the Patient Willing To Quit

Strategy A3. Advise — Strongly urge all tobacco users to quit	
Action	**Strategies for implementation**
Assess every tobacco user's willingness to make a quit attempt at the time.	**Assess** patient's willingness to quit: "Are you willing to give quitting a try?" • If the patient is willing to make a quit attempt at the time, provide assistance. — If the patient will participate in an intensive treatment, deliver such a treatment or link/refer to an intensive intervention. *See Chapter 4 of Tobacco Guideline for more information.* — If the patient is a member of a special population (eg, adolescent, pregnant smoker, racial/ethnic minority) consider providing additional information. *See Chapter 7 of Tobacco Guideline for more information.* • If the patient clearly states that he or she is unwilling to make a quit attempt at the time, provide an intervention shown to increase future quit attempts. *See Chapter 3B of Tobacco Guideline for more information.*

Strategy A4. Assist—Aid the patient in quitting (provide counseling and medication)	
Action	**Strategies for implementation**
Help the patient with a quit plan.	A patient's preparations for quitting: • **Set** a quit date. Ideally, the quit date should be within 2 weeks. • **Tell** family, friends, and coworkers about quitting, and request understanding and support. • **Anticipate** challenges to the upcoming quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. • **Remove** tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (eg, work, home, car). Make your home smoke-free.

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Information on Smoking Cessation for the Clinician

For the Patient Willing To Quit

Strategy A4. Assist—Aid the patient in quitting (provide counseling and medication) (cont)	
Action	**Strategies for implementation**
Recommend the use of approved medication, except when contra-indicated or with specific populations for which there is insufficient evidence of effectiveness (ie, pregnant women, smokeless tobacco users, light smokers, and adolescents).	Recommend the use of medications found to be effective in the Tobacco Guideline. Explain how these medications increase quitting success and reduce withdrawal symptoms. The first-line medications include bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, and varenicline; second-line medications include clonidine and nortriptyline. There is insufficient evidence to recommend medications for certain populations (eg, pregnant women, smokeless tobacco users, light smokers, adolescents).
Provide practical counseling (problem-solving/skills training).	**Abstinence.** Striving for total abstinence is essential, not even a single puff after the quit date. **Past quit experience.** Identify what helped and what hurt in previous quit attempts. Build on past success. Anticipate triggers or challenges in the upcoming attempt. Discuss challenges/triggers and how the patient will successfully overcome them (eg, avoid triggers, alter routines). **Alcohol.** Because alcohol is associated with relapse, the patient should consider limiting/abstaining from alcohol while quitting. (Note that reducing alcohol intake could precipitate withdrawal in alcohol-dependent persons.) **Other smokers** in the household. Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or to not smoke in their presence.
Provide intratreatment social support.	Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. “My office staff and I are available to assist you.” “I’m recommending treatment that can provide ongoing support.”
Provide supplementary materials, including information on quitlines.	Sources: Federal agencies, nonprofit agencies, national quitline network (1-800-QUIT-NOW), or local/state/tribal health departments/quitlines. **See Forms Guide Resources for more information.**

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Information on Smoking Cessation for the Clinician

For the Patient Willing To Quit

Strategy A5. Arrange—Ensure follow-up contact	
Action	**Strategies for implementation**
Arrange for follow-up contacts, either in person or via telephone.	**Timing:** Follow-up contact should begin soon after the quit date, preferably during the first week. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as indicated. For patients who are abstinent, congratulate them on their success. If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Consider use of or link to more intensive treatment.

Adapted from Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

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Information on Smoking Cessation for the Clinician

FDA-Approved Smoking Cessation Medications

Name	Forms	Dosage	Length of Use	Precautions	Adverse Effects
Bupropion, sustained-release	Wellbutrin SR, Zyban (Rx only)	150 mg in morning for 3 days, then 150 mg 2x/d	Begin 1-2 wk before quit date, then 7-12 wk	Seizures, eating disorders, use of MAO inhibitors	Insomnia, dry mouth, agitation, seizures
Nicotine gum	Nicorette, Nicorette DS, Nicorette Mint, Nicorette Orange (OTC only)	Up to 24 pieces/d; <25 cigs/d 2 mg; ≥25 cigs/d 4 mg	Up to 12 wk	Use of proper chewing technique	Sore mouth, dyspepsia, hiccups
Nicotine inhaler	Nicotrol Inhaler (Rx only)	6-16 cartridges/d 4-mg cartridge	Up to 6 mo		Mouth/throat irritation, rhinitis, cough
Nicotine nasal spray	Nicotrol NS (Rx only)	8-40 doses/d 1-2 doses/h	3-6 mo	Dependency	Nasal irritation, sneezing, cough
Nicotine patch	Nicoderm CQ (OTC only), generic/house brand patches (OTC and Rx) Nicotrol (OTC only)	21 mg/24 h; 14 mg/24 h; 7 mg/24 h; 15 mg/16 h	4 wk; then 2 wk; then 2 wk; 8 wk		Local skin reaction, insomnia
Nicotine lozenge	Commit (OTC)	1 lozenge q 1-8 h, 2-4 mg Time to 1st cig >30 min: 2 mg/lozenge Time to 1st cig ≤30 min: 4 mg/lozenge 20 lozenges/d	Up to 12 wk	Requires frequent dosing	Hiccups, nausea, dyspepsia
Varenicline	Chantix (Rx only)	0.5 mg in morning for 3 days, then 0.5 mg 2x/d x 4 days, then 1 mg 2x/d (Begin Rx 1 wk pre-quit)	Up to 12 wk; if successful with quitting 12 more weeks	Impaired renal function–titrate to 0.5 mg 2x/d End-stage renal disease 0.5 mg q day	Nausea, insomnia/abnormal dreams, vomiting, constipation, neuropsychiatric symptoms*

Abbreviation: OTC, over the counter. Zyban, Nicorette, and Nicoderm are products of GlaxoSmithKline; Nicotrol is a product of Pharmacia, Inc.; Chantix is a product of Pfizer, Inc.

*All patients should be observed for neuropsychiatric symptoms including changes in behavior, agitation, depressed mood, suicidal ideation, and suicidal behavior.

Adapted from US Dept of Health and Human Services. Public Health Service. Tobacco Use and Dependence Guidelines: 2008 Update; May 2008.

Information on Smoking Cessation for the Clinician

Promoting the Motivation To Quit For the Patient Unwilling To Quit

- All patients entering a health care setting should have their tobacco use status assessed routinely. Clinicians should advise all tobacco users to quit and then assess each patient's willingness to make a quit attempt.
- Patients unwilling to make a quit attempt during a visit may lack information about the harmful effects of tobacco use and the benefits of quitting, may lack the required financial resources, may have fears or concerns about quitting, or may be demoralized because of previous relapse.
- Such patients may respond to brief motivational interventions that are based on principles of Motivational Interviewing (MI).
- Clinicians employing MI techniques focus on exploring a tobacco user's feelings, beliefs, ideas, and values regarding tobacco use in an effort to uncover any ambivalence about using tobacco.
- MI researchers have found that having patients use their own words to commit to change is more effective than clinician lectures or arguments for quitting, which tend to increase rather than lessen patient resistance to change.

Strategy B1. Motivational interviewing strategies	
Express empathy.	• Use open-ended questions to explore: – The importance of addressing smoking or other tobacco use (eg, "How important do you think it is for you to quit smoking?") – Concerns and benefits of quitting (eg, "What might happen if you quit?") • Use reflective listening to seek shared understanding: – Reflect words or meaning (eg, "So you think smoking helps you to maintain your weight?") – Summarize (eg, "What I have heard so far is that smoking is something you enjoy. On the other hand, your boyfriend hates your smoking, and you are worried you might develop a serious disease.") • Normalize feelings and concerns (eg, "Many people worry about managing without cigarettes.") • Support the patient's autonomy and right to choose or reject change (eg, "I hear you saying you are not ready to quit smoking right now. I'm here to help you when you are ready.")

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Information on Smoking Cessation for the Clinician

Promoting the Motivation To Quit For the Patient Unwilling To Quit

Strategy B1. Motivational interviewing strategies (cont)	
Develop discrepancy.	• Highlight the discrepancy between the patient's present behavior and expressed priorities, values, and goals (eg, "It sounds like you are very devoted to your family. How do you think your smoking is affecting your children?") • Reinforce and support "change talk" and "commitment" language: – "So, you realize how smoking is affecting your breathing and making it hard to keep up with your kids." – "It's great that you are going to quit when you get through this busy time at work." • Build and deepen commitment to change: – "There are effective treatments that will ease the pain of quitting, including counseling and many medication options." – "We would like to help you avoid a stroke like the one your father had."
Roll with resistance.	• Back off and use reflection when the patient expresses resistance: – "Sounds like you are feeling pressured about your smoking." • Express empathy: – "You are worried about how you would manage withdrawal symptoms." • Ask permission to provide information: – "Would you like to hear about some strategies that can help you address that concern when you quit?"
Support self-efficacy.	• Help the patient to identify and build on past successes: – "So you were fairly successful the last time you tried to quit." • Offer options for achievable small steps toward change: – Call the quitline (1-800-QUIT-NOW) for advice and information. – Read about quitting benefits and strategies. – Change smoking patterns (eg, no smoking in the home). – Ask the patient to share his or her ideas about quitting strategies.

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Information on Smoking Cessation for the Clinician

Promoting the Motivation To Quit For the Patient Unwilling To Quit

Strategy B2. The 5 Rs — Enhancing motivation to quit tobacco	
Relevance	Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (eg, having children in the home), health concerns, age, gender, and other important patient characteristics (eg, prior quitting experience, personal barriers to cessation).
Risks	The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (eg, smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of risks are: • Acute risks: Shortness of breath, exacerbation of asthma, increased risk of respiratory infections, harm to pregnancy, impotence, infertility • Long-term risks: Heart attacks and strokes, lung and other cancers (eg, larynx, oral cavity, pharynx, esophagus, pancreas, stomach, kidney, bladder, cervix, and acute myelocytic leukemia), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), osteoporosis, long-term disability, and need for extended care • Environmental risks: Increased risk of lung cancer and heart disease in spouses; increased risk for low birth-weight, sudden infant death syndrome (SIDS), asthma, middle ear disease, and respiratory infections in children of smokers

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Information on Smoking Cessation for the Clinician

Promoting the Motivation To Quit For the Patient Unwilling To Quit

Strategy B2. The 5 Rs — Enhancing motivation to quit tobacco (cont)	
Rewards	The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of benefits are: • Improved health • Food will taste better • Improved sense of smell • Saving money • Feeling better about oneself • Home, car, clothing, breath will smell better • Setting a good example for children and decreasing the likelihood that they will smoke • Having healthier babies and children • Feeling better physically • Performing better in physical activities • Improved appearance, including reduced wrinkling/aging of skin and whiter teeth
Roadblocks	The clinician should ask the patient to identify barriers or impediments to quitting and provide treatment (problem-solving counseling, medication) that could address barriers. Typical barriers might include: • Withdrawal symptoms • Fear of failure • Weight gain • Lack of support • Depression • Enjoyment of tobacco • Being around other tobacco users • Limited knowledge of effective treatment options
Repetition	The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

Adapted from Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

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Information on Smoking Cessation for the Clinician

Promoting the Motivation To Quit For the Patient Who Has Recently Quit

- Smokers who have recently quit face a high risk of relapse. Although most relapse occurs early in the quitting process, some relapse occurs months or even years after the quit date.
- The best strategy for producing high long-term abstinence rates appears to be use of the most effective cessation treatments available; that is, the use of evidence-based cessation medication during the quit attempt and relatively intense cessation counseling (eg, four or more sessions that are ten minutes or more in length).
- Ex-smokers often report problems that have been worsened by smoking withdrawal or that coexisted with their smoking. If a clinician encounters a tobacco user who recently quit, the clinician might reinforce the patient's success at quitting, review the benefits of quitting, and assist the patient in resolving any residual problems arising from quitting.
- Expressions of interest and involvement on the part of the clinician might encourage the patient to seek additional help with cessation should she or he ultimately relapse.

Strategy C1. Intervening with the patient who has recently quit

The former tobacco user should receive congratulations on any success and strong encouragement to remain abstinent.

When encountering a recent quitter, use open-ended questions relevant to the topics below to discover if the patient wishes to discuss issues related to quitting:

- The benefits, including potential health benefits, the patient may derive from cessation
- Any success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc.)
- The problems encountered or anticipated threats to maintaining abstinence (eg, depression, weight gain, alcohol, other tobacco users in the household, significant stressors)
- A medication check-in, including effectiveness and side effects if the patient is still taking medication

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Information on Smoking Cessation for the Clinician

Promoting the Motivation To Quit For the Patient Who Has Recently Quit

Strategy C2. Addressing problems encountered by former smokers

A patient who previously smoked might identify a problem that negatively affects health or quality of life. Specific problems likely to be reported by former smokers and potential responses below:

Problems	Responses
Lack of support for cessation	• Schedule follow-up visits or telephone calls with the patient. • Urge the patient to call the national quitline network (1-800-QUITNOW) or other local quitline. • Help the patient identify sources of support within his or her environment. • Refer the patient to an appropriate organization that offers counseling or support.
Negative mood or depression	• If significant, provide counseling, prescribe appropriate medication, or refer the patient to a specialist.
Strong or prolonged withdrawal symptoms	• If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved medication or adding/combining medications to reduce strong withdrawal symptoms.
Weight gain	• Recommend starting or increasing physical activity. • Reassure the patient that some weight gain after quitting is common and usually is self-limiting. • Emphasize the health benefits of quitting relative to the health risks of modest weight gain. • Emphasize the importance of a healthy diet and active lifestyle. • Suggest low-calorie substitutes such as sugarless chewing gum, vegetables, or mints. • Maintain the patient on medication known to delay weight gain (eg, bupropion SR, NRTs—particularly 4-mg nicotine gum and lozenge). • Refer the patient to a nutritional counselor or program.
Smoking lapses	• Suggest continued use of medications, which can reduce the likelihood that a lapse will lead to a full relapse. • Encourage another quit attempt or a recommitment to total abstinence. • Reassure that quitting may take multiple attempts, and use the lapse as a learning experience. • Provide or refer for intensive counseling.

Adapted from Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

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Information on Smoking Cessation for the Clinician

Recommendations to Clinicians When Addressing Weight Gain

Clinician statements to help a patient prepare for and cope with post-cessation weight gain
The great majority of smokers gain weight once they quit smoking. However, even without special attempts at dieting or exercise, weight gain is usually 10 lbs. or less.
Some medications, including bupropion SR and nicotine replacement medicines, may delay weight gain.
There is evidence that smokers often gain weight once they quit smoking, even if they do not eat more. However, there are medications that will help you quit smoking and limit or delay weight gain. I can recommend one for you.
The amount of weight you will likely gain from quitting will be a minor health risk compared with the risks of continued smoking.
I know that you don't want to gain a lot of weight. However, let's focus on strategies to get you healthy rather than on weight. Think about eating plenty of fruits and vegetables, getting regular exercise, getting enough sleep, and avoiding high-calorie foods and beverages. Right now, this is probably the best thing you can do for both your weight and your health.
Although you may gain some weight after quitting smoking, compare the importance of this with the added years of healthy living you will gain, your better appearance (less wrinkled skin, whiter teeth, fresher breath), and good feelings about quitting.

Role of Exercise in Weight Gain
Available research does not show that interventions to increase exercise reliably boost smoking abstinence rates. One recent study showed that an exercise program occurring in three 45-minute sessions per week increases long-term smoking abstinence in women and delays weight gain when it is combined with a cognitive-behavioral smoking cessation program. As was the case for weight loss interventions, there is no evidence that exercise interventions undermine success in stopping smoking. Some evidence suggests that weight gain is reduced if smoking abstinence is accompanied by a moderate increase in physical activity. Vigorous exercise programs should not be implemented without consulting a physician. Although it may be difficult to get smokers to adhere to a vigorous exercise program, smokers should be encouraged to engage in moderate exercise and physical activity as part of a healthy lifestyle.

Adapted from Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

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Seven Steps for People Who Want to Quit Smoking

Step 1 ☐	Discuss quitting smoking with your health care provider. He/she may offer you support and medication to help you be successful.
Step 2 ☐	Write down the reasons why you want to quit smoking.
Step 3 ☐	If your spouse, significant other or roommate smokes, ask them if they are ready to quit. If not, ask them not to smoke around you or offer you any tobacco products.
Step 4 ☐	Write down any concerns or fears that will make it difficult for you to stop smoking.
Step 5 ☐	Set a quit date within 1 week after you decide to quit. **Write your quit-date here:**
Step 6 ☐	Sign a contract – Signing a contract with a support person can also help you succeed with quitting. Ask your health care provider for a copy of a contract. (See Contracts 3 PDF, 3A)
Step 7 ☐	Before your quit date, while you are still smoking, track your smoking habits in a log for one week. Write down: a. **What time** of day and **what you are doing while you are smoking** – (just getting out of bed, after a meal, on my break, with coffee/tea or an alcoholic drink, in my car). **b. How strong your urge** was to smoke on a scale of 1-5 with 5 being the highest urge. ❶ - no urge ❷ - mild urge ❸ - moderate urge ❹ - severe urge ❺ - worst urge ever

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Log for Tracking My Smoking Habit

Date	Time of Smoking Cigarette	Activity (what I am doing while I am smoking)	Urge to Smoke 1 not at all 2 mild urge 3 moderate urge 4 severe 5 worst urge ever
9/2/09	7AM	Just got out of bed **EXAMPLE**	5

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Plan for Your Smoking Urges: What to Do Instead of Smoking!

Check off those items you can do instead of smoking.	
☐ 1	Leave the table after eating.
☐ 2	Get out of bed and brush your teeth right away when you get up.
☐ 3	Have water or non-caloric drinks handy or non-caloric hard candies.
☐ 4	Do something with your hands to avoid smoking, such as picking up a straw or a pen.
☐ 5	If alcohol is a problem for you while first quitting smoking, avoid having a drink or avoid going to a bar.
☐ 6	Start an exercise program. Be sure to check with your health care provider before you begin.
☐ 7	Find a buddy you can call if you get an urge to smoke or relapse.
☐ 8	Stop seeing friends that are still smoking for a month after you quit.
☐ 9	Keep low-calorie foods in your refrigerator so you can grab them if you get the urge.
☐ 10	Go for a two-minute walk when the urge hits you.
☐ 11	List hobbies that you enjoy. Start a hobby you can use if you have an urge to smoke, for example, knitting.
☐ 12	Focus on the positive benefits of kicking the habit.

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How to Administer and Score the Smoking Confidence Questionnaire: For the Healthcare Professional

Once a person has made a commitment not to smoke, use this tool to assess how confident a person is to not smoke in the 14 situations on the questionnaire. Ask the person to look at each situation and score as follows: If you are absolutely certain that you would not smoke in a certain situation, mark 90 or 100%. If you think your chances of being able to resist the urge to smoke are low, give yourself a low number. If you aren't sure, simply select the best percentage number that you think relates to your confidence level now.

Patients who score 70% confidence on a situation are likely to be able to resist the urge to smoke. If scores are less than 70%, individuals should make a plan by selecting at least two coping strategies to help them if they encounter a high-risk situation. Example: Confidence is 30% for smoking after a meal—Coping strategy: Leave the table immediately after finishing the meal; call a friend to speak on the telephone; use self-talk by stating "I don't need that cigarette now. I can go do something else."

You can read the instructions to your patient and then administer the questionnaire yourself or give the questionnaire to the patient to fill in. The patient can fill in the questionnaire immediately or take it home and bring it back at a subsequent visit.

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Smoking Confidence Questionnaire

How confident are you that you can resist the urge to smoke in the 14 situations below?

Not at all Confident			Slightly Confident			Fairly Confident			Very Confident	
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

1	When you feel bored or depressed	
2	When you see others smoking	
3	When you want to relax or rest	
4	When you just want to sit back and enjoy a cigarette	
5	When you are watching TV	
6	When you are driving or riding in a car	
7	When you have finished a meal or snack	
8	When you feel frustrated, worried, upset, tense, nervous, angry, anxious or annoyed	
9	When you want a snack, but don't want to gain weight	
10	When you need more energy or can't concentrate	
11	When someone offers you a cigarette	
12	When you are drinking coffee or tea	
13	When you are in a situation where alcohol is involved	
14	When you feel smoking is part of your self-image	

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Tips For When You Have Stopped Smoking

1	Make sure you follow up with your health care provider, in person, by phone or email within 2 weeks after you quit. If you relapse call your health care provider right away.
2	Expect some weight gain but think of the health benefits of not smoking.
3	Put the cost of a pack/carton of cigarettes in your savings account. After a month reward yourself with a book, music, manicure or weekend trip.
4	If you relapse, call your healthcare provider or buddy right away to help you get back on track.
5	Call the quitline (1-800-QUIT-NOW) for advice and information.

Adapted from Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

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