

VA/DoD Clinical Practice Guideline for the Management of Tobacco Use - Update 2004

Key Points Card

1. **Every** tobacco user should be advised to quit.
2. Tobacco use is a **chronic relapsing condition** that requires repeated interventions.
3. Several **effective treatments are available** in assisting users to quit.
4. It is essential to **provide access** to effective **evidence-based** tobacco use **counseling treatments and pharmacotherapy**.
5. **Collaborative tailored treatment strategies** result in better outcomes.
6. Quitting tobacco leads **to improved health and quality of life**.
7. **Prevention strategies** aim at reducing initiation, decreasing relapse, and eliminating exposure to environmental tobacco smoke.



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Assessment and Treatment

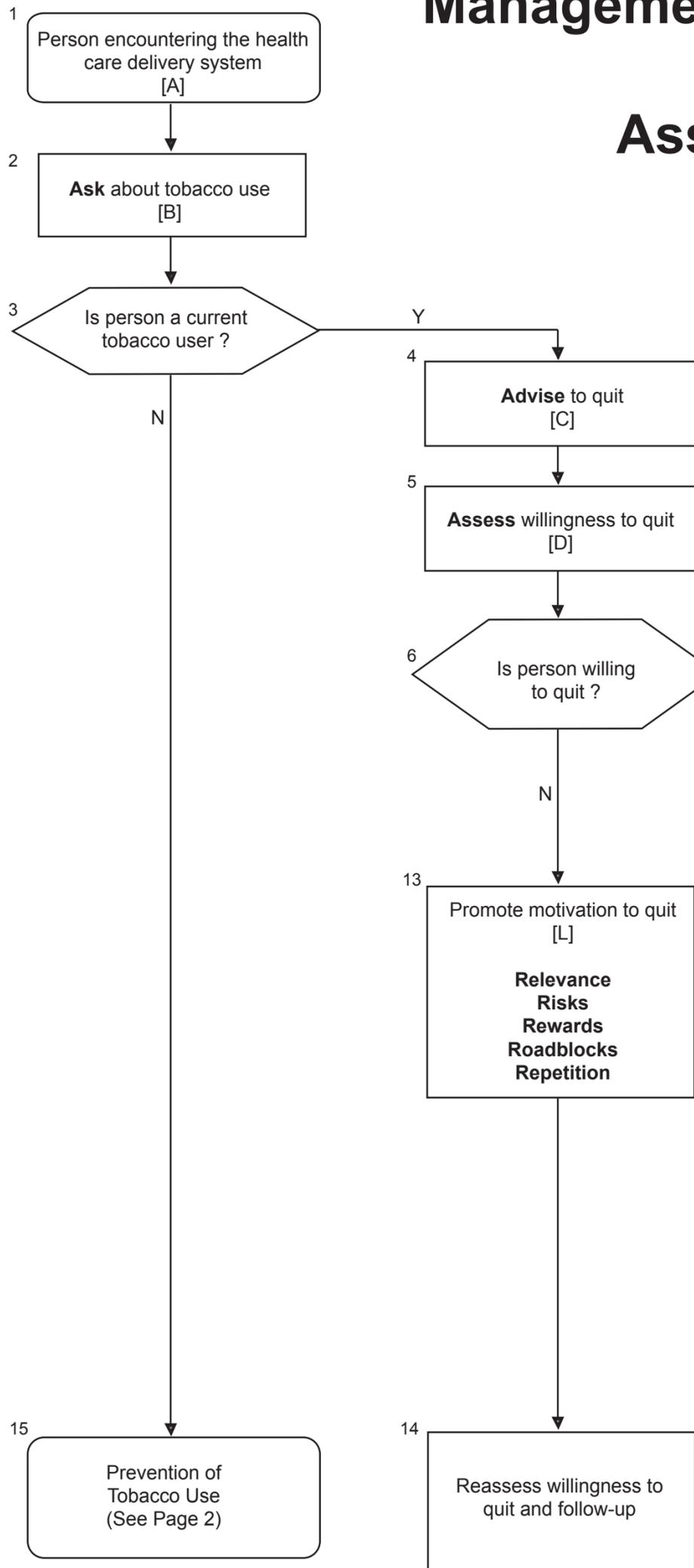
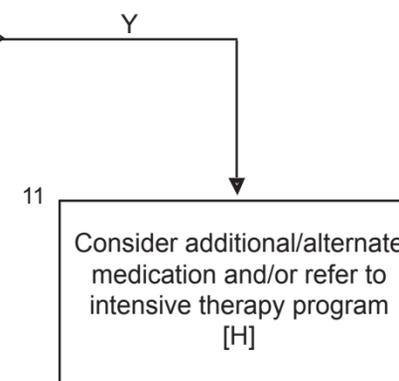
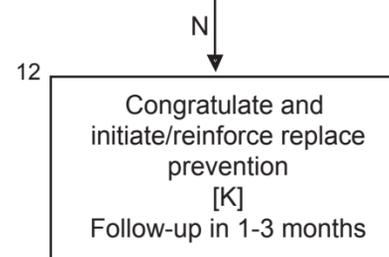
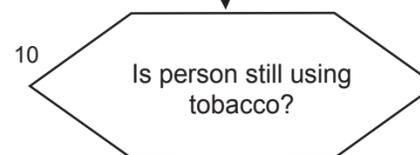
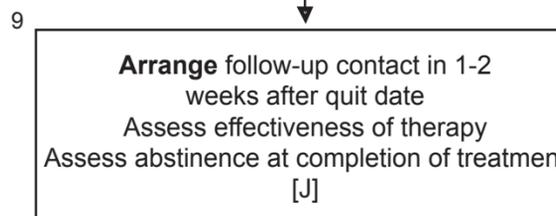
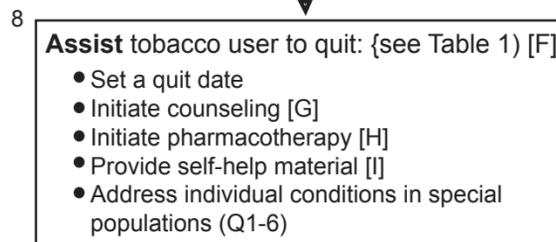
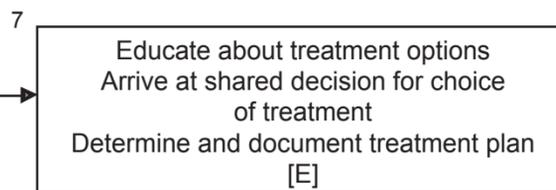


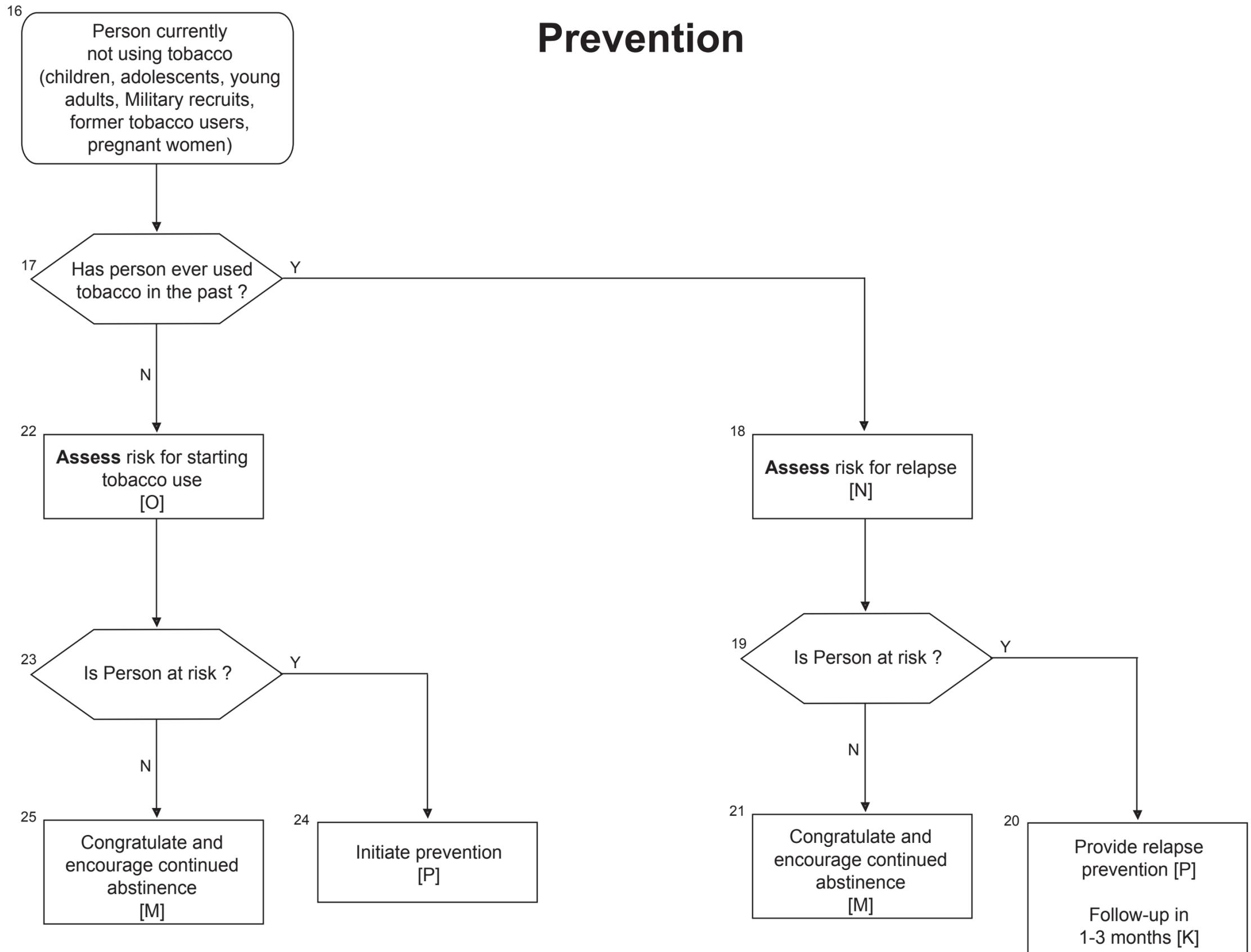
Table 1: Strategies for Tobacco Use Cessation				
Strategy	Counseling	Pharm.	Setting	Follow-Up
Minimal	1 session < 3 min.	Yes	Primary Care and/or other health care team members	Next routine visit
Intermediate	2 - 3 sessions 3 - 10 minutes	Yes	Telephone Quitline and/or Primary Care	1 - 2 weeks after quit date
Intensive	> 4 sessions > 10 minutes	Yes	Cessation program or telephone Quitline and/or Primary Care	1 - 2 weeks after quit date

Initiate therapy in the most intense setting the patient is willing to use/attend



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Prevention



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Level “A” Recommendations

RECOMMENDATIONS WITH THE HIGHEST EVIDENCE: The highest evidence for recommendations is A, defined as “a strong recommendation based on randomized controlled trials that the intervention is always indicated and acceptable.”

1. Patients should be asked about tobacco use at most visits, as repeated screening increases rates of clinical intervention. [R=A]
2. Tobacco users should be advised to quit at every visit because there is a dose response relationship between number of contacts and abstinence. [R=A]
3. Physicians should strongly advise tobacco users to quit, as physician advice increases abstinence rates. [R=A]
4. All tobacco users must have reasonable access to minimal counseling and to either an intermediate or intensive cessation program. [R=A]
5. Cessation treatments should include the following components:
 - Tobacco use cessation pharmacotherapy [R=A]
 - Counseling techniques that have been shown to be effective (problem solving, skill training, intra and extra treatment support) [R=A]
 - Multiple treatment sessions [R=A]
 - Multiple formats, proactive telephone counseling, and group or individual counseling [R=A]
6. Tobacco users who are willing to quit should receive some form of counseling. There is a dose response relationship between time spent in counseling and rates of abstinence. [R=A]
 - Minimal counseling (lasting less than 3 minutes) increases overall tobacco abstinence rates [R=A]
 - Intensive counseling (greater than 10 minutes) significantly increases abstinence rates [R=A]
 - Multiple counseling sessions increase abstinence rates [R=A]

7. Effective counseling can be delivered in multiple formats (e.g., group counseling, proactive telephone counseling and individual counseling) and may be more effective when combined. [R=A]
8. Counseling should be provided by a variety of clinician types (physicians or non-physician clinicians, such as nurses, dentists, dental hygienists, psychologists, pharmacists and health educators) to increase quit rates. [R=A]
9. Tobacco users who are willing to quit may receive counseling via telephone Quitlines, as proactive telephone counseling has been demonstrated to be effective. Pharmacotherapy still needs to be coordinated by the primary care provider. [R=A]
10. Tobacco users attempting to quit should be prescribed one or more effective first-line pharmacotherapies for tobacco use cessation. [R=A]
 - First-line therapies include five nicotine replacement therapy (NRT) [transdermal patch, gum, nasal spray, lozenges or vapor inhaler] and non nicotine replacement (bupropion IR or SR). [R=A]
 - Pharmacotherapy should be combined with minimal counseling (less than 3 minutes). [R=A]
11. Health care providers in a pediatric setting should advise parents to quit smoking to limit their children's exposure to second-hand smoke. [R=A]
12. Adolescents who use tobacco and are interested in quitting should be offered counseling and behavioral interventions that were developed for adolescents. [R=A]
13. All patients admitted to hospitals should have tobacco use status identified in the medical record. [R=A]
14. Tobacco users who are older should be given advice to quit. [R=A]
15. Tobacco users who are older should be given tobacco cessation treatment, including medication and counseling. [R=A]



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HEDIS PERFORMANCE MEASURES

- Percentage of patients advised to quit
- Percentage of patients who were recommended or discussed smoking cessation medications
- Percentage of patients who were recommended or discussed smoking cessation methods or strategies

TOBACCO MANAGEMENT WORKING GROUP SUGGESTED INDICATORS

- Decrease the number of *tobacco users*
- Increase the number of patients *screened* for tobacco use
- Increase the number of patients *advised to quit*
- Increase *documentation* of patient smoking status and treatment outcomes
- Increase number of *tobacco users* enrolled in treatment (e.g. prescribed pharmacotherapy)
- Increase level of *trained providers*

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DRUG DETAILS TABLE PRIMARY CARE**			
Agents	Sample Regimens	Typical Duration	Common Adverse Effects
Nicotine Replacement Therapy (NRT)			
Transdermal patch^{1,3} 24 hr (e.g., Nicoderm® CQ) (may be worn for 16 or 24 hours)	High dependence*: 21mg patch for 4-6 weeks, then 14mg patch for 2 weeks, then 7mg patch for 2 weeks Low dependence* 14 mg patch for 6-8 weeks, then 7mg patch for 2 weeks	8 – 12 weeks	<ul style="list-style-type: none"> • Sleep disturbance • Local irritation • Bone pain • Headache • Nausea
Nicotine polacrilex gum^{1,3}	High dependence*: 4 mg gum every 1-2 hours for 6 weeks then every 2-4 hours for 4 weeks then every 4-6 hours for 2 weeks Low dependence* 2 mg gum every 1-2 hours for 6 weeks then every 2-4 hours for 4 weeks then every 4-6 hours for 2 weeks	8 – 12 weeks	<ul style="list-style-type: none"> • Local mouth irritation • Jaw pain • Rhinitis • Nausea
Nicotine polacrilex lozenge³	High dependence*: 4 mg Low dependence*: 2mg Suck 1 lozenge every 1-2 hours for 6 weeks then 1 every 2-4 hours for 3 weeks then 1 every 4-8 hours for 3 weeks	8 – 12 weeks	<ul style="list-style-type: none"> • Local mouth irritation • Headache • Nausea • Diarrhea • Flatulence • Hiccup • Heartburn • Cough
Vapor inhaler (Nicotrol® Inhaler)	Inhale deeply or puff on cartridge for about 20 minutes (delivered dose 4mg/cartridge) Use 6-16 cartridges a day for 6 weeks then 4-8 cartridges a day for 2 weeks then 2-6 cartridges a day for 2 weeks	8 – 12 weeks	<ul style="list-style-type: none"> • Local irritation • Cough • Rhinitis • Headache • Dyspepsia
Nasal spray (Nicotrol® NS)	1 spray in each nostril = 1 dose (0.5mg each, 1 mg total) Use 1-2 doses/hr up to a maximum of 40 doses per day (80 sprays) for 6 weeks then 1-2 doses every 2-4 hours up to a maximum of 20 doses per day (40 sprays) for 2-4 weeks then 1 dose every 4-6 hours for 2 weeks	8 – 12 weeks	<ul style="list-style-type: none"> • Headache • Nausea • Confusion • Palpitations • Nasal irritation
Non-Nicotine Therapy (NNT)			
Sustained-release bupropion^{1,2}	150 mg/day for 3 days, then 150 mg twice a day	7 – 12 weeks	<ul style="list-style-type: none"> • Anxiety • Disturbed concentration • Dizziness • Insomnia
Bupropion IR¹	100 mg/ day for 3 days, then 100 mg three times a day to complete 7-12 weeks	7 – 12 weeks	<ul style="list-style-type: none"> • Constipation • Dry mouth • Nausea

* High dependence definition varies based on manufacturer's labeling and expert consensus. In general, use of tobacco greater than or equal to 20 cigarettes (one package) per day are considered high dependence or use of tobacco less than 30 minutes after awakening. If these criteria do not apply the patient is considered low dependent.

**For complete drug information, refer to manufacturer's drug information sheets.

1 Currently on formulary in the VA

2 Currently on basic core formulary in the DoD, may be available on local formulary

3 Available over the counter



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Tips for Brief Clinical Interventions

Getting Patients to Quit	
Ask	Review tobacco use at every healthcare encounter
Advise	Strongly urge all tobacco users to quit
Assess	Determine willingness to quit
Assess	Help tobacco user quit
Arrange	Schedule follow-up and relapse prevention

Increasing Motivation to Quit	
Relevance	Indicate why quitting is personally relevant
Rewards	Identify potential benefits of stopping tobacco use
Risks	Identify potential negative consequences of tobacco use
Roadblocks	Identify barriers or impediments to quitting and how to address them
Repetition	Motivational intervention should be repeated at every patient visit

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Primary Prevention in Young Adults and Adolescents

Suggested focused interventions for Primary Care providers to prevent initiation of tobacco use include the following:

Elementary School (through 6th grade):

1. Ask the child if he or she has experimented with tobacco.
2. Reinforce positive health choices.
3. Provide anticipatory guidance regarding the likelihood that he or she may encounter peers who use tobacco and discuss ways in which he or she might address peer pressure to try tobacco.

Middle School and High School (7th - 12th grade):

1. Reassure that most kids do not use tobacco.
2. Educate that all forms of tobacco (including snuff, cigarettes, dip, etc.) are equally dangerous and extremely addictive and once you are hooked, it is very hard to quit.
3. Readdress issues of peer pressure.

4. Introduce the idea that addiction to tobacco takes away one's independence.
5. Point out that tobacco leads to:
 - Bad breath
 - Brittle and smelly hair
 - Smelly clothes
 - Stained teeth and finger nails
 - More colds, shortness of breath, and minor illness
 - Decreased athletic performance
 - Fire and deaths
6. Tobacco companies market to teenagers that smoking is rugged, sexy and cool. Eighty-five percent of all teenagers say they would prefer a boyfriend or girlfriend who does NOT smoke.
7. Addiction to nicotine may make a person more susceptible to trying other dangerous drugs.
8. The rule of 4s: There are over 4000 chemicals in every cigarette; 400 are toxic, at least 40 are known to cause cancer, and they are the same chemicals as are found in dead bodies (formaldehyde), moth balls or urinal cakes (naphthalene), gas chambers (hydrocyanide), fertilizer (phosphatides), and decaying fish (methylamine).



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ICD-9-CM Codes for Tobacco

Medical

Tobacco Specific ICD-9-CM Codes	
Tobacco Use Disorder	305.1*
Accretions on teeth, including tobacco	523.6
Toxic Effect of Tobacco	989.84
History of Tobacco Use	V15.82
Tobacco Cessation Counseling	V65.49 4 (DoD unique extender) *
Accidental poisoning by second hand tobacco smoke	E869.4
Non-specific ICD-9-CM Codes That Can Relate to Tobacco Use	
Drug Withdrawal Syndrome	292.0
Complications of Pregnancy due to Drug Dependence	648.3X**
Procedure Code for Group Education	
Privileged Provider	99078 with E&M code 99499
Non-Privileged Provider	S9453 with E&M code 99499

* Recommend these two codes for a distinct visit targeted solely at addressing tobacco use cessation.

** Contact coder or coding help desk for assistance with fifth digit subclassification.

Dental*

Tobacco Specific American Dental Association (ADA) Code	
Tobacco Cessation Counseling	D1320
Non-specific ADA Codes That Can Relate to Tobacco Use	
Dental Examination	D0140
Oral Hygiene Instruction	D1330

* Current Dental Terminology, Fifth Edition (CDT-5)

VA/ DoD Websites for Clinical Practice Guidelines:

<http://www.oqp.med.va.gov/cpg>

<http://www.QMO.amedd.army.mil>

Coding Help Desk:

<http://www.pasba.amedd.army.mil>