

Advancing preventive care with clinical tobacco intervention

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Family practice is a unique venue for tobacco intervention because of primary care's access to the smoking population, its capacity for long-term follow-up, and its being widely regarded by smokers as an appropriate place to get help with smoking cessation. Clinical tobacco intervention, with its multiple components, is a highly effective measure that merits widespread delivery. *Clinical tobacco intervention* is more descriptive than *smoking cessation*: only a minority of smokers are ready to stop at a given time but a larger proportion will try proven behavioural or chemotherapeutic approaches to stop or reduce tobacco use. Physicians, primary care funders, and health care policy makers can deploy front-office staff, among other measures, to adapt clinical tobacco intervention to the practice setting.

A recent study reported in *Canadian Family Physician* found that front-office personnel (termed *health coordinators*) substantially increased the following evidence-based components of clinical tobacco intervention: smoking status chart reminders, advice to quit, self-management plans (including use of medication), target quit dates, referrals, and follow-up appointments.¹ The project's health coordinators comprised existing front-line staff, 1 per practice, who spent 1 day per week enhancing systematic clinical tobacco intervention. Only one other published study used front-office staff to help smokers.² That study also measured smoking cessation, which rose in the intervention group from 3% at baseline to 11% at follow-up, but which did not change in the control group (4% at baseline and 4% at follow-up). Increases in delivery of clinical tobacco intervention components were very similar in both studies.

Most primary care is driven by patients' symptoms, which cue diagnosis and treatment. But preventive care is designed to avert the condition and its symptoms; thus, the customary driver of care is absent. A systematic, proactive approach is required. Such an approach includes identifying patients' risks, recognizing their readiness (or hesitancy) to address risk, assessing relevant patient characteristics, supporting patients' efforts, and following up over the long term. Family physicians,

apart from the few who are in community primary care settings, seldom have the resources to do this. Those resources include time, staff, space, funding, information systems, training, and ongoing expert consultation.

Implementing clinical tobacco intervention in primary care

Thus, one of the most effective of all clinical maneuvers, clinical tobacco intervention, is not performed well. In fact, page 1 of each of the 1996,³ 2000,⁴ and 2008⁵ editions of the US clinical guidelines on tobacco addiction exhorts that tobacco addiction is lethal and prevalent but neglected, "despite effective and readily available interventions."⁵

Why is primary care a unique venue for clinical tobacco intervention? Primary care in British Columbia sees 70% to 85% of smokers annually. Furthermore, no other setting can conveniently offer the many years of follow-up required to treat tobacco addiction, a chronic condition. Moreover, when smokers are asked how they would like to get help with smoking cessation, they select "a program through your doctor" over any other choice.⁶ That also applies to other behavioural risks; "your doctor" was the favoured choice for where to get help with at-risk alcohol intake as well.

Most physicians help smokers, but their approach is often far from systematic. Simple advice to quit was once cutting-edge clinical practice, but that was decades ago. Today, for treatment of their addiction, smokers are often referred to a telephone quit line. Family practices can be more effective if they go beyond advice and referral to fully implement clinical tobacco intervention.

Front-office staff already employed in practices can help to implement systematic clinical prevention. Treating tobacco addiction is a good place to begin systematic, clinical prevention. Clinical tobacco intervention's "5 As" model (ask, assess, advise, assist, and arrange follow-up)⁵ can later be applied to other behavioural risk factors such as alcohol and depression. When front-office staff become involved in helping smokers, they will need to know the basics—what to ask, what to offer patients, what to record, where to record it, how to involve clinicians, and when to follow up.

The health coordinator pilot project found that health coordinators were initially shy about addressing smoking, especially with patients who were not ready

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to stop.¹ With time and using their existing communication skills, front-office staff built their confidence. Most patients welcomed and appreciated attention to their smoking from the health coordinators. Once smoking status was being systematically noted in the medical or electronic record, a spreadsheet was used to track the smoking cessation progress of the entire patient population. The pilot also addressed 3 risks associated with smoking: physical inactivity, depression, and at-risk alcohol use. It became clear that each risk had its own challenges.

How does this apply to you?

If you are a clinician, is your practice ready to begin a systematic approach to the most preventable cause of death, tobacco use? If so, on the basis of the best medical evidence and in the clearest and strongest terms, we advise you that your practice will benefit from systematic clinical tobacco intervention. If you are ready now, we recommend setting a target date for launching an enhanced approach to clinical tobacco intervention.

If you are a funder or policy maker in primary care, can you find the resources required for preventive care (eg, staff, space, funding, training, and ongoing expert consultation)—resources that you can both afford and sustain?⁵ Fiore et al recommend clinicians' advice be clear, strong, and personalized.⁵ They also recommend health care administrators offer support by providing adequate training, resources, and feedback, and dedicating staff to provide tobacco dependence treatment.

Success in Quebec

In October 2000, Quebec began to provide smoking cessation medication to any smoker whose physician endorsed its use. The province has since expanded coverage to include all smoking cessation medications, both over-the-counter and prescribed, and allows their use for extended periods of time.

Quebec's rank among the provinces in smoking prevalence has dropped from first (30.0%) in 1999 to fifth (17.1%) in 2012.⁷ This has been a notable victory for

clinical prevention and for Quebec's nonclinical components of tobacco control.

Conclusion

To realize the full potential of clinical prevention, 2 things are necessary: at the practice level, mobilization of resources such as involvement of front-office personnel; and at the health care system level, adequate funding of the resources necessary for clinical preventive care such as smoking cessation medication and the support of front-office personnel. 

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Competing interests

Dr Bass has served on the Varenicline Advisory (Pfizer) and as an adviser to Johnson and Johnson on nicotine replacement therapy, as well as a consultant in the more distant past to other pharmaceutical companies that were marketing smoking cessation medications.

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References

1. Bass F, Naish B, Buwembo I. Front-office staff can improve clinical tobacco intervention. Health coordinator pilot project. *Can Fam Physician* 2013;59:e499-506. Available from: www.cfp.ca/content/59/11/e499.full.pdf+html. Accessed 2014 Jan 29.
2. Katz DA, Muehlenbruch DR, Brown RL, Fiore MC, Baker TB; AHRQ Smoking Cessation Guideline Study Group. Effectiveness of implementing the Agency for Healthcare Research and Quality smoking cessation clinical practice guideline: a randomized, controlled trial. *J Natl Cancer Inst* 2004;96(8):594-603.
3. Fiore MC, Bailey WC, Cohen SJ, Dorfman SF, Goldstein MG, Gritz ER, et al. *Smoking cessation. Clinical practice guideline no. 18*. AHCPR Publication No. 96-0692. Rockville, MD: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research; 1996.
4. Fiore MC, Bailey WC, Cohen SJ. *Treating tobacco use and dependence: clinical practice guideline*. Rockville, MD: US Department of Health and Human Services, US Public Health Service; 2000.
5. Fiore MC, Jaén CR, Baker TB, Bailey WC, Benowitz NL, Curry SJ, et al. *Treating tobacco use and dependence: 2008 update*. Rockville, MD: US Department of Health and Human Services; 2008.
6. Council on Health Promotion. *Population surveys 1991-2005*. Vancouver, BC: British Columbia Medical Association.
7. Health Canada [website]. *Canadian Tobacco Use Monitoring Survey (CTUMS) 2012. Table 2. Smoking status and average number of cigarettes smoked per day, by province, age group and sex, age 15+ years, Canada 2012*. Ottawa, ON: Health Canada; 2012. Available from: www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/_ctums-esutc_2012/ann-eng.php. Accessed 2014 Jan 29.
