

Optional Section

Tobacco Knowledge

The goal of this lesson is to introduce you to the health impacts of tobacco use, the importance of tobacco cessation, the process of quitting, and approaches that providers can use to assist their patients in quitting.

Objectives:

- Explain why tobacco use is the leading cause of preventable death and disease in the United States.
- Describe the three factors that make quitting tobacco difficult.
- Describe the model used to identify a person's readiness to quit.
- Describe the Brief Tobacco Intervention (5A and 2A and R versions).
- Describe your role as it relates to pharmacotherapy.

Main Points:

- Tobacco use is the number one cause of preventable death and disease in the United States.
- Tobacco use is a known cause of cancer, cardiovascular disease and respiratory disease.
- There are three key factors that make quitting tobacco difficult – Biological Factors, Psychological Factors and Cultural Factors.
- Not everyone who uses tobacco is ready to quit.

- A number of treatment options exist to help people quit tobacco.
- The Brief Tobacco Intervention is an approach Health Care Providers can use to counsel their patients about tobacco cessation.
- Many tobacco cessation medications are on the market.

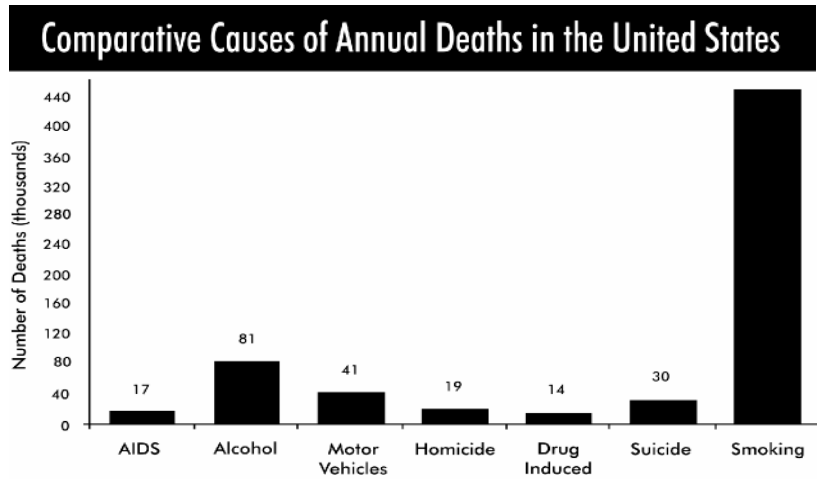
Introduction

This section of the training will provide you with a basic knowledge of the health impacts of tobacco use, reasons that tobacco is addictive, treatment options for quitting, and the role of the Health Care Provider in helping patients to quit.

Basics of Tobacco Cessation

Overview

According to the Centers for Disease Control (CDC), smoking and tobacco use harms nearly every organ of the body, causes many diseases and reduces the health of smokers in general. Tobacco use is the number one preventable cause of death and disease in the United States, accounting for an estimated 438,000 deaths each year (about one out of every five deaths). It causes more deaths than Human Immunodeficiency Virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicides and murders – combined.



Sources: (AIDS) HIV/AIDS Surveillance Report, 1998; (Alcohol) McGinnis MJ, Foege WH. Review: Actual Causes of Death in the United States. JAMA 1993; 270: 2207-12; (Motor Vehicle) National Highway Transportation Safety Administration, 1998; (Homicide, Suicide) NCHS, vital statistics, 1997; (Drug Induced) NCHS, vital statistics, 1996; (Smoking) SAMMEC, 1995

Tobacco Related Diseases

Smoking is a known cause of cancer, cardiovascular disease and respiratory disease (CDC).

Cancer: According to the CDC, smoking causes a wide number of cancers include cancer of the lung, bladder, oral cavity, pharynx, larynx, esophagus, cervix, kidney, pancreas and stomach. About 90% of lung cancer deaths in men and almost 80% in women are due to smoking. Cancer rates due to tobacco use vary widely among different ethnic/racial populations, but are generally highest in African-American men.

Cardiovascular Disease: Cigarette smoking causes a number of cardiovascular diseases by narrowing the blood vessels and reducing overall circulation. Among the diseases caused by tobacco use are stroke, peripheral vascular disease, aortic aneurysm and coronary heart disease. Smokers are 2 to 4 times more likely to develop coronary heart disease, the leading cause of death in the U.S., than non-smokers (CDC).

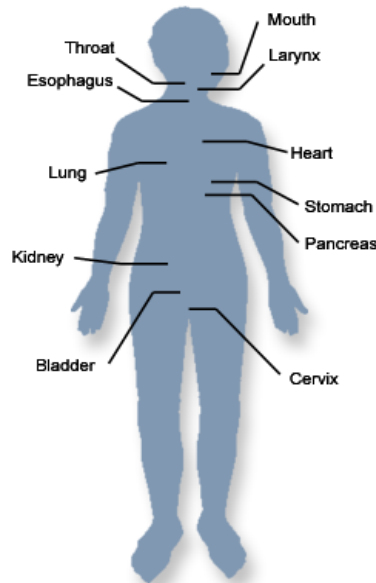
Respiratory Disease and Other Effects: According to the CDC, smoking causes a number of respiratory diseases including chronic obstructive pulmonary/lung disease (COPD), emphysema, and bronchitis. About 90% of COPD deaths are

due to tobacco use. Smoking also causes adverse reproductive effects including low birth weight, placenta previa, preeclampsia, still birth, preterm delivery and sudden infant death syndrome (SIDS).



For more information about the health effects of tobacco use, see the CDC website:

http://www.cdc.gov/tobacco/health_effects/index.htm



Secondhand Smoke: In 2006, the Surgeon General released a report on the health consequences of secondhand smoke. The report concluded that secondhand smoke exposure causes disease and premature death in children and adults who do not smoke; that children exposed to secondhand smoke are at an increased risk for SIDS, acute respiratory infections, ear problems and asthma; that exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system, the heart and the lungs; that there is no risk-free level of exposure to smoke; and that eliminating smoking in indoor spaces fully protects nonsmokers while separating smoking areas from non-smoking areas does not.



To see the detailed report from the Surgeon General, go to this link:

<http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet6.html>

Who Uses Tobacco?

Nationally, about one in five adults use tobacco (CDC, 2009). However, prevalence varies based on income level, education level, race/ethnicity, geographic location, disability, and sexual orientation. As discussed in Section 1, tobacco use rates are disproportionately higher among a number of disparate populations. For example, data indicate that Medicaid recipients have approximately 50% greater smoking prevalence than the overall U.S. population (CDC MMWR, 2004). American Indians and Native Americans have a national tobacco use prevalence that is greater than 40% (CDC MMWR, 2004). Individuals suffering from mental illness have rates of tobacco use between two and four times higher than the general population (Lising-Enriquez & George, 2009).

Due to their increased prevalence, a number of these disparate populations suffer disproportionately from tobacco-related death and disease. In many cases, these populations may also have reduced access to health care and/or have additional barriers that make quitting tobacco even more challenging.



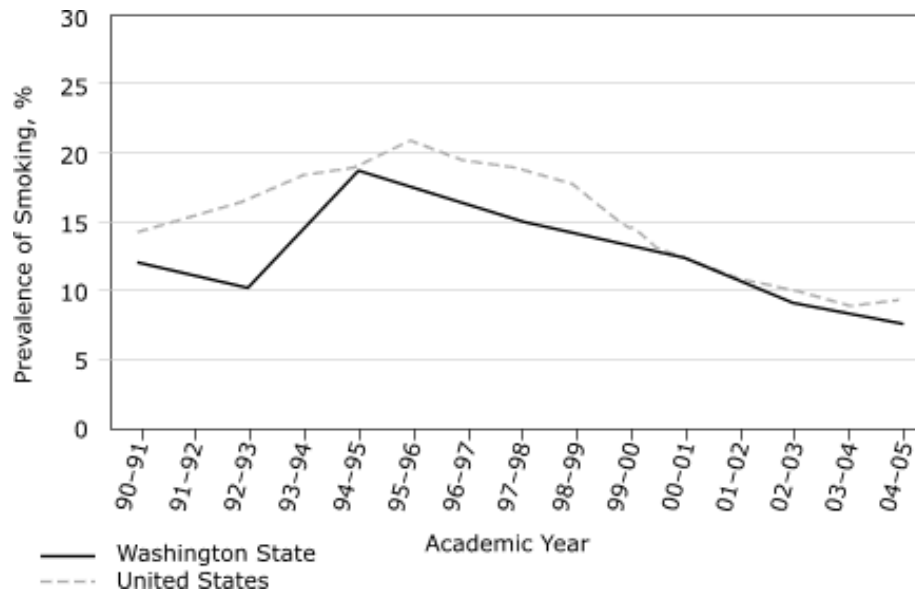
For more information about the impact of tobacco use in disparate populations, see the CDC's website about tobacco, smoking and health disparity:

http://www.cdc.gov/tobacco/health_disparities/index.htm

Tobacco Use in Washington State

At 16.5%, Washington has the sixth lowest prevalence rate in the nation behind Utah, California, Connecticut, Massachusetts and Minnesota. Since the implementation of a comprehensive approach to tobacco prevention and control, the prevalence of smoking has decreased significantly (see Table 1). Washington offers a number of free treatment options for tobacco users, including a free tobacco Quit Line. Nevertheless, 745,000 adults smoke in Washington State and the estimated Smoking-Attributable Mortality, Morbidity and Economic Cost (SAMMEC) in the state is about \$1.5 billion.

TABLE 1
Prevalence Rates in Washington Over Time
(Dilley et al. 2007)



Use the CDC “STATE System” to access current Washington data and to see how Washington compares to other states in tobacco prevalence rates, morbidity and mortality related to tobacco and more. <http://apps.nccd.cdc.gov/statesystem/>

For more information on the health effects of tobacco, see “Health Effects of Tobacco” – an online lecture course by the National Cancer Institute (NCI): www1.tobaccofreepatients.com/PageReq?id=2308:19202

Why Don't They Just Quit?

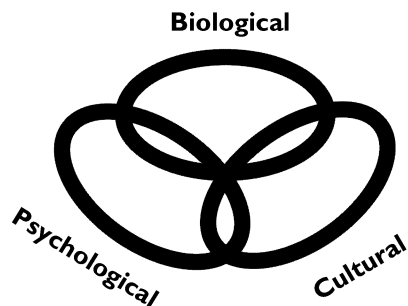
Data from the Behavioral Risk Factor Surveillance System (BRFSS, 2004) indicate that 41% of current smokers make a serious attempt to quit each year, and 70% of all current smokers report that they are interested in quitting.

The Three-Link Chain of Tobacco Dependence

When intervening with tobacco users, it is helpful to understand why so many people experience difficulty in quitting tobacco. The causes of tobacco dependence are complex and differ somewhat from person to person. A simple model, the “Three-Link Chain of Tobacco Dependence,” is

presented here to help you understand some of the biological, psychological, and cultural factors that contribute to tobacco dependence (Christen, McDonald, Klein, et al., 1990 as cited in Christen & Christen, 1994, adapted from Fisher et al., 1993).

The three-link chain of tobacco addiction



Link 1: Biological Factors

Tobacco use results in true drug dependence (on nicotine), which is comparable to the dependence caused by heroin, speed, and cocaine (Fiore et al., 2000).

Nicotine affects essential brain structures associated with feelings of reward and arousal.

Changes in one's brain structure and functionality persist long after a person stops using tobacco.

The addictive power of nicotine may strengthen the learned behaviors that form tobacco-use patterns and make users more resistant to change.

Withdrawal symptoms from tobacco occur with both abrupt cessation and gradual reduction in tobacco use. Withdrawal symptoms appear within hours of the last use of tobacco, are generally most severe within the first two weeks, and may recur in the form of cravings for months or even years (Hughes, 1994).

Link 2: Psychological Factors

Reinforced, conditioned drug-taking behavior is now thought to be central to the concept of addiction, in addition to physical dependence. (US Department of Health and Human Services, 1988).

Tobacco products are often used out of habit. Lighting up or dipping becomes an automatic behavior. People may not even realize that they are using the product.

Tobacco is used as a coping mechanism. People use tobacco to handle stress or when they feel lonely, bored, happy, or angry.

Nicotine may also be used to “self-medicate” underlying problems such as depression, anxiety, Attention Deficit Disorder, or stress (Orrick & Ferguson, 1998).

Link 3: Cultural Factors

Tobacco plays an important role in our society. It may be a part of identifying with a group or a regular part of social activities or cultural practices (adapted from Christen & Christen, 1990). The tobacco industry spends 13.4 billion annually to market their products. National marketing expenditures by the tobacco industry has increased 125% from 1999 to 2003 (Campaign for Tobacco Free Kids, 2005).

Tobacco use becomes a part of many daily activities and rituals. This contributes to the difficulty of breaking the addiction (adapted from Fisher et al., 1993).

Who Is Ready To Quit?

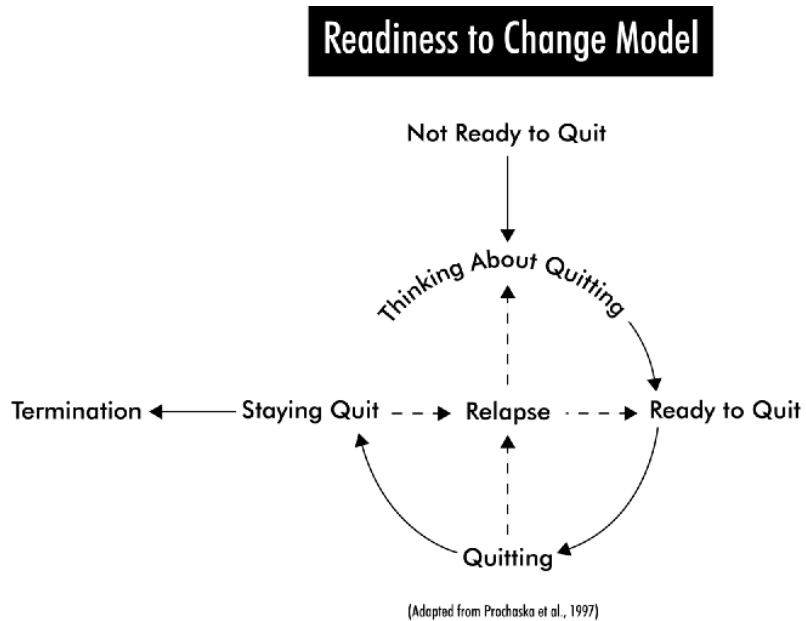
Not everyone who uses tobacco is ready to quit. Most tobacco users have tried to quit at one time or another. Some have tried multiple times. At any given time, about 20% of tobacco users are ready to quit, 40% are thinking about quitting, and another 40% are not ready to quit (Prochaska et al., 1997). When you are intervening with a tobacco user, it is helpful to know how ready that person is to quit, so that you can:

- Give the right help. There are ways to be helpful even with people who are not ready to quit.

- Be efficient and effective. Since it takes less time to intervene with someone who's not ready to quit, you can save your time to spend on those who are ready.

The Readiness to Change Model

The Readiness to Change Model (adapted from Prochaska et al., 1997; DiClemente et al., 1991; Prochaska & DiClemente, 1983) is a simple method used to identify a person's readiness to quit using tobacco.



Not Ready to Quit:	Has no intention to quit within the next 30 days.
Thinking About Quitting:	Intends to quit within the next 30 days.
Ready to Quit:	Is willing to set a Quit Date within the next 30 days.
Quitting:	Has remained tobacco free for less than six months.
Staying Quit:	Has remained tobacco free for more than six months.
Relapse	Is using tobacco again after a period of being tobacco free.

Because tobacco dependence is a chronic condition, tobacco users typically cycle through multiple periods of relapse (Fiore et al., 2000).



For more information on the health impacts of tobacco addiction, see “Tobacco Dependence” – an online lecture course by the National Cancer Institute (NCI): www1.tobaccofreepatients.com/PageReq?id=2308:11684

Please view the Webinar, ‘Why Should I Address Tobacco Use: <http://www.tobaccoprc.org/page.cfm?id=10>

Treatment for Tobacco Dependence

A number of treatment options exist to help people quit tobacco. In 2008, the U.S. Department of Health and Human Services published new guidelines on treating tobacco use and dependence to assist providers and health organizations in helping tobacco users to quit. The guidelines, called the Public Health Service Guidelines (PHSG), are based on an exhaustive review and analysis of the tobacco prevention and control literature.

Evidence-based tobacco cessation recommendations from the 2008 PHSG include:

1. Tobacco dependence is a chronic disease that requires repeated intervention and multiple attempts to quit. However, effective treatments exist.
2. Clinicians and Health Delivery Systems should consistently identify and document the tobacco use status of their patients and treat every tobacco user seen in a health care setting.
3. Tobacco dependence treatments are effective across a broad range of populations.
4. Brief tobacco dependence treatments are effective.
5. Individual, group and telephone counseling are effective and their effectiveness increases with treatment intensity.

6. Numerous effective medications are available for tobacco dependence and clinicians should encourage their use.
7. Counseling and medication are effective when used by themselves. However, their combination is more effective than either alone.
8. Telephone quitline counseling is effective with diverse populations and has broad reach.
9. If a tobacco user is unwilling to make a quit attempt, clinicians should use motivational interviewing techniques to increase future quit attempts.
10. Tobacco dependence treatments are both clinically effective and highly cost effective relative to interventions for other clinical disorders. Providing coverage for these treatments increases quit rates.

In this section, we will discuss a number of treatment recommendations offered by the new PHSG, including Brief Interventions and medications.



For more information on the new PHSG, see:
http://www.surgeongeneral.gov/tobacco/treating_tobacco_use_08.pdf

The Brief Tobacco Intervention

The Brief Tobacco Intervention is an approach Health Care Providers can use to counsel their patients about tobacco cessation.

When used appropriately and integrated into an organization, the Brief Tobacco Intervention is – brief! It takes 30 seconds to three minutes and it fits within the constraints of an office or clinic visit.

The 5A Model is the gold standard for the Brief Tobacco Intervention, however variations on the model have evolved due to provider time constraints, a lack of internal resources within clinics and hospitals, and the development of strong tobacco cessation focused referral resources. We will cover

both the 5A intervention and a variation of the 5As called the 2A and R.

The 5As

The key components of a brief tobacco intervention to break the three-link chain of addiction can be summarized in five words: Ask, Advise, Assess, Assist, and Arrange. An intervention should be relevant to the person receiving it and should address both the risks of using tobacco and the rewards of quitting. The brief intervention should be repeated to encourage tobacco users to quit and allow for changes in their readiness to quit (Fiore et al., 1996).

To maximize effectiveness, the tobacco cessation intervention should be adapted to fit the way each health care setting operates. That means there should be a system in place that allows tobacco use status to be documented, addressed and tracked on a regular basis. Smoking cessation interventions delivered by multiple types of Health Care Providers (e.g., dentists, nurses, psychologists, social workers, tobacco cessation specialists) markedly increase cessation rates compared with interventions where no provider intervenes.

5As Intervention Example:

Provider: “Good morning Ms. Fleming. What brings you in today?”

Client: “My son’s asthma is bad again and I think he might have an ear infection.”

Provider: “I’ll examine him and see what can be done to help him feel better. Before I do that I need to check something out with you. Are you still smoking?”

Client: “Yes I am.”

Provider: “Are you interested in quitting?”

Client: “I know I should quit, but I’m just not ready to do that.”

Provider: “I hear that you’re not ready to quit, but I need to tell you that your son’s health problems are related to his exposure to smoke and I advise you to quit.”

Client: “Oh, I didn’t know that. Maybe I should think about quitting. I just don’t know where to start.”

Provider: “Would it help if I told you some things that have helped other people who have been in a similar situation?”

Client: “Yes that would help.”

Provider: “OK. You could start by writing down the benefits you see in quitting. It also helps to write down the pros and cons of smoking. We could talk about those at your next visit and we’re here to help you whenever you are ready to quit. Now let’s have a look at your son.”

Client: “OK, I’ll follow your suggestions. Thank you.”

Steps of the 5As

1. Ask

Ask about tobacco use at every encounter with every person.

Asking individuals about their tobacco use is the first step in providing a brief intervention. Tobacco use may be obvious with family or friends. However, in workplaces, schools, and especially in health care settings, it is important to make identifying tobacco use a part of everyday practice.

Displaying tobacco education posters, tabletop signs, and other visible messages makes asking about tobacco use a normal and expected part of each patient encounter.

The PHSG recommends that medical offices include tobacco use as a vital sign. This policy provides a useful way to ensure proper documentation of tobacco use and intervention on the patient’s medical chart. They recommend that providers:

1. Include these questions on their vital sign stamp for patient records:

- “Have you ever used tobacco?”
- “Do you use tobacco now?”
- “Does anybody else in your home use tobacco?”

2. Develop a system to identify the tobacco status (use and exposure) of all patients.

Sometimes asking people about their tobacco use can feel uncomfortable. The recommendation is to keep it simple and remember that everyone deserves to hear the tobacco cessation message.

- “Do you use tobacco?”
- “Have you ever used tobacco?”

Because underreporting of smoking is very high—as much as 50% in some populations—you may want to ask:

“Which statement is true for you?”

- “I have never smoked or have smoked fewer than 100 cigarettes in my lifetime.”
- “I no longer smoke or use tobacco.”
- “I smoke or use tobacco occasionally.”
- “I smoke or use tobacco every day.”

2. Advise

In a clear, strong, and personalized manner, advise every tobacco user to quit.

“One of the best things you can do to improve your health and the health of your family is to quit smoking. We can help.” Do not assume that someone is too old or has too much stress in his or her life to quit using tobacco. Everyone can benefit from quitting tobacco.

To personalize the message, tie tobacco use to the individual’s:

- Health Status:
“As your health care provider, I want you to know that quitting smoking is the most important thing you can do to protect your current and future health. If you are thinking of quitting, I can help you get started. I encourage you to quit smoking so that you’ll have fewer upper respiratory infections this winter.”
- Costs—social and economic:
“Tobacco is very expensive. Right now you are smoking one pack a day. At \$5.70 a pack, you could save over \$2,000 a year if you quit! Your children have told you they don’t like the smell of tobacco on your clothes. Medicine can help with withdrawal symptoms.”

- Motivation level:
“You’ve told me that you’re concerned about having another heart attack. Quitting tobacco will help. I know that you want to continue to enjoy your life. Quitting tobacco increases your chances of a high quality life as you age. It’s not too late to reap the benefits of quitting.”
- Impact of tobacco use on children or others in the household:
“Ms. Brown, if you quit smoking now, your child will come less often to the emergency room for his asthma. If you want to try, I can help you.”
- For a pregnant woman:
“After just one day of not smoking, your baby will get more oxygen. Each day that you don’t smoke, you are helping your baby grow.”

3. Assess

Determine the tobacco user’s willingness to make a quit attempt at the present time.

- “Have you thought about quitting tobacco?”
- “When do you think you might be ready to quit?”
- “Are you willing to quit in the next 30 days?”

If the person is willing to make a quit attempt, provide assistance. If the person clearly is unwilling to make a quit attempt, you can offer non-judgmental support and information to get them thinking about quitting. Provide information specific to that person, for example: an adolescent, a pregnant/postpartum smoker, an older adult, a member of a group with increased risk of hypertension.

4. Assist

Assist the tobacco user who is ready to quit.

Tobacco users who are willing to make a quit attempt need help developing a Quit Plan. Information on creating a simple Quit Plan will be covered in Module 5.

The core components of a Quit Plan to break the three-link chain of tobacco addiction include:

- Setting a Quit Date.
- Identifying social support.
- Providing specific problem-solving suggestions.

- Giving information about medications.
- Providing self-help materials.
- Referring to intensive services, if interested.

Remember the three-link chain of tobacco dependence. Assist the person in breaking all three links: biological, psychological and cultural.

Assist the tobacco user who is not ready to quit.

Tobacco users who are unwilling to quit can also be helped to take steps towards quitting. It is NOT necessary (or helpful) to try to talk someone into quitting. People who are unwilling or unready to make a quit attempt may be ready the next time.

- Avoid being judgmental or trying to pressure the tobacco user into quitting.
- Offer written materials that emphasize the benefits of quitting tobacco. A Benefits of Quitting Tobacco sheet is included in the Tools Section of this guidebook.
- Provide a brief motivational message using motivational interviewing.



For more information on motivational interviewing, do to this link: <http://motivationalinterview.org/clinical/index.html>

5. Arrange

Arrange for follow-up whenever possible.

Follow-up may be an invitation to talk about quitting in the future, or it may be arranged for a specific time, such as when a person returns to the dental clinic, or when a student comes in for a sports physical.

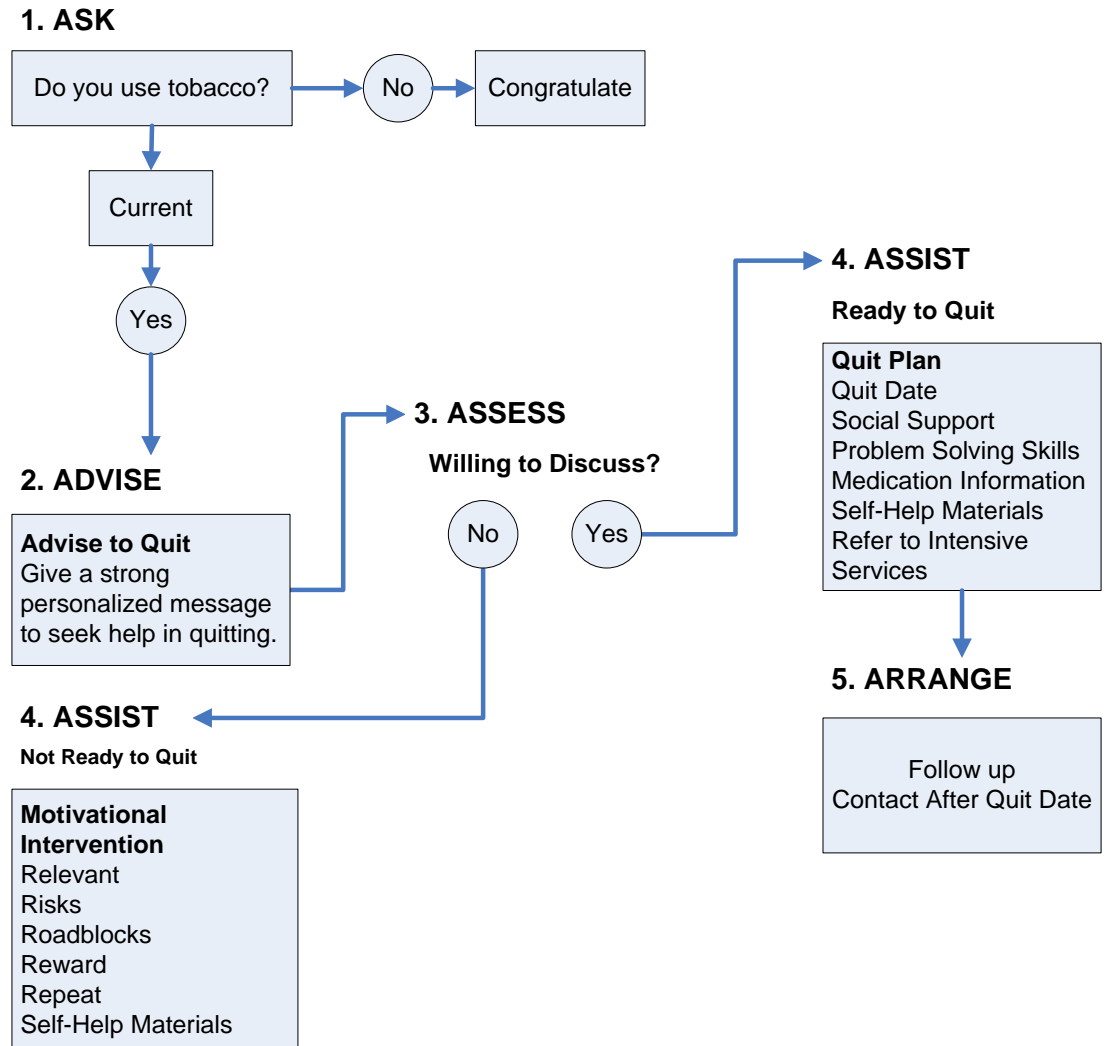
It is particularly important to arrange follow-up contact with a tobacco user who is making a quit attempt. Whenever possible, arrange the follow-up within a week after the individual's Quit Date.

During the follow-up contact:

- Ask about tobacco status.
- Congratulate people who are tobacco-free and support them in staying tobacco-free.
- Support people who have relapsed and assist them in making a new quit attempt.

Brief Tobacco Intervention Flow Chart (5A)

The Brief Tobacco Intervention Flow Chart is a tool that outlines the recommended steps to take when providing a 5A Brief Tobacco Intervention.



A Team Approach

A team approach can be used to deliver the 5A brief tobacco intervention so that each staff member has a role to perform. Listed below are examples of how this can work.

1. Ask

Asking about and documenting tobacco use status could be done by the receptionist checking the client in or by the staff person (e.g., a medical assistant) preparing the client for the clinic visit.

2. Advise

3. Assess

Advise and Assess functions could be performed by the provider seeing the client for the appointment. If the client is not ready to quit, the practitioner could deliver a brief message using the 5R's. If the client is interested in quitting within one month, a referral could be made to another staff person (e.g., a trained nurse) for cessation assistance.

4. Assist

A staff nurse or other trained and designated staff person could help the client establish a quit plan and provide information about resources and medication available.

5. Arrange

A staff nurse or other trained individual could follow-up by phone or in person after the client's Quit Date to determine progress and provide assistance.

The 2A and R Brief Tobacco Intervention

For providers and clinics that do not have the time or resources to conduct a full 5A intervention, a shorter version called the 2A and R exists. While it is abbreviated for the provider, the patient still receives a full intervention. The 2A and R intervention uses a team approach in which providers ask all patients about their tobacco use, advise those who use tobacco to quit, and refer those who are ready to quit to resources to help them in their quitting process. This shifts the

burden of providing the tobacco cessation treatment away from the provider and on to a devoted resource that is specifically equipped to help patients who are trying to quit tobacco. See below for the steps of the 2A and R intervention:

1. Ask

Providers should ask all patients about their tobacco use and document their tobacco-use status.

“Do you use tobacco?” or

“Have you used tobacco in the past 30 days?”

2. Advise

Providers should offer a strong personalized message encouraging patients to seek help in quitting.

“Quitting tobacco is one of the best things you can do for your health. I strongly encourage you to quit. Have you thought about it?”

3. Refer

If interested in quitting:

Provide direct referral to a resource that will complete the “Assess, Assist and Arrange” steps:

“This is a resource I trust and recommend. They will provide you with support, create a quit plan and help you overcome urges.”

The Quit Line is a good example of a resource that will complete the “Assess, Assist and Arrange” steps outline in the 5A model. Other examples of resources may include hospital or community-based classes.

Referral resources should be easily accessible, without financial or geographic barriers, convenient and acceptable to the patient. A referral resource that provides feedback to the referring provider on the progress of the patient is ideal.

If not interested in quitting:

The provider should offer self-help materials and let the patients know he/she is available for future support:

“When you are ready to quit, I am here to support you and have resources that can assist you.”

Providers should be sure to follow-up with patients at each visit.

A team approach can still be used for the 2A and R brief tobacco intervention to help divide the work among different staff.

2As and R Example

Provider: “Hello Mr. James. What brings you in today?”

Mr. James: “Oh, I think I’ve got bronchitis again. This is the third time I’ve had it this year.”

Provider: “OK, I’ll listen to your chest in just a minute, but I need to ask if you currently smoke or use other kinds of tobacco like chew or cigars.”

Mr. James: “Yes, I smoke. But I am, but I’m trying to cut back.”

Provider: “It is good that you are taking steps to cut back. Your recurring bronchitis is strongly related to your smoking. I would advise you to quit. It’s the best thing you can do for your health. Do you think you would like to try to quit smoking completely?”

Mr. James: “Yeah – I really would. It’s just so hard and I don’t know where to start.”

Provider: “I would suggest that you contact the Washington State Tobacco Quit Line. They have been very successful in helping many of my patients quit smoking. Here is the card with their phone number.”

Mr. James: “Thanks. I’ll give them a call.”

Provider: “Good. Now let me listen to your chest.”

2A and R Online Training

In 2008, TCRC launched an online training for health care providers that teaches them how to intervene with their patients who use tobacco. The training also reviews all of the resources available to support them in this process and reviews the services offered through the Quit Line. After viewing this training, you will have an understanding of the 2A and R brief intervention, the resources that are available to support providers, and knowledge about the Quit Line.



To view the training, go to: www.2AandR.org

Pharmacotherapy

Over the last decade, many tobacco cessation medications have emerged on the market. As the Outreach Specialist, you are not expected to have in depth knowledge about any particular medication, but rather to serve as a resource to providers in a more general capacity. Examples of this might include:

- Offering providers a list of all medications that are recommended for cessation.
- Discussing the 2008 U.S. Public Health Service Guideline recommendations for prescription.
- Sharing basic information about medication coverage on the Quit Line or other state programs (Medicaid, etc.).

The provider's role is then to research the medications and to select the appropriate product, as necessary, for each patient.

Treating tobacco use and dependence requires a multimodal approach. After a comprehensive review of the literature, the 2008 Public Health Service Guidelines states recommend the following:

“Medication and/or counseling are effective and should be provided as stand-alone interventions when it is not feasible to do both or when the patient is not interested in both. By combining medication and counseling, however, the clinician can significantly improve abstinence rates.”

The PHSG recommends that providers should encourage all patients attempting to quit tobacco to use effective medications, unless contraindicated. The guidelines also note that the prescribing provider (e.g., MD, Physician's Assistant, Dentist) does not need to be the same provider who offers the counseling or intervention (e.g., social worker, health educator, hygienist, etc.).

The following are the seven first-line medications identified by the USPHSG as pharmacotherapy options that can reliably increase long-term smoking abstinence rates. “OTC” denotes an “over the counter” product that is available without a prescription. “Rx” denotes a product that is only available with a prescription.

- Nicotine gum (OTC)
- Nicotine inhaler (OTC)
- Nicotine lozenge (OTC)
- Nicotine nasal spray (OTC)

- Nicotine patch (OTC)
- Bupropion SR (Rx)
- Varenicline (Rx)



For more information about these products, see the documents on the TCRC website under “How to Select Pharmacotherapy”: <http://www.tobaccoprc.org/page.cfm?id=9>



You can also view the TCRC Webinar ‘Pharmacotherapy for Tobacco Dependence: What You Need to Know to Help Your Patients Quit’: <http://www.tobaccoprc.org/page.cfm?id=10>

Activity 1 - Section 2 Worksheet

For this section, answer the following questions from the pre-reading.

1. How many deaths are attributed to tobacco use each year?

2. Name three tobacco related illnesses.

3. What is the impact of secondhand smoke?

4. Compared to other states, how does Washington compare in tobacco prevalence, morbidity, and mortality?

5. What programs have contributed to Washington's lower tobacco prevalence rates?

6. Why don't tobacco users just quit?

6. What are the 5As?

7. What is the philosophy behind the 5A model?

8. Name the 2As and R.

9. What is the difference between the 2A and R intervention and the 5A intervention?

10. As an Outreach Specialist, give an example when a provider or clinic would use the following intervention models:

5A Brief Tobacco Intervention

2A and R Brief Tobacco Intervention
