Utah Secondhand Smoke Policy Implementation Guide

Healthcare Settings
Revised January 2007

The TRUTH

Utah! Tobacco Prevention & Control Program

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Based on Taking Action Against Secondhand Smoke: An Online Toolkit—Employee and Employer Action Steps, Centers for Disease Control and Prevention (CDC).

Action Step 1: Gather Relevant Facts and Information

The first thing to do is familiarize yourself with the policy changes that can be implemented in healthcare settings which can range from developing a smoke-free hospital campus policy to a clinic institutionalizing the U. S. Public Health Service Guidelines. This section addresses all possible policy changes within a healthcare setting. What policy change you start with depends on the healthcare organization and their readiness for change. For example, in some healthcare settings, it may be easier to start with a patient education component (Public Health Service Guidelines) than advocate for a smoke-free policy. Once a relationship is developed with the healthcare organization, it may then be appropriate to advocate for a smoke-free policy. Policies and procedures in healthcare settings should incorporate:

- A smoke-free environment that is safe for clients, employees, and visitors.
- Systems and procedures for educating current and expecting parents about the harmful effects of their tobacco use on their children.
- Systems and procedures for assisting clients to quit using tobacco.
- Systems and procedures for encouraging clients who are experiencing or who are at high risk for tobacco-related complications to avoid secondhand smoke.

Not only does prohibiting smoking protect nonsmokers from exposure to secondhand smoke and reduce the risk of fire, it benefits smokers by reducing the risk of adverse effects of tobacco on care, treatment, or services.[1]

The Coalition for a Tobacco Free Utah

The Coalition for a Tobacco Free Utah (CTFU) is a collection of concerned citizens, businesses, and nonprofit organizations, agencies and healthcare professionals who are working to improve the health and quality of life for all Utahns by minimizing and reducing the health risks associated with tobacco use and exposure. CTFU is comprised of several different committees. The Healthcare Committee meets once a month and coordinates tobacco efforts among healthcare providers statewide. Getting involved with this committee is an excellent way to stay

connected with statewide goals and resources in your work with healthcare providers. Email ctfutah@gmail.com to learn more.

Professional Association Anti-Tobacco Initiatives

There are a number of healthcare professional associations that have made tobacco treatment a priority. Some examples include: the American Academy of Family Physicians, the American Dental Hygienists' Association, and the American Medical Association. Go to http://www.tobaccofreeutah.org/healthcarelinks.html to find out if the healthcare group you are working with has adopted tobacco control as a priority. You will be able to maximize your work by knowing more about and linking with these national initiatives.

The Utah Indoor Clean Air Act

At a minimum, Utah healthcare settings are required to limit smoking at their facilities in compliance with the Utah Indoor Clean Air Act (UICAA). However, healthcare organizations are encouraged to go beyond the minimum requirements of the Utah Indoor Clean Air Act and make their facilities completely smoke-free.

The Utah Indoor Clean Air Act (UC 26-38-1 to 8) and its accompanying rule (R 392-510-1 to 16) make the following legal requirements about smoking at Utah healthcare settings. The law provides minimum requirements; organizations may voluntarily choose to impose stricter rules, such as banning all tobacco use on the whole campus.

- **In general, smoking is prohibited in all publicly owned buildings and in all indoor places of public access.** Privately owned buildings are considered publicly accessible if people who are not employed there have regular access to the building. Publicly accessible places include common areas of nursing homes, residential health care facilities, assisted living facilities, and hospitals. Lobbies, hallways, elevators, restaurants, cafeterias, dining areas, and restrooms are all considered common areas. Nursing homes, residential health care facilities, assisted living facilities, and hospitals may legally have designated enclosed areas where smoking by residents is permitted, but these areas must be designed and operated to prevent secondhand smoke exposure to people outside of the designated smoking area. Nonresidents, including employees and visitors, may not smoke indoors according to Utah law.
- **Employees and visitors may not smoke closer than 25 feet from entryways, exits, air intakes, or open windows.** Nursing homes, residential health care facilities, assisted living facilities, small health care facilities, and hospitals with a certified swing-bed program may legally create designated outdoor smoking areas within 25 feet of entryways, exits, air intakes, or open windows for residents only. However, if the healthcare organization does choose to create such a designated outdoor smoking area, it may not allow anyone besides facility residents to smoke in the designated area. There is a legal exception to this prohibition for entryways with double vestibule doors.
- **All smoking and nonsmoking areas must be designated with signs.** In general, signs must include both words and the international "smoking" or "no smoking" symbols. On nonsmoking area signs, the words "No Smoking" must be at least 1 ½ inches in height.[6]

For instructions on how to comply with the signage rule, see the Utah Indoor Clean Air Act Business Guide—Signs and Announcements at http://www.tobaccofreeutah.org/uicaa-busguide-signs&announcements.htm

JCAHO Standards for Designated Smoking Areas

While Utah law does permit indoor designated smoking areas for residents at residential healthcare facilities, organizations that choose to create such smoking areas should follow the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 2004 Standards for Management of the Environment of Care. These standards include the following:

- **Maximize the safety of the designated smoking area.**
  - The designated smoking area must be environmentally separate from care, treatment, or service areas.
  - The organization must take measures to minimize fire risks.
- **Limit the persons who are allowed to use the designated smoking area.**
  - Only residents may smoke in designated smoking areas, not employees or visitors.
  - The organization may never permit tobacco use by child or adolescent residents.
  - Residents are only permitted to smoke in the designated area if they meet criteria set by organization leadership. (Such standards may include making smoking at the facility a last resort if other options to combat withdrawal symptoms are inappropriate.)
- **Discourage residents from smoking, even where permitted.**
  - Even if residents are permitted to smoke in the facility's designated smoking area, residents who do smoke should be discouraged from doing so and be provided with tobacco education, including information about options for smoking cessation.[7]

Some of the Risks of Continued Smoking to Medical Patients

The U.S. Public Health Service points out that smoking cessation is cost-effective for hospitalized patients. Successful tobacco abstinence not only reduces general medical costs in the short-term, but also reduces the number of future hospitalizations.[2]

- Among cardiac patients, second heart attacks are more common in those who continue to smoke.
- Lung, head, and neck cancer patients who are successfully treated, but who continue to smoke, are at elevated risk for a second cancer.
- Smoking negatively affects bone and wound healing.[3]

An Opportunity for Cessation

The illness resulting in hospitalization may have been caused or exacerbated by smoking, highlighting the patient's personal vulnerability to the health risks of smoking. Meanwhile,

temporarily housing the client in a smoke-free environment can be used to initiate the quitting process. Together, the patient's medical condition combined with living in a smoke-free environment can be a powerful motivator to quit.

In order to take advantage of this opportunity, promote the following strategies to healthcare organizations:

- Ensure that all sections of the hospital are entirely smoke-free.
- Post signage and remove ashtrays.
- Ask each patient on admission if he or she uses tobacco, and document tobacco use status.
- For current tobacco users, list tobacco use status on the admission problem list and as a discharge diagnosis.
- Identify one or more clinicians to deliver tobacco dependence inpatient consultation services for every hospital.
- Provide advice and assistance on how to quit smoking during hospitalization and remain abstinent after discharge.
- Use counseling and pharmacotherapy to assist all tobacco users to quit, maintain abstinence, and treat withdrawal symptoms. Referring to the Utah Tobacco Quit Line may provide counseling: 1-888-567-TRUTH (8788), (for Spanish) 1-877-629-1585, or (TTY) 1-877-777-6534.
- Reimburse providers for tobacco dependence in-patient consultation services.
- Expand hospital formularies to include FDA-approved tobacco dependence pharmacotherapies which are nicotine replacement therapy (NRT), bupropion SR (Zyban), and varenicline (CHANTIX).
- Educate hospital staff that first-line medications may be used to reduce withdrawal symptoms; even if the patient does not intend to quit.[4, 5]

Educate Parents about Secondhand Smoke and Encourage Them to Quit

A meta-analysis of several studies showed that informing parents about the harmful effects of exposing children to secondhand smoke reduces childhood exposure to secondhand smoke and may reduce parental smoking rates. Furthermore, even less than three minutes of advice to quit smoking by a health care provider, using the Public Health Service "5 A's" method outlined in *Clinical Practice Guideline for Treating Tobacco Use and Dependence*, has been proven to significantly increase tobacco abstinence rates. Therefore, clinicians have an important role in limiting secondhand smoke exposure to children.[8]

Encourage Clients to Avoid Secondhand Smoke

Use the 5 A's with Nonsmokers

The 5 A's counseling approach can be applied to nonsmokers to help them eliminate their exposure to secondhand smoke.[14] To learn how to adapt the 5 A's approach to talk with nonsmokers about their secondhand smoke exposure, see ***Attachment D***.

Counsel Groups at High Risk for Secondhand Smoke-Related Complications

Secondhand smoke is harmful to everyone, and all patients should be encouraged to avoid exposure. However, emphasis should be placed on counseling patients who are experiencing smoke-related problems or for whom secondhand smoke poses the greatest risks. Pregnant women should be advised to stop smoking and to avoid secondhand smoke from the very beginning of pregnancy, as secondhand smoke exposure harms the fetus even during early pregnancy.[15] This smoke exposure can lead to an unhealthy birth and to disease or death after the baby is born. Since children also suffer more negative consequences due to secondhand smoke exposure than the average adult, their guardians should be counseled to protect them from secondhand smoke. Several medical conditions interact with secondhand smoke, leading to substantially higher risks of complications. For some examples of groups at high risk for secondhand smoke-related complications, see ***Attachment E***.

Guidelines for Pediatricians

With regard to tobacco, the U.S. Public Health Service *Clinical Practice Guideline for Treating Tobacco Use and Dependence* makes the following recommendations for pediatricians and other clinicians that serve children:

- Clinicians should screen pediatric and adolescent patients, and their parents, for tobacco use and provide a strong message regarding the importance of totally abstaining from tobacco use.
- Clinicians in a pediatric setting should offer smoking cessation advice and interventions to parents to limit children's exposure to secondhand smoke.[9]

JCAHO affirms the responsibility of pediatric healthcare providers to educate their patients' parents about exposing them to secondhand smoke. In January 2004, JCAHO implemented a performance measurement system called ORYX. One standard to be measured is whether pediatric healthcare providers consistently counsel the caregivers of children with community-acquired pneumonia to stop smoking.[10] To learn more about this standard, see ***Attachment A***.

Guidelines for Prenatal and Postpartum Care Providers

The U.S. Public Health Service *Clinical Practice Guideline for Treating Tobacco Use and Dependence* makes the following recommendations for clinicians that serve pregnant women who smoke:

- "Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered extended or augmented psychosocial interventions that exceed minimal advice to quit."
- "Although abstinence early in pregnancy will produce the greatest benefits to the fetus and expectant mother, quitting at any point in pregnancy can yield benefits. Therefore,

clinicians should offer effective smoking cessation interventions to pregnant smokers at the first prenatal visit as well as throughout the course of pregnancy."

- "Pharmacotherapy should be considered when a pregnant woman is otherwise unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking."[11]

The PHS Guideline provides this rationale for following these recommendations:

> Smoking in pregnancy imparts risks to both the woman and the fetus. Cigarette smoking by pregnant women has been shown to cause adverse fetal outcomes, including stillbirths, spontaneous abortions, decreased fetal growth, premature births, low birth weight, placental abruption, sudden infant death syndrome (SIDS), cleft palates and cleft lips, and childhood cancers. Many women are motivated to quit smoking during pregnancy, and health care professionals can take advantage of this motivation by reinforcing the knowledge that cessation will reduce health risks to the fetus and that there are postpartum benefits for both the mother and child.
>
> It is important to note that smoking cessation is also cost-effective in special populations such as hospitalized patients and pregnant women. Smoking cessation interventions for pregnant women are especially cost-effective because they result in fewer low birth weight babies and perinatal deaths, fewer physical, cognitive, and behavioral problems during infancy and childhood, and also yield important health benefits for the mother.[12]

While it is important to emphasize the risks of smoking during pregnancy, healthcare providers should also begin during pregnancy to talk with the future parents about the effects of secondhand smoke on their child after the child is born. During pregnancy, prospective parents, especially prospective mothers, are highly motivated to stop smoking. Many quit and stay quit throughout pregnancy. However, even women who have maintained total abstinence from tobacco for six or more months during pregnancy have a high rate of relapse in the postpartum period. Postpartum relapse may be decreased by continued emphasis on the relationship between maternal smoking and poor health outcomes of secondhand smoke on infants and children such as SIDS, respiratory infections, asthma, and middle ear disease. Relapse prevention should start during pregnancy and should continue after the child is born and while receiving pediatric care.[13]
To learn more about prenatal and postpartum care, see ***Attachment B*** and ***Attachment C***.
First Step is a cessation program for pregnant women that is administered by local health departments. For a First Step contact in your area, please visit:
http://www.tobaccofreeutah.org/firststep.html

Select Healthcare Organizations for Partnership

Evaluate State and Local Data

Prior to making a decision about which healthcare organizations to work with, you will want to consider which populations in your area are most affected by secondhand smoke. You can use this information to help you choose healthcare organizations that have access to subpopulations most affected by tobacco-related problems. Here are some resources that will help you:

Utah Tobacco Facts and Figures
Look at this web page first. It will provide you with valuable resources to learn about current tobacco use rates, secondhand smoke exposure rates, and health care provider rates of implementing the 5 A's through resources such as the Utah Facts sheet and legislative reports.
http://www.tobaccofreeutah.org/facts.html
Another resource that may be helpful to you is "Barriers to Tobacco Cessation Counseling Among Healthcare Providers in Utah" report found at:
http://www.tobaccofreeutah.org/hcpreport.pdf

Working Together to Bridge the Gap: A Strategic Plan to Identify and Eliminate Tobacco-Related Disparities in Utah
This report lists groups recognized as disparately affected by tobacco use in Utah and explains the statewide plan to reduce these disparities. http://www.tobaccofreeutah.org/strategicplan.pdf

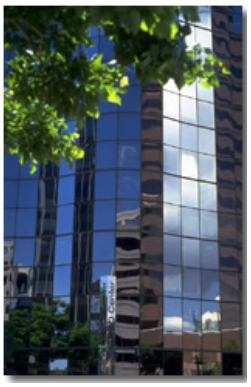
IBIS-PH
On this website, you can search for Utah and local census data, smoking rates, ETS exposure rates, and the number of Utah births to women who smoked during pregnancy. Many fields can be queried by subpopulations. http://ibis.health.utah.gov/index.html

Utah Census Information
This site provides demographic information.
http://www.governor.state.ut.us/dea/Census2000Data.html

Assess Potential Healthcare Organization Partners

A phonebook is a simple tool you can use to assess the kinds and number of organizations available in your area. Consider these questions to narrow the list of organizations you consider working with:

- Does the organization have clinicians that treat tobacco-related problems, such as dentists, prenatal care providers, general practitioners, respiratory therapists, pediatricians, etc.?
- Does the organization have local authority to change tobacco-related policies and procedures?
- Where is the organization located?
- Does the organization serve populations disparately affected by tobacco use?
- What is the history of the organization's partnership with the health department?



? Track your Progress

- Are you familiar with existing healthcare guidelines or laws about clean air policies, educating parents about secondhand smoke, and encouraging people to avoid secondhand smoke?
- Which populations in your area are most affected by secondhand smoke?
- What criteria will you use to select healthcare organizations for partnership?

Action Step 2: Make Your Case

Identify Potential Champions

Identify a person in the organization who may be willing to get a smoke-free policy considered and adopted, initiate the process of organizing systems for tobacco-related treatment, and influence others in the organization to change treatment practices.[16] You will need someone who has the time and inclination to work with you and someone who has authority in the organization—if you are lucky, you may find one person who meets both descriptions. If not, you may need two champions: one who has time to help you follow the action steps in the guide, and another who has power to implement policy change after you and your other champion have done the legwork.

Approach Potential Champions

Share the information about secondhand smoke policies from Action Step 1 with your potential champion(s). If you have not worked with this person or organization before, it may be helpful to share information on all aspects of the PHS Guideline rather than focusing specifically on secondhand smoke, in order to approach tobacco-related policy change holistically. Offer resources to the organization, such as cessation programs for its patients and materials for its clinics. Ask if he/she would be willing to work with you to assess current policies and procedures in the organization and implement policy changes if necessary. Partner with this person to follow the action steps listed in this section.

Overcome Barriers

You may need to help healthcare providers resolve their concerns before they are ready to become champions. The following table lists some common barriers to tobacco-related treatment among healthcare providers, along with ideas to overcome them. If a person is still highly concerned after attempting resolution, you may consider finding someone else to be your champion who is more enthusiastic about tobacco control. Though you will eventually need to convince less enthusiastic people in the organization in order to achieve policy change, your initial champion needs to be a strong advocate for your cause.

Concern	Resolution
I don't have time.	Tell them that the 5 A's intervention is only 3 minutes long and that those 3 minutes can be divided among multiple staff. Also, reassure them that healthcare providers are only expected to refer patients to cessation counseling services; healthcare providers do not need to provide the counseling themselves.[18, 19]
I don't know how.	Offer training on the U.S. Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence.

Concern	Resolution
It doesn't do any good.	Share with them the evidence in the U.S. Public Health Service Clinical Practice Guideline demonstrating a significant increase in tobacco cessation after advice from a healthcare provider. Also, help them understand that since tobacco dependence is a chronic disease, it often takes several attempts before a person quits for good. However, each attempt increases the likelihood of success on the next attempt.[20]
I don't want to offend my patients.	Share with them research demonstrating that patients believe that tobacco-related advice is a healthcare provider's job, and that tobacco users want and expect such advice.[21, 22]
My patients can't afford cessation treatment	Inform them about free resources available to Utah residents, such as the Utah Tobacco Quit Line and Utah QuitNet.
It's too inconvenient.	Explore options for systems changes in their clinic to make tobacco-related treatment easier. For example, they could change the medical record form, use chart stickers to identify tobacco users, or implement the fax referral system.
This isn't my job.	Many respected professional organizations have declared that tobacco control is an important part of their fields. See some of these position statements at http://www.tobaccofreeutah.org/healthcarelinks.html#Professional%20Association%20Anti-Tobacco%20Initiatives

? Track your Progress

- What organizations did you approach?
- Who are your champions? What are their positions in their organizations?
- How did you approach potential champions?
- How did you address any barriers?

Action Step 3: Assess the Organization's Readiness

Assess Willingness

Before you can successfully implement a new policy or protocol, you should find out if current management and clinicians are open to new tobacco control activities. This assessment can be informal in nature. Here are some example questions to ask your champion:

- Does this organization treat tobacco-related problems (e.g., dental, prenatal, etc.)?
- Is there concern among clinicians and staff about the prevalence of tobacco use among your clients or in your community?
- Are any departments or clinicians already working on tobacco-related activities?
- Are senior leaders and decision makers (i.e., a physician, medical director, or opinion leader) supportive of developing new efforts to reduce and prevent tobacco-related problems?
- Can you identify other professionals in the organization who would be willing to serve on a tobacco program planning committee?

- If the organization is a health plan, do purchasers in your area express interest in tobacco treatment for their employees (i.e., do they ask about this in RFPs)?
- Is your organization interested in performance report cards (i.e., HEDIS, FACCT, etc.) and/or accreditation through NCQA, JCAHO, or other organizations? [23]

Assess Current Policy and Practices

With your champion, learn about and document the current policies and procedures in the organization. Thoroughly understanding current policies and procedures helps you avoid wasting time promoting policies that are already in place, or worse, stirring up controversy about polices that currently favor tobacco control. You can learn about them by first reviewing any existing written policies and protocols and then by informally interviewing your champion for information that cannot be discovered through documents. The Tobacco Prevention and Control Program Clinic Policy Assessment is one tool you might use to guide you through this process. This assessment measures all aspects of tobacco dependence treatment. If appropriate, you may limit your assessment to questions 13-15 and 27-29a to focus on secondhand smoke issues. For a copy of the assessment tool, see ***Research Tool 1.*** In addition, ***Research Tool 6*** will help you conduct observations to assess evidence of smoking on premises and existing tobacco practices. Use ***Research Tool 6*** after your policy has been implemented to document evidence of changes in tobacco use on the premises.

Prioritize Policies and Procedures to Change

Compare the policies and procedures to the ideals recommended in Action Step 1, and discuss the differences with your champion. With your champion, select a few policy change goals based on feasibility, organizational support, and the needs of the population served by the organization.

? Track your Progress

- Which organizations were open to new tobacco control activities?
- Which were not? Why not?
- Of the organizations that were open to change, which ones worked with you to assess current policy?
- Based on the assessments, what gaps in policies and procedures were discovered?
- Which policies or procedures were prioritized for change? Why were these selected?

Action Step 4: Organize Your Approach

Plan for Program Success

According to the American Association of Health Plans, six factors are critical to successful planning of tobacco control programs in healthcare systems. These aspects should be incorporated into your strategic plan:

1. **Use a population-based perspective and data.**
   - Recognize tobacco use as a key health indicator.
   - Focus on the needs of your population and be evidence-driven.
   - Know the results of relevant scientific research and apply those results.
2. **Obtain broad organizational support.**
   - Seek support at all levels of the organization (i.e., CEO, middle managers, customer service staff, etc.).
   - Figure out departmental self-interest and work with it.
   - Set a high goal and interim objectives for reaching it.
3. **Provide adequate support for clinical activity.**
   - Remove financial and organizational barriers to effective tobacco dependence treatment.
   - Rigorously and comprehensively, evaluate to be prepared for internal and public scrutiny.
   - Integrate the tobacco control program into other quality improvement, disease management, and guideline projects.
   - Communicate the availability of the program through numerous channels (i.e., newsletters, direct mailings, company advertisements, etc.).
   - Form lasting partnerships between tobacco control program staff and clinical staff.
4. **Establish local ownership.**
   - Identify and support local leadership.
   - Share data and progress reports.
5. **Empower and support local healthcare teams.**
   - Solicit opinions and feedback from healthcare professionals.
   - Wherever appropriate, make changes based on healthcare teams' suggestions.
6. **Provide organizational support for policy and community-based activities.**
   - Apply organizational weight to policy and community initiatives.
   - Engage physicians in policy advocacy.[24]

Tailor Your Strategy to the Organization

Find out the process for changing policies and procedures in that healthcare organization. Tailor an approach to fit the size, type, and culture of the organization. Discuss the following questions with your champion:

- What process would this organization need to go through to adopt new SHS policies and procedures? Identify the necessary steps.
- How can we help make that process happen?
- Who has power to make changes in this organization?
- What is the best way to approach these individuals?

Consider these questions to further guide your strategic plan: "Nine Questions: A Strategy Planning Tool for Advocacy Campaigns" at
http://www.cdc.gov/tobacco/ETS_Toolkit/9questions.htm

? Track your Progress

- Do you have a written plan outlining how you will persuade organization leadership to effect policy change?
- Does the plan encompass all of the "critical factors for program planning success"?
- Did you consider CDC's "Nine Questions" when creating your plan?
- Did your champion actively participate in creating the plan?
- Does your champion believe the plan is appropriately tailored for his/her organization?

Action Step 5: Educate Clinicians and Staff

Teach Clinicians and Staff the 5 A's

Educate clinicians and staff on how to implement the U.S. Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence by utilizing the TRUTH Network materials at: http://www.tobaccofreeutah.org/providerguide.pdf. You will need to work with your champion to determine the best way to train your group, but here are some general guidelines:

- Always provide resources to assist clinicians in implementing what you teach them. Tobacco training for healthcare providers has been proven effective when combined with resources, but has not been proven effective without.[25]
- Adapt the training module to your audience. Consider their area of specialty. For example, if you are speaking with prenatal care providers, talk about the special issues associated with treating pregnant tobacco users; if you are speaking with dental hygienists, highlight the effects of tobacco on oral health. Also, consider how much time the clinicians have to counsel patients and whether or not they have the authority to prescribe medications. Shift the focus of your training accordingly.
- Be flexible and considerate of clinician time. The length of time needed to teach the 5 A's varies, depending on how much detail is provided. Since it is only a 3-minute intervention, it is possible to explain the basics of the intervention in a short meeting rather than in a formal training, as long as you leave supplementary materials to remind the clinician of your discussion.
- In general, attendance at formal trainings is better when it is incorporated into existing staff meetings, trainings, or conferences rather than being scheduled as an extra meeting for people to attend. You may also consider using an online course instead of in-person training. You can find links to on-line courses at http://www.tobaccofreeutah.org/healthcare.html
- Look for incentives to encourage participation such as continuing education credit, refreshments, and complimentary resources. Publicize these incentives before the training takes place.

Discuss these questions with your champion as you plan the training:

- How do clinicians in this organization usually obtain training?
- Does this organization have standing meetings or trainings into which tobacco training could be incorporated?
- What incentives would motivate clinicians in this organization to participate in training?
- Are these clinicians interested in continuing education credit? If so, how could we arrange for continuing education credit to be offered for participating in the training?
- Would clinicians in your organization prefer in-person or online training?

During trainings, you may distribute an attendance log to help you evaluate the number and type of clinicians that attended and brief feedback forms to get ideas from attendees about how to improve your trainings in the future. See ***Research Tool 2*** and ***Research Tool 3***.

Assign Roles

The 5 A's may be and should be divided or shared among multiple members of the healthcare organization. With your champion, encourage organization leadership to form a multidisciplinary team to define the implementation plan. This team should consist of a variety of disciplines, such as dentists, physicians, administrators, hygienists, physical therapists, pharmacists, nurses, respiratory therapists, and other professionals, if such a variety is part of the healthcare organization. If applicable, it is also important to include members of the quality improvement and staff education teams.[26] Facilitate a discussion about who should implement which procedures. Ensure that someone is responsible for each aspect of the 5 A's intervention. After the group reaches a consensus, encourage leadership to formally assign roles to various individuals and incorporate these roles into written protocols or job descriptions. Administrators can reinforce these roles by discussing them at performance reviews and offering feedback on tobacco dependence treatment in staff meetings and bulletins. The following are some examples of role assignments:

University of Minnesota, Division of Periodontology, "Program Responsibilities"
http://www1.umn.edu/perio/tobacco/respncbl.html

Addressing Tobacco in Managed Care: A Resource Guide for Health Plans, "Case Study: Kaiser Permanente Northwest"
https://www.freeclear.com/~content/~downloads/ATMC-ResourceGuideForHealthPlans.pdf
(After clicking on the link, use the Acrobat Reader arrows in the lower left-hand corner to scroll to page 27.)

You may use ***Research Tool 4***, the Role Assignment Worksheet, to assist you in documenting the implementation plan and to ensure that all aspects of the 5 A's intervention are assigned.

? Track your Progress

- Were trainings conducted? How were they conducted?
- What incentives were used to encourage participation?
- How many clinicians and staff were trained? What kinds of clinicians and staff were trained?
- Was pertinent staff missing from your training?
- What kind of feedback did you receive from clinicians? Did they have any good suggestions for future trainings?
- Did the organization assign roles? Did you participate in this process, or did the organization handle it internally? If you participated, how did you participate?
- Are there any gaps in role assignments?

Action Step 6: Implement the Policy

Implement the Clean Air Policy

Help the organization plan for adequate time for publicity and education before implementing a change in policy. Ongoing education is also needed for long-term reinforcement and because of staff turnover. An important part of this education campaign is publicizing resources available to support patients and staff who wish to quit smoking or need pharmacotherapies to relieve withdrawal symptoms.[27] Offer to help the organization communicate the policy and its rationale to staff, patients, and visitors through letters to staff physicians, letters to patients scheduled for elective procedures or admissions, newsletters, staff meetings, presentations, etc. For examples of policies, communicating the smoke-free message, providing systematic assistance with cessation and other helpful resources, please view:

Smoke-Free Hospital Toolkit Resources
http://www.uams.edu/coph/reports/SmokeFree_Toolkit/downloadpage.asp

It is not necessary to phase in the policy (i.e., to provide gradually more restricted smoking areas). The full policy can be implemented at the outset. If a smoking area is for some reason deemed unavoidable, it should be physically distant from the main campus so as not to compromise the smoke-free campus standard. Ideally, there should not be any smoking areas anywhere on hospital grounds; experience in Michigan has shown that this type of policy is easiest to enforce. The policy should specifically include parking lots, but it is not necessary to include smoking in private vehicles.[28]

A mechanism should be specified in which special exceptions to the policy would be considered in the case of rare extenuating circumstances, such as a decision by a committee of two or three individuals. In practice, institutions have found that exceptions are rarely, if ever, needed. The purpose of setting up such a mechanism is to avoid allowing individual physicians or others to grant routine exceptions.[29]

Once established, the best way to inform patients and visitors of a smoke-free policy is to post prominent signs in all smoking and nonsmoking areas.[30] Such signs are legally required by the UICAA administrative rule.[31] For instructions on how to comply with the signage rule, see:

The Utah Indoor Clean Air Act Business Guide—Signs and Announcements
http://www.tobaccofreeutah.org/uicaa-busguide-signs&announcements.htm

Removing ashtrays from smoke-free areas, if possible, should also reinforce the policy. Their absence demonstrates the nonsmoking norm.[32] Legally, organizations may leave ashtrays in outdoor areas within 25 feet of door and windows, but only if they are labeled with a sign such as "For extinguishing only" (R392-510-9(1)(c)).[33] Removing them completely is a much better way to discourage smoking than labeling them. The organization might further reinforce the policy by posting anti-tobacco posters and flyers. Such materials may be obtained at this website:

Free Tobacco Cessation Resources for Clinicians
http://www.tobaccofreeutah.org/free_resources_for_clinicians.html

You may use ***Research Tool 5***, the Healthcare Organization Clean Air Policy Critique, to assess whether the proper policy details and implementation steps are in place to facilitate implementation and enforcement of a smoke-free healthcare setting and whether or not the policy meets Utah law requirements and JCAHO standards.

Implement the 5 A's

Clinicians and staff are more likely to implement the 5 A's intervention, including educating parents about the harmful effects of their tobacco use on their children and encouraging clients to avoid secondhand smoke, when appropriate systems are in place to facilitate tobacco dependence treatment.[35] For recommended system changes, see:

The Utah Tobacco System and Treatment Guidelines
http://www.tobaccofreeutah.org/uthlthcaretobsysguide.html

Many of these systems changes require that resources be available in the healthcare setting, such as chart stickers to identify tobacco users, quit cards and pamphlets for distribution to patients, and reminders of the 5 A's intervention. The Tobacco Prevention and Control Program offers several resources to healthcare providers to assist them in implementing the 5 A's. The TRUTH Network: Treating Tobacco Dependence" guide explains the 5 A's of tobacco control, pharmacologic therapies, statewide cessation programs and fax referral to the Utah Tobacco Quit Line. Two pamphlets to share with patients accompany the guide, one for orienting patients to the Quit Line (when they fill out a fax referral form) and another to motivate patients who are not ready to quit.
For a complete list of available resources and for instructions on how to order them, see:

Free Tobacco Cessation Resources for Clinicians
http://www.tobaccofreeutah.org/free_resources_for_clinicians.html

You may use the Role Assignment Worksheet (***Research Tool 4***) to assist you in documenting how systems tools will be incorporated into the implementation plan.

? Track your Progress

- Were any changes made to the policy as a result of your intervention?
- Does the clean air policy comply with Utah law?
- Does the policy comply with JCAHO standards?
- Are there any areas in which the policy could still be improved?
- How does the organization publicize its policy? Did you participate in this process? If you participated, how did you participate?
- What systems changes were implemented to facilitate physician interventions?

Action Step 7: Enforce the Policy

It is not necessary to actively enforce organization policies about clinician practices, such as educating parents about the harmful effects of their tobacco use on their children or encouraging clients to avoid secondhand smoke. Promote clinician implementation of these policies through clinician education as described in Action Step 5, combined with frequent evaluation and feedback and appropriate systems changes as described in Action Step 6.

However, clean air policies must be strictly enforced in order to be effective. Regardless of whether the healthcare organization is completely smoke-free or creates smoking designated areas, the clean air policy must be supported by procedures for handling violations. Instead of being strictly punitive, such procedures should include help for violators, i.e., referrals to cessation services.

Legal Obligation to Enforce

Utah Code 26-38-7 requires owners of smoking-prohibited places, or their employees or agents, to ask anyone with a lighted tobacco product in the smoking-prohibited area to extinguish it. If that person refuses, the owner, employee or agent is required to ask the smoker to leave the premises. If the smoker still refuses, they may receive monetary penalties through the local health department and criminal charges through local law enforcement.[36] According to Utah Code 26-23-6 any person, association, or corporation that refuses to enforce smoke-free areas as legally required by the UICAA may be subject to a civil penalty of $5000 per occurrence.[37]

JCAHO Standards for Enforcement of Clean Air Policies

JCAHO's 2004 Standards for Management of the Environment of Care include the following standards for enforcement of clean air policies:

- The organization must identify and implement a process for monitoring compliance with the policy.
- The organization must develop strategies to eliminate the incidence of policy violations when identified.[38]

General Enforcement Procedures

The security staff's important role in enforcement should be emphasized and reinforced. Security managers should ensure that enforcement is delivered consistently and, as much as possible, with a helpful positive approach. All hospital staff should be encouraged and expected to participate in enforcement as well. A recommended mechanism is to use a widely available pre-printed card that staff would present to offenders in the case of violations, specifying available enforcement measures. For visitors, these measures could include the possibility of being escorted by security from the grounds of the healthcare setting. For staff, these measures could ultimately include dismissal for repeat violators. These measures have rarely, if ever, been carried out at institutions that use this method. The purpose of such written policies is not necessarily to carry them out, but to communicate the fact that the policy is a formal and serious one. In practice, 95 to 98% (not necessarily 100%) compliance is expected and easily achieved with education and reinforcement methods only.[39]

Cultural Sensitivity

Patients, employees, and visitors are more likely to comply with smoke-free policies or be motivated to quit smoking when information is presented in their language, in a manner sensitive to their culture. For more information, see:

The Provider's Guide to Quality and Culture
http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

Enforce the Policy Among Employees

According to the Centers for Disease Control and Prevention, inserting the following statement into the employee handbook sufficiently addresses enforcement of the smoking policy among employees:
Any violation of this workplace smoking policy will result in disciplinary actions, up to and including discharge under (insert name of organization) progressive discipline policy. Smoke-free policies are enforced among employees similarly to drug-free policies. Structure your policy with the following points in mind:

- Enforce the policy in a fair and equitable manner.
- Distribute written information on the policy to all current and new employees.
- Provide a form to be kept in each employee's personnel file that states that the employee has received a copy of the policy and enforcement procedures, and that he/she has agreed to abide by the company's smoke-free workplace policy.
- Decide which department or individuals will handle complaints, address infractions, and enforce the new policy (e.g., department managers, human resources, risk management). Whatever you decide, make sure that these designated officers are trained in enforcement procedures, handling of filed complaints and conflict management.
- Provide all personnel with the names and contact information of the personnel responsible for enforcing the policy.[40]

Legal Penalties for Violators

People who smoke in legally defined smoking-prohibited areas are subject to civil penalties of $100 or less for their first violation and $100 to $500 for subsequent violations (Utah Code 26-38-8). Smoking in indoor areas where the proprietor or manager of the area has voluntarily posted a "No Smoking" sign, even if the area is not legally required to be smoke-free, is subject to the same fines as smoking in areas required to be smoke-free by the UICAA (Utah Code 26-38-2(1)).[41]

Refer Tobacco Users to Cessation Services

Organization leaders can make adhering to a smoke-free policy easier for their employees and patients by offering and referring them to cessation services. Refer all patients and employees who have been caught violating the clean air policy, those who desire quitting services, or those who find it difficult to follow the smoke-free policy because of nicotine addiction, to the Utah Tobacco Quit Line and Utah QuitNet. Also, the organization should choose a health plan for its employees that include cessation medications and cessation counseling as covered benefits; then advertise the availability of this coverage to its employees.

The following services are offered free of charge to Utah residents. Healthcare organizations can obtain referral cards and posters advertising these programs by calling the Tobacco Free Resource Line at 1-877-220-3466 or emailing TheTRUTH@utah.gov.

Services to Help Utahns Quit

Utah Tobacco Quit Line
1-888-567-TRUTH

Spanish Quit Line: 1-877-629-1585
TTY: 1-877-777-6534

- A personal plan for quitting, developed by you and your qualified Quit Coach
- A connection to benefits provided by your health insurance or programs in your area
- A Quit Guide to walk you though the quitting process step by step
- Nicotine Replacement Therapy if eligible and appropriate

To learn more about the Utah Tobacco Quit Line, see: http://www.tobaccofreeutah.org/quitline.htm

UTAH QUITNET
The TRUTH UTAHQUITNET.COM

- Tools to walk you through the process of quitting
- Access to the world's largest online community of smokers and ex-smokers helping each other quit
- A medication guide to help you determine which, if any, Nicotine Replacement Therapy option is right for you
- Special support forums and one-on-one interaction with quitting experts

To learn more about Utah QuitNet, see: http://www.utahquitnet.com

The Fax Referral System

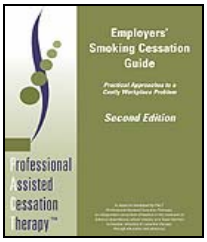
Clinicians may refer patients and employees to the Quit Line by simply giving the tobacco-user the Quit Line's toll free phone number. However, some people are uncomfortable initiating contact with the Quit Line and others lose the phone number before they have an opportunity to call. Instead, clinicians can directly refer tobacco-users with the Utah Tobacco Quit Line Fax Referral Form. After obtaining the patient's signature of consent, the organization faxes the completed referral form to the Utah Tobacco Quit Line. The Quit Line proactively calls referred clients to help them quit. Then the Quit Line faxes intervention results to the referring agency, providing useful information for the patient's health record and facilitating follow-up with the client. The Fax Referral System was designed to facilitate referral of patients to the Quit Line by healthcare providers, but may be used to refer organization employees as well.

An additional advantage of recommending the fax referral system is that the Quit Line tracks the organization's use of the system and creates reports that are accessible to local health department staff. This is a valuable evaluation tool to examine the implementation of cessation referrals in the organizations you work with. Clinicians can download a Fax Referral Form personalized for their clinics at: http://www.tobaccofreeutah.org/utqlprofax.html

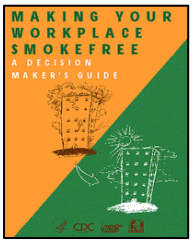
It is helpful if you download the form on behalf of clinics you work with in order to save them a step before they start implementing the program. For information about how local health departments should present the form, see http://www.tobaccofreeutah.org/profaxrefsyslhd.htm.

Employee Cessation Benefits

Employers should purchase health plans for their employees that include cessation benefits, inform them that these benefits are available, and encourage them to use these services. These benefits should include FDA-approved tobacco dependence pharmacotherapies, including NRT, bupropion SR, and varenicline as well as group or individual counseling. Group or individual counseling should last 90 to 300 minutes and involve at least 4 sessions.[42] To learn more about how you can help employees in need of cessation services, go to the following resources:



Employers' Smoking Cessation Guide: Practical Approaches to a Costly Workplace Problem
http://www.freeclear.com/~content/~downloads/PACTEmployersSmokingCessationGuide.pdf



Making Your Workplace Smoke-Free: A Decision Maker's Guide
Chapter 4: Support for Employees who Smoke
http://www.cdc.gov/tobacco/research_data/environmental/chap4.pdf

You may use the ***Research Tool 5***, the Healthcare Organization Clean Air Policy Critique, to assess whether the proper policy details and implementation steps are in place to facilitate implementation and enforcement of a smoke-free healthcare setting and whether or not the policy meets Utah law requirements and JCAHO standards. Observation logs are a good way to monitor adherence to the smoking policy. (See ***Research Tool 6***.)

? Track your Progress

- Were any changes made to the enforcement and cessation referral protocol as a result of your intervention?
- Are there any areas in which the protocol could still be improved?
- Did you assess compliance to the smoking restrictions? Was there any evidence of noncompliance?

Action Step 8: Ensuring Policy Sustainability

Post Signage

The most important way to publicize your smoke-free policy is by posting signs. Contact the Utah Department of Health, Tobacco Prevention and Control Program, for signage template examples.

Before you purchase and post signage keep the following items in mind:

- What is your budget for signage?
- How many signs do you need?
- What type of material should your sign be on (i.e., wood, metal, plastic)?
- Which logo(s) need to be on the sign?
- Does the signage need to be approved by the administration before it is printed?
- Does the signage need to be in a different language?
- What is the timeline?

Celebrate

Celebrate all of your hard work and success! Invite those who made the policy change possible to celebrate with an event/luncheon etc. to thank partners for making the venue a healthier place to live, work and play. This could be the start "kick off" to educating the community about the new policy.

Educate the Community About the New Policy

Educating the community about the new policy will be a big part of ensuring that the policy creates change. This is especially important for enforcement reasons. Depending on the policy language, staff members may be the ones enforcing the policy. This self-enforcement will only happen if the community is made aware of the changes. This could include media outreach, community events, business outreach, direct mail, collateral materials, law enforcement, etc.

Education Checklist:

- Educate staff and volunteers during meetings and trainings and explain how to enforce the smoke-free policy.
- Add the smoke-free policy and its rational to the organization policy manual.
- Create small notification cards explaining the policy, to be distributed by staff to those using the venue.
- Submit articles to a local newspaper.
- Publish articles in organization newsletters.
- Distribute policy statements to administration, staff, patients, and visitors.
- Post information on organization websites.
- Announce the policy over intercoms.
- Hold a kick off celebration or community event with smoke-free educational activities.

Share Progress

Throughout the process make sure you take the time to share your progress with local and state partners. It is important that those who were involved in passing the policy see continued success. Share results with stakeholders and those in the healthcare community that are trying to pass similar policies or might be interested in passing similar policies.

Action Step 9: Evaluate Your Efforts

The tools provided in this section are intended to help you document the process and the initial outcomes of your tobacco policy project. This documentation will be crucial in reporting your progress, planning future projects and sharing project outcomes with tobacco prevention and control partners. Following are two forms designed to help you evaluate your efforts: the Process Evaluation Worksheet and the Outcomes and Recommendations Table.

1. Process Evaluation Worksheet: Fill out sections of this worksheet as you work on your project, ideally after you complete each Action Step. Use the progress tracking questions (? Track Your Progress) and the Community Tools suggested in the Action Steps, where applicable. Some questions may not apply to your project. In that case, mark the question as not applicable (N/A) and briefly explain why it is not applicable.

2. Outcomes and Recommendations Table: Use your notes from the Process Evaluation Worksheet and any other pertinent information to complete this table.

You are not required to submit either of these forms, but they are designed to assist you in reporting your progress to TPCP.

Process Evaluation Worksheet

Action Step 1: Learn Relevant Facts and Information

- Please check which of the following you are familiar with:
  - ❑ existing healthcare guidelines or laws about clean air policies
  - ❑ strategies for educating parents about secondhand smoke
  - ❑ strategies for encouraging people to avoid secondhand smoke
  - ❑ available cessation services

- What criteria will you use to select healthcare organizations for partnership?
  List criteria:

  _____
  _____
  _____
  _____

Action Step 2: Make Your Case

- What organizations did you approach, how did you approach them, who did you try to recruit as a champion, and what was that person's position in the organization?

Organization	Approach	Champion	Position

- What barriers did you encounter and how did you resolve them?

Barrier	Resolution

Action Step 3: Assess the Organization's Readiness

- Which organizations were open to new tobacco control activities? Which of these organizations worked with you to assess current policy?

Organization	Assessed current policy?

(If you will be working with more than two or three organizations, you may want to make multiple copies of the remaining documentation sections to ensure enough space to record detailed information for each organization.)

Did you complete the Community Tobacco Policy Assessment (Research Tool 1) ☐ Yes/ ☐ No
Did you complete any observations to assess smoking behavior? ☐ Yes/ ☐ No

- Based on your assessments, what gaps in policies and procedures were discovered?

  _____
  _____
  _____
  _____
  _____
  _____

- Which policies or procedures did you prioritize for change? Why did you select these?

Prioritized policy/procedure	Reason for selection

To assist with future efforts, please report which organizations were <u>not</u> open to new tobacco control activities? (Please list the organizations and their reasons for not considering new activities.)

_____
_____
_____
_____
_____

<u>Action Step 4: Organize Your Approach</u>

- Do you have a written plan outlining how you will persuade organization leadership to effect policy change? ☐ Yes ☐ No

- Does the plan encompass all of the "6 critical factors for program planning success"?
  ☐ Yes ☐ No

- Did you consider CDC's "Nine Questions" when creating your plan?
  ☐ Yes ☐ No

- Did you tailor your plan to fit the healthcare setting you chose to target? ☐ Yes ☐ No

- Did your champion actively participate in the creation of the plan? ☐ Yes ☐ No
  If yes, please describe the participation:
  _____
  _____
  _____
  _____

- Does your champion believe the plan is appropriately tailored for his/her organization?
  ☐ Yes ☐ No

  If not, please explain why you chose to continue with this plan.
  _____
  _____
  _____

Action Step 5: Educate Clinicians and Staff

- How many trainings were conducted? _____

- Did you track attendance at the trainings? ☐ Yes / ☐ No

Please complete the following table to describe the trainings that were conducted. Add additional rows if necessary.

Trainings	Date	Location	Facilitator	Attendance	Goal	Comments
1.						
2.						
3.						

What incentives were used to encourage participation?
_____
_____

- How many clinicians and staff were trained in total?
  Clinicians: _____
  Staff: _____

- What kinds of clinicians and staff were trained?
  Clinicians: _____
  _____
  _____

  Staff: _____
  _____
  _____

  Was pertinent staff missing from your training(s)?
  _____

- Did you seek feedback from attendees? ☐ Yes/ ☐ No

  What kind of feedback did you receive from clinicians and staff? Did they have any good suggestions for future trainings?
  _____
  _____
  _____
  _____

- Did the organization assign roles for implementing the 5 A's? ☐ Yes ☐ No
  If yes, did you participate in this process, or did the organization handle it internally?
  ☐ I participated. (Please describe how.) _____
  _____
  ☐ The process was handled internally.

- Are there any gaps in role assignments?
  ☐ Yes (Please describe gaps.) _____
  _____
  ☐ No

Action Step 6: Implement the Policy

- Does the new or revised policy comply with Utah law? ☐ Yes ☐ No

- Does the policy comply with JCAHO standards? ☐ Yes ☐ No

- Are there any areas in which the policy could still be improved?
  ☐ Yes (Describe suggestions for improvements.) _____
  _____
  ☐ No

  How does the organization publicize its policy? (Describe methods.)
  _____
  _____

Did you participate in this process?
☐ Yes (Describe how.) _____

_____

☐ No

Action Step 7: Enforce the Policy

- Are there any areas in which the protocol could still be improved?
  ☐ Yes (Describe improvements.) _____

  _____

  ☐ No

- Did you assess compliance to the smoking restrictions?
  ☐ Yes / ☐ No

  If yes please provide dates of observations in relation to policy implementation or describe other ways you assessed compliance.

  _____

  _____

  _____

Did you gather any evidence of noncompliance? ☐ Yes / ☐ No
If yes, please describe the evidence.

_____

_____

_____

Evaluation Outcomes and Recommendations Table

Outcomes
Were any changes made to the policy as a result of your interventions? Describe policy changes.
What systems changes were implemented to facilitate physician interventions?
Did your efforts lead to an increase in clinician implementation of tobacco-related interventions? (You may use fax referral reports to assess implementation.) Please describe the increase and any documentation you have for it.

Did your efforts lead to improved partnerships between the healthcare organization and the health department? If so, please describe.
Were any changes made to the enforcement protocol as a result of your interventions? If so, please describe.
Lessons Learned
What factors contributed to success?
What barriers limited or threatened success?
How were barriers addressed?
What were the relative costs (including staff time) and results of different aspects of your efforts? Did some activities appear to work as well as others but cost less?
Recommendations
What are the next steps in continuing your partnership with this healthcare organization?
What will you do differently the next time you work with a healthcare organization to improve SHS policies and procedures?
Which activities and strategies should be continued the next time you work with a healthcare organization to improve SHS policies and procedures?

Source: Utah Department of Health, Tobacco Prevention and Control Program.[43]

Research Tool 1: Clinic Tobacco Policy Assessment

Instructions

Step 1: Ask a key informant, such as a clinic administrator, for permission and assistance to complete this assessment. DO NOT give this assessment to informants to fill out themselves—it is not a survey. This assessment should only be used in clinics that treat tobacco-related problems (e.g., dental, family practice, ob-gyn, etc.) and that have agreed to work with you to improve their tobacco-related policies, protocols, and systems.

Step 2: Throughout the assessment, look for and follow *italicized* special data collection instructions.

Step 3: Request copies of clinic documents related to tobacco from the key informant: the clinic smoking policy, tobacco cessation treatment protocols, tobacco-use status documentation forms (request forms that have not been filled out yet to avoid patient privacy issues), etc.

Step 4: Use these documents to fill in all the answers you can. Attach copies of these tobacco documents to the assessment.

Step 5: Interview the key informant for information that cannot be answered using documents.

Step 6: Compare current practice in the clinic to the PHS Guideline and Utah tobacco policy recommendations. With your key informant and other clinic personnel, prioritize areas for improvement.

Step 7: After working with the clinic to improve in the selected areas, evaluate your efforts by reporting which ones have changed and which have not. (e.g. "At the initial assessment, Clinic A answered no to question 16; they had no designated place to record tobacco use status. Clinic A selected documentation as an area for improvement. Three months later, clinic A is using chart stickers for documentation.")

Clinic_____Date_____

Person interviewed_____Title_____

Documents Reviewed and Attached: o Tobacco cessation protocol o Tobacco use status documentation forms o Clinic smoking policy

o Tobacco cessation monitoring/evaluation tools o Others (explain)_____

A. Tobacco Treatment Protocol

1. Does the clinic have a written tobacco cessation protocol for treating tobacco use and dependence? Yes_____ No_____

Note: *Do not mark yes in column "C" unless the assignment is documented in written job descriptions or protocols. The job description or protocol should be attached to the assessment to validate all "yes" answers.*

Task	a. Is this task done at this clinic?	b. Who does this? Please list their title(s).	c. Is this task formally assigned to them (part of written job descriptions or protocols)?	d. Describe how this task is implemented.	e. Describe how implementation of this task is documented, monitored, and/or evaluated.
2. Identify and document tobacco use status for every patient.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		(See Question 16)
3. Advise every tobacco user to quit.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
4. Ask all tobacco-using patients if they are willing to make a quit attempt.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
5. Discuss the risks of tobacco use, rewards of quitting, and solutions to barriers with all tobacco-users who do not want to quit.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
6. Briefly teach tobacco users who are ready to quit methods for quitting successfully.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		

Task	a. Is this task done at this clinic?	b. Who does this? Please list their title(s).	c. Is this task formally assigned to them (part of written job descriptions or protocols)?	d. Describe how this task is implemented.	e. Describe how implementation of this task is documented, monitored, and/or evaluated.
7. Help patients who are willing to quit to select a quit date within 2 weeks after their appointments.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
8. Prescribe bupropion SR, varenicline, or NRT to all adult patients who desire to quit, except when contra-indicated.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
9. Refer patients to the Utah Tobacco Quit Line, Utah QuitNet, or to another cessation counseling service.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
10. Give patients cessation materials, such as self-help manuals or brochures.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
11. Schedule follow up for patients who have set a quit date within 2 weeks (either in person or by phone).	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		

Task	a. Is this task done at this clinic?	b. Who does this? Please list their title(s).	c. Is this task formally assigned to them (part of written job descriptions or protocols)?	d. Describe how this task is implemented.	e. Describe how implementation of this task is documented, monitored, and/or evaluated.
12. Follow up with patients about 2 weeks after they have set a quit date (either in person or by phone).	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
13. Enforce nonsmoking areas.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
14. Ask guardians of pediatric patients if they smoke. If they do smoke, advise them to quit or avoid exposing the child to SHS.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		
15. Encourage clients who are experiencing or are at high risk for tobacco-related complications to avoid SHS.	❑ Yes, consistently ❑ Yes, sometimes ❑ No		❑ Yes ❑ No		

B. Training and Feedback in PHS Guidelines

Note: *Interview your key informant to answer items 16, 16a, and 16b. It is unlikely that you can answer these questions using documents.*

16. How many clinicians and staff are trained in the U.S. Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence?____out of___

16.a. When were they trained?_____

16.b. Who trained them?_____

17. Does the clinic provide feedback to clinicians and staff on their performance at treating tobacco use? Yes_____ No___

17.a. If so, how is feedback provided?_____

_____

_____

C. Documentation of Tobacco Use Status

Note: *Do not mark "yes" to item 18 unless there is a space or field specifically about tobacco use on the form or computer prompt system, or there is a sticker or stamp to make recording easier. (For example, doctors may write about tobacco use status in the chart if they choose to, but if there is no specific space on any chart or other form that says "Tobacco User" to check, or there is no sticker/stamp to make it easier for them, the answer to question 18 is "no." A copy of the form/sticker/computer-based prompt should be attached to the assessment.)*

18. Does the clinic routinely document tobacco use status in a designated place? Yes____ No____ (If no, go to Question 20.)

18.a. Which of the following systems does the clinic use to document tobacco use status? Mark all that apply.

- ❑ Stickers or stamps placed in patient charts
- ❑ Medical history form
- ❑ Computer-based reminder systems
- ❑ Other (explain)_____

Note: *Answer items 19-22 by analyzing a copy of the form, sticker, or computer prompt. For example, a chart sticker that only says "Smoker" does not help clinicians identify chewers, and so you would answer "no" to item 19. Do not use interviews to answer these items.*

19. Does the documentation system identify all tobacco users, including those that are not smokers (e.g., chewers)? Yes___ No___

20. Does the documentation system identify former tobacco users who have quit, as well as current tobacco-users? Yes___ No___

21. Does the documentation system indicate when former tobacco-users quit using tobacco? Yes___ No___

22. Are pregnant women asked about tobacco use status using the multiple-choice format recommended by PHS? Yes___ No___

How often are these records updated for:

23. adolescent patients?_____

24. adult tobacco-using patients?_____

25. adult former tobacco users?_____

25.a. The clinic continues to regularly update the tobacco use status records of former tobacco users until they have maintained abstinence for _____. (Specify length of time.)

D. Cessation Materials

Note: *Interview your key informant to answer question 26. It is unlikely that you can answer this question using documents.*

26. Which of the following materials are currently maintained and/or distributed at this clinic?

- ❑ *The U.S. Public Health Service Clinical Practice Guidelines for Treating Tobacco Use and Dependence*
- ❑ "5 A's" reminders (e.g. laminated cards)
- ❑ Utah Tobacco Quit Line referral cards
- ❑ Utah Tobacco Quit Line Fax Referral Forms
- ❑ The Utah Tobacco Cessation Resource Directory
- ❑ Tobacco cessation insurance benefits information
- ❑ Tobacco cessation self-help manuals
- ❑ Anti-tobacco brochures and handouts
- ❑ Preprinted prescription pads for tobacco-related prescriptions
- ❑ Anti-tobacco posters
- ❑ Other tobacco materials (explain) _____
  _____

E. Clean Air

Note: *Do not mark "yes" to item 27 unless there is a written policy or posted signage. If the smoking policy is only implied or understood, the answer is "no." The smoking policy should be attached to the assessment.*

27. Does the clinic have a written policy that restricts smoking at the clinic? Yes_____ No_____

28. Is smoking allowed in the following areas? Please check all that apply.

- ❑ 28.a. Any areas inside the buildings (specify) _____

  _____

- ❑ 28.b. Any areas within 25 feet of building entrances, exits or windows (specify)_____

  _____

- ❑ 28.c. Any other outdoor areas (specify)_____

  _____

Source: Utah Department of Health, Tobacco Prevention and Control Program[44]

Research Tool 2: Tobacco Dependence Treatment Training Attendance Log

Location_____ Instructor_____

Date_____

	Name	Job Title	Organization
1.			
2.			
3.			
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35.			
36.			

Source: Utah Department of Health, Tobacco Prevention and Control Program[45]

Research Tool 3: Tobacco Dependence Treatment Training Feedback Form

List two things you liked best about the training.

List two suggestions for improvement.

……

Tobacco Dependence Treatment Training Feedback Form

List two things you liked best about the training.

List two suggestions for improvement.

Source: Utah Department of Health, Tobacco Prevention and Control Program[46]

Research Tool 4: Role Assignment Worksheet

Task	Person(s) Responsible List title(s).	Additional Implementation Details
1. Identify and document tobacco use status for every patient.		❑ Documentation System: ❑ Stickers or stamps placed in patient charts ❑ Medical History Form ❑ Computer-based reminder systems ❑ Other (explain) How often are these records updated for: adolescent patients?_____ adult tobacco-using patients?_____ adult former tobacco users?_____ ~Continue to regularly update the tobacco use status records of former tobacco users until they have maintained abstinence for_____(Specify length of time.)
2. Advise every tobacco user to quit.		
3. Ask all tobacco-using patients if they are willing to make a quit attempt.		
4. Discuss the 5 R's with all tobacco-users who do not want to quit.		
5. Briefly teach tobacco users who are ready to quit methods for quitting successfully.		
6. Help patients who are willing to quit to select a quit date within 2 weeks after their appointments.		
7. Prescribe bupropion SR, varenicline, or NRT to all adult patients who desire to quit, except when contra-indicated.		
8. Refer patients to the Utah Tobacco Quit Line, Utah QuitNet, or to another cessation counseling service.	Responsible for referring: Fax Referral contact person:	Fax Referral System? ____Yes ____No Quit cards? ____Yes ____No

Task	Person(s) Responsible List title(s).	Additional Implementation Details
9. Give patients cessation materials, such as self-help manuals or brochures.	Responsible for distributing: Responsible for maintaining stock:	Distribution protocol: Items to be distributed:
10. Schedule follow-up for patients who have set a quit date within 2 weeks (either in person or by phone).		
11. Follow up with patients about 2 weeks after they have set a quit date (either in person or by phone).		
12. Enforce nonsmoking areas.		
13. Ask guardians of pediatric patients if they smoke. If they do smoke, advise them to quit or avoid exposing the child to SHS.		
14. Encourage clients who are experiencing or are at high risk for tobacco-related complications to avoid SHS.		
15. Document, monitor, and/or provide feedback.		Utilize Fax Referral System reports? ____Yes ____No

Source: Utah Department of Health, Tobacco Prevention and Control Program[47]

Research Tool 5: Healthcare Organization Clean Air Policy Critique

Instructions: Mark **"F"** on all statements that are **NOT** true for the organization. Leave true statements unmarked. Statements with an **"F"** are potential areas for improvement.

- ◆ Legal minimum requirement for non-residential healthcare organizations[48]
- ▲ Legal minimum requirement for residential healthcare organizations[49]
- ● JCAHO standard[50]

Mark "F" if FALSE	Smoking Restrictions		
❑	1. The organization has a written policy that clearly states where smoking is permitted and where it is prohibited.		
❑	2. A mechanism is specified in which special exceptions to the policy would be considered in the case of rare extenuating circumstances, such as a decision by a committee of two or three individuals.		
❑	3. The policy requires the whole healthcare organization campus to be smoke-free. IF YES, SKIP TO "Signage."		
❑	4. Smoking is prohibited in all indoor areas. IF YES, SKIP TO #15.	◆	
❑	5. Smoking is prohibited in all lobbies.	▲	
❑	6. Smoking is prohibited in all hallways.	▲	
❑	7. Smoking is prohibited in all elevators.	▲	
❑	8. Smoking is prohibited in all restaurants, dining areas, and cafeterias.	▲	
❑	9. Smoking is prohibited in all restrooms.	▲	
❑	10. Only residents may smoke in enclosed, designated smoking areas, not employees or visitors.	▲	●
❑	11. Residents are only permitted to smoke in the designated area if they meet criteria set by organization leadership.	●	
❑	12. Designated smoking areas are designed and operated to prevent secondhand smoke exposure to people outside of the designated smoking area, including the ventilation and HVAC system requirements listed in R392-510-6-9.	▲	
❑	13. The designated smoking areas are environmentally separate from care, treatment, or service areas.	●	
❑	14. Measures have been taken to minimize fire risks in designated smoking areas.	●	
❑	15. Smoking is prohibited in all areas within 25 feet of all windows, air intakes, exits, or entryways, including areas within 25 feet of double vestibule doors. IF YES, SKIP TO 'Signage."		
❑	16. Smoking is prohibited in all areas within 25 feet of windows, air intakes, exits, or entryways, except for those with double vestibule doors.	◆	

Mark "F" if FALSE	Smoking Restrictions		
❑	17. Employees and visitors may not smoke within 25 feet of all windows, air intakes, exits, or entryways, including areas within 25 feet of double vestibule doors. IF YES, SKIP TO #19.		
❑	18. Employees and visitors may not smoke within 25 feet of windows, air intakes, exits, or entryways, except for those with double vestibule doors.		▲
❑	19. Residents are only permitted to smoke within 25 feet of windows, air intakes, exits, or entryways, if they are in a designated resident outdoor smoking area. IF YES, SKIP TO "Signage."		
❑	20. Residents are only permitted to smoke within 25 feet of windows, air intakes, exits, or entryways if they are in a designated resident outdoor smoking area or if the exit or entryway has double vestibule doors.		▲

Mark "F" if FALSE	Signage		
❑	1. All nonsmoking areas are designated with signs.	◆	▲
❑	2. All smoking areas are designated with signs.	◆	▲
❑	3. There are no ashtrays in nonsmoking areas. IF YES, SKIP TO "Enforcement Procedures."		
❑	4. Ashtrays in nonsmoking areas are labeled with signs such as, "For extinguishing only."	◆	▲

Mark "F" if FALSE	Enforcement Procedures		
❑	1. Employees are required to ask anyone with a lighted tobacco product in a nonsmoking area to extinguish it.	◆	▲
❑	2. If a smoker refuses to extinguish a tobacco product in a smoking prohibited area, employees are required to ask the smoker to leave the premises.	◆	▲
❑	3. The organization has identified and implements a process for monitoring compliance.	●	
❑	4. The organization has developed strategies to prevent repeat policy violations after primary offenses are discovered.	●	
❑	5. The policy clearly states the consequences of noncompliance by visitors, patients, and employees and the process for administering them.		
❑	6. One or more persons are assigned to handle complaints, address infractions, and administer consequences.		
❑	7. The organization provides immediate follow-up on all questions, concerns, or complaints that employees, patients, and visitors have about smoking.		
❑	8. The organization has developed a card or letter to present in the case of violations, explaining the policy and available enforcement measures.		

Mark "F" if FALSE	Cessation Referral Process
❑	1. The organization refers patients and employees who have been caught violating the clean air policy to the Utah Tobacco Quit Line, Utah QuitNet, or the employee health plan cessation programs.
❑	2. The organization purchases health plans for employees that include Nicotine Replacement Therapy (NRT).
❑	3. The organization purchases health plans for employees that include Bupropion (Zyban).
❑	4. The organization purchases health plans for employees that include group or individual cessation counseling.
❑	5. The organization informs employees of health plan cessation benefits and encourages them to use these services.

Mark "F" if FALSE	Employee Education Plan
❑	1. Written information on the policy is distributed to all new employees.
❑	2. All personnel have the names and contact information of the personnel responsible for enforcing the policy.
❑	3. Employees assigned to enforce the policy are trained in enforcement procedures, handling of filed complaints, and conflict management.
❑	4. Ongoing education on the policy occurs at staff meetings or through other appropriate means as needed.

Source: Utah Department of Health, Tobacco Prevention and Control Program[51]

Research Tool 6: Tobacco Observation Log

Obtain permission to visit all smoking and nonsmoking areas of the property, including outdoor areas, during hours when employees and clients are present to answer the questions below. Complete signage observations once per assessment. Repeat smoking observations at multiple regularly scheduled intervals during your assessment. Make extra copies of smoking observation logs as necessary.

Signage Observations

• Date of Observation		
• Number of entrances		
• How many building entrances have signs indicating that no smoking is allowed within 25 feet of the entrance?		
• How many of the entrances without signs have double vestibule doors (i.e., two sets of doors that close after entry)?		
• How many building entrances have ashtrays located within 25 feet of building entrances?		
• How many ashtrays located within 25 feet of the entrances are marked with signs stating, "for extinguishing purposes only" or similar language?		
• Are all smoking and nonsmoking areas designated with signs?	❑ Yes	❑ No
• Is the "No Smoking" language at least 1 ½ inches high and do the signs contain a universal no-smoking symbol?	❑ Yes	❑ No
• If not, which areas are missing signs?		

Smoking Observations (Repeat the following observations at regularly scheduled intervals.)

• Date of Observation		
• Time of Observation: a.m. / p.m. until a.m. / p.m.		
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in indoor nonsmoking areas?	❑ Yes	❑ No
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in outdoor areas within 25 feet of windows, entryways, or doors?	❑ Yes	❑ No
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in other outdoor nonsmoking areas?	❑ Yes	❑ No
• Do you see smoking or smell tobacco smoke in nonsmoking areas?	❑ Yes	❑ No
• If yes, where do you see smoking or smell tobacco smoke?		
• How many people do you see smoking?		
• Are the smokers employees, patients, or visitors?		

Smoking Observations		
• Date of Observation		
• Time of Observation: a.m. / p.m. until a.m. / p.m.		
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in indoor nonsmoking areas?	❑ Yes	❑ No
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in outdoor areas within 25 feet of windows, entryways, or doors?	❑ Yes	❑ No
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in other outdoor nonsmoking areas?	❑ Yes	❑ No
• Do you see smoking or smell tobacco smoke in nonsmoking areas?	❑ Yes	❑ No
• If yes, where do you see smoking or smell tobacco smoke?		
• How many people do you see smoking?		
• Are the smokers, employees, patients, or visitors?		

Smoking Observations		
• Date of Observation		
• Time of Observation: a.m. / p.m. until a.m. / p.m.		
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in indoor nonsmoking areas?	❑ Yes	❑ No
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in outdoor areas within 25 feet of windows, entryways, or doors?	❑ Yes	❑ No
• Do you see tobacco-related litter (cigarette butts, empty cigarette packets) in other outdoor nonsmoking areas?	❑ Yes	❑ No
• Do you see smoking or smell tobacco smoke in nonsmoking areas?	❑ Yes	❑ No
• If yes, where do you see smoking or smell tobacco smoke?		
• How many people do you see smoking?		
• Are the smokers, employees, patients, or visitors?		

Utah Department of Health, Tobacco Prevention and Control Program[52]

Attachment A: JCAHO ORYX Performance Measurement Initiative

Hospitals and long-term care, home care, and behavioral healthcare organizations submit performance measurement data to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as part of the ORYX initiative. Previously, more than 200 measurement systems met the Joint Commission's ORYX requirements. However, healthcare organizations must use the same measures to be comparable. To address this problem, standardized sets of valid, reliable, evidence-based "core" measures are being implemented by the Joint Commission beginning with January 1, 2004 discharges. Currently, these measures are centered on treatment of four conditions:

- Acute myocardial infarction (AMI), including coronary artery disease
- Community-acquired pneumonia (CAP)
- Heart failure (HF)
- Pregnancy and related conditions, including newborn and maternal care (PR)

Three of the four measurement sets include indicators for tobacco cessation advice and treatment.

ORYX Performance Measures Related to Tobacco

Adult smoking cessation advice/counseling (Measurements AMI-4, CAP-4a, and HF-4)

Numerator: Adult patients with the medical condition who receive smoking cessation advice or counseling during the hospital stay. "Adult Smoking Counseling" is defined as documentation indicating the patient received one of the following:

- Advice to stop smoking, whether or not the patient is a current smoker
- A viewing of a smoking cessation video
- Brochures or handouts on smoking cessation
- A smoking cessation aid such as Nicoderm or Zyban

Denominator: Adult patients with the medical condition and a history of smoking cigarettes anytime during the year prior to hospital arrival.

Pediatric smoking cessation advice/counseling (Measurement CAP-4b)

Numerator: Pediatric CAP patients and/or their caregivers who receive smoking cessation advice or counseling during the hospital stay. **"**Pediatric Smoking Counseling" is defined as documentation indicating the patient and/or caregiver received one of the following:

- Advice to stop smoking, whether or not the patient and/or caregiver is a current smoker
- A viewing of a smoking cessation video
- Brochures or handouts on smoking cessation
- A smoking cessation aid such as Nicoderm or Zyban

If both patient and caregiver smoke, both must receive counseling to meet this indicator.

Denominator: Pediatric CAP patients and/or their caregivers with a history of smoking cigarettes during the year prior to hospital arrival.

For more complete information about the ORYX initiative or about these specific core measures, visit the JCAHO website: http://www.jointcommission.org/

Source: Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[53]

Attachment B: U.S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence, Pregnancy

Recommendations

- ➔ Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered extended or augmented psychosocial interventions that exceed minimal advice to quit. (Strength of Evidence = A*)
- ➔ Although abstinence early in pregnancy will produce the greatest benefits to the fetus and expectant mother, quitting at any point in pregnancy can yield benefits. Therefore, clinicians should offer effective smoking cessation interventions to pregnant smokers at the first prenatal visit as well as throughout the course of pregnancy. (Strength of Evidence = B*)
- ➔ Pharmacotherapy should be considered when a pregnant woman is otherwise unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking. (Strength of Evidence = C*)

* Strength of the Evidence" is the degree to which the recommendation is substantiated by research, according to the PHS Guideline panel.

Clinical Practice when Assisting a Pregnant Patient in Smoking Cessation

1. **ASK Assess the pregnant woman's tobacco use status using a multiple-choice question.**

Research has shown that the use of a multiple choice question, as opposed to a simple yes/no question, can increase disclosure among pregnant women by as much as 40 percent. For example:
Which of the following statements best describes your cigarette smoking?

a. I smoke regularly now -- about the same, as before finding out I was pregnant.
b. I smoke regularly now, but I've cut down since I found out I was pregnant.
c. I smoke once in a while.
d. I have quit smoking since finding out I was pregnant.
e. I wasn't smoking around the time I found out I was pregnant, and I don't currently smoke cigarettes.

2. **ADVISE Give clear, strong advice to quit as soon as possible.** Quitting early in pregnancy provides the greatest benefit to the fetus.

3. **ASSESS Ask, "Are you willing to quit?"**

4. **ASSIST Motivate quit attempts by providing educational messages about the impact of smoking on both the woman's and the fetus' health.** Suggest the use of problem-solving methods. Provide social support and pregnancy-specific self-help materials. Clinicians may choose to consider pharmacotherapy for pregnant smokers who have been unable to quit using psychosocial interventions. In such cases, the clinician and pregnant smoker must contrast the risks and unknown efficacy of pharmacotherapy in pregnant women with the substantial risks of continued smoking. If the clinician and pregnant or lactating patient decide to use NRT pharmacotherapy, the clinician should consider monitoring blood nicotine levels to assess the level of drug delivery. In addition, the clinician should consider using medication doses that are at the low end of the effective dose range, and consider choosing delivery systems that yield intermittent, rather than continuous, drug exposure (e.g., nicotine gum rather than the nicotine patch).

5. **ARRANGE FOLLOW-UP Arrange for follow-up assessments throughout pregnancy, including further encouragement of cessation.** Quitting smoking prior to conception or early in the pregnancy is most beneficial, but the woman and her fetus will benefit even when quitting occurs late in pregnancy. Therefore, a pregnant smoker should receive encouragement and assistance in quitting throughout her pregnancy. Congratulate those smokers who have quit to encourage continued abstinence. Prevent postpartum relapse. In the early postpartum period, assess for relapse and use relapse prevention strategies, recognizing that patients may minimize or deny tobacco use. Even women who have maintained total abstinence from tobacco for six or more months during pregnancy have a high rate of relapse in the postpartum period. Postpartum relapse may be decreased by continued emphasis on the relationship between maternal smoking and poor health outcomes in infants and children such as SIDS, respiratory infections, asthma, and middle ear disease. Relapse prevention may start during pregnancy.

Source: Treating Tobacco Use and Dependence: Clinical Practice Guideline.[54]

Attachment C: Helping a New Mother Avoid Postpartum Tobacco Relapse

Risk Factors for Postpartum Relapse

Most women who quit smoking during pregnancy start using tobacco again after giving birth. Therefore, postpartum care for all former tobacco users should include tobacco relapse prevention. The following types of patients are at even higher risk for relapse than other ex-smokers:

- Patients who have smoked longer or who were heavier smokers.
- Patients who have a partner who smokes. (Intervention is recommended for the partner as well.)
- Patients with significant pregnancy weight gain or who use smoking for weight control.
- Other risk factors include being of African American descent, having more than one child, having late or no prenatal care, undergoing stressful events, and attending social events where people are smoking.[55]

Guideline for Preventing Tobacco Relapse

The U.S. Public Health Service *Clinical Practice Guideline for Treating Tobacco Use and Dependence* recommends the following actions to prevent patients who have quit using tobacco from relapsing:

- Congratulate the patient for quitting tobacco use.
- Briefly, discuss the benefits the patient derived from quitting, such as giving birth to a healthy baby.
- Encourage the patient to stay tobacco-free. For women that have given birth, this often involves explaining that secondhand smoke continues to negatively affect their children after they are born.
- Ask about any problems encountered or anticipated threats to continued abstinence from tobacco.
- Help the patient resolve these problems.[56]

Example
A 32-year-old patient has just delivered her first child. At an early prenatal visit, a staff nurse practitioner identified her as a smoker and advised her to quit. Although she had smoked for many years, including throughout her two earlier pregnancies, she quit during this pregnancy.

Congratulations	Clinician: I'm really proud of you for quitting! I know it was very hard.
Benefits from quitting	Because you quit, your baby was born at a healthy, normal weight and was able to come home with you from the hospital. She was able to get more oxygen when you quit, which helped her grow. You have also done yourself a favor. You will be able to breathe better, too, and you will have more energy to enjoy your baby.
Encouragement to stay tobacco-free	Continue not to smoke, and your baby will continue to benefit as she grows up. The air will be clean in your house, so your baby and your other children will be less likely to develop breathing problems.

Asking about problems	Is there anything I can do to help you stay smoke-free?
	Patient: I'm concerned about how much weight I've put on. Also, I still really want to smoke—especially when I'm around friends who smoke.
Helping the patient resolve problems	Clinician: It's normal to put on weight when you are pregnant, and it's best to not try to lose weight too fast. You have made a very healthy lifestyle change by quitting smoking. I can offer you materials to help you continue to improve your health by making good food choices, like avoiding high-fat foods. Also, remember that you started taking walks as a way to take your mind off smoking? Continuing to do this will help keep your mind off smoking and will help you stay healthy. The more you move around, the more calories you burn.
	Patient: What about when I'm around other smokers? My excuse for asking them not to smoke before was that I was pregnant, but now that the baby is here, that excuse won't work.
	Clinician: If you need an excuse to ask your friends not to smoke around you, tell them that your doctor has told you that your baby should not be around smoke. Even though you are not smoking yourself, your baby's health is still affected when she is around smoke. Also, remember all of the coping mechanisms you used while you were pregnant and you visited your friends who smoke. You made a list of things to distract yourself. Let's talk about some of the things you did that helped you the most.
	The clinician and the patient review coping strategies to help her stay smoke-free, and the clinician provides the patient with self-help material about nutrition and weight management. The clinician plans for a staff nurse to call the patient in a week to ask how she is doing. To ensure continuity of care now that the patient has delivered her baby, the clinician sends a letter to the patient's pediatrician stating that the patient has successfully quit smoking, but still needs follow-up during this high-risk postpartum period.[57]

Source: American College of Obstetricians and Gynologists[58] and Treating Tobacco Use and Dependence: Clinical Practice Guideline.[59]

Attachment D: Help Clients Avoid Secondhand Smoke with the 5 A's

1. **ASK** Ask if anyone smokes around your clients and find out where (home, car, work, friend's house, etc.). Be sure to document the source and frequency of secondhand smoke exposure in the patient record.

You Could Say:	"I want to talk to you briefly about how you are handling those who smoke around you (and your child)." "Does anyone smoke around you?" (Spouse/partner, family member(s), friend(s), coworker(s), other) "Where do others smoke around you?" (Your home, car, friend's home, relative's home, bars/clubs, work, other)

2. **ADVISE** Provide clear and strong advice to eliminate exposure to secondhand smoke. Educate on the risks of secondhand smoke exposure to themselves and their children (if pregnant or parenting). Provide educational materials on secondhand smoke. Emphasize the benefits of eliminating exposure to secondhand smoke, not just the health risks.

You Could Say:	"I'm concerned about your health (and the health of your child) when you breathe in secondhand smoke (from other people's cigarettes, cigars, and pipes)." "Why do you think it is a good idea to avoid breathing in secondhand smoke?" "Your reasons for avoiding others' smoke are important because . . . (list some reasons)."

3. **ASSESS** Assess if they are willing to make an effort to eliminate exposure to secondhand smoke. In order to eliminate exposure, they may need to make changes to their daily activities and be willing to talk to smokers about not smoking around them.

You Could Say:	"Would you be willing to talk to the people who smoke around you (spouse, family members, friends, etc.)? And ask them not to smoke in your home and car?" "Would you be willing to avoid places that allow smoking (homes where smoking is allowed, bars, clubs, etc.)?"

4. **ASSIST** Help them to think of ways to avoid situations where they might be exposed to secondhand smoke. Discuss how they could talk to their spouse/family member/friend about not smoking around them.

You Could Say:	"What do you think makes it difficult for you to avoid being exposed to secondhand smoke?" "What makes it difficult for you to avoid places where smoking is allowed?" "Does talking to your spouse/partner about his smoking raise a particularly difficult situation for you?" "What would make it easier for you to talk to your spouse/partner about not smoking around you? Do you think there is something that I could do to help you with this?" Here are some suggestions on how you might avoid being exposed to secondhand smoke <u>inside</u>

your home:

- Ask others to smoke outside.
- Keep a "No Smoking" sign in the house.
- Ask your health care provider, friend, or family member to talk to the smoker about not smoking around you.
- Ask the smoker to read a brochure about the effects of secondhand smoke on pregnancy/the baby.
- Do not allow others to smoke around you and the baby.
- Do not allow a babysitter or child-care worker to smoke when caring for your baby/child.
- Here are some suggestions on how you might avoid being exposed to secondhand smoke outside of your home:
- Try to avoid places where smoking is allowed.
- Go to smoke-free bars, clubs, and events and/or ask to sit in the non-smoking section in places where smoking is allowed.
- Ask those who are smoking around you to stop, for your and the baby's health.
- Write a letter to the management of your workplace, bars, clubs, outdoor venues, etc. about making them smoke-free.
- Do not allow a child-care worker to smoke when caring for your baby/child.

5. **ARRANGE FOLLOW-UP** Taking the time to arrange follow-up shows that eliminating secondhand smoke exposure is very important for the client's (and his/her child's) health. Ask about secondhand smoke exposure at every visit. Be sure to document all secondhand smoke counseling activities in the patient record.

If clients are not willing or not ready to make the changes that are necessary to eliminate secondhand smoke exposure, give them a brochure on secondhand smoke to review at home. Ask them what they thought about the brochure at their next visit. See if they are willing to discuss how to avoid secondhand smoke.

If clients are willing and ready to make the changes necessary to eliminate secondhand smoke exposure, then you should discuss how they eliminated their exposure during follow-up visits.

You Could Say:	• "Here is some information on secondhand smoke for you to read at home. We can talk about it at your next visit." • "What we discussed today is very important. I'll make a note in your chart to follow up with you at your next visit." • "Here is the list of what you said you wanted to do to eliminate your exposure to secondhand smoke. Please keep it handy as a reminder."

Source: Women and Tobacco Coalition for Health (WATCH).[60]

Attachment E: Conditions Complicated by Secondhand Smoke

Please note that this list is not comprehensive. You may search for other conditions complicated by secondhand smoke in search engines such as PubMed and Ebscohost.

Pregnancy

- Exposure to secondhand smoke (SHS) during pregnancy is linked to an increased risk of premature birth.[61]
- Exposure to SHS during pregnancy increases the risk for Sudden Instant Death Syndrome (SIDS).[62]
- Maternal exposure to SHS is a risk factor for persistent pulmonary hypertension of the newborn.[63]
- Prenatal exposure to tobacco smoke is the main modifiable risk factor for lower respiratory tract diseases in the first three years of life.[64]

Childhood

- Babies of mothers who smoke are up to five times more likely to be at risk from SIDS.[65]
- Passive smoke exposure reduces natural killer-cell activity in infant immune systems. This could explain the increased incidence of lower respiratory tract viral infection and childhood cancer observed in infants exposed to passive smoke.[66]
- Exposure of children to environmental tobacco smoke (ETS) increases the risk of having night cough and respiratory infections such as bronchitis, bronchiolitis, and pneumonia.[67]
- SHS is a risk factor in meningococcal disease and tuberculosis in young children.[68]
- Recurrent ear infections in children are associated with exposure to SHS.[69]
- SHS exposure increases children's risk of dental caries.[70]

Asthma

- Exposure to SHS increases the symptoms of asthma. In patients with asthma, exposure to ETS is not only associated with more severe symptoms, but also with lower quality of life, reduced lung function, and increased health care utilization for asthma, including hospital admissions.[71]

HIV

- Side-stream cigarette smoke induces increasing oxidative stress, reduces nutrient concentrations, and suppresses immune function, potentially accelerating AIDS progression.[72]

Sickle Cell Disease

- Children with sickle cell disease who are exposed to tobacco smoke in the home suffer more complications from the disease than children living in a smoke-free environment.[73]

Cardiovascular Conditions

- Nonsmokers occasionally exposed to cigarette smoke have a 26% higher risk of acute coronary syndromes compared to nonsmokers not exposed to smoke, while regular exposure is associated with 99% higher risk. These risks increase progressively by between 15% and 256% if one or more cardiovascular risk factors (i.e., hypertension, hypercholesterolemia, diabetes mellitus, sedentary lifestyle, and family history of premature coronary heart disease) are present.[74]

Source: Utah Department of Health, Tobacco Prevention and Control Program.[7]

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