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Focus on Any Tobacco Use and Quit Help Programs Improves Cessation Results

Two-thirds of US adults who use tobacco want to quit and just over half actually make the attempt every year. But trying to quit cold turkey, all at once, without help, is tough. Only 4% to 7% of tobacco users manage to quit on their own. The key to improving tobacco cessation rates is to make it easy to get help. Counseling and behavioral interventions can help, medication can help, and combined behavioral and medical interventions were found to be more effective than any single intervention. For Rush Copley Medical Center in Aurora, Ilinois, the first step in helping patients quit tobacco is knowing who is using it.

Rush Copley staff realized several years ago that conventional smoking cessation programs were missing an important population of tobacco users, those who did not smoke cigarettes, said Deborah Brunelle, RN, team member of the Rush Copley Tobacco Oversight Committee, a subcommittee of Rush University Medical Center Tobacco Oversight Team. The harmful effects of tobacco and its constituent products, including nicotine, the primary addictive component, varies by method of use, Brunelle noted, but there is no evidence that the use of tobacco in any form is safe.

Tobacco cessation is one of the most challenging tasks in any medical institution or practice. The health harms of smoking and other forms of tobacco use have been well known and documented for more than 50 years.

Years of consistent smoking cessation messages have gotten the message across. When asked about smoking, the majority of stroke patients at Rush Copley Medical Center said they had quit.

At the same time, a number of stroke patients and staff were asking to take an e-cigarette break, Brunelle said. A handful of older patients continued to smoke cigarettes, but younger patients in their 50s, 60s and 70s, had switched to electronic cigarettes. "They think they are safer because they don't smoke, but they're not," Brunelle said. "They didn't quit smoking, they just switched to a different type of tobacco with a different profile of harms. We had done such a good job with the message that smoking cigarettes is bad that we had missed the larger message, that using tobacco in any form is bad. We needed to expand the question 'Do you smoke?' to 'Do you use any kind of tobacco product? Do you vape or use JUUL?' Even some of our nursing staff had failed to realize that tobacco is harmful no matter the form. It's hard to fault patients who believed the ads that e-cigarettes or some other form of tobacco is safe when some of our nurses thought that by switching from cigarettes to some other form of tobacco, they were avoiding the harms of smoking. A lot of them are shocked to learn that switching to a different tobacco product isn't going to make them any healthier."

The Tobacco Oversight Committee started small with new tobacco educational materials for nursing staff. The new materials discussed the growing variety of different tobacco products that are currently available, cigarettes, cigars, cigarillos, pipes, snuff, snus, chewing tobacco, e-cigarettes and other vape products, heat-not-burn devices, and their different health and environmental effects. Each tobacco product and device carries a distinctive risk profile for a variety of harms including lung cancer, esophageal cancers, cancers of the oral cavity and other parts of the body, tooth loss and other effects. Some forms of tobacco also create harmful environmental residues that are the functional equivalents of second-hand and third-hand smoke.

The next step was to revise the existing intake and screening tools that focused on cigarette smoking to include any form of tobacco use. Patient feedback revealed a hidden barrier to tobacco cessation, family members who use tobacco. "Patients told me 'The education and support you gave me to help me quit was wonderful, but I'm coming home to a household full of smokers,'" Brunelle explained. "'So why should I quit? How can I quit when I'm surrounded by smokers?'" Patient screening now includes questions about tobacco use by family and household members, and their willingness to support the patient in quitting tobacco. Educational materials regarding tobacco cessation also includes the entire household, not just the patient being admitted.

The current intake process screens all patients for tobacco status, from current user to former user, to never user. Never users are congratulated on their choice to forego tobacco. Former users are congratulated on their decision to quit—and asked for more detail on when they stopped and how successful their quit experience has been. Relapse rates are highest during the first one to two weeks after quitting tobacco, but relapse is always possible, especially during times of stress, such as a health emergency or hospital admission.

Rush Copley routines automatically set up cessation interventions for current tobacco users, starting with a referral to the Illinois state I Quit telephone help line. Every hospital unit has binders with tobacco cessation materials and tobacco cessation interventions have become standard of care for all patients on all units. Tobacco cessation intervention has been transformed from an optional "add-on" to care into an "opt-out" activity that patients must specifically decline. Most patients are receptive. "Tobacco oversight is house-wide," Brunelle said. "Some of our surgeons are no longer scheduling patients for elective and non-urgent surgery until they commit to quitting tobacco. Quitting tobacco is about universal screening, staff education, patient and family education, using every opportunity to intervene and expanding our outreach to the community."

For more information about GWTG and how to become involved, contact your local American Heart Association Quality Improvement Initiatives Representative or log on to www.americanheart.org/getwiththeguidelines.