TOBACCO FREE FUTURES guidelines

Alberta Health Services

Disclaimer

Every effort has been made to ensure the links in this document are up to date; however, we cannot guarantee they will work. Some links will give error messages because of the security settings on the source files. These files are accessible to AHS staff only. AHS staff can access the documents by copying and pasting the link into their browsers.

Copyright

CHAPTER 15

Specific Care Settings:

Emergency and Urgent Care

Alberta Health Services

ADDRESSING TOBACCO USE IN EMERGENCY AND URGENT CARE

Emergency departments (EDs) provide another underused health care setting to support tobacco users by coordinating with and linking to cessation supports.[1] In the 2010–2011 fiscal year, Alberta Health Services reported 2,118,956 ED and urgent care visits.[2] It has been reported that tobacco users account for a disproportionate share of ED visits with cited rates from 20% to 40%, and higher rates were noted in urban EDs.[1,3,4] Using a conservative rate of 25%, this translates into more than 500,000 visits by tobacco users to Alberta EDs and urgent care centres annually. Brief tobacco interventions result in an estimated 2% to 4% of current tobacco users quitting.[5] If brief tobacco interventions were performed consistently in emergency and urgent care departments in Alberta, this could translate to 10,000 to 20,000 people quitting annually.

Although EDs deal with many patient visits for life-threatening emergencies for which brief tobacco intervention would not be appropriate, a considerable number of tobacco-using patients present for non-emergency health care.[6] Emergency and urgent care settings are often the primary source of health care for persons of lower socio-economic status, as well as ethnic minority populations.[7] The prevalence of tobacco use among patients/clients in emergency care is high. For non-emergent patients, minimal contact strategies, such as a brief tobacco intervention, should become part of an ED's routine practice.[7]

Assessment of exposure to second-hand smoke (SHS) is appropriate, particularly for children who present in emergency and urgent care settings with conditions such as asthma, respiratory infections and otitis media, which are known to be linked to tobacco exposure.[8] In Alberta, the rates of household exposure to SHS for children aged 0–11 years has decreased significantly from 28% in 1999 to only 5% reported in 2009.[9] This positive trend can be further supported during visits to EDs and urgent care centres. These visits present opportunities to engage parents/caregivers and have been found to have a positive effect on their efforts to quit tobacco use or limit their child's exposure.[8]

CAN-ADAPTT guidelines (2011)
Health care providers caring for children and adolescents should counsel parents/guardians about the potential harmful effects of second-hand smoke on the health of their children.[10]

Tobacco Free Futures model in emergency and urgent care

Potential barriers to implementing tobacco treatment into routine practice in ED settings include lack of time, lack of patient interest and beliefs that this setting is inappropriate for cessation advice and care.[11]

A 2002 systematic review of the literature, focussing on tobacco intervention in the ED, recommended routine screening of all patients for tobacco use and referral of tobacco users to further cessation support, even though there is limited data to support ED practice, given

- the strong evidence to support intervention in primary care settings
- the burden of disease related to tobacco use
- the relative ease of brief tobacco intervention[5]

For over a decade, it has been proposed that tobacco use status be added as a new fifth vital sign, alongside blood pressure, pulse, temperature and respiratory rate.[11]

The brief intervention model outlined in Chapter 7 ("Brief Intervention") can be easily integrated into the emergency and urgent care settings. Table 15.1 outlines potential considerations for implementating the model in emergency and urgent care settings.

A study of emergency department patients identified that, of those who smoked, 68% wanted to quit and 49% wanted to quit within a month.[1]

Table 15.1: Treatment Model: Considerations for Emergency and Urgent Care Settings		
	MODEL COMPONENT	**CONSIDERATIONS**
ASK	**ASK** all patients if they have used tobacco in the past year. **ASK** about pattern of use.	• All tobacco users should be identified during visits, as appropriates. • Parents/guardians of children should be asked about SHS exposure. • Electronic or paper-based forms used in the care setting should be modified as necessary to document tobacco use status. Consider as a vital sign.[12] Appendix 7(a)
ADVISE	**ADVISE** all patients regardless of tobacco-use status about the Tobacco and Smoke Free Environments Policy. **ADVISE** current tobacco users to stop using tobacco. Personalize message.	• Patients and family/support persons should be made aware of Tobacco and Smoke Free Environments Policy. Many patients admitted to inpatient care are first seen in emergency care. Initiating brief intervention at time of admission may strengthen consistent messaging around the policy. • Integrating brief advice to quit into routine practice in the ED has the added benefit of reaching patients who may experience a teachable moment if the reason for the visit is related to their tobacco use.[13]
ASSESS	**ASSESS** readiness to quit. **ASSESS** interest in support for relief of withdrawal.	• Assessing readiness to quit is appropriate for patients presenting with non-emergent conditions. • Admission to an ED or urgent care setting may mean a stay of several hours. Therefore, the offer of pharmacotherapy support for nicotine withdrawal should be made to all tobacco users as a comfort measure.
ASSIST	**ASSIST** the patient who is not interested in support with brief information. **ASSIST** the patient who is interested with link to prescriber pharmacotherapy support and/or behavioural support.	• 17% of highly motivated tobacco users will quit when provided with nothing more than a self-help brochure.[1] Identified self-help resources for patients should be stocked in the department and easily accessible to staff and patients (www.albertaquits.ca). • The AHS standard initiation order set can be used to facilitate short-term NRT use while a patient is under care in the ED. Appendix 9(a) • Ensure communication between ED and inpatient staff to facilitate continuity of care for patients who are admitted for further care. Appendix 7(a) • Pharmacotherapy initiated in ED should be continued for inpatients. Appendix 9(a) • When available, it is appropriate to arrange for a consultation with an onsite tobacco counsellor/specialist. Appendix 8(a)
ARRANGE	**ARRANGE** follow-up after discharge for any pharmacotherapy started and link to further behavioural support.	• For patients who are interested, facilitate discharge pharmacotherapy. Appendix 9(b) • Follow-up after hospitalization is a key factor in effective interventions. Link to community behavioural support, preferably by fax referral. Appendix 7(b)

REFERENCES

1. Lowenstein, S., Tomlinson, D., Koziol-McLain, J., & Prochazka, A. (1995). Smoking habits of emergency department patients: An opportunity for disease prevention. *Academic Emergency Medicine, 2*, 165–171.

2. Alberta Health Services. (2011). *2010–2011 annual report.* Edmonton, AB: Author.

3. Richman, P., Dinowitz, S., Nashed, A., Eskin, B., Sylvan, E., Allegra, C., Allegra, J., & Mandell, M. (2000). The emergency department as a potential site for smoking cessation intervention: A randomized, controlled trial. *Academic Emergency Medicine, 7,* 348–353.

4. Smith, P. (2011). Tobacco use among emergency department patients. *International Journal of Enviornmental Research and Public Health, 8,* 253–263.

5. Bernstein, S., & Becker, B. (2002). Preventive care in the emergency department: Diagnosis and management of smoking and smoking-related illness in the emergency department: A systematic review. *Academic Emergency Medicine, 9,* 720–729.

6. Elders, M. (1995). Smoking cessation efforts. *Academic Emergency Medicine*, *2,* 161–162.

7. Greenberg, M., Weinstock, M., Fenimore, D., & Sierzega, G. (2008). Emergency department tobacco cessation program: Staff participation and intervention success among patients. *Journal of the American Osteopathic Association, 108*(8), 391–396.

8. Tanski, S., Klein, J., Winickoff, J., Auinger, P., & Weitzman, M. (2003). Tobacco counseling at well-child and tobacco-influenced illness visits: Opportunities for improvement. *Pediatrics, 111*(2), 162–167.

9. Statistics Canada. (2012). Canadian tobacco use monitoring survey (CTUMS): Smoking prevalence 1999–2012. Retrieved from http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/_ctums-esutc_prevalence/prevalence-eng.php

10. Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-Informed Tobacco Treatment (CAN-ADAPTT). (2011). *CAN-ADAPTT Canadian smoking cessation clinical practice guideline.* Toronto, ON: Centre for Addiction and Mental Health. Retrieved from http://can-adaptt.net

11. Prochazka, A., Koziol-McLain, J., Tomlinson, D., & Lowenstein, S. (1995). Smoking cessation counseling by emergency physicians: Opinions, knowledge, and training needs. *Academic Emergency Medicine, 2,* 211–216.

12. Ahluwalia, J., Gibson, C., Kenney, E., Wallace, D., & Resnicow, K. (1999). Smoking status as a vital sign. *Journal of General Internal Medicine,* 14, 402–408.

13. Richmond, R. (1999). Opening the window of opportunity: Encouraging patients to stop smoking. *Heart, 81,* 456–458.