TOBACCO FREE FUTURES guidelines

Alberta Health Services

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CHAPTER 18

Specific Care Settings:

Transition and Continuing Care

Alberta Health Services

IMPLEMENTATION OF *TOBACCO FREE FUTURES* IN TRANSITION AND CONTINUING CARE

Continuing care refers to an integrated range of services supporting the health and well being of individuals living in their own homes, or in supportive living or long-term care settings. Continuing care clients are not defined by age, diagnosis or the length of time they may require service, but by their need for care. They may be young adults with acquired brain injuries, adults with developmental disabilities or seniors.

This section of the guidelines will focus on how health care providers can support tobacco-dependent patients/clients who

- are in acute care, are receiving transition care and are awaiting transfer to alternate care settings
- reside in designated supportive living settings
- reside in long-term care facilities

In 2008, the Alberta Government published the *Continuing Care Strategy: Aging in the Right Place.* This five-year strategy reported 14,500 seniors and persons with chronic illnesses or disabilities living in long-term care facilities. It also acknowledged that, due to the shortfall in available space, there were many more patients occupying hospital beds who did not need acute services but, due to advancing age and/or complex medical and psycho-behavioural issues, were unable to be discharged.[1] AHS is committed to supporting the *Continuing Care Strategy* with the right level of services provided in the right settings. AHS increased capacity within the system by adding 3,000 new continuing care spaces by 2013. Further capacity will be required to deal with the increasing and aging population of Alberta. It is anticipated that by 2031, one in five Albertans will be a senior.[2]

AHS Transition Care/Coordinated Access Services provides the link between acute care services and those available in the community across the spectrum of continuing care. These services vary somewhat throughout the province; however, they all ensure an assessment of patients and clients in their current settings and facilitate the placement or transfer from one level of care to another in an efficient and timely manner. These services are normally undertaken in collaboration with an expanded health care team and the client/patient's family.[2]

In some acute care hospitals, transition care units or beds have been added in order to free up acute care beds, reducing wait times for treatment and surgery. Transition units provide a stop gap for clients who are awaiting placement in a continuing care setting that is more appropriate for their care needs. Clients who use tobacco products are finding it increasingly difficult to find a continuing care living option where they can continue to use tobacco products. Their situations are often complicated by cognitive problems and associated behaviours. This creates delays in moving to the right setting for those individuals who are unwilling or unable to stop their tobacco use.

Prevalence of tobacco use

Among seniors, the mortality rate of current smokers is double that of those who have never smoked. Eight of the top 14 causes of death among seniors have been linked to smoking and 50% of all long-term smokers die of tobacco-related illnesses. The majority of seniors who currently smoke have been smokers for most of their lives, having had their first cigarette by age 20. These seniors are often less accepting of the health risks associated with smoking and may actually see smoking as a positive coping mechanism.[3]

Individuals with intellectual or developmental disabilities are not immune to tobacco use and dependence. Existing data is limited, but it clearly indicates that these individuals also smoke cigarettes and are more likely to do so if they are higher functioning, live in less restrictive environments, are male or have concurrent substance use disorders.[4]

In 2010, 9% of Canadians 65 years and over were current smokers. Smoking was more prevalent amongst Aboriginal seniors, with 22% for First Nations seniors, 24% for Metis seniors and 36% for Inuit seniors.[3] Canadian tobacco use statistics from 2012 identify 16.1% of people 15 years and over as current smokers. The prevalence was highest amongst young adults, with 21.8% for 25–34 year olds and 20.3% for 20–24 year olds. Adults 55 years and over had the second-lowest prevalence rate, at 12.2%. More males than females were current smokers, at 18.4% and 13.9%, respectively, continuing a downward trend for both genders.[5]

In Alberta, 17.4% of people 15 years and over were current smokers in 2012. The prevalence was, again, highest amongst young adults, at 24.5% for 20–24 year olds, followed by 18% for adults 45 years and over. More females than males were current smokers, at 17.7% and 17.1%, respectively. This represents an increase for females and a decrease for males compared to 2011.[5]

Alberta has been home to 40% of national smokeless tobacco sales (e.g., snuff, chew) for more than 10 years. Smokeless tobacco use is most prevalent in males, with 9% aged 15–19 years and 2% 30 years and older reporting using snuff or chew in the past month, as of 2008. In Alberta, the highest prevalence of smokeless tobacco users tends to be found in the oil and gas and agricultural industries, especially the rodeo. A 2012 survey of 510 participants at two Alberta rodeos found that 27% of males and 1% of females used smokeless tobacco products, compared to 2% in general population of Western Canada. One half of Canadians who have tried smokeless tobacco products live in the western provinces, even though this region is home to less than one third of the Canadian population.[6] Smokeless tobacco products contain high levels of nicotine and are linked to cancers of the mouth and digestive tract, cardiovascular disease and dental decay.

Integration of tobacco-free environments in continuing care

The physical and cognitive challenges make nursing home residents 2–3 times more likely to be burned by cigarettes.[7]

The provincial Tobacco Reduction Act (TRA) prohibits smoking in "public places," which includes "group living facilities" such as supportive living and long-term care facilities. An exemption clause allows operators to permit smoking by residents as long as they provide designated smoking rooms that have separate ventilation systems that conform to the regulations. Alberta Health Services's *Tobacco and Smoke Free Environments Policy* exceeds the restrictions outlined in the TRA, and since all designated continuing care spaces in the province operate under the auspices of AHS, they fall under the scope of this policy. Many private continuing care providers have also made the decision to implement tobacco-free policies voluntarily, for a variety of reasons.

See Chapter 5: Policy

There is a trend across Canada towards care facilities being smoke free, including the elimination of designated indoor smoking areas. The dilemma, however, is that not every person who is awaiting placement for or living in continuing care settings is ready or interested in quitting, and when the only available alternative is a smoke-free facility, there may be resistance from clients or their families.

For continuing care sites in the process of becoming tobacco free, management, staff, residents and families will often continue debating the merits of such policies. One frequently cited argument is that these facilities are also residents' homes and a person should be free to make personal choices within his or her home. There may also be concern about making residents who are smokers feel stigmatized, controlled and as though one of their few remaining pleasures is being taken away. Although some may concede health benefits at any age, there is also an attitude that their life expectancy is minimal anyway, and even if a resident stops smoking, there may not be a significant benefit, especially when compared to the perceived difficulty of quitting. Staff and family often express concern for client/resident safety when they are required to go outside to use tobacco, potentially exposing them to hazards such as inclement weather. There are also concerns about the risks related to fire safety if residents attempt to hide their smoking habits while in a smoke-free facility.[8]

Some advocate that, at a minimum, designated outdoor smoking areas should be available for residents. However, a 2004 study of one geropsychiatric nursing home found that the creation of an outdoor designated smoking area was counterproductive. In this environment, residents who were classified as "safe smokers" were allowed to use the outdoor area, while those identified as "unsafe smokers" had enforced cessation that was supported with behavioural and pharmacotherapy interventions. As a result, staff found that ongoing triggers by those using tobacco caused the "unsafe smokers" to experience increased agitation and also led to altercations with "safe smokers," resulting in the facility choosing to become completely tobacco free.[9]

The purpose of making multi-unit dwellings and health care environments (including continuing care settings) smoke and tobacco free is not to force people to quit. Rather, it is to protect everyone in those environments from the hazards of second- and third-hand smoke. As per the requirements of the TRA, many facilities have dealt with this issue by providing special ventilated smoking areas. While this has been a strategy in the past, current research has found that the only way to protect non-smokers from exposure to second-hand smoke is to remove all smoking from indoor environments. The American Society of Heating and Air-Conditioning Engineers (ASHRAE) has stated that because there is no acceptable level of exposure to the chemicals found in cigarette smoke, there is no acceptable ventilation standard for second-hand smoke.[12,13]

The evidence is clear that there is no safe level of exposure to second-hand smoke and therefore all staff, clients/residents and the public have a right to be protected.[11]

There are several well-founded safety concerns related to tobacco use and residents in continuing care. Smoking poses an obvious and documented fire safety threat for all residents of group living facilities. In Canada and the United States, smoking materials are the leading cause of death in residential fires.[14] Those over age 65 are twice as likely to die in home-related fires than the average person, and that risk increases with age: those 75 and older are three times more likely, and 85 and older are 3.5 times more likely.[15] Smoking materials account for 72% of fire-related deaths and 43% of fire-related injuries in long-term care facilities. The acuity of care for residents in long-term settings will only increase as more complex care is moved out of hospitals and less complex care remains in the home. Increased acuity will result in increased smoking risks.

Facilities that allow resident smoking can have additional costs, such as increased insurance premiums, as well as additional cleaning, staff supervision and supplies related to tobacco use (e.g., smoking aprons). In some cases, additional human resources are needed to supervise smokers, taking staff away from other nursing duties. The Tobacco and Smoke Free Environments Policy stipulates that AHS employees and other persons acting on behalf of AHS shall not facilitate patient/client use of tobacco products.[16,17]

See Chapter 5: "Policy"

Supporting clients with brain injury and concurrent disorders

Within the continuing care population are those people living with acquired brain injuries and concurrent disorders. These people are cited as the most difficult to assist in finding a continuing care living option. There is limited research on these types of patients/residents related to tobacco reduction and institutionalization. Most head injuries occur in males 20–30 years of age, and result from motor vehicle collisions and alcohol use. Some patients may also already have a mental illness or substance use disorder. It is difficult to distinguish between symptoms related to mental health, substance use and brain injuries, as many of them overlap (e.g., memory problems, emotional outbursts, difficulty initiating tasks). Health professionals typically treat these problems separately, which can create other difficulties, as the cause of specific behaviours may not be correctly identified. Treatment can therefore take up to three times longer, with the patient/resident going through cycles of getting better and slipping back again.[10]

Table 18.1 outlines some of the general treatment considerations for those with acquired brain injuries and concurrent disorders. Further detail regarding tobacco treatment for clients with mental illness and addiction, including a section on Alzheimer's disease and dementia, can be found in chapter 19 ("Addictions and Mental Health").

Table 18.1: Treating Acquired Brain Injuries and Concurrent Disorders[10]

Symptoms brain injury and mental illness may have in common:	• memory problems • unpredictable behaviour • being very emotional • concrete thinking • seemingly low motivation • impaired capacity for insight • substance abuse • social isolation • failing to acknowledge having a problem
Symptoms brain injury and substance abuse may have in common:	• short-term memory loss • impaired thinking • difficulty with balance/coordination • impulsivity • mood disturbances (diminished emotional control) • personality changes • diminished judgment • fatigue • depression • sleep problems • decreased frustration tolerance
Acquired brain injury (ABI) workers should:	• educate ABI clients/family about risks of using substances • involve family/social networks in supporting client to address issue • take specific history of client's past and current substance use • ask what effect substance use is having on client's life (e.g., social life, family, job, legal) • assess stressors/risk factors that might cause client to begin using (e.g., isolation, boredom, depression, job loss) • help clients find meaningful, substance-free activities • establish ongoing contact with addiction professionals to exchange information and ensure client gets appropriate treatment
Addiction workers should:	• screen for acquired brain injury (ABI): ask about crashes, blows to the head, falls, fights, periods of unconsciousness and hospitalization • adapt substance abuse treatment for people with ABI: slow down and use simple language • provide extra time for clients to complete tasks • repeat information and use short, simple phrasing • encourage client to take notes • anticipate off- topic remarks • keep instructions brief and clear • encourage feedback (ask "Do you understand?") • give rest periods • reduce distractions • consult with ABI specialists to tailor treatment to client's learning style • remain in contact to monitor progress and make changes, as needed

Tobacco Free Futures in transition and continuing care

Everyone who uses tobacco products benefits from quitting, no matter their age. Those benefits include improved health, increased quality of life, greater satisfaction with leisure activities and social relationships, more money in their pockets and better access to housing. Even someone who does not quit smoking until age 60 can increase their life expectancy by three years, compared to those who continue to smoke.[3] A study from the United States found that quitting smoking at 65 years of age leads to an increased life expectancy of 1.4–2 years for males and 2.7–3.7 years for females. Older smokers who try to quit are more likely to seek assistance and more likely to be successful in their efforts.[18] Cessation rates in older women are shown to increase with brief interventions by a physician or health professional, receiving the correct information and thinking quitting is not difficult, especially when they smoke fewer than 10 cigarettes per day.[19]

Health professionals working in home care, transition and continuing care settings have an important opportunity to identify tobacco use and provide advice and supportive care to their patients/clients.

It is important to have family support for patients/residents as they become tobacco free. Family members need to be involved in the initial discussions so they understand the policy, the benefits to the patient/resident and what supports are available (e.g., nicotine replacement therapy, educational materials, cessation counselling).

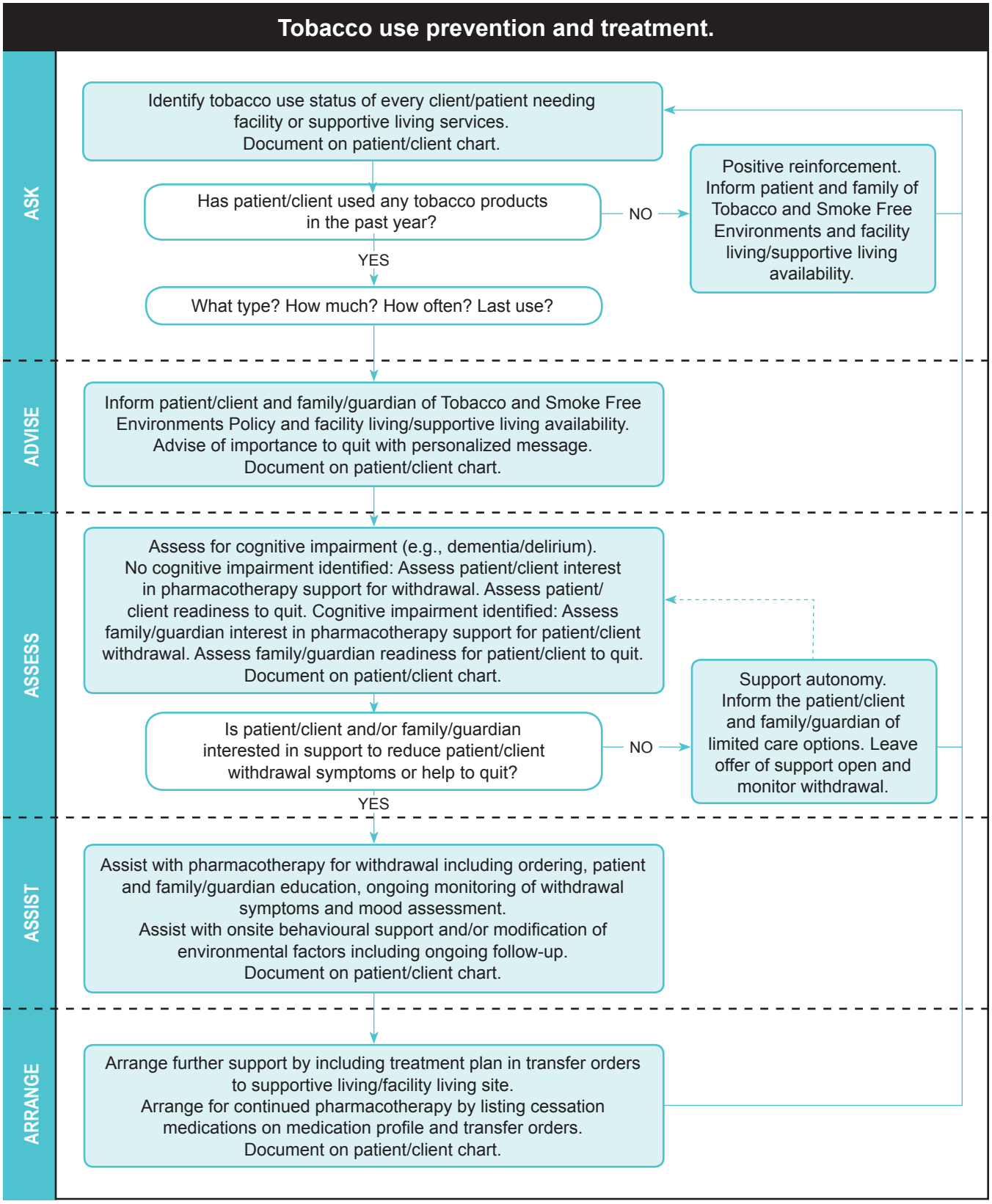
The AHS Vascular Risk Reduction Project (2014) advocates consideration of tobacco use as a vital sign in every patient contact.

Continuity of care planning is essential as a client transfers from one setting to another. It is also key to maintain communication between the care teams, the patient/resident and the family members.

The brief intervention model outlined in chapter 7 (“Brief Intervention”) was modified for the home care setting in chapter 16 (“Home Care). In this chapter it has been modified once again in Figure 18.1 for clients in transition or continuing care. Table 18.3 outlines potential considerations for implementation of the model in transition and continuing care settings. More intensive support, as outlined in chapter 8 (“Intensive Cessation Counselling”) may be required to assist those who are interested in cessation. Zone coordinators with the Tobacco Reduction Program are available to support transition and continuing care settings as they implement the *Tobacco Free Futures* guidelines in settings managed both by AHS and its contracted partners.

See Chapters 16: “Home Care” and 19: “Addictions and Mental Health”

Figure 18.1: *Tobacco Free Futures*: Transition and Continuing Care Intervention Model



Pharmacotherapy should be considered to mitigate the nicotine withdrawal symptoms of all patients/residents, especially in settings that restrict or prohibit tobacco use.[21,22] All patients/clients in acute care who are awaiting placement should be given access to a safe and comfortable detoxification from tobacco, as is done with other addicting substances, to prevent the emergence of nicotine withdrawal symptoms.[23]

See Chapter 9: "Pharmacotherapy"

Individuals living in community or supportive living settings may be eligible for coverage of nicotine replacement therapy and/or cessation medications through the Alberta Health Supplementary Health Benefit Program or the Alberta Human Services Drug Benefit Supplement. Table 18.2 summarizes present coverage, which is subject to change. Refer to *http://www.health.alberta.ca/services/benefits-supplementary.html* for up-to-date information.

Table 18.2: Alberta Drug Benefit Cessation Medication Coverage Eligibility

MEDICATION	APPLIES TO CLIENTS OF	COVERAGE CRITERIA
Nicotine replacement therapy (NRT) • mouth spray • inhaler • patch • gum • lozenge	Alberta Health/Alberta Blue Cross • Child and Family Services • Alberta Child Health Benefit • Children and Youth Services • Income Support • Learners Program • Alberta Human Services (AISH) • Alberta Adult Health Benefit	• Restricted benefit • Coverage is limited to a lifetime maximum of $500 per participant for all over-the-counter smoking cessation products listed in the Alberta Human Services Drug Benefit Supplement • Does not include lozenges
	First Nations and Inuit Health Branch • non-insured health benefits	• Quantity limited for each product for one year from when first prescription was filled: ◦ 945 pieces for gum, inhaler and lozenges ◦ 70–84 patches, depending on type • Mouth spray not included
Varenicline tartrate (Champix®)	Alberta Health/Alberta Blue Cross • Non-group coverage • Coverage for seniors • Alberta Widow's Pension Plan • Palliative Care Drug Coverage • Alberta Child Health Benefit • Income Support • Learners Program • Alberta Human Services (AISH) • Alberta Adult Health Benefit	• Restricted benefit • This product is a benefit for patients 18 years of age and older for smoking cessation treatment in conjunction with smoking cessation counselling • Coverage will be granted for a total of 12 weeks • Special authorization coverage may be granted for a maximum of 24 weeks of therapy per year
	First Nations and Inuit Health Branch • non-insured health benefits	• Quantity limited to 165 tablets for one year from when first prescription filled
Bupropion SR (Zyban®)	Alberta Health/Alberta Blue Cross • Child and Family Services • Alberta Child Health Benefit • Children and Youth Services • Income Support • Learners Program • Alberta Human Services (AISH) • Alberta Adult Health Benefit	• Regular benefit
	First Nations and Inuit Health Branch • non-insured health benefits	• Quantity limited to 180 tablets for one year from when first prescription filled

Note: Benefit criteria are subject to change. Refer to Alberta Health and Health Canada for up-to-date information.

Sources:

Alberta Drug Benefit List (2014): https://www.ab.bluecross.ca/dbl/publications.html

Health Canada Drug Benefit List (2013): http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/provide-fournir/pharma-prod/med-list/index-eng.php

Table 18.3: Treatment Model: Considerations for Transition and Continuing Care Settings		
	MODEL COMPONENT	**CONSIDERATIONS**
ASK	**ASK** all clients if they have used tobacco in the past year. **ASK** about patterns of use. **ASK** about exposure to second-hand smoke (SHS).	• All tobacco users should be identified during assessment, preferably before or, at a minimum, during admission to transition care units or continuing care facilities. • Electronic or paper-based forms used in the care setting should be modified as necessary to document tobacco use status. • Status should be communicated with transfer information.
ADVISE	**ADVISE** current tobacco users to stop using tobacco. Personalize message. **ADVISE** client and household members that there is no safe level of exposure to SHS. **ADVISE** of policy, as applicable.	• All patients/clients/residents and their families must be advised of the tobacco policy of the current facility and the facility they will be placed in for the long term. • Engagement of the family is critical from the outset. • Clients and family should be informed of the impact of their tobacco-use status on placement within continuing care facilities. • Family, clients and volunteers must be informed of the policy that staff cannot facilitate smoking behaviour (e.g., purchasing or lighting tobacco, supervising). • All clients and families should be informed that there are health benefits to quitting tobacco at any age. • Advice must be communicated in a non-judgmental manner and tailored to each individual. • Electronic or paper-based forms used in the care setting should be modified as necessary to document what has been advised.
ASSESS	**ASSESS** readiness to quit. **ASSESS** interest in support for relief of withdrawal.	• Assessing readiness to quit is appropriate for all clients who use tobacco. • Assess interest in withdrawal relief through pharmacotherapy for those who are interested in quitting or reducing their tobacco use. • Whenever possible, assessment should be performed by a tobacco specialist. • Assessment of patient's interest in quitting and/or interest in receiving support for withdrawal symptoms may take several visits to complete. It is important for the care provider to establish a relationship with the patient. • For patients who don't initially appear to be ready to make a change, the offer of support should be left open. It is still important, however, to monitor for signs of withdrawal and of changes in interest in receiving treatment. • A follow-up assessment should be arranged for no more than three months after the initial assessment has been completed. • Electronic or paper-based forms used in the care setting should be modified as necessary to document the assessment.

Table 18.3 *(continued)*

	MODEL COMPONENT	CONSIDERATIONS
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.	• It is recommended that the care team hold an initial meeting to frame the approach for each patient within the first week of that patient being admitted to the unit or facility. • A multidisciplinary health care team approach, involving physicians, nurses, recreational therapists, protection services and tobacco cessation specialists is recommended. • For extra ongoing support, it is recommended that a tobacco specialist, either onsite or from the community, provide the one-on-one support that the patient might need. The tobacco specialist can ◦ coordinate the patient assessment ◦ document the patient's tobacco use history and assessments according to site standards ◦ coordinate involvement of the family, nursing and other professionals and resources, as needed ◦ provide tobacco behavioural counselling and support ◦ provide pharmacotherapy assessment, support and proper use teaching • Communication between the transition and continuing care staff will facilitate continuity of care for clients who have been receiving treatment before transfer. Consider building this into referral process. • Depending on the patient/client's cognitive capabilities, there may be a need to focus on the environmental factors that contribute to the addictive behaviour. Longer treatment times may be needed to establish trust and rapport with the patient. • Pharmacotherapy is recommended for all clients who are interested, except in the case of direct contraindications. Clients with conditions such as oral cancers may be unable to use short-acting NRT products (e.g., gum, spray, inhaler, lozenge), so products such as the patch, bupropion or varenicline may be appropriate. • Electronic or paper-based forms used in the care setting should be modified as necessary to document the assistance.
ARRANGE	**ARRANGE** follow-up and link to further behavioural support.	• Ongoing tobacco dependence support is essential for a patient/client who is transferred to an alternate level of care.

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