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| **Tobacco Cessation Services:**  **Workflow Integration for Community Pharmacies** | | | | | | | | |
| **Tobacco Cessation Provision** | | **Implementation Location** | | | **Team Member**  **Responsible** | | | |
| **Counseling area** | **Pick up,**  **Drop-off, or Drive-through** | **Other** | **Pharmacist** | **Technician** | **Clerk** | **Pharmacy Intern/**  **Student** |
| **ASK** | * Ask patient about tobacco use/vaping history. |  |  |  |  |  |  |  |
| **ADVISE** | * Advise current tobacco users to quit using clear, strong, and non-judgmental phrasing. |  |  |  |  |  |  |  |
| **REFER** | * Patients not ready to quit: provide information for tobacco quitline (1-800-QUIT NOW) and document follow-up |  |  |  |  |  |  |  |
| * Refer high-risk patients to a primary care or other providers, including:  1. Pregnant female or a female who intends to become pregnant within 6 months 2. Patient who has cardiovascular disease and has:    * Had a heart attack in the past 2 weeks    * Unstable angina or experiences chest pain with strenuous activity    * History of arrhythmia or irregular heartbeat 3. History of mental health disorder and is not perceived to be stable |  |  |  |  |  |  |  |
| * For non-high-risk patients refer to pharmacist for prescribing medication and providing behavioral counseling |  |  |  |  |  |  |  |

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| **Tobacco Cessation: Assessing, Assisting, and Arranging Follow-Up for Patients Ready to Quit:**  **Workflow Implementation** | | | | | | | |
| **Tobacco Cessation Provision** | | **Implementation Location** | | | **Team Member(s) Responsible** | | |
| **Counseling area** | **Pick up,**  **Drop-off, or Drive-through** | **Other** | **Pharmacist** | **Technician** | **Pharmacy Intern/**  **Student** |
| **ASSESS** | * Assess readiness to make a quit attempt and complete a Patient Intake Form\* if:   + Patient is ready to quit   + Patient is interested in receiving tobacco cessation services |  |  |  |  |  |  |
| **ASSIST** | * Assist patients who are ready to quit by setting a quit date and creating a Patient Treatment Plan\* |  |  |  |  |  |  |
| * Determine how the patient will receive behavioral counseling\*   + Referral to tobacco quitline   + Referral to group or web-based program   + In the pharmacy |  |  |  |  |  |  |
| * Create prescription for medications eligible for standing order\*   + Standing order provider (Indiana): Kristina Box, MD   + Patient Treatment Plan can be used as guide for prescription creation   + Prescription and subsequent refills are good for 6 months from date tobacco cessation service was provided |  |  |  |  |  |  |
| * Dispense prescribed medications |  |  |  |  |  |  |
| * Bill for tobacco cessation services |  |  |  |  |  |  |
| * Bill insurance for prescription |  |  |  |  |  |  |
| * Collect payment from patient for medication (if appropriate) |  |  |  |  |  |  |
| * Counsel on medications dispensed   + Discuss interaction between caffeine and tobacco smoke |  |  |  |  |  |  |
| * Provide the patient with copy of Patient Treatment Plan Summary\*   + Benefits of quitting smoking handout   + Withdrawal symptoms handout   + Coping strategies handout   + Patient medication education handout(s) |  |  |  |  |  |  |
| * Fax the Patient Treatment Plan Summary\* to patient’s PCP (if applicable) within 3 days of providing tobacco cessation services |  |  |  |  |  |  |
| **ARRANGE** | * Schedule first follow-up session   + Must be within two weeks of initial visit\* |  |  |  |  |  |  |
| * Conduct first follow-up visit and complete Initial Follow-Up Form\*   + Make adjustments to medication regimen, if necessary   + Remind patient to follow-up with PCP at next regularly scheduled visit |  |  |  |  |  |  |
| * Schedule final follow-up session   + Must occur at completion of medication therapy |  |  |  |  |  |  |
| * Conduct final follow-up and complete Final Contact Form\*   + Keep documentation for 7 years |  |  |  |  |  |  |

\* General forms suggested by this document can be found in the Implementation Toolkit at: <https://rxforchange.uscf.edu>. Please note that states differ in their regulations regarding prescribing requirements for pharmacists, and these forms are specific for requirements outlined by the State of Indiana.

Please adjust forms accordingly to meet the specified requirements outlined by the state in which you practice.

Timeframe requirements for submission of documents to prescriber, scheduling of follow-up consultations, and other tasks also vary by state.

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| **Additional Considerations for Implementation** | | | | | | |
| **Responsibility** | | | | **Team Member Responsible** | | |
| **Pharmacist** | **Technician** | **Pharmacy Intern/Student** |
| **Recordkeeping** | * Where will blank documents be stored? | Patient Intake Form | Location in Pharmacy |  |  |  |
|  |
| Patient Treatment Plan Summary | Location in Pharmacy |  |  |  |
|  |
| Initial Follow-Up  Form | Location in Pharmacy |  |  |  |
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| Final Follow-Up  Form | Location in Pharmacy |  |  |  |
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| * Where will patient files with completed documents be stored? | Location in pharmacy | |  |  |  |
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| **Follow-up** | * Who will be responsible for tracking patient outreach for each follow-up encounter? | Patients requiring initial follow-up |  |  |  |
| Patients requiring final follow-up |  |  |  |
| * Who will be responsible for patient follow-up? | Patients requiring initial follow-up |  |  |  |
| Patients requiring final follow-up |  |  |  |