



## Complete Summary

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### GUIDELINE TITLE

Counseling to prevent tobacco use and tobacco-caused disease: recommendation statement.

### BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Counseling to prevent tobacco use and tobacco-caused disease: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003 Nov. 13 p. [22 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This updates a previously published guideline: U.S. Preventive Services Task Force. Counseling to prevent tobacco use. In: Guide to clinical preventive services, 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. p. 597-609.

### \*\* REGULATORY ALERT \*\*

### FDA WARNING/REGULATORY ALERT

**Note from the National Guideline Clearinghouse:** This guideline references a drug(s) for which important revised regulatory information has been released.

- [May 2, 2007, Antidepressant drugs](#): Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

### COMPLETE SUMMARY CONTENT

\*\* REGULATORY ALERT \*\*

SCOPE

METHODOLOGY - including Rating Scheme and Cost Analysis

RECOMMENDATIONS

EVIDENCE SUPPORTING THE RECOMMENDATIONS

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

QUALIFYING STATEMENTS

IMPLEMENTATION OF THE GUIDELINE

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

## SCOPE

### **DISEASE/CONDITION(S)**

- Tobacco dependence
- Tobacco-related illness, including:
  - neoplasms
  - ischemic heart disease
  - cerebrovascular disease
  - low weight births (in pregnancy)

### **GUIDELINE CATEGORY**

Counseling  
Prevention  
Screening  
Treatment

### **CLINICAL SPECIALTY**

Family Practice  
Internal Medicine  
Obstetrics and Gynecology  
Pediatrics  
Preventive Medicine

### **INTENDED USERS**

Advanced Practice Nurses  
Nurses  
Physician Assistants  
Physicians  
Public Health Departments

### **GUIDELINE OBJECTIVE(S)**

- To summarize the U.S. Preventive Services Task Force recommendations on counseling to prevent tobacco use and tobacco-caused disease and the supporting scientific evidence
- To update the 1996 recommendations contained in the *Guide to Clinical Preventive Services*, Second Edition

### **TARGET POPULATION**

General population, including adults, pregnant women and children, seen in primary care settings

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Tobacco Cessation Interventions**

1. Screening to identify and document tobacco use status
2. Counseling and patient education, including:
  - "5-A" behavioral counseling framework (ask, advise, assess, assist, arrange)
  - 5 R's used to treat tobacco use (relevance, risk, rewards, roadblocks, repetition)
  - Telephone quit lines
  - Augmented pregnancy-tailored counseling
  - Self-help materials
3. Pharmacotherapy, including:
  - Nicotine replacement therapy (i.e., nicotine gum, nicotine transdermal patches, nicotine inhaler, and nicotine nasal spray)
  - Sustained-release bupropion
  - Clonidine
  - Nortriptyline

## **MAJOR OUTCOMES CONSIDERED**

- Quit rates
- Abstinence rates
- Birth weights

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The U.S. Preventive Services Task Force (USPSTF) tobacco recommendation statement is based on evidence contained in the Public Health Service (PHS) "Clinical Practice Guideline: Treating Tobacco Use and Dependence," which included a search of the available literature from 1975 to 1999.

In addition, the USPSTF performed targeted searches to clarify certain issues (i.e., pediatric/pregnant populations) or to update epidemiological information after 1999. This search yielded four substantive new references and a number of epidemiologic updates.

### **NUMBER OF SOURCE DOCUMENTS**

Not stated

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

The U.S. Preventive Services Task Force grades the **quality of the overall evidence** for a service on a 3-point scale (good, fair, poor):

#### **Good**

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

#### **Fair**

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

#### **Poor**

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

## **METHODS USED TO ANALYZE THE EVIDENCE**

Review  
Review of Published Meta-Analyses

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Balance Sheets  
Expert Consensus

### **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service.

Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affect benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

The U.S. Preventive Services Task Force (USPSTF) grades its **recommendations** according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

### **A**

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

### **B**

The USPSTF recommends that clinicians provide [this service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

### **C**

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

### **D**

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

### **I**

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Comparison with Guidelines from Other Groups  
Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Peer Review. Draft recommendations were circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments were discussed before the whole U.S. Preventive Services Task Force before final recommendations were confirmed.

Recommendation of Others. Recommendations for counseling to prevent tobacco use from the following groups were considered: the Public Health Service, the Centers for Disease Control and Prevention, the American Academy of Family Physicians, the American Academy of Pediatrics, the Canadian Task Force on Preventive Health Care.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products **(A recommendation)**.

*The USPSTF found good evidence that brief smoking cessation interventions, including screening, brief behavioral counseling (less than 3 minutes), and pharmacotherapy delivered in primary care settings, are effective in increasing the proportion of smokers who successfully quit smoking and remain abstinent after 1 year. Although most smoking cessation trials do not provide direct evidence of health benefits, the USPSTF found good evidence that smoking cessation lowers the risk for heart disease, stroke, and lung disease. The USPSTF concluded that there is good indirect evidence that even small increases in the quit rates from tobacco cessation counseling would produce important health benefits, and that the benefits of counseling interventions substantially outweigh any potential harms.*

The USPSTF strongly recommends that clinicians screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling to those who smoke **(A recommendation)**.

*The USPSTF found good evidence that extended or augmented smoking cessation counseling (5-15 minutes) using messages and self-help materials tailored for pregnant smokers, compared with brief generic counseling interventions alone, substantially increases abstinence rates during pregnancy, and leads to increased birth weights. Although relapse rates are high in the post-partum period, the USPSTF concluded that reducing smoking during pregnancy is likely to have substantial health benefits both for the baby and the expectant mother. The USPSTF concluded that the benefits of smoking cessation counseling outweigh any potential harms.*

The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for tobacco use or interventions to prevent and treat tobacco use and dependence among children or adolescents (**I recommendation**).

*The USPSTF found limited evidence that screening and counseling children and adolescents in the primary care setting are effective in either preventing initiation or promoting cessation of tobacco use. As a result, the USPSTF could not determine the balance of benefits and harms of tobacco prevention or cessation interventions in the clinical setting for children or adolescents.*

## **Clinical Considerations**

- Brief tobacco cessation counseling interventions, including screening, brief counseling (3 minutes or less), and/or pharmacotherapy, have proven to increase tobacco abstinence rates, although there is a dose-response relationship between quit rates and the intensity of counseling. Effective interventions may be delivered by a variety of primary care clinicians.
- The "5-A" behavioral counseling framework provides a useful strategy for engaging patients in smoking cessation discussions: (1) Ask about tobacco use; (2) Advise to quit through clear personalized messages; (3) Assess willingness to quit; (4) Assist to quit; and (5) Arrange follow-up and support. Helpful aspects of counseling include providing problem-solving guidance for smokers to develop a plan to quit and to overcome common barriers to quitting and providing social support within and outside of treatment. Common practices that complement this framework include motivational interviewing, the 5 R's used to treat tobacco use (relevance, risks, rewards, roadblocks, repetition), assessing readiness to change, and more intensive counseling and/or referrals for quitters needing extra help. Telephone "quit lines" have also been found to be an effective adjunct to counseling or medical therapy.
- Clinics that implement screening systems designed to regularly identify and document a patient's tobacco use status increased their rates of clinician intervention, although there is limited evidence for the impact of screening systems on tobacco cessation rates.
- FDA-approved pharmacotherapy that has been identified as safe and effective for treating tobacco dependence includes several forms of nicotine replacement therapy (i.e., nicotine gum, nicotine transdermal patches, nicotine inhaler, and nicotine nasal spray) and sustained-release bupropion. Other medications, including clonidine and nortriptyline, have been found to be efficacious and may be considered.
- Augmented pregnancy-tailored counseling (e.g., 5-15 minutes) and self-help materials are recommended for pregnant smokers, as brief interventions are less effective in this population. There is limited evidence to evaluate the safety or efficacy of pharmacotherapy during pregnancy. Tobacco cessation at any point during pregnancy can yield important health benefits for the mother and the baby, but there are limited data about the optimal timing or frequency of counseling interventions during pregnancy.
- There is little evidence addressing the effectiveness of screening and counseling children or adolescents to prevent the initiation of tobacco use and to promote its cessation in a primary care setting, but clinicians may use their discretion in conducting tobacco-related discussions with this population,

since the majority of adult smokers begin tobacco use as children or adolescents.

## **Definitions**

The Task Force grades its **recommendations** according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

### **A**

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### **B**

The USPSTF recommends that clinicians provide [this service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

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### **D**

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

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The USPSTF grades the **quality of the overall evidence** for a service on a 3-point scale (good, fair, poor):

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Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

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### **Poor**

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

## **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

#### **Smoking Cessation Benefits**

There is good quality evidence that smoking cessation lowers the risk for heart disease, stroke and lung disease.

#### **Effectiveness of Counseling**

The U.S. Preventive Services Task Force (USPSTF) found good quality evidence examining the efficacy of various levels of intensity of tobacco cessation counseling by clinicians based on a meta-analysis of 43 studies. Compared with no intervention, minimal counseling, lasting less than 3 minutes, has been shown to increase overall tobacco abstinence rates. Increasing session length and frequency increased efficacy in a dose-response manner. There is limited evidence to determine the optimal duration and periodicity of tobacco counseling interventions.

#### *Pregnancy-tailored Counseling*

A meta-analysis of 7 studies found that abstinence rates were higher (16.8% vs 6.6%) for pregnant smokers receiving pregnancy-tailored counseling and self-help materials compared with pregnant smokers receiving brief counseling or "usual care."

## *Counseling for Children/Adolescents*

The USPSTF found limited evidence of the efficacy of counseling children or adolescents in the clinical primary care setting, but found that school- and classroom-based smoking cessation programs may be more effective than no intervention among tobacco users who attend these programs. As with tobacco cessation programs for adults in the community setting, programs with a greater number of counseling sessions and increasing intensity of follow-up had higher quit rates.

### **Effectiveness of Pharmacotherapy**

Several FDA-approved pharmacotherapies have been identified as safe and effective in helping adults to quit smoking.

- Nicotine products, including nicotine gum, transdermal patch, nicotine nasal spray, and nicotine inhaler, have all been studied in comparison with placebo. There are good quality studies to support the abstinence rates among people who use these products compared with those who do not: 18% to 31% versus 10% to 17%. (Although nicotine lozenges are currently available, at the time of this review they were not FDA-approved and therefore not included in this recommendation statement.) There are fair quality studies showing that combining the nicotine patch with either the gum or nasal spray is more efficacious than using a single form of nicotine replacement therapy alone.
- Sustained-release bupropion has been shown to be efficacious compared with placebo, with an estimated cessation rate of 23% to 38% compared with 17%.
- Other pharmacotherapies, including clonidine and nortriptyline, have been shown to result in higher smoking cessation rates when compared with placebo, although their use may be limited by side effects.

### **POTENTIAL HARMS**

There is little evidence on the safety and efficacy of tobacco cessation pharmacotherapy for the pregnant woman, the fetus, or the nursing mother and child. Therefore, pharmacotherapy for pregnant women may be considered when the likelihood of quitting and its potential benefits outweighs the risks of the therapy and continued smoking. Likewise, there is little evidence on the safety and efficacy of tobacco cessation pharmacotherapy in children or adolescents.

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its [Web site](#). The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

### IMPLEMENTATION TOOLS

Foreign Language Translations  
Patient Resources  
Personal Digital Assistant (PDA) Downloads  
Pocket Guide/Reference Cards

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Staying Healthy

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Counseling to prevent tobacco use and tobacco-caused disease: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003 Nov. 13 p. [22 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

1996 (revised 2003 Nov)

### GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

### GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

### SOURCE(S) OF FUNDING

United States Government

## **GUIDELINE COMMITTEE**

U.S. Preventive Services Task Force (USPSTF)

## **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Task Force Members\**: Alfred O. Berg, MD, MPH (Chair); Janet D. Allan, PhD, RN, CS, FAAN, (Vice-chair); Paul Frame, MD; Charles J. Homer, MD, MPH; Mark S. Johnson, MD, MPH; Jonathan D. Klein, MD, MPH; Tracy A. Lieu, MD, MPH; C. Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J. Pender, PhD, RN, FAAN; Albert L. Siu, MD, MSPH; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; and Steven H. Woolf, MD, MPH

*\*Members of the Task Force at the time these recommendations were finalized.*

## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.

## **GUIDELINE STATUS**

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This updates a previously published guideline: U.S. Preventive Services Task Force. Counseling to prevent tobacco use. In: Guide to clinical preventive services, 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. p. 597-609.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

#### Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):36-43.
- Whitlock EP, Orleans CT, Pender NJ, Allan J. Evaluating primary care behavioral counseling interventions: an evidence-based approach. *Am J Prev Med* 2002;22(4):267-84.

Electronic copies: Available from [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

The following are also available:

- The guide to clinical preventive services, 2006. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2006. 228 p. Electronic copies available from the [AHRQ Web site](#).
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the [AHRQ Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

The [Electronic Preventive Services Selector \(ePSS\)](#), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

#### **PATIENT RESOURCES**

The following are available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Copies also available in Spanish from the [USPSTF Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

- Quit smoking: consumer interactive tool (PDA/Palm). Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004. Downloads are available from the [AHRQ Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## **NGC STATUS**

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on November 12, 2003. The information was verified by the guideline developer on November 13, 2003. This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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