

## Algorithm Annotations

### Pneumococcal Immunization (Level I)

#### Service

High-risk groups must be immunized once. Reimmunize those at risk of losing immunity once after five years. Immunize at age 65 if not done previously. Reimmunize once if first received was greater than five years ago and before age 65 or an immunocompromising condition is present.

#### Related guideline

ICSI Immunizations guideline.

### Tobacco Use Screening and Brief Intervention (Level I)

#### Service

Providers must establish tobacco use status for all patients and reassess at every opportunity. All forms of tobacco should be included. Provide ongoing cessation services to all tobacco users at every opportunity (*U.S. Preventive Services Task Force, 2009b [R]; Fiore, 2008 [R]*).

Reinforce non-users to continue non-use of tobacco products.

Offer tobacco cessation services on a regular basis to all patients who use tobacco. (All forms of tobacco should be considered.)

Establish secondhand smoke exposure status for all patients. Advise all patients exposed to secondhand smoke that exposure is harmful. Encourage a smoke-free living and working environment for patients, and assist the exposed patient to communicate with other household members about decreasing smoke in their house. Encourage the patient to support smoking cessation efforts among other household members who use tobacco (*Fiore, 2008 [R]*).

#### Efficacy

Tobacco use is the single most preventable cause of death and disease in our society. There is good evidence that clinical-based interventions are effective. There is good evidence that tobacco cessation interventions are best carried out when the entire clinical staff is organized to provide these services (*U.S. Preventive Services Task Force, 2009b [R]; Fiore, 2008 [R]*).

Structured physician clinical-based smoking cessation counseling is more effective than usual care in reducing smoking rates (*Katz, 2004 [A]*). The addition of telephone-based counseling may result in further improvements in cessation (*Zhu, 2002 [A]*). The success of this approach in the adult population has led to the adoption of the same approach in the pediatric population. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking.

While readiness-stage intervention is commonly used, evidence does not strongly support it (*Riemsma, 2003 [M]*).

Two treatment elements are effective for tobacco cessation intervention: social support for cessation and skills training/problem-solving. The more intense the treatment, the more effective it is in achieving long-term abstinence from tobacco.

#### Counseling messages

The key components of successful tobacco cessation interventions are:

- Ask about tobacco use and smoke exposure at every opportunity.
- Advise all users to quit.

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- Assess willingness to make a quit effort.
- Provide a motivational intervention if the user is not ready to make a quit effort (*Fiore, 2008 [R]*). See ICSI Primary Prevention of Chronic Disease guideline for more information.
- Assist users who are willing to make a quit attempt.
- Arrange follow-up.

### For all ages:

- If accompanying household member uses tobacco, encourage member to quit. If the member user is interested in quitting, encourage a visit at his or her clinic for more cessation assistance.
- Provide educational and self-help materials.

### Related guideline

ICSI Primary Prevention of Chronic Disease guideline.

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## 3. Preventive Services That Providers and Care Systems *Should* Assess the Need for and Offer to Each Patient. These Have Value but Less Than Those in Level I (Level II)

Level II services have been shown to be effective and should be provided whenever possible. If systems/care management teams are successful in keeping patients on time with high-priority services during illness and disease management visits, preventive services in the second group can be delivered at any opportunity once Level I services are complete.

### Abdominal Aortic Aneurysm Screening (Level II)

#### Screening

For *men* ages 65-75 who have *ever* (greater than 100 cigarettes in lifetime) smoked, a one-time screening ultrasonogram for abdominal aortic aneurysm should be performed.

For *men* ages 65-75 who have *never* smoked, there are no recommendations for or against a one-time screening ultrasonogram for abdominal aortic aneurysm.

For *women*, regardless of age or smoking status, screening ultrasonography for abdominal aortic aneurysm *is not recommended*.

(*Fleming, 2005 [M]*)

#### Efficacy

An abdominal aortic aneurysm (AAA) is defined as an infrarenal aortic diameter greater than 3.0 cm (normal diameter 2 cm). The overall prevalence of AAA is 4.2%-8.8% in men and 0.6%-1.4% in women. About 9,000 deaths occur annually in the U.S. due to AAA rupture; the majority of deaths occur before the victim reaches the hospital, but the surgical mortality is also very high (41%). Elective repair of AAA bears a relative low mortality and ranges from 1% to 5% depending upon technique used, volume of AAA procedures done by the operator and hospital, etc.

The most prominent AAA risk factors are male gender, age and smoking. Other risk associations include family history, coronary artery disease, hypercholesterolemia and hypertension. Negative risk associations include female gender, diabetes and black race.

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