DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Today's webinar:

Smoking Cessation: Policy and Research as it Relates to Evidence-based Practices in the Military and Veteran Health Care Settings

Feb. 27, 2014, 1-2:30 p.m. (EST)

Moderator:
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Presenter:
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Chief, Health Promotion
Air Force Medical Support Agency
Falls Church, Va.

Presenter:
Miles McFall, Ph.D.,
Chief, Psychology Service and
Director of Outpatient Mental Health Services
Veterans Affairs Puget Sound Health Care System
Professor, University of Washington School of Medicine
Seattle, Wash.

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
National Center for Telehealth & Technology

Webinar Details

- Live closed captioning is available through Federal Relay conference captioning (see the “Closed Captioning” pod)
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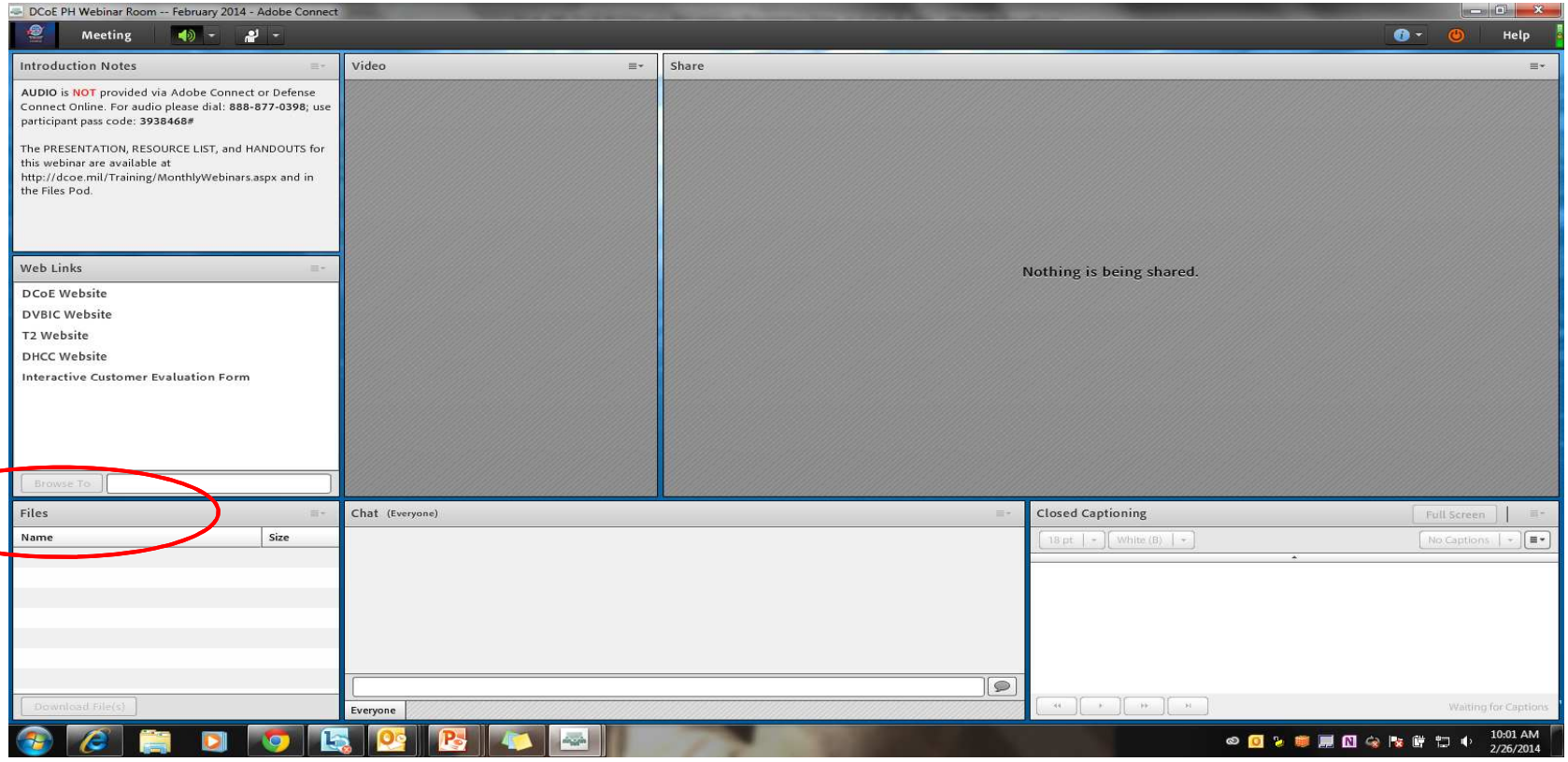

Continuing Education Details

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Webinar Overview

On January 11, 1964, Surgeon General Dr. Luther Terry released the first Surgeon General's Report on Smoking and Health. This scientifically rigorous federal government report not only linked smoking with ill health and diseases such as lung cancer and heart disease; it also laid the foundation for tobacco control efforts in the United States.

Fifty years later, despite the release of 31 subsequent Surgeon General's Reports on Smoking and Health detailing the devastating health and financial burdens caused by tobacco use, smoking remains the leading cause of preventable deaths in the United States and kills 443,000 people each year (U.S. Department of Health and Human Services, 2014).

The Defense Department (DoD) and Department of Veterans Affairs (VA) are committed to helping service members and veterans quit smoking. Webinar presenters from both agencies will highlight policy recommendations and research studies that translate into evidence-based practices for military and veteran populations.

After completion of this webinar, participants will be able to:

- Discuss DoD and VA's commitment to meeting smoking cessation goals.
- Employ evidence-based behavioral counseling and pharmacological treatments for smoking and/or tobacco cessation.
- Evaluate pharmacological and behavioral counseling interventions for tobacco cessation for patients with posttraumatic stress disorder.

Presenter: Col. John Oh

- Col. Oh is Chief of Health Promotion at the Air Force Medical Support Agency.
- He supports the Air Force Surgeon General to develop, implement and evaluate Air Force health promotion policies, with particular focus on tobacco, physical activity and nutrition.
- He completed residencies in internal medicine and general preventive medicine.
- Operational and staff assignments include flight surgeon and preventive medicine physician.
- Col. Oh has particular interest in applying the social-ecologic model of health behavior to promote healthy living as the easy, default choice and social norm in the Air Force and DoD.

Integrating Policy Change: Promoting Tobacco Free Living in the Military Services

Col. John Oh, M.D., M.P.H.
Chief, Health Promotion
Air Force Medical Support Agency
Falls Church, VA

Disclosure

- The views expressed in this presentation are those of the presenter and do not reflect the official policy of the U.S. Air Force, DoD or U.S. Government.
- I have no relevant financial relationships and do not intend to discuss the off-label / investigative (unapproved) use of commercial products/devices.

Agenda

- Epidemiology
- Military policies and culture perpetuating tobacco epidemic
- DoD "tobacco free" living activities

Polling Question #1

Which intervention would have the most impact in reducing tobacco use in the military?

a. Prohibit tobacco sales in military exchanges and commissaries

b. Prohibit tobacco use on military installations

c. Prohibit tobacco use in uniform

d. Fund a tobacco counter marketing campaign

e. Improve clinical tobacco cessation support

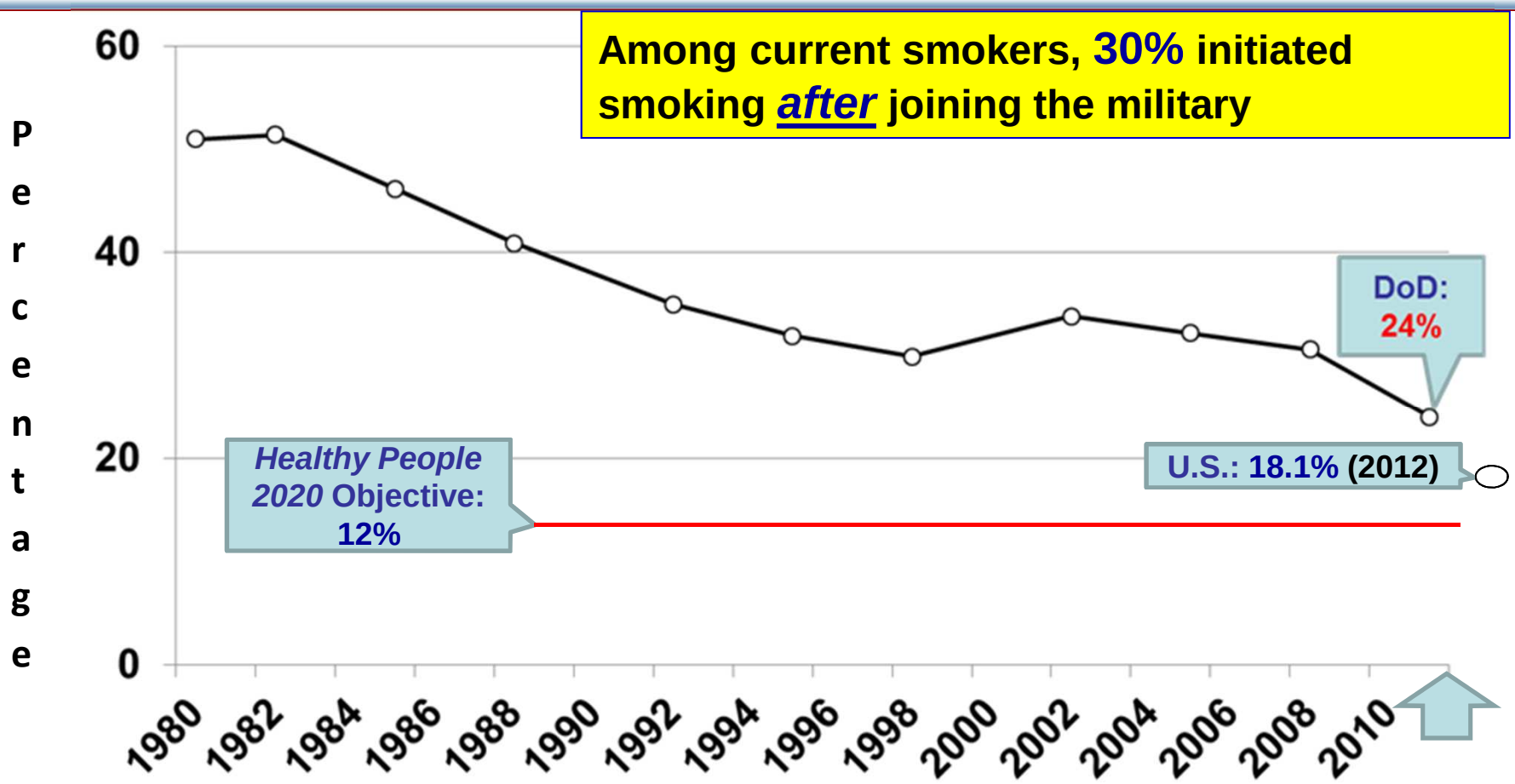
Comparison of Military and Civilian Estimates to Healthy People 2020 Goals

Measure	Healthy People 2020 Objective	Civilian Estimate	Military Estimate
Obese (20 years and older)	≤ 30.6%	34.0%	11.0%
Healthy Weight (20 years and older)	≥ 33.9%	30.8%	36.0%
Moderate / Vigorous Physical Activity Past 30 Days	≥ 47.9%	43.5%	73.2%
Seat Belt Use	≥ 92.4%	84.0%	98.6%
Motorcycle Helmet Use Past 12 Months	≥ 73.7%	67.0%	94.0%
Any Cigarette Use Past 30 Days	≤ 12.0%	20.6%	22.8%
Smokeless Tobacco Use Past 30 Days	≤ 0.3%	2.3%	12.5%
Binge Drinking Past 30 Days	≤ 24.3%	27.0%	33.3%

"Medically Ready Force…Ready Medical Force"

(U.S. Department of Defense, 2013)

Cigarette Smoking: DoD 1980–2011



* Note: 2011-Survey method changed to internet only

"Medically Ready Force…Ready Medical Force"

(U.S. Department of Defense, 2013)

Polling Question #2

Which military service has the highest prevalence of cigarette smoking?

a. Air Force

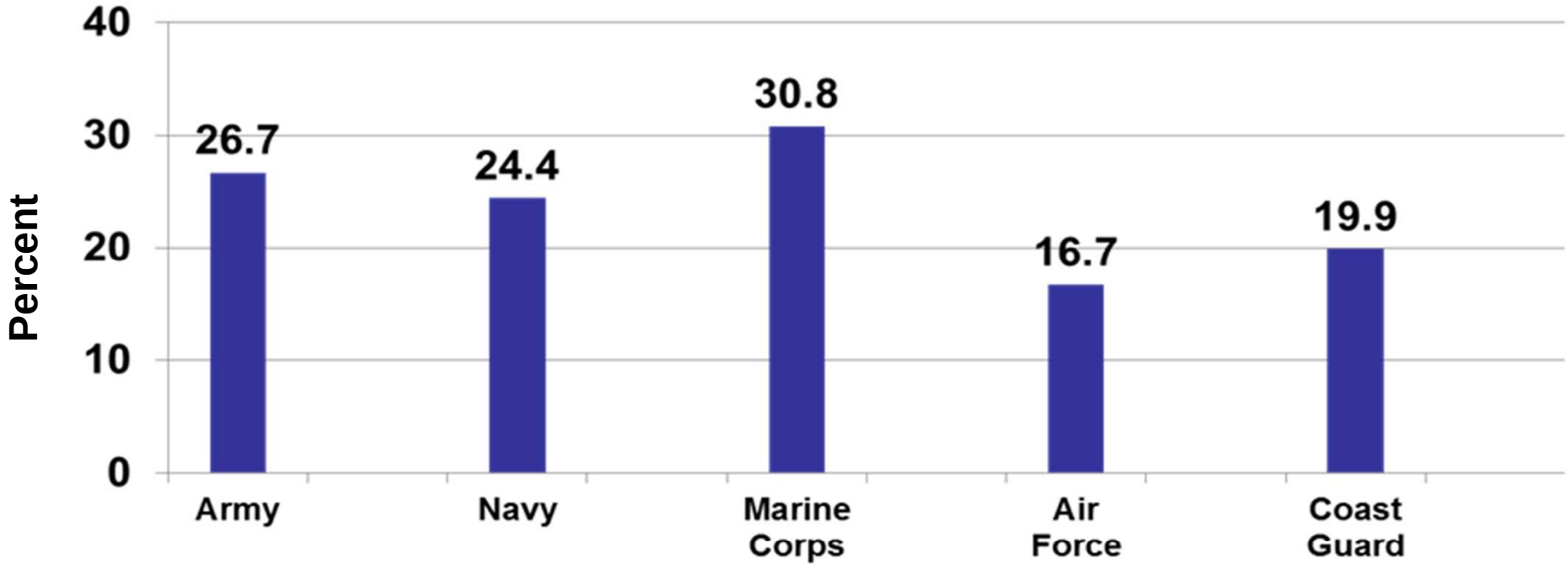
b. Army

c. Coast Guard

d. Marine Corps

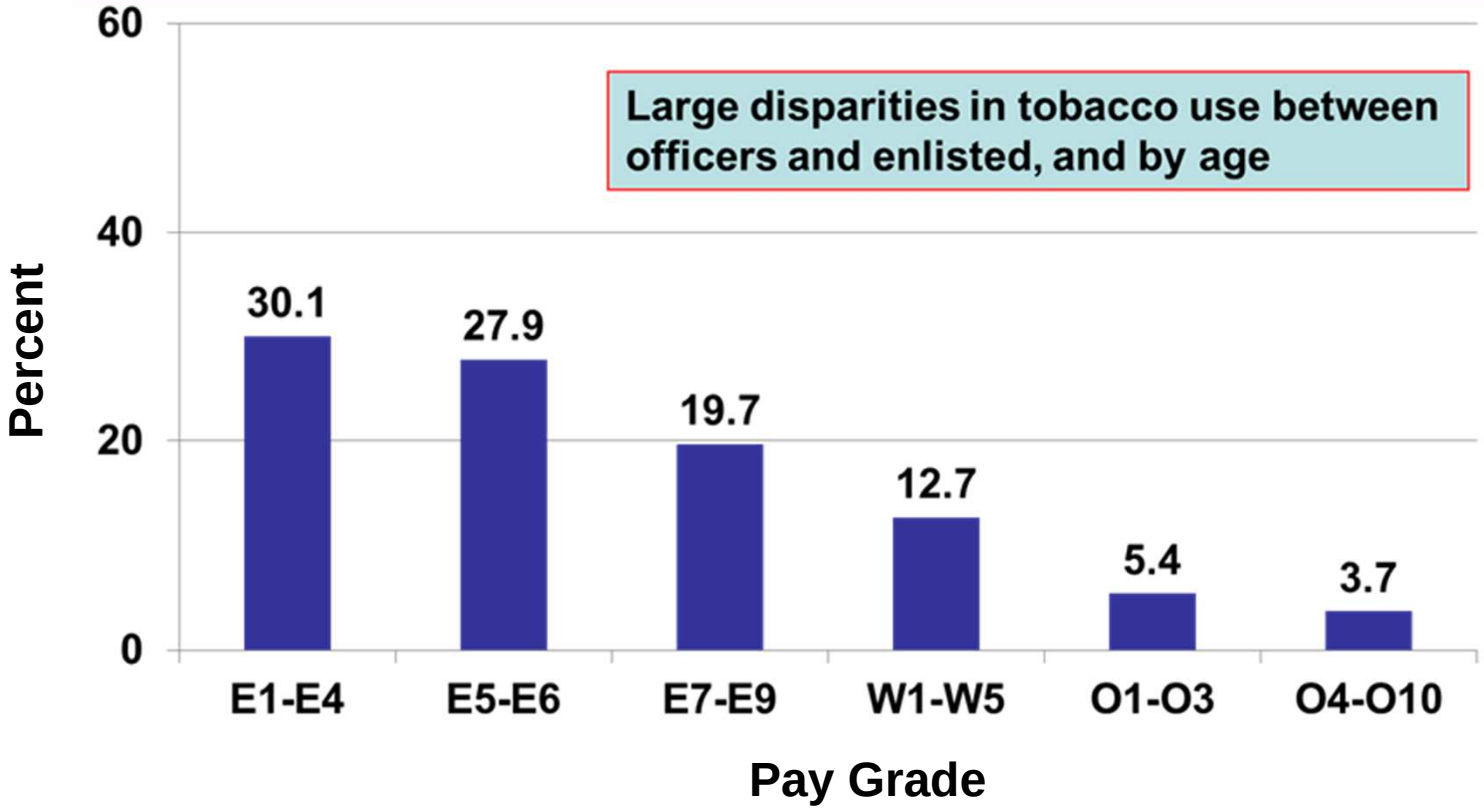
e. Navy

Tobacco Use Among Military Services 2011



(U.S. Department of Defense, 2013)

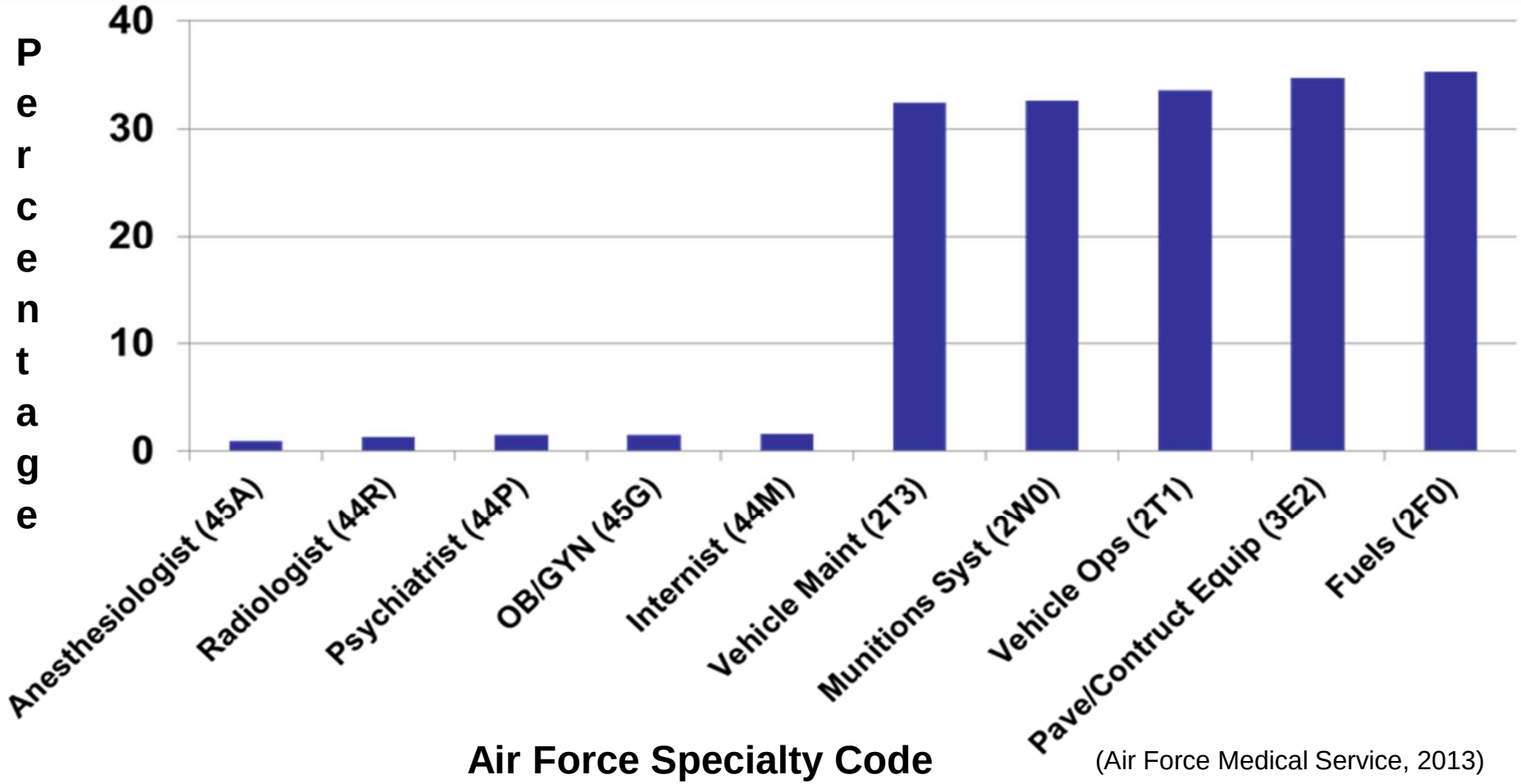
Cigarette Smoking – by Pay Grade 2011



Tobacco use consumes up to 14% of enlisted service members' base pay

(U.S. Department of Defense, 2013)

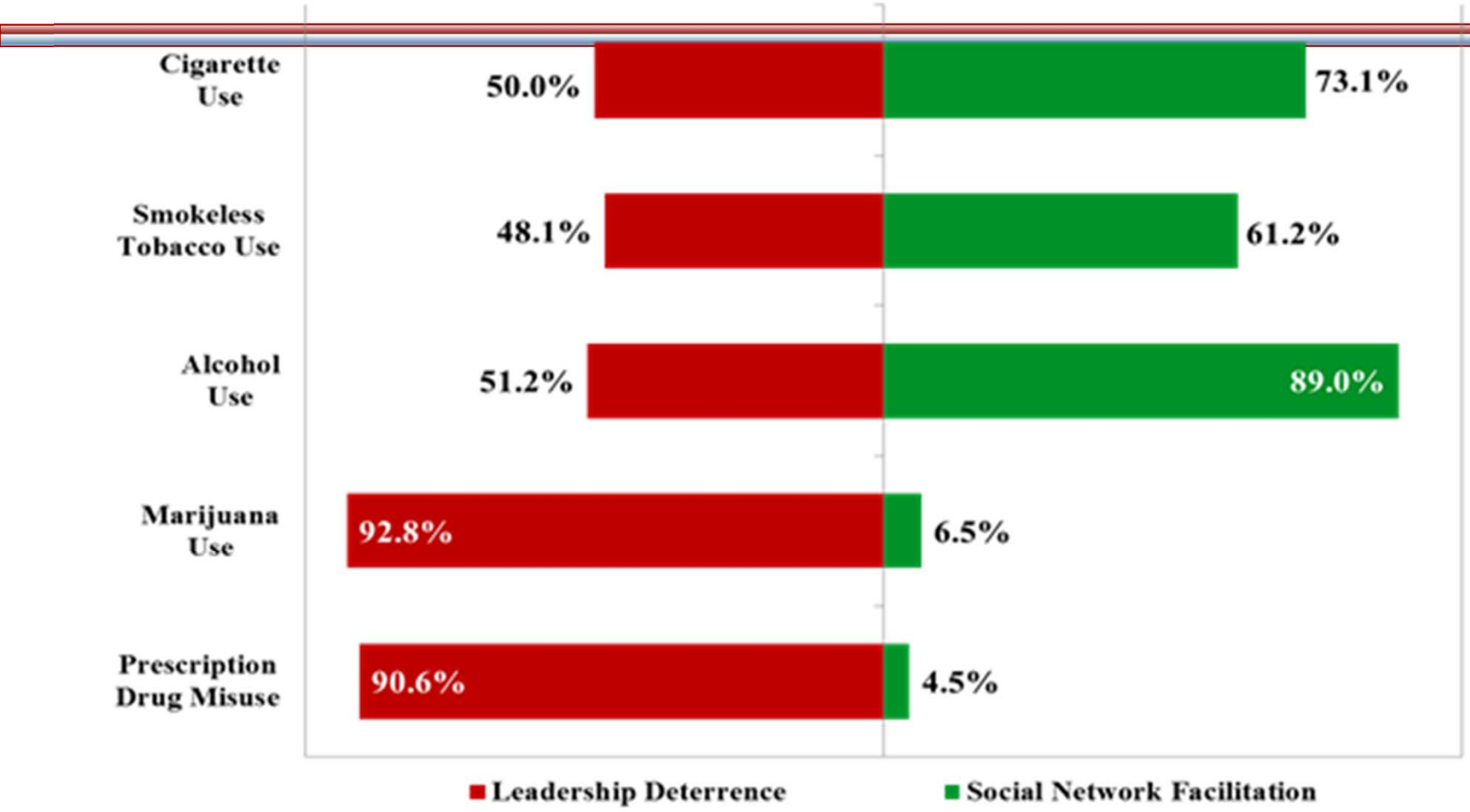
Low to High Tobacco Use: U.S. Air Force 2011



(Air Force Medical Service, 2013)

"Medically Ready Force…Ready Medical Force"

Military Culture of Substance Use



(U.S. Department of Defense, p. 179, 2013)

Polling Question #3

What is the average state cigarette excise tax?

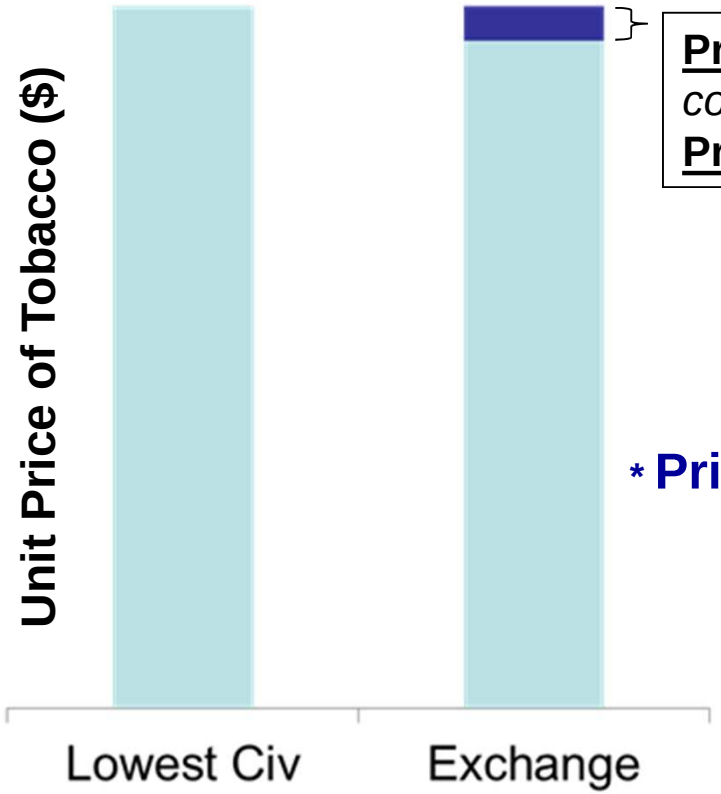
a. $0.17

b. $0.48

c. $1.53

d. $4.35

Cheap Tobacco Use: DoD Policy



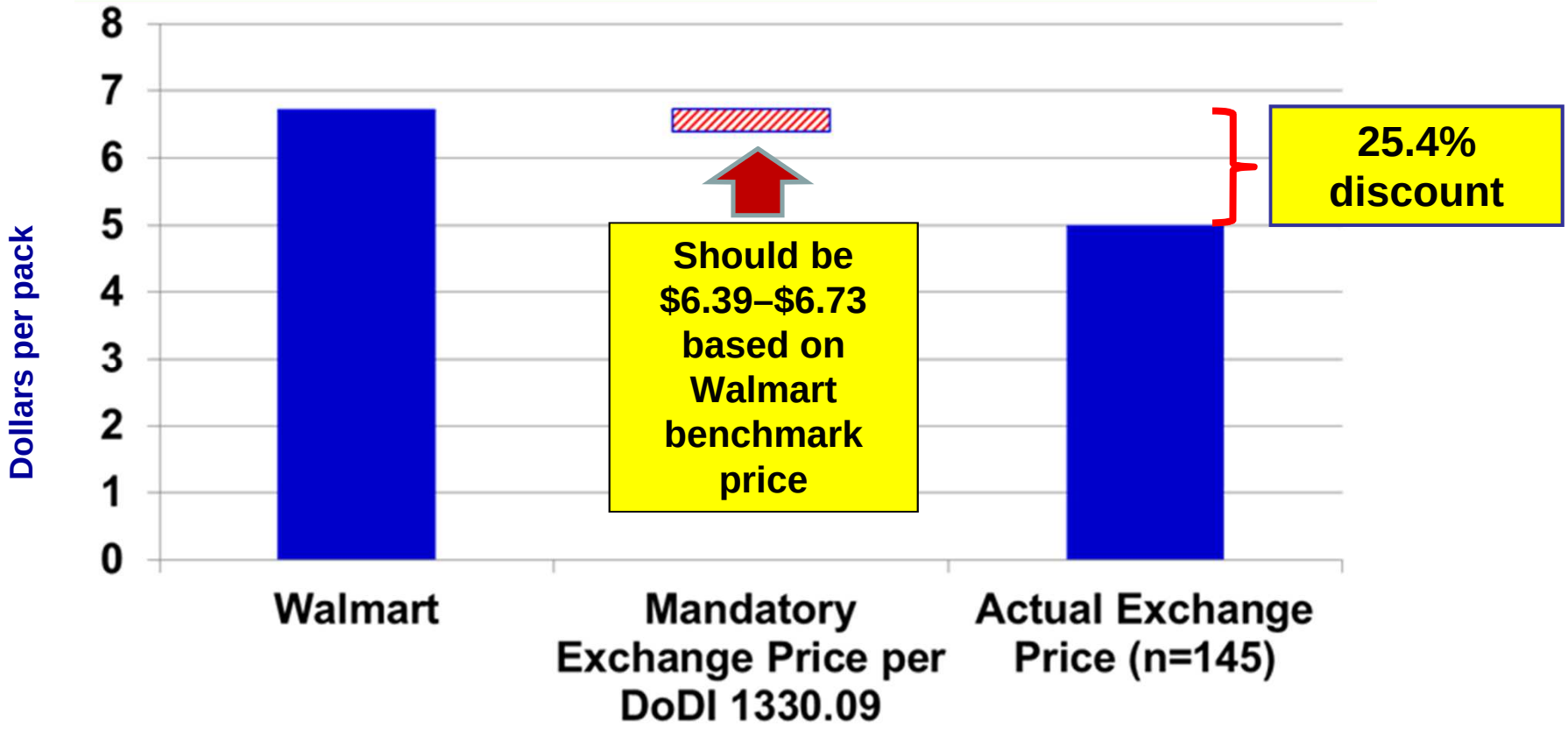
Price ceiling = *"most competitive commercial price in local community"* *
Price floor = 5% below

* **Price does not include state/local sales taxes**

DoDI 1330.09, "*Armed Services Exchange Policy*", Dec 7, 2005

(U.S. Department of Defense, 2005)

2011 Survey of *Marlboro Red* Prices



(Jahnke, et al., 2011)

Military Exchanges are not in compliance with tobacco pricing policy in DoDI 1330.09

Tobacco Marketing in Stores

(Photos courtesy of Col John Oh)

DoD
Tobacco Free Living Activities

- Population Health Policy
  - 2006 – Launched "Quit Tobacco – Make Everyone Proud" Campaign
    - www.ucanquit2.com (Department of Defense, 2007)
  - Operation Live Well /Healthy Base Initiative (McCronk, 2013)
  - Tobacco cessation clinical services
- 2009 National Defense Authorization Act (NDAA) Requirements (H.R. 5658--110th Congress: Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, 2008)
  - Managed Care Support Contract smoking cessation 24/7 telephone lines
  - Smoking cessation pharmaceuticals
  - Smoking cessation counseling
  - Print and web-based smoking cessation material
- Local decentralized tobacco cessation efforts with great variability

DoD
Tobacco Cessation Website
www.ucanquit2.com

(U.S. Department of Defense, 2007)

Social Media Competition to Fight War Against Tobacco

"Fight the Enemy": www.health.mil/FightTheEnemy

(Military Health System, 2014)

Vision for Tobacco Control: DoD Tobacco Free Living Game Plan

PRE-DECISIONAL

- Follows Best Practices
  - Interventions well-supported by the tobacco control literature
  - Leverage tobacco control experiences from CDC Office of Smoking and Health, state health departments, Campaign for Tobacco-Free Kids
- Low-cost
  - Priority on policies that incur no or minimal cost
- Game-changing
- "*All of DoD in*"
  - Line must be actively engaged and committed
  - Medical provides subject matter expertise

We must "de-normalize" tobacco use in DoD

Tobacco Free Living Game Plan
Four Lines of Effort

PRE-DECISIONAL

Lines of Efforts derived from CDC *Best Practices,* IOM "*Combating Tobacco Use in Military and Veteran Populations*"

Line of Effort 1: Reform tobacco pricing and display policies

Line of Effort 2: Expand tobacco-free environments, with goal of tobacco-free DoD installations by *2020*

Line of Effort 3: Sustain an effective DoD tobacco counter marketing campaign

Line of Effort 4: Optimize clinical tobacco cessation

(National Research Council, 2009)

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U.S. Department of Defense. (2009). 2008 Department of Defense Health Related Behaviors Survey of Active Duty Military Personnel; A Component of the Defense Lifestyle Assessment Program (DLAP). Retrieved Feb 18, 2014 from http://www.tricare.mil/tma/2008HealthBehaviors.pdf

Presenter: Dr. Miles McFall

- Dr. McFall is Chief, Psychology Service and Director of Outpatient Mental Health Services at the VA Puget Sound Health Care System.
- He is a Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine.
- He formerly directed inpatient and outpatient posttraumatic stress disorder (PTSD) programs at the VA Puget Sound Health Care System for nearly 25 of his 30 years with the VA.
- Dr. McFall conducted a number of clinical treatment trials for veterans with PTSD and published widely on the topic of tobacco cessation in veterans with PTSD.
- He provides leadership within the VA in education and dissemination of evidence-based clinical practices for tobacco cessation in veterans with PTSD and other mental health disorders.

Integrating Tobacco Cessation Into Mental Health Care for Veterans

Miles McFall, Ph.D.

Chief, Psychology Service

Director of Outpatient Mental Health Services

VA Puget Sound Health Care System

Professor, University of Washington, School of Medicine

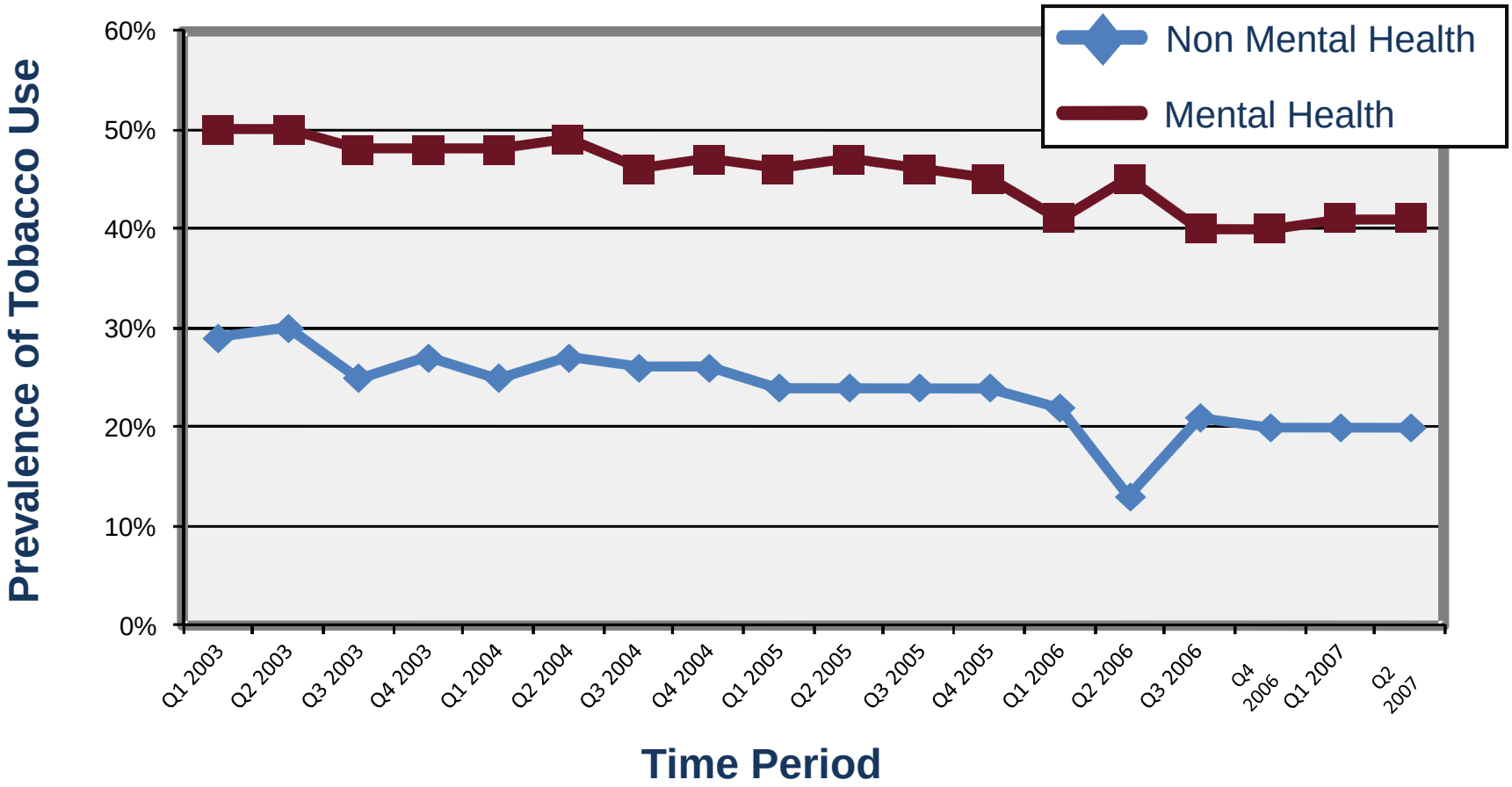
Seattle

Disclosure

- The views expressed in this presentation are those of the presenter and do not reflect the official policy of the VA or the U.S. Government.
- I have no relevant financial relationships and do not intend to discuss the off-label / investigative (unapproved) use of commercial products/devices.

Smoking Rates of Veterans Receiving VA Care

VHA National Tobacco Use (Office of Quality and Performance/EPRP, 2008)



(Department of Veterans Affairs, 2008)

Tobacco Use in Veterans with Posttraumatic Stress Disorder (PTSD)

- Veterans with PTSD smoke at twice the national rate (30 percent to 50%)
- More Veterans with PTSD are heavy smokers (48 percent) compared to Veterans without PTSD (28 percent)
- Smoking quit rates for PTSD are half the quit rates of smokers without mental disorder (23 percent versus 50 percent)
- Smoking likely contributes to the excessive physical health problems, medical service utilization, and premature mortality of Veterans with PTSD

(Department of Veterans Affairs, 2008)

Barriers to Effective Tobacco Cessation Service Delivery

- Brief, episodic tobacco cessation treatments are no match for chronic, relapsing disorders such as nicotine dependence
- Limited provider time for repeated monitoring of status, response to relapses, and pursuit of drop-outs
- Provider beliefs that cessation treatment is ineffective and uninteresting to do
- Insufficient training in cessation treatment
- Limited time and training to address smoking complicated by PTSD

Rationale for Integrating Smoking Cessation Treatment Into Mental Health Care for PTSD

- Advanced training in treating behavioral and substance use disorders is applicable to nicotine dependence
- Positioned to tailor cessation treatment to address the dynamic interaction of tobacco use with psychiatric symptoms
- The frequent, continuous nature of mental health care promotes ongoing monitoring of smoking relapses and "recycling" using a *chronic disease management model*

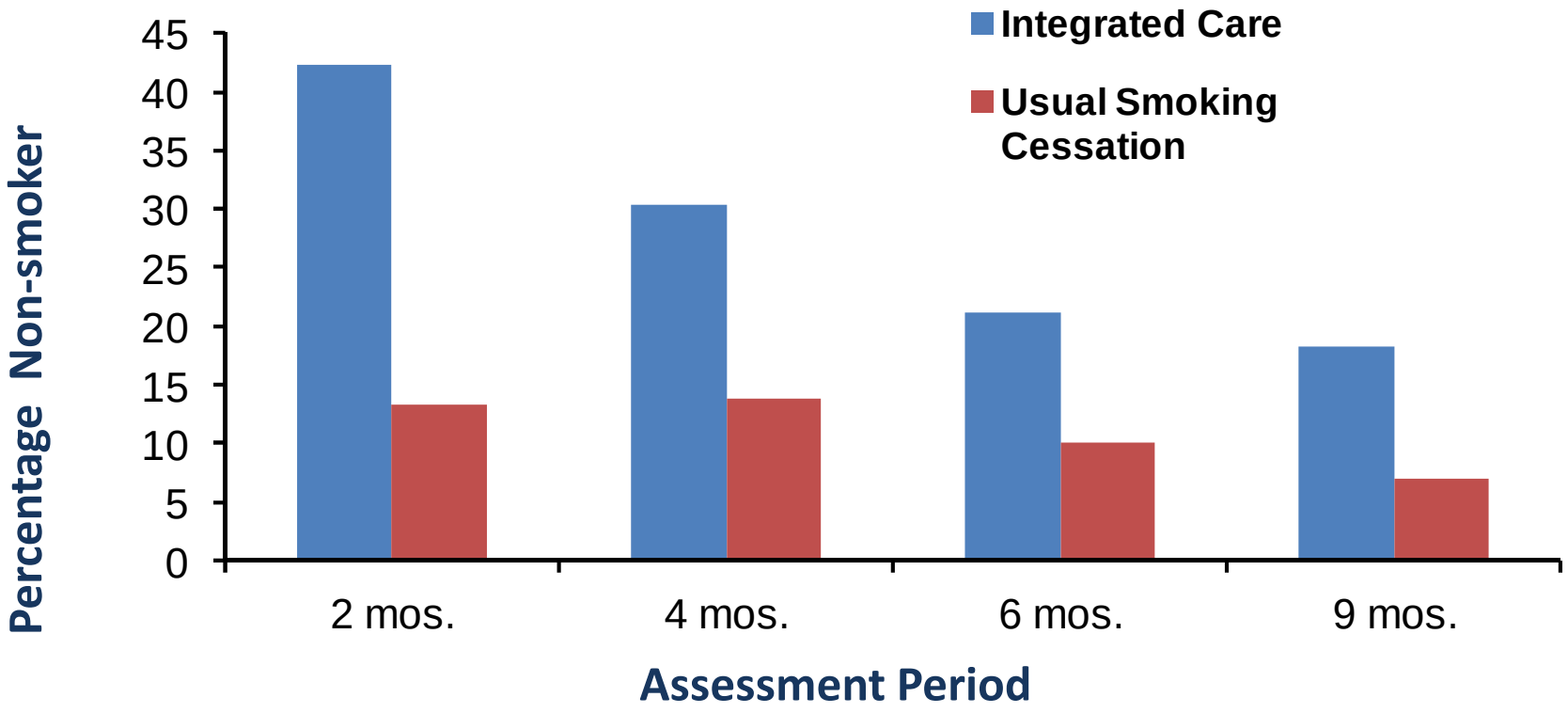
Improving the Rates of Quitting Smoking for Veterans With Posttraumatic Disorder

- **Integrated Care versus the Usual Standard of VA Care for Nicotine Dependence in PTSD**
  A Preliminary Randomized Clinical Trial

(McFall et al., 2005)

Clinical Outcomes:

Seven-day Non-Smoking Status (N=66)



GEE Analysis Results: Odds Ratio = 5.23, $p < .0014$

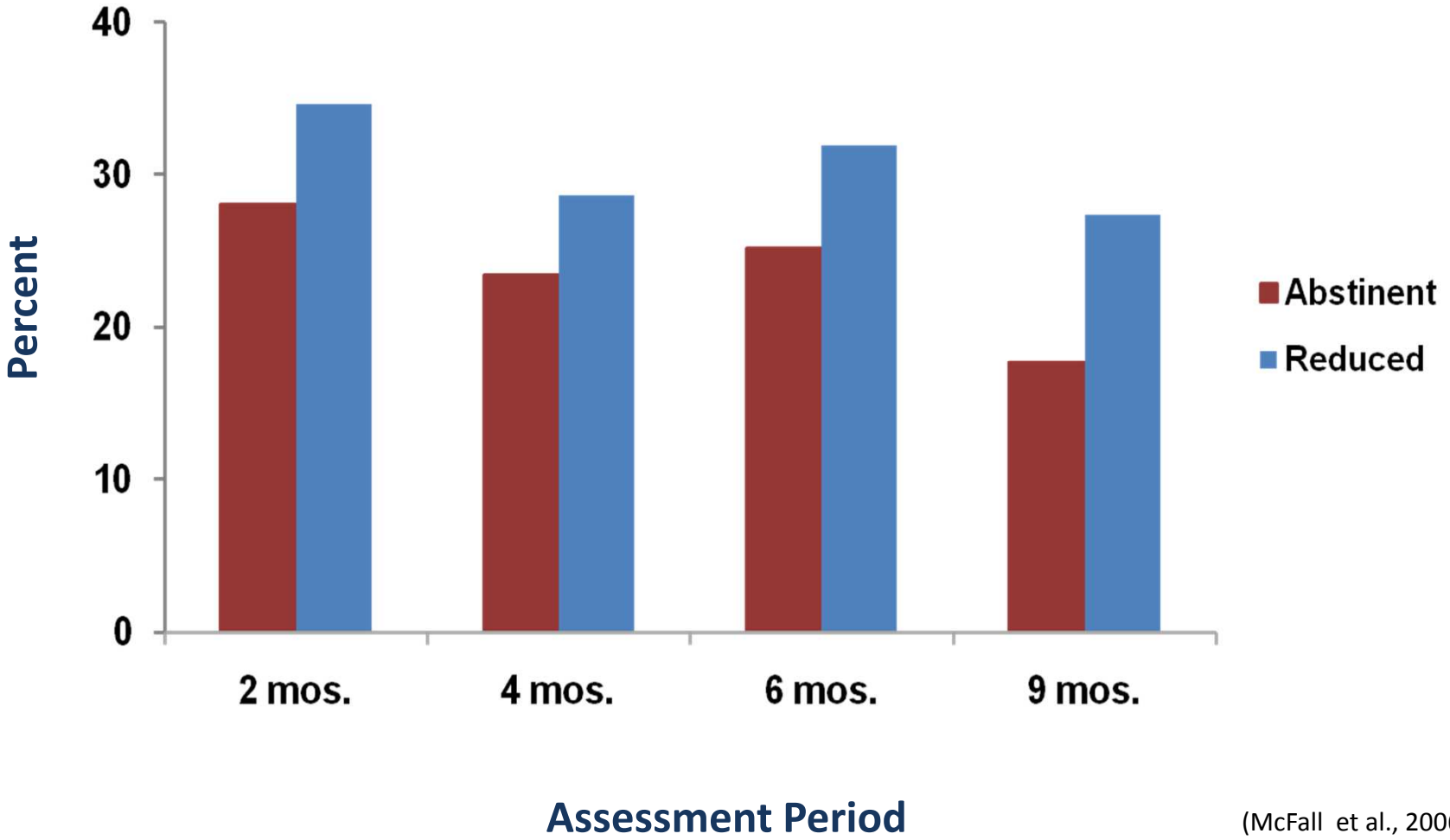
(McFall et al., 2005)

Integrating Tobacco Cessation Treatment into Mental Health Care for Patients with Posttraumatic Stress Disorder

- **Practice-Based Integrated Care for Nicotine Dependence in PTSD**
  An Open Clinical Effectiveness Trial

(McFall et al., 2006)

Seven Day Point Prevalence Abstinence and Percent Reduction for Continued Smokers (n = 107)



(McFall et al., 2006)

- **VA Cooperative Studies Program 519:**
  - ***Integrating Tobacco Cessation into Mental Health Care for Posttraumatic Stress Disorder***
    A Randomized Controlled Trial

(McFall et al., 2010)

Study Objectives

1. Test whether integrating smoking cessation treatment into mental health care for PTSD (Integrated Care [IC]) improves prolonged abstinence from smoking, compared to the VA's usual standard of care for smoking (Smoking Cessation Clinic [SSC])

2. Identify treatment process variables that mediate differences in smoking abstinence rates observed between IC and SCC

3. Determine whether cessation from smoking is associated with worsening symptoms of PTSD and/or depression

(McFall et al., 2010)

Overview of Study Design

- Randomized, controlled clinical trial with a parallel comparison of:
  - **Integrated Care (IC)**
  - **Smoking Cessation Clinic (SCC)**
- 943 patients randomized to IC vs. SCC
- 10 participating sites (VA PTSD clinics)

(McFall et al., 2010)

Integrated Care
Treatment Components

- **Skills Acquisition (five weekly core treatment sessions)**
  - –Behavioral Counseling (five sessions totaling approximately 150 minutes)
  - –Pharmacotherapy
  - –Self-help readings
- **Relapse Prevention and Management**
  - –Three weekly follow-up sessions
  - –Monthly “check in” booster sessions as needed

Integrated Care
Who Provides Treatment?

- Case manager (coordinates overall mental health care) provides tobacco cessation counseling
- Team psychiatrist or nurse practitioner prescribes medications
- Ongoing, continuous contact and familiar relationship
- Ability to monitor, detect and respond to relapses over time

Primary Outcome
Prolonged Abstinence

	Number Quit	Percent	Adj. Odds Ratio (95% CI)	P-value
PA (Self-Reported)	IC = 73 SCC = 42	IC = 15.5% SCC = 7.0%	2.59 (1.67 – 4.02)	< .001
PA (Bioverified)	IC = 42 SCC = 21	IC = 8.9% SCC = 4.5%	2.26 (1.30 – 3.91)	< .004

(McFall et al., 2010)

Clinical Outcomes
Summary

- Integrated care worked twice as well as VA's usual "gold standard" of care for nicotine dependence in Veterans with PTSD

Secondary Outcomes

- Treatment "dose" variables explained nearly 40 percent of the treatment effect between Integrated Care (IC) versus Smoking Cessation Clinic (SSC)
  - **Number of cessation counseling sessions was greater for IC (8.8) than for SSC (2.4)**
  - **Days of use of tobacco cessations was significantly greater for IC than SCC**

(McFall et al., 2010)

Explanation of Treatment Effect

- Integrated care worked better than standard care, in part, because it delivered a therapeutic “dose” of cessation treatment (more cessation counseling sessions and more days of use of cessation medications).

Secondary Outcomes
Adverse Outcomes Averted

Symptoms of PTSD and depression did not worsen from stopping smoking

Secondary Outcomes
Adverse Outcomes Averted

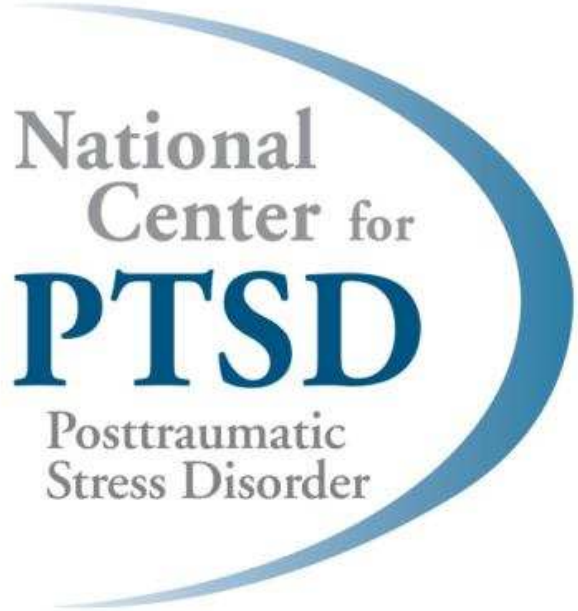
- Patients who received tobacco cessation from their mental health provider (IC) showed equivalent reductions in PTSD symptoms compared to patients referred to Smoking Cessation Clinic.

- Administering integrated care for tobacco use did not detract from the effectiveness of PTSD treatment.

Translating Research Findings into Clinical Practice

Stay Quit Coach

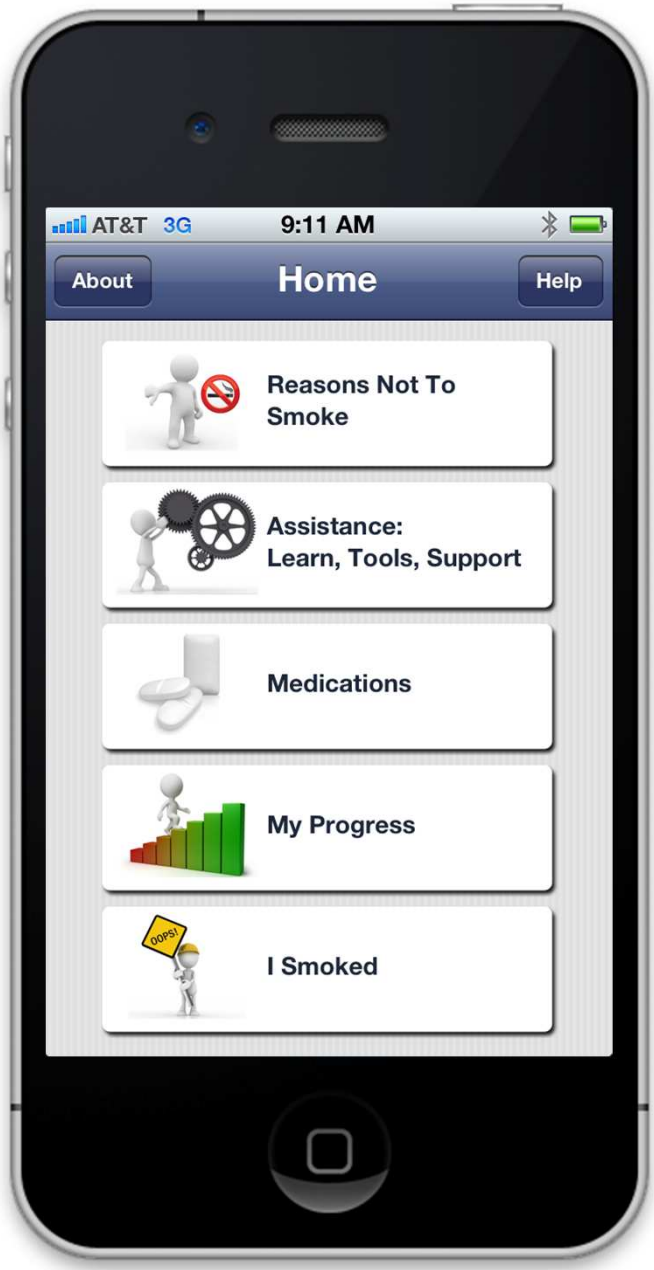
Partner Organizations



CPH Clinical Public Health

Home Screen

- From the Home screen, users can choose from the five main sections of the application.
- The About button provides users with information about the application and the team that built it.
- Users may use the Help button for a brief description of the main sections of the app.



(Veterans Affairs, 2013)

Medications

(Veterans Affairs, 2013)

AARM Coping Plans

(Veterans Affairs, 2013)

Integrated Care Learning Collaborative
Aims and Objectives

- A Learning Collaborative focuses on engaging an entire service delivery system –
  - Management
  - supervisors
  - Direct service providers

- And integrates best practices in training and consultation with quality improvement methods to help organizations rapidly implement and sustain evidence-based practices

Integrated Care Learning Collaborative

Participating Partners

- VHA Public Health Strategic Health Care Group
- Mental Illness Research, Education and Clinical Center
- VA Puget Sound Health Care System Center for Excellence in Substance Abuse Treatment and Education
- Evidence-based Practice Implementation Center (EPIC)
- National Center for PTSD Dissemination and Implementation Division
- PTSD Clinical Teams at six participating VA Medical Centers

Integrated Care Learning Collaborative *Program Components*

- Expert panel formulation of mission and objectives
- Information and awareness (IC as health care priority)
- Built-in mechanisms in clinics for screening and assessment
- Case review during designated clinic meeting
- Access to training and resources for skill building
- Ongoing consultation to review barriers to implementation
- Create time in clinicians' schedules to do the innovation
- System redesign that allows timely access to medications
- Metrics track provider adoption and patient enrollment
- Document IC delivery using templates
- Design a plan for sustainability and spread

Integrated Care Learning Collaborative
Outcomes Highlights

- Twelve participating VA sites
- Fifty-two clinicians trained during protocol
- An additional 45 clinicians trained “organically” at site level
- About 400 patients received IC
- Fifty-five percent of IC patients completed all 5 “core” sessions
- Eighty-eight percent of patients received tobacco cessation medications

Integrated Care Learning Collaborative *Lessons Learned to Date*

- Successful translation of research findings into clinical practice requires a distinct process for "rolling out" evidence-based innovations involving:
  - Initial training to develop clinical skills in the innovation
  - Ongoing consultation to refine clinical skills
  - Consultation and guidance in resolving institutional and systemic barriers to implementation
  - Recognition and support by management
  - Metrics: What gets measured gets changed

Appendix

Integrated Care

Session Outline

Goals of Integrated Care

Create a clinic culture prioritizing tobacco cessation care as a core responsibility of PTSD program providers

- Assess and treat tobacco use disorder in all willing patients undergoing mental health treatment
- All mental health providers embrace tobacco cessation as part of their job
- Provide brief and/or intensive interventions on repeated occasions to Veterans who smoke, in multiple settings

Who Should Provide Treatment?

- Primary mental health provider
  - Primary point of contact for patient who coordinates his/her overall mental health care
  - Ongoing, continuous contact and familiar relationship
  - Ability to monitor, detect and respond to relapses over time

Session Plan

- Five weekly core treatment sessions (skills acquisition)
  - Behavioral counseling
  - Pharmacotherapy
  - Patient manual
- Three weekly follow-up sessions (relapse prevention management)
- Monthly follow-up (“booster”) sessions (relapse prevention and management)
- Additional “re-treatment” contacts, as needed

Session 1

- Assess tobacco use, abstinence attempts and reasons for quitting smoking
- Advise quitting based on known health risks and personalized reasons for quitting
  - Use motivational interventions if necessary for ambivalent smokers
- Orient to plan for behavioral counseling
- Provide information on smoking cessation medications, assess past medication use and provide rationale for medication use
- Review guidelines for setting a quit date
- Coordinate care with prescriber
- Ask patients to
  - 1) read about negative physical and mental health consequences of smoking
  - 2) record reasons for quitting smoking and review these reasons daily before smoking

Strategies for Dealing with Resistance: The Four R's

- **Relevance** to particular smoker
  - Personalized reasons
- **Risks** of continued smoking
  - Personalized risks including acute, long term, environmental
- **Roadblocks** to quitting smoking
  - Identify and provide education regarding treatments that will help with obstacles
- **Repeat** motivational intervention at each clinic visit
  - Until willing to set a quit date or refuses stop smoking treatment

Session 2

- Establish a quit date for smoking cessation
- Assist patient in identifying smoking triggers
- Discuss strategies for reducing smoking prior to the quit date.
  - If the patient is interested in reducing smoking, set appropriate smoking reduction goals
- Introduce skills for coping with smoking triggers
  - controlled breathing
  - identify existing patient-generated coping skills
- Ask patients to
  - 1) detail their smoking triggers
  - 2) utilize personalized coping skills to deal with smoking triggers
  - 3) start reducing smoking if appropriate
  - 4) continue to review reasons for quitting prior to smoking

Session 3

- Review assignment to practice coping with smoking triggers
- Review status of reduced smoking when applicable
- Teach principles of coping with smoking triggers:
  - avoid external trigger situations
  - alter or change trigger situations
  - replace smoking with substitute behaviors
  - mentally cope with internal emotional triggers
- Develop action plan for coping with smoking triggers
- Assess the Veteran's understanding of smoking cessation medications and check the status of the appointment with the mental health prescriber
- Ask patients to:
  - 1) practice resisting smoking in three trigger situations using personalized coping skills
  - 2) continue to reduce cigarette consumption if applicable
  - 3) continue to review reasons for quitting before smoking

Session 4

- Review assignment to practice coping with smoking triggers
- Review use of controlled breathing or other coping strategies
- Review status of reduced smoking when applicable
- Discuss behavior changes to prepare for quit date
- Identify sources of social support and how others will help the patient stop smoking
- Assess availability and use of smoking cessation medications
- Ask patients to:
  - 1) begin taking actions to prepare for the quit date
  - 2) identify people who will be supportive of the quit attempt and begin asking others for support
  - 3) continue to practice resisting smoking in trigger situations using identified coping skills
  - 4) continue to reduce cigarette consumption if applicable
  - 5) continue to review reasons for quitting before smoking

Session 5

- Review assignments to practice coping with smoking triggers and to use social supports
- Review status of reduced smoking when applicable
- Review preparation for quit date assignment and discuss actions to take on quit date
- Introduce relapse prevention. Discuss how to respond if a smoking lapse occurs and identify high risk situations
- Review plan for using smoking medications
- Ask patient to:
  - 1) review actions to take on and after the quit date
  - 2) review coping skills to plan for dealing with high risk relapse triggers

Follow-Up Visits

- For abstinent patients:
  - Support continued abstinence
  - Discuss positive experiences
  - Assess and resolve problems
- For patients who continue to smoke:
  - Renew commitment to abstinence
  - Reinstate appropriate treatment by utilizing motivational interventions and re-administering interventions from Sessions one-five as needed
  - Set new quit date as appropriate

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