DCoE Psychological Health Webinar (February 2014)

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

Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I will turn the meeting over to Lieutenant Commander David Barry. You may now begin.

Thank you. Good afternoon and thank you for joining us today for the DCoE Psychological Health February webinar. My name is Lieutenant Commander David Barry. I work at Deployment Clinical Health Center in Silver Spring, Maryland. I will be your moderator for today's webinar.

Before we begin, let us review some webinar details. Live closed captioning is available through Federal Relay Conference Captioning,. Please see the pod beneath the presentation slides. Today's webinar is hosted using Defense Connect Online and Adobe Connect Technical Platform. Should you experience technical difficulties, please visit dcoe.mil/webinars and click on the troubleshooting link under the monthly webinars heading. There may be an audio delay as we advance the slides in this presentation. Please be patient as the connection catches up with the speaker's comments.

The full presentation and resource list is available in the file download box. During the webinar, you're welcome to submit technical or content-related questions via the question box. The question box is monitored and questions are forwarded to the moderator for the response during the question-and-answer session held during the last half hour of the webinar. Our presenters and I will field as many questions as time permits. Please feel free to identify yourself to other attendees via the chat box; however, please use the question box for technical or content-related questions.

Today's presentation and resource list are available for download from the files box below. Please note that continuing education credit is not available for this event. I will now move on to today's webinar topic, "Smoking cessation policy research as it relates to evidence-based practices in the military and veteran health-care settlings."

On January 11th, 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 in health and diseases such as lung cancer and heart disease, it also laid the foundation for tobacco control efforts in the United States. The Defense Department and Department of Veterans Affairs 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 Defense Department and VA's commitment to meeting smoking cessation goals, employ evidence-based behavioral counseling and pharmacological treatments for smoking and/or tobacco cessation, and evaluate pharmacological and behavioral counseling interventions for tobacco cessation for patients with post-traumatic stress disorder.

I would now like to introduce our first present e, Colonel John Oh. Colonel Oh is the chief of health promotion at the Air Force Medical Support Agency in Falls Church, Virginia. In this role, 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. Colonel Oh has particular interests in applying the social ecological model of health behavior to promote healthy living as the easy default choice and

social norm in the Air Force and Defense Department. Thank you for your participation, and welcome, Colonel Oh.

Great. Well thank you very much. It's an honor to be here. I appreciate it. Let me just go ahead and read the disclosure before I go ahead and get started. Here we go. So the views expressed in this presentation are those of the presenter, myself, and do not reflect official policy of the Air Force, DOD, or the U.S. Government. I have no relevant financial relationships and do not intend to discuss any off-label investigative or unapproved use of any commercial products or devices. Okay, with that, we'll go ahead and get started.

So, as Commander Barry said, I'm chief of health promotion here at Air Force Medical Support Agency, and our mission is really to kind of cultivate a fit and healthy force. So we cover a number of topics to improve people's health. But I can tell you that I think tobacco is probably my real passion, and it's largely because, you know, there's not a real need to sort of develop a lot of original content. As CDC has said that tobacco is a winnable battle, and we know what it takes to sort of do this. I think the challenge is that really just exercising the political will to execute what we know works.

So you can see the agenda. I'll first talk about the epidemiology of tobacco use in the military, and I'll talk about, you know, some of the policies that we have in our culture that's maybe perpetuating this tobacco epidemic and kind of review some of the things that we're doing in DOD in relation to tobacco-free living.

So we're going to first start, though, with the first of three poll questions. So it's a little bit interactive, so if we can put the first one on, give everyone a chance to vote. And the question is, which intervention would have the most impact in reducing tobacco use in the military? So, you know, you can submit prohibit tobacco sales in the military exchanges and commissaries, prohibit tobacco use on military installations, prohibit tobacco use in uniform, or fund a tobacco counter-marketing campaign, or improve clinical cessation supports? So I'll just give it a few seconds for everyone to vote.

Okay, so we can see the results here. All right, well we're still moving. It looks like about half say that improving clinical cessation supports; maybe a quarter prohibit tobacco use at installations; and then it looks like a third is to prohibit tobacco use in uniform. Well this was somewhat of a trick question, because the point of this is that when we look at the successful comprehensive tobacco-controlled program, it's really, you know, the whole package. It's all of the above. And it's really not just one thing that, you know, helps lower tobacco use but it's everything working together. But I think it is interesting to hear people's perceptions. There's no right answer to this question, by the way. It was really just trying to get people's opinions. Okay, if we can move on to the next slide.

So as many of you know, we have healthy people 20/20 objectives. And what I'm showing here on this slide is, you know, how the military compares with the civilian side. Now in some things, such as obesity, you know, the military does much better, you know, than the civilian side. So, for example, where as one in three civilians is obese, BMI 30 or more, only one in ten in the military are. And that's not really too surprising, because there's a little bit of a selection bias in that we all know that childhood obesity is a predictor for adult obesity, so if you are ruled out from service in the military, then, you know, we're going to end up having a force that just is selected for being at lesser risk for obesity.

Certainly, I think just by virtue of culture, we have very high rates of physical activity. And in our military installations we have policies mandating seat belt use, motorcycle helmet use, so it's no surprise that those are very high. But if you look at where we are compared with civilians in terms of cigarette use and smokeless tobacco use, you can see that we're worse than the civilian averages, particularly in regards to smokeless tobacco use. Next slide.

So this is a graphic showing kind of the trend line for cigarette smoking in the military over the course of the last 30 years. And a couple things to sort of point out here is, one, you see a nice sort of decrease from 1980 up until about 2000 or so, and then it hasn't really changed much over the course of the past decade. Part of that is we really don't know for sure, but I think the consensus view, if you will, is that the very high up tempo from wars in Afghanistan and in Iraq, I think a lot of the emphasis was on the war-

fighting mission, and I think some of the health promotion activities, you know, probably were marginalized. In fact, many things, deploy settings were often permissive environments to perpetuate tobacco use.

The other thing I'll point out here is that you see there is a little bit of a decrease when we look at 2008 to 2011. This is data from our triennial DOD survey of health-related behaviors, and, you know, the smoking rate did go down from 30% to 24%. Now we're not sure to what extent that's a real trend. Part of it is there's a methodological difference in how they did the survey. In 2011 they moved to 100% Internet-only survey. Unfortunately the response rate was not great. It was 22%. And if you look at junior enlisted in some services like the Army and the Marine Corp, the response was less than 10%. And those are actually our highest risk demographics for smoking. But none the less, you know, we'll have to see how this sort of pans out. But overall, it looks like we have made progress, although, again, in that decade between 2000 and 2010, we kind of lost a little bit of progress.

So now we'll go to the next polling question, and that is, which service has the highest prevalence of cigarette smoking? And you can pick among the options there; Air force, Army, Coast Guard, Marine Corp, or Navy. I'll just wait a minute while it comes up. There we go. Obviously this is not an opinion question, it's more of a fact question. Okay, and let's look at the results here. Okay, so 70% saying the Army; 23% say the Marine Corp; I find it interesting that 0% said the Air Force. I guess I don't know if it's because I'm an Air Force guy or what.

But if we can go onto the next slide, you know, this is a, again, dated from the DOD survey of Health-related behaviors, and the correct answer actually is the Marine Corp. The Marine Corp. has the highest rate of smoking, actually, also smokeless tobacco use, in DOD, and you can see there is some variation. Actually Air Force, it is the lowest service that's there. Now we'll talk a little bit about why that may be the case.

So if you can go to the next slide, this is like drilling down into smoking by pay grade. And I think if you look at civilian data, and I think it's the same with what we see in the military, is that probably the biggest factor in whether one smokes cigarettes or not is education level. And, you know, if you look at for example, CDC data, if you have a graduate degree or more, I mean smoking prevalence is 5%, whereas if you have a high school degree it's much higher.

So you can see here that, again, this is from our 2011 HRB survey, and there are large disparities in smoking. And, unfortunately, those that have the highest prevalence of smoking are those that make the lowest amount of pay. And as you can see that tobacco use can consume a big chunk of an enlisted service members base pay. So I think keep that in mind as we think about well what kind of interventions would be most effective for the groups that are at highest risk.

We clearly have an issue with smoking being concentrated in certain communities. Now what I've done here is presented information from our annual, what we call "Web HA," which is we require all airmen every year to do an annual health risk assessment, and we ask they will about smoking and smokeless tobacco use, and what this is showing are the five specialties that have the lowest rate of smoking, and comparing it with the five that have the highest rates. So that's why you see the big divergence. Now there are hundreds of specialties that I didn't show you because, obviously, it would clutter the slide.

But a couple of things stand out. One is that you can see that the lowest rates, you know, they're all medical specialties; you know, psychiatrists, OB/GYN, et cetera. The five highest rates, first of all, they're all enlisted, what we call "Air Force specialty codes," and they cluster in, like, maintenance and logistics and so forth. So you can clearly see that, you know, there is a problem with social networks influencing. I think that's probably the case. I can't think of, in my experience, one physician that I know that smokes cigarettes, or at least that would admit to smoking cigarettes, because it's really just socially unacceptable now to be a physician and to smoke cigarettes.

So this is the data kind of, again, from the HRB survey, looking at the military culture. And it's a little bit complicated, but on the right side what we're looking at are social networks. So what they do is they ask

the service members in your off-duty hours how many of you friends used any of the following: smoked cigarettes, smokeless tobacco, and so forth. You can see that 61% for smokeless and 73% for cigarette use you know, admit to having some or at least some or most of their friends using those products.

On the other side, the left-hand side, with the red, is, you know, looking at leadership and supervisor influence. And whereas you can see that there's a lot of strong leadership and supervisor messages regarding prescription drug misuse and marijuana, that's not necessarily the case with cigarette use or smokeless tobacco use. So we'll go to the next slide.

This is the last polling question, so what is the average state cigarette excise tax? And we'll talk about this as we talk about, you know, one of the challenge that is we have, at least in the medical community in terms of changing our environments to promote tobacco-free living. As many of you know, we do have tobacco product sales in our military exchanges and in some of our commissaries, and the sales of tobacco products are actually exempt from any state or local taxation, whether it's an excise tax or a sales tax. So we'll just give everyone a chance to vote on this question. We're good?

Okay, let's look at seen what people think is the average state excise tax. So the average is $1.53. And , yeah, that's right, it is $1.53. 17 cents is actually the lowest state, Missouri; $4.35 is the highest state, New York State; and 48 cents is the sixth, historically, tobacco producing states, which Virginia, where I currently am, is one of them.

So if you go to the next slide, one of the challenges within our DOD is we actually have a policy in DOD instruction 1330.09 that basically calls for, you know, access to discounted tobacco products. So if you read this DOD instruction, you will see that tobacco products cannot be priced any higher than the most competitive commercial price in the local commune thank you. So in some respects if you buy a tobacco product, you're guaranteed to have most favored nation status if you buy it on the base. Now there is a floor. You can't go 5% below that, so there's a narrow band in which the tobacco products should be sold in your exchanges and our commissaries.

If you go to the next slide, this was a study that some of you probably saw by Sara Jahnke and others back in 2011. They published this as a JAMA letter. They surveyed the price of a pack of Marlboro Red pack of cigarettes in exchanges and compared it with the closest Wal-Mart that was outside of the base. And, you know, they used Wal-Mart as the reference price, realizing that, you know, based on the policy that I told you, we don't know for sure if it's the most competitive commercial price, but it's probably an approximation, and as you can see here, the price of tobacco products or cigarettes in the exchanges were at a substantial discount. And even if you were to say that Wal-Mart is 10%, even 20% higher than the most competitive price, this would demonstrate that on average the exchanges are actually not in compliance with their very own DOD instructions.

So another problem that we have is tobacco marketing. We have this issue as well in our exchanges, like we do in all of our retail establishments, and tobacco marketing is a $10 billion a year industry. In fact, if you think about it, you know longer see tobacco products advertised on television, radio, very rarely if in print adds. So, really, the industry has shifted quite a bit of their marketing to the retail environment. So you can see in the area of power walls that, you know, that these are actually very highly engineered to try to stimulate impulse purchases, and we think this is a problem.

So let's go over some of the things that we're doing. First of all, we have a campaign called "Quit tobacco, make everyone proud." I know we've got a few folks from Quit Tobacco on this call, which is great. You can access it at youcanquittoo.com or try youcanquittoo.org, either one works okay. And this is really kind of our education and counter-marketing program in DOD, particularly aimed at younger service members.

We have a number of other initiatives, "Operation Live Well," which is kind of an umbrella term that we use for all of the health promotion activities that we're doing in DOD. "Healthy Base Initiative" is actually a demonstration project. Here we're working at selected bases, only about 12, trying to make them very healthy environments to promote healthy eating, physical activity, you know, tobacco-free living, et cetera.

One thing about clinical services, you know, congress in the 2009 NDAA, they really upgraded this smoking cessation benefit. So now as part of the Tricare benefit package, you know, you have access to all of the FDA-approved smoking cessation medications. Counseling is provided without charge. There is 24/7 access to a quit line. So this has just been implemented within the last year, but it's very exciting because it's really, I think, improving the accessibility of cessation services to our population. Just one caveat is that if you're Medicare eligible and you have Tricare then you'll actually not eligible for this benefit, and that's the way it was written into law.

Okay, youcanquittoo.com, so this is just, you can see a screen shot from the website that's there. And the next slide I would be remiss if I didn't talk about our ongoing video contest that we have, and it's open until March 14th. It's called "Fight the enemy." I know I've been involved in this since we first kind of conceptualized this over a year ago. But you go to that website you can see that there are five videos that were submitted by people out in the field. And you can actually vote for your favorite one, and we're trying to promote kind of awareness of tobacco-free living and getting people, you know, energized about voting for this. But we do think that this is an opportunity to sort of identify messages that may resonate well with, again, our junior population.

So there are a few things that we've got in terms of our vision for tobacco control. I think one of the things we really want to do is, again, just implement what we know has worked elsewhere with state-based comprehensive tobacco-controlled programs. And so we've got a game plan that's pre-decisional, but we tried to kind of conceive of things that were low cost. Obviously, as many of you are aware, this is not the kind of environment where very costly type of interventions, you know, are going to be received very well.

If you look at the next slide, this kind of shows you the different line of effort that we've derived there. A lot of this was derived, again, from CDC best practices, as well as the Institute of Medical Report in 2009 on "Combating Tobacco Use in Military and Veteran Populations." Fist of all, I think we've got to do something about tobacco pricing and display policies. We've had a number of discussions, and, actually, the Secretary of the Navy, Secretary Mabus, has actually been way out in front of everyone else in terms of trying to get rid of that discount for tobacco products in Navy and Marine Corp exchanges.

Many of you know that CVS, you know, announced that they were going to get rid of tobacco products from their stores. They did this earlier this month. I think that there's a lot of momentum. In fact, there was a letter, an open letter that was signed by a number of health and public health organizations, just yesterday, to America's retailers, you know, calling for them to do something similar too what CVS has done. So I think this is, hopefully, a message that we hope will get out there, you know, also to our military community. Believe me, it's something that we've tried to do.

Second is that we want to try to extend tobacco-free environments. You know, we've been doing well with tobacco-free medical campuses, but we want to try to expand them to the rest of the installation, along the lines of what health and human services has done as well. Counter-marketing is very important, you know, particularly for that junior-enlisted population. And finally, we definitely need to, at the clinical side, need to optimize our clinical tobacco cessation.

But kind of getting back to that original question, I think that even with the best clinical tobacco cessation program, unless we have an environment that is supportive for tobacco-free living, I think it's going to be kind of an uphill battle.

So with that I think my time is allotted, and I think we'll take questions afterwards. Thank you for your attention, and, you know, look forward to answering any questions you have or receiving any comments you may have for us.

Thank you for your presentation. If you have any questions for Colonel Oh, please submit them now via the question box on the screen. I would now like to introduce our second presenter, Dr. Miles McFall. Dr. McFall is chief of Psychology Service and director of Outpatient Mental Health Services at the VA Puget Sound Health Care System in Seattle. He is also professor in the Department of Psychology and Behavioral Sciences at the University of Washington School of Medicine.

Dr. McFall has conducted a number of clinical treatment trials for veterans with post-traumatic stress disorder 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. Thank you for your participation and welcome, Dr. McFall.

Thank you for the privilege of speaking to this fine audience about a topic I'm very passionate about. I believe I'll advance on to the disclosure slide, if you don't mind. Let's see, there we go. Let me just read the disclosure slide; that the views that I express in this presentation are those of mine and mine alone. They do not reflect the official policy of the V.A. or U.S. Government. I have no financial relationships relative to this talk, and I do not intend to discuss the off-label or investigatives for unapproved use of commercial products and devices.

Okay, well let me just start out with a few general comment. I have a half an hour, I believe, to speak. We're probably not going to get through all the slides in the materials you have. That's okay, because I think what I'd like to do is just give you, really, the take-home messages, and give you a half dozen points here at the very beginning, and have those stick with you, and then use the slides as kind of reference material for you to rely on and study on your own. You're free to call me and contact me for any consultation issues thereafter. This talk is relevant mostly to mental health professionals but not exclusively. I I'd say that anybody in the health-care field who is working with patients who have mental health problem would find, hopefully, my remarks useful and applicable to your workplace.

Let me start out by saying that tobacco cessation interventions are really one of the most important services we can provide to prolong the lives and improve the quality of life in our patients. Too often, as Dr. Oh mentioned, tobacco cessation can go to the rear of our priority, and I'm trying to make the point that really should elevate itself more towards the top. You know, we have many other concerns to take care of when we're treating our patients.

I would further state that treating nicotine addiction is well within the wheelhouse of mental health professionals, and I might even go so far as to say that it's really an imperative for mental health professionals to address tobacco in their patients, for a number of reasons. First of all, more mental health patients actually want to quit smoking than we think. And there's widespread belief that psychiatric patients aren't interested in quit and they need nicotine to calm their nerves and so on. That's turning out actually to not be true. They want to quit at the same rate that people without psychiatric illness want to quit.

Second of all, there's a widespread belief that people with psychiatric disorders can't quit. That's not true either. And if you look at various studies of tobacco cessation, what we find are that the quit rates of those with mental illness are nearly comparable of those without mental illness. Not quite as high, but very close. The second reason why I think that it's imperative for us is because we mental health providers come prepackaged, if you will, with the skill sets necessary to provide tobacco cessation and counseling to our patients.

We already know how to do it by virtue of our training and background. And I might add, too, that we now know smoking cessation outcomes are actually boosted or improved by adding mood management elements of treatment, as opposed to just standard tobacco cessation five days approach. So who better than mental health professionals to add that mood management intervention, which actually super charges and improves the outcomes.

And lastly, I would say that if not mental health providers who else is really going to take on the task of providing tobacco cessation treatment for our psychiatrically ill patients. Probably nobody, or at least nobody can do it as well as we can, given the dynamic interaction between mental illness and tobacco use motives, so we're best poised to treat that.

Now, of course, many people are going to be asking, well what business is that of the mental health professional? Patients comes to us with problems other than that; depression and so on. And I would argue that smoking is actually directly related to many of the mental health concerns and symptoms that our patients come to us to begin with, and, moreover, helping them quit tobacco actually will help reduce the very symptoms that they are asking us to help them with. Let me be a little more specific.

In addition to the usual problems that you know, which is that tobacco users have a 40% chance of dying from tobacco-related illness and the average smoker is going to lose somewhere between 13 to 14 years of their life, I think we all know smoking is dangerous. I wasn't aware that it was that dangerous until I got into this field. But in addition to those issues, smoking actually worsens many of the symptoms our patients come to us in the first place, specifically depression. We now know from longitudinal studies, actually tobacco contributes to the depression; suicidality, increasing risk for suicidality by a factor of two to three. Some studies show even higher. Anxiety and panic symptoms in particular are very much exacerbated by tobacco use. Pain sensitivity, at least in the VA, our patients with PTSD, over half of them; 70% actually have chronic pain problems. Tobacco increases that pain sensitivity and makes it worse for them. Poor quality of life in many spheres. And many of you may not have known that tobacco use is actually the third most preventable risk factor for Alzheimer's disease. So it's a contributing factor to the ills and ailments that our patients come to us for help with.

Moreover, stopping smoking is actually causally related to reducing depression and suicide risk, reducing anxiety, and actually reduces the perception patients have of having less like stress. If you talk to most patients, particularly with anxiety problems, I'll tell you they smoke to reduce their stress and handle their stress. Well many studies have been done showing that patients who actually are people who quit smoking actually report less stress in their lives thereafter. Also, quitting smoking will improve pain sensitivity, not by a huge margin but a significant amounts, and, of course, quality of life.

The last message I'd like to give you is that tobacco cessation approaches for us really needs to follow the chronic disease management model. An episodic quick-hit approach is not as effective as taking a chronic disease management approach, where are follow our patients and detect relapse, ask them on multiple occasions about whether they quit or not, bearing in mind that most patients who are successful at quitting eventually have had to try and fail six to eight times. So it's persistence that will really pay off here, in the effort of really encouraging our patients to recycle or reapply treatment on as many occasions as it takes to be successful.

So those are my, really, opening comments and main points, to be honest with you, that I'd like to have to stick with you. Even if you're not enamored with the slides that come thereafter, that's really the take-home message.

Now I understand I do have some polling questions here, so let's see if we can get to that with our moderator here. Okay, we have some polling questions. During a patient's appointment, do you regularly ask about tobacco use? Go ahead and take your votes please. Okay, it looks like we're still counting them up. And we seem to be coming in at about around 80%, or so, if I read this right, say, yes, and about 20%, or a fifth of the audience say, no. It looks like we're still counting votes. But that's really, really very good. You know, there was a day when we asked that patient a few decades ago and the result would be quite different, with health providers not routinely asking, but we find, increasingly, that health providers are routinely asking about tobacco use, whereas as the deficiency, however, is follow through with treatment.

So let me ask the second question here. Do you regularly ask your patients if you can assist them in quitting once you've determined that they are a smoker, the data on that? Well that's actually, again, pretty good. It looks like about two-thirds of the audience say that they, in fact, assist patients with quitting, as in prescribing a medicine or seeing that they get the medicine, or are doing some kind of behavioral counseling. That's actually very good. I have to commend the audience and the Department of Defense the you're doing that. That's actually quite a bit better, frankly, than the private sector, where, historically, physicians and other health-care providers are, in fact, asking about tobacco use in the vicinity of, you know, 80 to 95%. But when it gets to, "Well did you prescribe a medicine to help them, did

you coach them and so forth," we're coming in typically at the rate of 10%, to maybe up to 30% on a good day. The fact that 68% of the audience here is, in fact, assisting patients makes you an outstanding health-care organization I declare, so that's great.

Now do we have another polling question, or are we onto our slides now? Okay, it looks like we're back to slides. Okay, well this is to make the point that many of you know, which is the rates of smoking, at least in the VA population where I work, trended over time. And what you can see is that for patients who do not have a mental illness there's been a decrease, on the blue bar, around 30% or so, back in 2002, down to about less than 20%, around 20%, which is close to the national average. But if you look for mental health patients, those with a psychiatric condition, even though they have trended downward, we've made some impact, their rates of tobacco use currently still remain at least double that of patients without mental illness. And we find that over and over again in the literature, that those with a psychiatric supporter are at very, very high risk of use of tobacco.

And there are data showing that actually people with mental illness smoke somewhere between 30% to 44% of all the cigarettes manufactured. So I'm interested in PTSD. At the VA we see lots of patients with PTSD, as I suspect you do in the Department of the Defense. Some of this data is a little bit old and I think the prevalence for rates are actually not as bad as they are shown here.

These studies were primarily gathered on patients who were Vietnam veterans, and maybe, you know, the data is at least ten year old or so, and I believe, as Dr. Oh showed us, that the current Department of Defense population, the smoking has been more aggressively tackled, and I think these rates are overly high. But they're still not completely out of league; meaning, patients with PTSD smoke a lot, much more than average. And, sadly, they have a harder time quitting. Sadly, they smoke more heavily, which is a problem, because the more you smoke, the dose-respond effect, there is the likelihood of having lung disease and cardiac risk factors as well. And we do know now that people with PTSD are much more likely, veterans in particular, to use a great deal more medical resources, much more consumers of health-care system, and they're more likely to have morbidity of all kinds, cancers and heart disease and emphysema, and they're much more likely to die prematurely. And I would submit that the high rates of tobacco use in that population have more than a little to do with their risk for more morbidity and mortality.

Okay, let's go by this slide. I don't want to spend too much time. We need to advance a little more quickly if you don't mind. I'm going to make the case here that mental health professionals are really well poised to be the agents of change, one of the best platforms. First of all, as I mentioned earlier, mental health professionals are already trained in how to treat substance abuse problems and deal with mood disturbances, so we already know how to do this with very limited training. Second of all, there is a dynamic relationship between why people smoke and their moods. Patients will tell you they relapsed because they were angry, irritable, stressed out, depressed, and we have to manage both of those things, because each is driving the other.

Finally, I would say that we have a leg up as mental health professionals, because unlike primary care provider who often see patients maybe twice a year, or something like that -- it depends -- but we mental health professionals see patients routinely, oftentimes for an intensive episode of care and may follow them for many, many months or years thereafter. So we have a platform for applying a chronic disease management model that involves recurrent assessment and recycling and reapplication of treatment after relapse occurs, which it will occur for more people than not.

Okay, well just kind of to prove my point here, providers tell me that smoking cessation is as easy as falling off a log, and that's kind of the motto. And I'll tell you a story behind that. I had a bit of a midlife crisis here when I was in my early 50s. I wanted to something important and wasn't sure I was as an catecholamine researcher and so on. So I decided I wanted to do something really important. What might that be? Well, save the lives of our veterans with PTSD, what could be more important. And of course, smoking being the most preventable cause of death in America, including our veterans, I decided to select that topic.

Knowing nothing about it at all, I traveled to the Mayo Clinic and went through a three-day seminar on how to do tobacco cessation, come back to my mental health team. I'm a director of a PTSD team, 20 people or so, and say, "Let's go for it." I'm going to write up my note and do a manual and say let's start doing tobacco treatment and let's get on it. And nobody, including me, had treated even one patient.

So we did a small study where we randomly assigned patients who were smokers to integrative care, and that's where we clinicians in mental health who are providing PTSD care provide tobacco cessation care simultaneously, one-stop shopping in our shop. So we treat that condition right along with PTSD and our other comorbidities, rather than referring it out. The standard of practice in the VA has typically been to refer patients to a specialized tobacco cessation clinic in the organization or the primary care, and basically make it their responsibility. So I was hoping that we mental health professionals in my PTSD clinic would do just as well as the professionals could do this all day long in our facilities who are top-notch nurses and doctors who do this tobacco cessation all day long. I just wanted to do as well.

Well this slide shows we did a lot better. These are quick rates at two month, four month, six months, and nine months. The blue bar being integrated care, that's where he we mental health professionals provided the treatment along with PTSD treatment, versus the red bars, which is where we referred the patients out to a clinic in our facility where they got that care from professionals, while we just pay attention to the PTSD. So the nine open month mark is probably what you want to pay attention to, and you can see quit rates at that point are about 18% or so, about three times better for the comparison condition.

That surprised me a lot. So we did another study, just taking 107 patients, or so, who were smokers in what's called a "Practice-based quality improvement study," because when you do these randomized control trials you're getting a very selected population of patients and the enthusiasm of the investigator like me is hard to conceal, and you can have all kinds of biases. So we just let the clinicians treat 107 patients. And the next slide is what you get. That's the quick rates, the red bar. Pretty much the same thing. Let's just pay attention to the nine month terminal point, 18, 19%. What are the recur rates?

Now don't pay attention to the blue bars. I put them there for reference. We thought that if you didn't quit smoking at that time -- somehow my slide disappeared. Let me get become to that. Okay, sorry, folks, but I'm somehow disconnected here to my slide show, so I'm going to -- give me a moment, please. I'm disconnected let me just connect it to my slide show. Hang on. There we go, okay, we're back. The blue bar is -- we once believed that if you couldn't stop smoking it would be a good idea just to reduce smoke, that's good enough. So cut the cigarettes from 20 cigarettes a day down to 10 cigarettes and we'll call it good. Wrong.

So you can see the intervention did, in fact, result in a reduced number of cigarettes per day. But the case I'm going to make for you here is that that is a bad end-point objective. Reduced smoking is not known to improve the health or result in health benefits for the smoker, for a variety of reasons. One is people who have reduced smoking tend to smoke cigarettes, they have harder and they ingest more carcinogen. They get a hotter burn, and that's one of many reasons. They actually can ingest many more carcinogen rather than less. Also, the road back to full-time smoking in the face of stress is a very short one. So most people are going to end up going back up to 20 cigarettes per day pretty quickly.
So reduced smoking is only of value is only a means for patients to learn skills to control tobacco urges. But the end point as to still be to quit.

I'm wanting to go through these slides more quickly, because they're a little bit more data rich and may not be so important to you. But, again, when people do research, you have the problem that are kind of side effects, where you have enthusiastic people like me and my investigators generating this data that cannot be replicated elsewhere. So the VA spent a lot of money doing a ten-side controlled randomized trial that was published in JAMA in December of 2010, where we compared -- made a comparison of the integrated care, as I described it to you, one-stop shopping for mental providers to deliver tobacco cessation care, versus patients being randomized to experts in their health-care organization, smoking cessation clinics. That was our goal, is to see which would work better.

The second goal was to figure out why integrated care worked. And then finally we wanted to figure out if stopping smoking associated with the worsening symptoms of PTSD or depression, which many people feared would happens.

Okay, so this is basically the design of it. I don't want to get too much into detail, but there were ten participating VA medical centers, the PTSD clinics. We had 943 patients who were randomly assigned through integrated care versus smoking cessation care. The treatment is as following: It involved a behavioral counseling component, as you can read for yourself, which had developing skills for stopping quitting, you know, learning how to control smoking urges, identify smoking triggers, find alternative activities, very standard stuff, as well as some mood management elements. It also included some follow-up sessions around relapse prevention, and, more apropos, relapse management, because we're not really preventing much relapse. What we're doing is managing relapses that occurred. So we had those booster sessions.

I would add that the appendix, which we will not get to, actually lays out for you in detail what that treatment looks like, so that's available. And we also have treatment manuals that are very detailed. please.

Also, it's important to note that, in addition to counseling, we had medication supports. We had a team psychiatrist or nurse practitioner who provide tobacco cessation medicines that are FDA approved, and we wanted the deliverer of the tobacco cessation treatment to be somebody who knows the patients and follows them over time, who had an ongoing continuous relationship where they could monitor smoking status, detect relapse, and respond in the course of their routine PTSD therapy. And we treat PTSD, depression, anxiety problems, alcohol problems, just all rolled into one. It's just another topic during our sessions with patients.

Okay, how did it work? Well this is a lot of numbers, but just pay attention to the fourth column over, where it says "adjusted odds ratio." The first row is what's called "prolonged abstinence," PA, and that just means that patients were assessed at multiple points in time over the course of the year. We assessed them every three months, and asked them, "Have you been smoking or not," during the prior three months, asked the patient. And if the patient said on each occasion they had not had any cigarettes except for a minor puff on a cigarette or a very limited amount, then they were considered to be a non-smoker. They had to be a non-smoker at each of those assessment intervals, those four assessment intervals over the space of a year.

And what you find there is that the integrated care approach that I described worked about two-and-a-half times better than -- or the likelihood of quitting was two-and-a-half times greater than if you got integrated care than the comparison condition. Again, the comparison condition was randomly assigning patients to get smoking cessation in the health-care organization by smoking cessation experts.

The row below basically gives you the same result, only we did what's called "bioverification," meaning, not only do we rely on what patients said to us about they had quit, but we had them give a urine sample, and we had them give a carbon monoxide sample breath analysis to determine if there were metabolites or biological derivatives of smoking in their system. And if they said they had stopped smoking and one or the other of those two biomarkers did not verify it, then we considered them to be a treatment failure and a smoker.

I think that the real smoking rates lie somewhere between what you see here, where integrated care, which always worked at least twice as well as comparison condition, ranged somewhere between about 9% versus about 15.5%. I think the truth is probably in the middle. It's harder to know how to actually measure smoking cessation than you think, because it depends on how rigorous your measure is and bioverification and so on.

Part of our problem was that half the patients who participated in the study lived with people who were smokers, and if they ingested second-hand the smoke of their cohabitants, they would show up positive on the carbon monoxide reading, even though they declared that they were not a smoker and they hadn't

touched the stuff, and even though maybe a cotinine test showed that they were positive on breath analysis, possibly because of ingesting second-hand smoke, we had to declare them a treatment failure. That's why I think it might be too low an estimate. But 15%, people could argue about whether that's too high.

The point you're going to get here is most people who try to stop smoking are going to fail at it, and as providers we need to understand that and not be discouraged by it and realize that a quit rate of 15% translates into lives saved. It's an important contribution in our business. So let me kind of go forward a few more slides even though I'm running out of time.

Okay, so that's the bottom line, is that integrated care worked twice as well, over twice as well as the competition. Now many people want to know, well why did it work? Well there's a dose response effect. Basically patients randomized with either condition had the same opportunity to get the same treatment; namely, the same medicines or the same number of sessions. It was between the doctor and the patient, what they did, as long as it was practice guideline driven and FDA approved, same opportunity.

Well it turns out that the patients who got integrated care were more receptive to tobacco cessation treatment. They got more of the treatment. And if you don't get the treatment you don't get the cure. So there's a dose response effect. We know in this business where the bigger the dose of treatment tobacco cessation the more likely it is you're going to quit, up to a certain point. So integrated care was simply a better vehicle than getting patients more sessions. Also, patients who were in the integrated care condition, treatment provided by PTSD clinicians, were using their tobacco medications more often, so they were getting more drug to help them with their smoking urges.

I think that there are other more subtle things going on here, and it's not just dose. I think the quality of the relationship that mental health professionals have with their parents is very intimate, very special, and we have a lot of leverage to motivate patients within that context of a trusting and aspiring relationship, as opposed to a referral-based situation where they go and talk to another provider that they don't know, time limited. They just don't have the trust or the leverage of therapeutic reliance. But I can't prove that.

Next slide. Okay, well it basically reiterate. Next slide please. It just to reiterates. Now I will say on that last comment that as far as why did integrated care work better, it is true it is the dose. But we're able to measure statistically the effects of things as to how much of the result was due to one versus the other. It turns out that 40% of the reason for variance as to why integrated care worked better than standard care is because of those dose variables. To be more specific, 30% was because of the increased number of sessions, behavioral counseling sessions, for tobacco that patients integrated care. 10% of that variance had to do with the medicines. That's not saying that therapy, talking therapy, counseling is more important than medicine. I'm not saying that. In this particular study it seemed to have more weight. Both interventions are needed, medicine and counseling.

Now there was a lot of concern and some evidence in the past that if patients quit smoking, their depression or PTSD would get worse, because after all, they cope with those symptoms by smoking to calm down. That's the first patients will tell you. That proved to be absolutely false. If we compared patients who quit smoking versus those who did not quit smoking there was no regression at all or difference between those conditions in terms of relapse or worsening or PTSD or depression. And as time has gone on, more people have done these studies, and think I we can now declare that the worry that patients will relapse to depression, or have their psychiatric symptoms worsen if you successfully treat their smoking, that that's a myth. I don't think that's going to happen. I will say, however, that what can really ensure that lowering that risk of relapse is for them to continue to stay into treatment in mental health. That's maybe a buffering effect to prevent that relapse back to worsening depression.

Okay, the other concern here that is on people's minds is that if I, as a mental health provider who is really charged with treatment patients for PTSD, which they come here for, their depression, that's my business, that's my job. That's what I'm told to do. If I start spending some of that time in our sessions talking about smoking rather than talking about PTSD people worry that I'm shortchanging the patient and not giving the full dose of PTSD treatment because we've kind of shunted off some of our energies

towards this other topic. So there's a lot of anxiety that patients will not do as well with respect to reducing their PTSD symptoms because we're spending so much time talking about smoking instead. Not true at all.

Patients who received integrated care from us, take me for example, where I was treating PTSD plus smoking, did just as well with respect to having their PTSD symptoms relieved, as did a patient who was randomly assigned to get their smoking elsewhere, from another provider attending only to their PTSD in their sessions. So the point is that your worry that you're distracting yourself and your patients is the primary mission of PTSD care, that's not a worry. You can do both without jeopardizing the patient's care, the primary presenting illness.

Okay, I think that I'm getting -- if I got it right, I've got one more minute, so I'll go ahead and do this. The whole issue of having these studies done and data sitting around in warehousing websites is that they cannot be used for or translated into clinical practice. That's the risk of it. So the VA has taken a full-on effort to translate these findings into clinical practice to get clinicians to actually do the treatment. And we call that "uptake of the innovation."

So I'm just going to orient you very quickly to an iPhone app. It's called "stay quit coach." Why don't you just advance through the slides very quickly, please, so the audience can see. It's a collaboration between the National Center for PTSD and we have the Telehealth Development organization and so on.

Yeah, so you can see how this goes. Many of you are probably very computer savvy and use apps. This is the home screen. You can see that there's, yeah, coping plans, you know. Next slide please. Okay, that let's go back. There you go. Let's just end there. I'm just giving you a sampling of some of the menu options on this iPhone app that you can download at the App Store. There's also a non-app, you know, non-Mac, android version of this available. It's really a good program, and you can find it, again, just on the Internet, where patients, particularly those who substitute for clinical intervention. But how it should be used, it's for patients who are getting a clinical intervention from you could also be using this app and using it after your treatment is done to help prevent relapse, or, more importantly, recover from relapse when it occurs. So the whole program is really laid out in that iPhone.

So there's other things we have done by way of implementation, called a "learning collaborative." You could about that more in maybe in the question-and-answer period. The slides are in your appendix and really lay that out, should DOD wish to pursue that avenue as well. So I think I'm done, and there may be some polling questions if I'm not mistaken.

Okay, after attending this webinar, do you intend to ask the patient about tobacco use? Well, success. It looks like we have a good hit rate there, 100%. Do you intend to ask the patient if you can assist them to quit? Great, perfect score. A+ for everybody. It looks, to me, I think the last one is very important. After attending the seminar do you feel you possess a level of confidence and clarity to help your patients to quit? Actually, what's encouraging about that is the score is higher, because there's no way in a half-hour talk I can educate you about how to be you know principles of tobacco cessation. So I think it's encouraging nearly 80% of the audience has the skills now, today, to do it. That tells me that the DOD has been very assertive about arming you with that skill set and that knowledge.

No surprise that maybe a quarter of the audience is a little shaky about it. No worries. Remember what I said, doing tobacco cessation treatment, even if it's just five days, is as easy as falling off a log. This is a drum beat of other clinicians who have learned this. They don't even want me to talk to them anymore. They just pick up the manual and the paper material and kick me out of their training session because I'm distracting them, because they can just pick up the manual and figure it out on their own. There are so many resource on the Web and so much has been formulated in practice guidelines, you know, DOD and VA, U.S. Department of Health. This is all just laid out in very nice diagrams, and any skilled clinician will just be able to pick it up and do it and make a lot of headway. So those of you who are a little bit shady in your confidence, lacking, please access those websites and maybe talk with a colleague or peer who has been down the road and you will feel very comfortable very quickly.

I don't know if there's any other polling questions. I think that may be it, so I will stop talking.

Thank you for your presentations. If you have questions for Dr. McFall, please submit them now via the question box located on the screen. Now it's time to answer questions from the audience. We are monitoring the question box and will forward questions to our presenters for response. If you have not already done so, you may submit questions now via the question box located on the screen. We will respond to as many questions as time permits.

So our first question, "The Marine Corps tends to use other tobacco sources, such as dip and chewing tobacco. Has this been addressed with leaders, and how does the PCM address this in the clinical setting?"

Sorry, John Oh here, I guess that's for me. You know, I think that a common theme is that there are a number of emerging tobacco products, including electronic cigarettes, and, you know, it's really, I think, incumbent upon us to try to brief it to leadership. Now I think one thing that I've learned is that when you speak with line leaders, you know, flag officers, I think that, at an abstract level, arguments toward health, they certainly are supportive. But I think that the best way, I think, to get through to them is to sort of put this into terms that they can kind of understand.

What line leaders really understand is they understand military productivity, readiness, and they also, you know, understand the economics, you know, sequestration and all the stresses that we're undergoing. You know, I what I try to emphasize is that Tricare has estimated that tobacco costs DOD $1.6 billion annually in health-care costs and lost productivity. I think many of you know that our health-care budget in the military health system, or I should say Tricare, is over $50 billion a year. It's about one in ten dollars that DOD spends, and that amount keeps growing, you know, every year.

So I think it's really incumbent upon us to sort of make the case that tobacco is not just about, you know, having nice breath or looking better or health, it's really kind of gets down to the readiness of our force, as well as, really, the sustainment of our military fighting capabilities.

Dr. McFall, I believe this next question may be for you. "What are your thoughts on short-term electronic cigarettes, which may be used as a nicotine replacement in short term? It may also assist with the habit of putting something this mouths."

I don't want to pretend that I'm an expert on this. I defer to others. But in preparing for this talk I guess I would say that there are concerns that the -- I'm reaching for an article actually that is pertinent to that that the FDA has. You may want to check out the FDA website. But the concerns are that, first of all, it's not an FDA-proved method of treatment, okay, like nicotine replacement therapy and so on, so it's not FDA approved, and people don't know, really, what's in these products, electronic cigarettes, whereas as our manufacturers the chemical composition, you don't really know what's in there. So that's one statement. It's not an FDA-approved method of treatment. A lot is unknown about these products in terms of what you're really ingested.

And, finally, I can tell you that the VA does not recommend that as an evidence-based method of treatment. I know that others, as I read in the media, others are more enthusiastic about it in helping people to quit. But we do know that those who use -- I've been told by informed sources that those who do use electronic cigarettes tend to also use combustible cigarettes. which, if you're still involved with combustible cigarettes, there's a high likelihood you're going to continue to do that, and possibly ratchet up your use of that.

So I wish I had a more definitive answer. I think we just don't know a thing, that couldn't be helpful, but we don't know for sure that it is. And right now we're just recommending traditional methods of treatment for people who want to quit and to include nicotine replacement therapy, medicines like Bupropian and Varenicline, as prescribed a licensed health-care professional. As you know, nicotine replacement therapy -- patches, gum, lozenge -- are available over the counter without a prescription.

Hey, this is John Oh. Can I just also address the electronic cigarettes, Commander Barry.

Yes, please do so.

Yeah, so the "Air Forces Times," they did an interview with me a couple of days ago about electronic cigarettes. I mean, clearly, this is an area that is controversial, it's an emerging area. You know, the latest estimates in our Air Force is that we've got about 5% of our airmen that have admitted to using electronic cigarettes, and it wouldn't surprise me that that will keep getting higher and higher because I think for high school students we're up to about 10% that have said that they've tried electronic cigarettes.

So in the Air Force we categorize electronic cigarettes just like any other tobacco product, so they're subject to all the same types of re-r restrictions in terms of where you can use tobacco products. So, for example, we have a tobacco-free medical campus policy, and that means that you can't use cigarettes, cigar, smokeless tobacco, and electronic cigarettes. Now I'm very appreciative of the very impassioned arguments of some that have said that, "Hey, electronic cigarettes, they enabled or helped me to quit smoking." And, you know, there's the harm reduction-type argument.

To that I'll say that, you know, right now we do have FDA-approved forms of tobacco cessation, and we kind of encourage our airmen and others to use those. I think we don't really know enough about the long-term health effects, the second order of consequences of e-cigarettes to start recommending that we treat them any differently. And, in fact, the FDA categorizes them as an e-cigarette, I think as many of you know.

But I think our real concern with e-cigarettes is that if we have a different policy for them, that -- you know, the biggest concern I think that we have, those of us in the public health community, is that could e-cigarettes start being a gateway drug, you know, whereby people will start using them, get hooked on nicotine, because ultimately they are just a nicotine delivery device, and then expand their use to other forms of tobacco products that we know are more harmful, like cigarettes and smokeless tobacco and so forth.

I think the other concern is that, you know, e-cigarettes, if we don't have the same rules then it may actually make it harder for people to quit smoking cigarettes, for example, because in situations or in areas where they can't use cigarettes, they'll just light up on their e-cigarette. And we often note that one of the best incentives to quit smoking is tobacco free environments because that there help kind of motivate one to try to quit. I think e-cigarettes, it may give those that are hooked on nicotine an out to sort of perpetuate the habit.

And I think another concern also is sort of with e-cigarettes, if we start seeing them in various venues, restaurants, sporting events, I heard like at the Golden Globe Awards they were puffing on e-cigarettes in the audience. I didn't see it myself. But, again, it's sort of contributing to -- it's working across purposes, so I think what we've done in the last generation in terms of trying de-normalize tobacco use. It's sort of taking a step backwards.

So I think that we're certainly open to adjusting our policies in the Air Force. Right now there's not any DOD policy on electronic cigarettes, but we're open to it. But it's going to have to be based on evidence. We want to have science-basted policies. So if we want to make any change, we want it based on the fact that we know we're comfortable with the long-term safety and the risks. Yeah, I think my point of view in this is really -- I think, Dr. Oh stated it exactly. And certainly we treat e-cigarettes in the same as regular smoking, which is you cannot do it on campus. There are designated places where it happens.

And I would caution people against the temptation that patients may say, "Well, they'll just cut their smoking in half, from 20 combustible cigarettes down to 10 and use e-cigarettes and they'll think that they're healthier. There's no evidence that that's the case. I see all kinds of problem with that, one of which is there's evidence that actually nicotine content, the density concentration of nicotine in cigarettes today is greater than it used to be. So the addictive potential, even at the smaller number of cigarettes because of the higher nicotine load is a problem with respect to maintaining addiction. And there's always

the behavioral issues of hand-to-mouth contact and rituals that one goes through, whether it's an e-cigarette or a combustible cigarette, the pathway is too close and makes it, in my belief, a challenge to get over as far as actually having people quit all of it together, which is the goal.

This next question is for both of you. And thank you for providing us a really nice conversation and discussion on our questions. The next question for both, Dr. McFall and Colonel Oh is, "Will there be more training focusing on treatment best practices, such as nicotine replacement therapy?

Yeah, so this is John. I wasn't sure who was going to answer first. I think, clearly, as I outlined in terms of, you know, the tobacco free-living game plan, we need to optimize clinical cessation support. You know, we'd think that everyone sort of follows the VA DOD clinical practice guidelines, but I think there's probably room for improvement. You know, certainly I think there are some skills that are captured in the Public Health Service Clinical Practice Guideline, which I know in the chat room, it's actually identical to the VA DOD Clinical Practice Guidelines. You foe, for example, I think there's a lot more emphasis in terms of using motivational interviewing techniques.

So, for example, I've give you sort of a scenario that I've been trying out more recently, is that there was a study published about a year ago, which looked at the number of years life lost from smoking cigarettes. And it turns out it's about ten years of life, on average, those who smoke cigarettes lose. But the good news is that if you quit you can regain a lot of those lost years, and especially if you quit when you're younger. You know, I mean certainly it's best to quit any time. But if you quit by the age of 40, you can get back all of those years, and I think that's a very important message. I think some of the folks that I see, you know, over at the pentagon, they're you recall more senior in rank, and they're going to be putting in their 20 years minimum to retire. Many of them have already gone past the 20 years, so they're going to get that nice defined benefit military pension that congress, thankfully, you know, restored. And I try to tell them, hey, you know, let that pension some -- you know, take full advantage of it, let it stretch out. Why give back, five, six, ten years, or so, from this smoking habit.

So I think it's really a question of, you know, how do we come up with the best messages that they resonate with a particular person, and then I think that's realty the crux of motivational interviewing. So I know for myself that I'd like to sort of learn more about that particular technique and, you know, I think it's a great opportunity to, again, as a primary care clinician, to sort of partner with the experts in motivational interviewing, which is our mental health professionals who really understand, I think, you know, behavioral change and addiction and so forth.

I can add a few comments on the VA side. That's what I'm familiar with. So think the question was about training. I think what Dr. Oh said is right on target, about motivational interviewing, because in reality, most mental health patients seen in primary care or seen by somebody other than a mental health specialist, for a variety of reasons. So outfitting our primary providers with some rudimentary behavior change skills is key. In the VA we've hired at the medical center what's called a "behavioral health coordinator" that's embedded in primary care. And those people are typically psychologists, and their job is to do just that, which is to train as in primary care providers as they can get their hands on, on how to do brief motivational interviewing techniques to target tobacco, as well as other health risk behaviors. So that's happening today, as far as the training intervention goes.

On smoking, more broadly, the VA is very committed to -- I don't think proving the tobacco decision works as an intervention. That's been proven. It's basically getting providers to actually do what we know works. So, in fact, there was a webinar just a couple weeks ago -- I think Dr. Oh participated on it -- that went out nation would. There's a training the VA is offering in, actually, two weeks for provider throughout our entire country, VAs throughout the country. It's going to be in Atlanta, Georgia, to basically teach them how to integrate tobacco cessation into their practice, not only for mentally ill patients but also for patients who are in substance abuse programs, or, of course, patients who are at very high risk for smoking, as well as medically ill patients who don't have a concurrent psychiatric illness.

I will emphasize one point, too, that the reasons for quitting are very important to establish on a personal note for patients. Many of the mentally ill patients I see, they don't care about living longer. Their life to

them feels very painful, and idea of having more of it doesn't appeal to them. So it's very important to come up with reasons that are personally relevant to them. And that may be, really, the quality of life that they're living now for the years that they have left. I mean I've had people quit when I told them that there dog is twice as likely to get cancer and die as a result of their smoking, and they were horrified by this fact when I showed them the paper. That was the incentive for quitting. It wasn't about them. It was about Fido.

So you never know what you're going to discover as you try to mine the personal reasons that a veteran may have. You know, it may just be wanting to share experiences walking in the woods with their granddaughter, as their grandpa did with them. And they can't do it because they're out of breath, and they would like to have that experience. So it could be very personal. And I would encourage you to find those reasons so they don't end up kind of letting them know that smoking is going to dill you and you should quit so you live longer. That will work for some people, but perhaps not others.

The next question I have for Dr. Oh. With the Air Force closing the health and wellness centers, is integrated care with mental health, taking the smoking cessation program, and where do you see the program going?

Yeah, so I think we've got challenges, obviously, in our health promotion program. I think, you know, the biggest thing is that in the military health system, Dr. Woodson, who is our assistant secretary of defense for health affairs, he really refers quite a bit to we need to move from health care to health. We need to be less a health-care organization and more an organization that kind of helps actualize health for everyone. And I think in the Air Force what we probably need to do is we need to get more into the mindset that health promotion is not something, whether it's tobacco cessation, promoting physical activity, or, you know, healthy eating, or whatever, it's not something that sort of, you know, is compartmentalized just to a couple people at work and health promotion. It's got to permeate throughout the Air Force medical service.

So I think that, you know, there are some opportunities, I think, to expand tobacco cessation services. It's probably a little bit early to sort of say definitively, you know, because I'd just really be kind of if she can late at this point, but I do think that, you know, there's a big push in and out in the military toward this whole concept of patient-centered medical home, PCMH. You know, we're going to be aiming for all of our medical treatment facilities to be NCQH certified as PCMH, and I think there's opportunity to partner with PCMH, with the mental health, and with various other stakeholders, not necessarily even on the medical side. You know, for example, we've been partnering with the youth centers on the annual campaign for Tobacco-Free Kids Kit Butt Day, which is coming up on, I think, March 19th. So I think there's some opportunities to sort of kind of collaborate within other medics, as well as on the line side. But, clearly, I think that there's opportunity to improve what we're doing.

The next question is a two-part question. First, Dr. McFall, is it a standard VA practice to follow the recent quitter for nine months, and following up with this question, Colonel Oh, what level of follow-up support or care is provided to a recent quitter in the military.

I can handle the first part. The answer, no. You know, if you've seen one VA you've seen one VA. So there are differences. There may be some VAs that do follow patients over time. But I suspect that that would be rare. Many patients are treated in primary care for smoking. And the concern I have about that is that the intensity of the delivery of care -- remember, dose response effect -- that the intensity may not be what's required to get a good result, particularly with patients who have a co-occurring problem and a mental disorder.

So you may be able to in primary care environments, the mental health professionals who are there, typically do briefer care. So I think if I had the answer to the question one way of the other, yes or no, the answer would typically be, no, there isn't that follow up. And that's what's got me into this study that I told you about, because, as mental health professionals, we naturalistically, especially mental health, especially in mental health, we naturalistically follow our patients many times for many, many months, and many times for many, many years. We treat people with chronic mental health problems, so we actually

have that baked into the cake, that long-term relationship. So what I'm trying to do and others in the VA, is to get us mental health professionals, to embrace just what you asked about, which is to get our patients to make a good attempt and, in fact, follow them up for nine moneys or a year or two years or three years in the course of their clinical care. And it's just part of the standard with practice.

So I would say, no, we're not doing it system wide. But, yes, some mental health programs, particularly PTSD programs, are doing this, because we've been working in the integrated care environment for many years trying to implement this method that I described to you in the space. So it's in transition, a work in progress.

Yeah, so this is John Oh. I think it's hard to sort of generalize, because there's not really any enterprise level kind of standard in terms of follow-up care for those in the military. So I think you're going to see some variability depending on the clinician and depending on the particular facility, you know, tobacco cessation program. I do think that, you know, since tobacco is listed as a vital sign and so it's going to check periodically -- I'm sorry, at every visit. I think that it's an opportunity for clinicians just to continually kind of check and see how progress is and to kind of help congratulate those that are maintaining abstinence, maybe asking about how well things are going, some temptations or, you know, high-risk relapse situations and so forth. But I think other than sort the individual clinician, sort of really reinforcing kind of tobacco-free living, that's probably the extent of what we have.

And similarly, I probably should have mention, we, too, have a call in the VA what are call "clinical reminders," when patients come back periodically. Every year or so these reminders turn on in the medical record where your providers are asked to screen patients for tobacco use and other things, so we have that. But by follow up, I was referring to if you deliver an intervention to help patients quit, do you routinely follow them periodically over time to see if they have relapsed or not. That latter is not in place, but the former is, of recurrence screening.

All right, that will conclude our questions at time. Thank you again to our presenters. Today's presentation will be archived the monthly webinar session of the DCoE website. To help us improve future webinars, we encourage you to complete the feedback tool that will open in a separate browser on your computer. To access the presentation and resource list for this webinar, visit the DCoE website at dcoe.mil/webinars. An edited transcript of the closed captioning will be posted to that link, and an audio recording of this webinar will be available as a downloadable podcast.

The next DCoE traumatic brain injury webinar topic, "Progressive Return to Activity follow a Concussion," is scheduled for March 13th, 2014, from 1:00 to 2:30 p.m. Eastern Standard Time. And the next DCoE psychological health webinar topic, "Mild TBI and Co-occurring Psychological Health Disorders, is scheduled for March 27th, 2014, from 1:00 to 2:30 p.m. Eastern Standard time. Thank you again for attending, and have a great day.

This now concludes today's call. You may disconnect. Thank you.