Transcript: February 2015 CardioLAN Webinar

The Health Impact of Tobacco Use & Cessation

Cindy Sun: Hello, everyone. Welcome to the HHQI CardioLAN Webinar. This particular meeting is held in February of 2015, and I mention that only because this is being recorded, and we do not want you get confused if you do go back and listen to this again. The content presented today will be available to you on the website as an archived recording.

So I would like to welcome everybody, and thank you for taking the time to join us today because the content that is going to be presented by Dr. Karen Hudmon is something that we hope that you will be able to implement almost immediately into your current practice. Karen will be along in a little bit and be able to introduce herself and give you more of her history of how all of this has impacted her practice. For those of you I haven’t met, my name is Cindy Sun, and I am one of the RN Project Coordinators on the call today. And with us, we also have Stacie Deslich who is a health information data analyst. Stacie will be along in just a minute to talk about what is going on with the registry. So before we go on, I want to just mention that this is a webinar that many have you called in. The lines are currently muted; we will unmute the lines a little later in the call for Q and A, but you can also chat your question to us through the chat window on the right side of your screen, so please use either way. If you are using the computer only, not phoning in, you only be able to communicate through the chat window so please submit all of your questions that way, and we’ll get as many as we possibly can. So at this time, I am going to go ahead and turn this over to Stacie for Stacie’s Corner and a campaign update. Stacie you may have us on mute.

Misty Dyke: Cindy, this is Misty Dyke. Stacie might be dialing back in. I do not see her on the panel.

Cindy Sun: Oh, okay, well it is no problem at all. Now I am not as good as Stacie so I will apologize to all of you in advance, but I can tell you, she has some really interesting news to share with everyone today and one is that the measure performance rates are holding steady; this is talking about Home Health Cardiovascular Data Registry or the HHCDR. So for all of you that are performing on that, we thank you for continuing to do that, and it is really interesting that what we have found is that Aspirin – which was the measure that was the most abstracted in the past – this month, blood pressure is catching up and tobacco has surpassed it, which is very interesting considering that is the topic of our conversation today. So for all of you that are continuing to abstract, thank you for doing that, and we hope that you are starting to see some value to what you are doing. We know that, abstracting and entering information in to the registry is new, but hopefully this is starting to show up as to where you can focus your efforts and where are some gaps in care or do you have any gaps in the care that your patients are receiving. So it will be interesting to watch over the coming months to see if tobacco remains the most abstracted or if blood pressure or the hypertension measure takes over. So we will go ahead and watch that. We would also like to say congratulations to St. Rita’s Home Health from Lima, Ohio. St. Rita’s Home Health was the first agency in January to close-out their data for the month. So keep in mind we want to highlight all of your efforts, so we look forward to seeing who is going to be first, who has already closed out their data for the February month. So with that, we will go ahead and turn this over to Dr. Karen Hudmon and ask that Dr. Hudmon go ahead and introduce herself because I want you to understand her intricate knowledge of this entire topic, so Karen, thank you I will turn this over to you.

Dr. Karen Hudmon: Great, thanks. Can everybody hear fine on the other side?

Cindy: Absolutely, you sound great.
Dr. Karen Hudmon: Perfect, okay, so I am a professor at Purdue College of Pharmacy. My background is in pharmacy, I am a pharmacist but my doctorate is in public health and as a graduate student at the University of Texas and the Anderson Cancer Center, I started studying tobacco because quite honestly it was personal. My mother had died of tobacco-related illness. She developed lung cancer when she was 49; she was dead at 50. And so as a graduate student, a blossoming student, I was looking for an area that was meaningful to me that also could have a large impact on public health in general, so as I was pursuing my doctorate in public health, I was studying epidemiology and I was studying behavioral science, but I still had my clinical background from pharmacy, and I was trying to find a way to merge those two fields together and it made a lot of sense at that time and still does today. I just turned fifty, the age my mother was when she died. So I have been studying tobacco for quite sometime and I have been studying it in different venues, I studied the genetics of tobacco use looking at predictors of individual starting smoking based on your genetic profile, I have studied ways to measure tobacco use and addiction but the most important thing that I have done was, in my, for my perspective, for my career is developing a tobacco cessation training program. And when I was at the university of California, actually before that I was at the Stanford Research Institute, I started working with a group of faculty, pharmacy faculties across the state of California to develop a tobacco curriculum because I had just completed a survey of pharmacies throughout the state of California that showed that like that less than nine percent had had formal training for helping patients quit smoking but they were almost, all of them were interested in getting training as that would increase the number of patient they counsel, the quality of their counseling they though they could make a difference and so to fill this gap in knowledge within pharmacy which is actually not unique to pharmacy, it is really all health professional disciplines to have a huge void in the amount of tobacco education training that they received as clinician during training and/or post graduate. So we developed a program started with pharmacy and then we extended to every other discipline essentially, working with different groups through out the country which then brought me together with this group, which nobody really looked at much about tobacco for home health care. And so I was very interested in that so we can talk a little bit more later about why I think that, the work that you did could have an enormous impact on tobacco cessation initiatives that have been started and other settings and then transition into the home health care. So the program that we developed called Rx for a change it's been in existence, unbelievably fifteen years. And I count the gray hair so I have from all about that we developed it without funding, we then later got a grant from NAH to disseminated to schools of pharmacy and we had like 98% of the school participated in trainings and 85% actually adopted the curriculum so we had a massive change in the pharmacy profession for our preparedness for helping patients quit smoking, so if that is not worth, you know that is great to be doing a pharmacy but it is even more important to work with other disciplines because what we do know from the clinical practice guideline which was published in 2008, it was the third version. Is it when patients hear that quit smoking methods or get assistance from multiple types of health care providers they are much more likely to be able to quit and to stay quit. So it’s important and the approach that we take now in helping patients quit is more of a team-based approach that is what we are promoting. So we know back in 1964 – you know, I remembered that because that is the year I was born – this was C. Everett Koop who was probably my favorite surgeon general, and he said “Cigarette smoking is the chief, single, avoidable cause of death in our society and the most important public health issue of our time.” Every form of tobacco is harmful, so harmful in different way, some are worse than others but all of them are harmful and none of them should be promoted by a health care provider, ever. And so, we recently have the fifty year anniversary of that and there was a new surgeon general support that came out and I was fortunate to see and meet the new surgeon general give a talk about that report, earlier in 2014. So, we do know that the trends in tobacco use have gone down substantially, if you look at this graph, males have always been higher than females but now we are under twenty percent. And we have been a couple of years but the decline is slow. So there is more work to be done but the good news is that that almost seventy percent of patients who smoke want to quit. So to me that is an opportunity, most of them do not know how to do it, you know, how to get the best type of help, a lot of them, most of them try to do it without help but just, you know not at good thing and I’ll show you some things in a
minute but the other thing is that most of try to quit in the past year. However you see a fifty percent, fifty three percent or so try to quit in the past year but that is, you know the greatest question of why are not more being successful? We have successful methods, we need to use those, and we need to recommend them to patients. And so that is part of the mission, what we do with Rx for change and our faculty across the country. Tobacco is harmful, I don’t need to tell anybody on this call back here we list some different gases and particles that all bad; you know nicotine is actually not the harmful part of tobacco but it keeps people coming back for more, it is the addictive component, that keeps bringing them back and they are exposed to the other human carcinogen; so there are eleven proven although there is more almost seventy, that are actually suspected with a pretty significant amount of evidence that suggests that they really are carcinogenic but more data need to be shown to show that their proven. So you know as I mentioned nicotine really does not cause ill effects of tobacco use. Contrary to what a lot of people think so in 2014 this the report of the surgeon general that I just mentioned, you know it is a very thick document if you, if you have not seen it, I encourage you to try to get your hands on, take a look at least feel how heavy it is because there is so much of evidence, you know, tobacco use is probably the most studied topic ever and you know, with in the realm of health care, in terms of evidence or what is you know the negative health effects but also the you know the benefits of quitting are very well documented as well. So here we list a lot of major conclusions related to this report and on the sex side, I want to highlight that tobacco causes negative effects on virtually every system in the body; every organ, every system, everything. And so here we have the long list that comes from that report and so, you know, we often think lung cancer and you know alone is the number one tobacco attributable death. It is actually cardiovascular metabolic diseases. Now if you lump together lung cancer with other cancers, it is higher than cardiovascular disease. So either way, no matter how you look at it, no matter how you slice it, cardiovascular and cancer are at the very top of pulmonary is just right way behind it. And that is what you expect, but we also have a lot of deaths related to second hand smoke which can be very important in a home environment which can be very important to the work that you do as well. So we are converging on half a million deaths annually which is a lot of people that could, their death could be prevented through tobacco cessation or failure to initiate tobacco use. So we are back to this one, I highlight in red to specific area so that I want to talk a little bit more in depth about, so if you are in a cardiac discussion group here, talk a little bit about cardiovascular diseases associated with tobacco use and who knows what the mechanisms are, but I also want to focus on postoperative complications here at the bottom because transition home after surgery is also you know something at home health care is responsible for. So let’s talk a little bit first about cardiovascular diseases and so there are many postulated mechanisms we know, the people who smoke are more likely to die due to tobacco use. We know the people who smoke have worst lipid profile. You know, they have inflammation, they have strokes, thrombosis, and so the mechanisms that underlie this are caused by tobacco, you know say for example thrombosis smoking activates platelets, in an increases platelets aggravation which we leads to stroke and leads a blood clot. Patients that smoke have lower HD cholesterol level which is good cholesterol and higher LDL and triglyceride levels. And so that effects the lipid metabolism so all these factors working together put a stronger load a cardiac load on the patient makes the heart work harder and it increases a oxygen demand and it decreases the oxygen delivery. So all these factors working together and lead to cardiac related tobacco disease. Okay, so on this slide, this is actually really interesting data that was put together by my colleague Jodi Prochaska who used to be UCSF with me and now is at Stanford and she developed the cardiac version of Rx for change. She also developed psychiatry version of what if you are a little bit of cardiovascular version later in the talk. So standard treatment to reduce the risk of deaths among patients with cardiovascular disease, and so aspirin 15 percent, beta blockers 23%, ACE inhibitors 23% and statins 29 to 35% percent. So what we know is with each puff of a cigarette blood pressure will increase on average at 20 mmHg so think about your blood pressure measures, okay. The blood pressure lowering effects of medications is really modest and for the most single agents like, if you see one of these independently the others about 10 to 15 mmHg reduction for systolic blood pressure, 6 to 10 for diastolic blood pressure. So smoking will increase the blood pressure and what we call it dose dependent response and smoking cessation can lower blood pressure if you quit completely by about forty mmHg which is none of the medications compare so you can treat the
conditions with medications; however, it is not going to cure the cause. So when you quit smoking, you can actually reverse lot of the negative health effects of tobacco use on the cardiovascular system, it takes sometime but it is actually is reversible over time. And so quitting smoking unlike cancer where if you, cancer process is already started in somebody's body, you cannot reverse that by quitting smoking what you can do by quitting smoking is starting adding on additional risk that you would get if you continued smoking. Okay so cancer you cannot stop it but you can keep it from getting much worse if it has not already started the cancer process now with cardiovascular you can sure reverse a lot of it; so many reasons to quit smoking and in patients with cardiac disease, so let us talk about some of the relations here with postoperative outcome. We do know that quitting smoking will improve surgical outcomes but the other benefit, patients that are undergoing surgery is kind of a window of opportunity if you can get them to quit smoking because of the surgery especially if it is tobacco related there is a good chance of they will be able to quit, and stay quit for good. So if you get the right help, okay. So quitting will reduce the incidence of cardiovascular complications, this is all related to surgical outcome, respiratory complications, wound-related complications, and also preoperative abstinence can decrease of frequency of intraoperative ischemia. So these are data that have been published in the peer review literature and we actually worked with some folks at the Mayo Clinic, David Warner and Lowell Dale developed a version of Rx for change for surgical provider. And so that was a really unique version or application of Rx for change, they kind of took the lead on and working with some of the anesthesiology societies as well as the wound folks; so surgery, smoking cessation reduces post operative complications, here are some data from a clinical trial. Hundred and twenty orthopedic patients randomized to receive a tobacco cessation intervention or a control group, six to eight weeks prior to surgery and if you look at the data here, the control group, okay, the percent of complications versus the intervention so much lower in patients who actually have the intervention were able to quit. So 80% of intervention patients were able to quit or reduce smoking and reduction will lead to improvement but it is not as good as quitting completely. Okay, so here is the citation, I try to read citation incase somebody wants to pull the original literature. Okay, so we talked about some of the death due to second hand smoke, you know, there really, there is no safe, there is no form of tobacco, they are all harmful and it is not safe to be around any form of second hand smoke, so basically, you know nothing. So second hand smoke cause premature death and disease in nonsmokers in children, it causes this. It is associated with an increase of risk for SIDS, acute respiratory infections, ear problems, exacerbated asthma. Here is another one, respiratory symptoms and slowed lung growth if parents smoke so you know babies are born with lungs are not fully developed and so if they are exposed to that it slows the growth of their lungs. And then in adults, we have already talked about this, the most, you know lot of people are still expose to smoke in their home and work places, I know you have all been driving down the road and seeing, you know mother or father smoking in a car with small children in the back, and it just you know breaks your heart because there is no way that they can get away from that indoor spaces, eliminating smoking fully protects nonsmokers that you know having a separate area, then ventilation, clean none of those are effective. They are still harmful levels of smoke that individuals can be exposed too. And you know there has been several studies recently, meaning in the past ten years that have shown that indoor smoking bans have led to reduction in the number of acute myocardial infection, admission to hospitals and so for example in Helena, Montana, there was site is the first one that was done was actually it is my favorite study, ever published to be honest that I have been read. What they did was there, you know, they had no smoking ban and they implemented a smoking ban in the area of Helena and nothing outside of it, just that area and then that was reversed and so what they have was they showed a 40% reduction in the number of acute myocardial infarction admission to the hospital during that period, when there was a ban and then when they reversed the ban, the legislation was reversed that went right back to where it was. Okay and so that tells you that, yeah it is probably related to the ban but the other data that was really of great interest to this and provided some more credibility to the validity of that is it that in all the areas surrounding Helena there was no ban was ever implemented, their level of admission for acute MI stayed the same throughout the study period. So that was the data that I pushed for CDC to move forward with some of the recommendations for the you know indoor smoking bans and it is really to me was pivotal, absolutely pivotal in light of the indoor legislation that has been passed over the last
couple of years, so. Okay let us talk a little bit about smokeless tobacco, I did say there is no safe form of tobacco but we do know that, smoke, use of smokeless tobacco will have a lower incidence, it is associated with a lower incidence of lung cancer for example and for obvious reasons, because smokeless tobacco is absorbed through mouth, right it is not going into the lungs as smoke. However you have an increased of oral cancer and pharyngeal cancer and you know it is oral leukoplakia which is a precancerous lesion in the mouth as what you see here. So it also dental caries and gingival recession, and bone attachment loses and so that is very bad for your mouth basically. Nothing good about it, okay and so in the United States and these data were just updated in the surgeon general report. In this number here I find to be astounding for every pack of cigarette smoked, it causes society over 19 dollars and cost so then includes healthcare expenditures, lost productivity due to premature mortality that doesn’t include lost productivity because of increased morbidity. That is the just mortality. So these numbers are conservative and total like economic burden almost 300 billion dollars per year because of tobacco, very high and so you know that states that her you know going under because of healthcare cost they really need to look to the cause of that and ramp up their cessation programs. So really is no more effective intervention in terms of reducing healthcare cost and smoking cessation, so it should be on the top of everyone's radar. Okay, so we talked about some of the health consequences of the smoking, what about the health benefits, what are they? So you know really within 24 hours you started having some effect on the blood pressure and other things but the main thing is as mentioned here you know is that increased lung function is the pretty short time length two weeks to three months to get some of this improved circulation, walking becomes easier on the right in one to nine months you know is that really improved effects on the lung, noticeable improvement. Now some patient will say, sorry I have a bird who is having a good time back there, sometimes patients will say well it made my lungs worse, so the truth is when you quit smoking, it does feel worse for a while because your lungs are starting to clear the mucous or trying to get the crud out and so it does get worse for a short period of time. After one year excess risk of coronary heart disease, decreases to half of that of a continuing smoker. Okay, so this is some of the benefit as I said ger reverse over time. Risk of stroke is reduced to that of people who have never smoked after five years and then lung cancer definitely drops to half that of the continuing smoker and then it is really not technically decreases because you do not have additional risk adding on and so after it is secondly 10 to 15 years risk of coronary heart disease is similar to that of people who have never smoked. Okay, so lots of benefits of quitting and we do know that on average cigarette smoker die approximately 10 years younger than non-smoker. Okay, so it is not just about the length of life, its about the quality of life as wall and that is the, kind of one of the main messages that we gave the patient yeah and there is always the patient say so would if I die few years early because of smoking, well its not just about that. It is about how you like your life and how you feel and how you go through your life and so, though to continue smoking at least half will die due to a tobacco related disease. These data come from British physician's mail and British physicians are the longest that studies that were done on tobacco by Sir Richard Doll who is like the tobacco cancer epidemiologist from England, wonderful guy. But what we know even though these were male; we know that if woman smokes like men they are going to die like men and so the data shows very clearly that is not just about man, so even though that study was about men. So let us talk a little bit about nicotine pharmacology. So what happens when you smoke a cigarette within 10 to 20 seconds the nicotine reaches the brain and that is faster and the glucose which is the primary energy source for the brain very rapidly okay and so what happens that as you know you get that rapid satisfaction is actually alleviation of withdrawal in both and so that keeps you coming back some more, so that a immediate reinforcement you know from the nicotine replacing in that alleviating withdrawal so, nicotine pharmacodynamics. So pharmacodynamics is what the drug does to the body. It is supposed to pharmacokinetics which is let the body does to the drug. It breaks down and it is reset in so forth. So talking about pharmacodynamics what are the effects of the nicotine while you can see them here, this is no mystery to anyone who have seen it, but these were all the positive things about to that which make people want to continue smoking. Okay, on the left and then on the right you know we talked about the increased heart rate, you know cardiac output, increased blood pressure, nicotine leads to coronary vasoconstriction as well and so these are things that are going on the background. So we have to try to counteract our interventions for
cessation with trying out deal with the fact the patient wanted to continue smoke for the positive reasons. They enjoy it and feels good, keeps them out of withdrawal, so but we have to think about tobacco use as well as cessation is kind of a pyramid thinking about the individual, the pharmacology which we just talked about and also the environment. People that were around them we felt tobacco advertising and some people associates smoking with very specific behaviors like they have a drink and they smoke a cigarette. Okay and they also with certain people social interaction as well. Okay, but when we think about tobacco dependence as well as cessation we think if it is a two part problem. So physiological where you are addicted to nicotine we have treatment FDA approved proven medication for cessation. We have talked about those but is also behavior some people call to have it and you know like to me as addiction and you keep it back some more. So but we have treatments for that. It is a behavioral change program and would sometime like to separate this by treating behavior first while we give them a medication that would place as nicotine so they can work on the behavior and then later taper off as the nicotine replacement therapy and then addresses the physiological but both of them are important and you know it is true that the medication on its own can improve the patient's ability to quit however it is better if they gets the behavioral counseling with that. You really want to stack the patient to that you want them to have the best chance of quitting by giving them the best help that they were willing to take. Okay, so first let us talk a little bit about the behavior and I mentioned the clinical practice guideline with released in May 2008 which is I believe it is long time ago already and this is the third version, so lot of organizations worked on this together with the series amount of analysis basically states recommendations for how to proceed with the patient's intervention. So we did mention the effects of clinicians improve the patient's ability to quit and hear with the referent group of no clinician and non physician clinicians will give him the 70% increase and ability according to physician clinician more than double cessation with ability to quit then I would say these are averages you know it could be anyone individual that resonate with any one patient and you know that makes that difference for that patient pushes them forward to help and quit though you know everybody being involved is important and even if you are not in the 2.2 bar with the physician and then at the very beginning of this talk. I also mentioned that the more types of clinicians that help the patient the more likely they are to be successful and these are pretty significant numbers here. However even if the best bar which is 2.5 if you look to the left access here the Y-axis what you see is it is really just under 25% of patients are able to quit and stay quit if five or more months. We have lot room for improvement and so we know we continued to work on this but no quitting does not happen overnight and that is why you have to help patient you know it is like learning anything out and you are learning to be a nonsmoker. Okay so in the clinical practice guideline, they delineate the five stage process for helping the patient to quit and I love this framework. It is simple clinician get it and it does not use a lot of theoretical jargon, so you know you ask about tobacco use, they have advised the patient to quit. You assessed readiness. If they do not ready to quit, we will give them a very different intervention then if they are ready, right. Your system was quitting and he will arrange followup and that is where home health care comes into play in a very significant way. So you know what talked about arranging and unfortunately this is the piece of the 5 A's that rarely gets done. There is an intervention and there is no follow up at all; so huge opportunity here if we could operationalize way to make this transition happen that would be fantastic. So you can think here is essentially linear the number of sessions and does not matter how long they are sometimes more, its better but the number of interactions with the patient. It actually has a significant increase in the likelihood of quitting, so you know the multiple clinician and multiple sessions, medications and the behavioral counseling than you are going to pretty much maximize your chance of quitting it and does not mean that this has to be one person or one office or one home healthcare group doing all of this. Part of this can be done through referral to quit line were through online programs, so there is all kind of options now for cessation so we will talk a little bit more about this in a minute; but it’s a key to assist the patient throughout the quit attempt and to make them feel like they can come back but also not feel like if they stays with us; if the relapse and they are being judged. Okay, because of the very sensitized topic for the patient and most patient is not going to be proud of it and so they do not want to be lectured. They wanted an advisor who is part of the plan. He is not directing the plan for quitting and so I mentioned about the referral, you know I always tell people that I try and if you don’t have the time or you do not have the expertise anybody
can ask about tobacco use and advice the patient to quit and refer them to other resources. It is sometimes just that little intervention can be all the difference, okay and so here we talked about having somewhat else to assist and arrange and that could be the quitline: 1-800-QUIT-NOW. Here’s the number. So the Ask, Advise, Refer intervention could be done in less than a minute to be honest you know and if we all did that with every patient it will be amazing. So brief interventions have been shown to be effective intervention is you know less than three minutes have been effective. Okay so here is number 1-800-QUIT NOW and I am using get cards from the tobacco quit lining or stay. They would probably be more than happy to provide you with whatever materials you would need to help push the patient for the quit line. You know I actually, I had a research study where we had pharmacies asked by is now referred to the tobacco quit line and let me tell you based that up and we had a significant increase the number of patient who referred and I mean huge increase and just with even a small number of pharmacies we had 64 pharmacies in our study so really you know in people clinicians want to do something but they do not have time to do at all so they want to find a brief way to make a meaningful contribution but if you can do this the followup with the quit line, you can actually have the quit line call the patient if they want that. So that is called per active referral versus the passive referral where you just give the patient card and so called them and they’ll help, and I sat beside the counselors at Free&Clear or Alere Wellbeing which is based in Seattle and they service 20 some states now, those counselors are amazing and that is me saying it has been counseling for the patient for at least you kind of 20 some years so I think they do terrific job and that some think we should all be doing more, promoting the quit line or group programs have also been found to be effective in the clinical practice guidelines and recommends it. They do not recommend online programs but that only because there was enough data at the time of the guideline was published but my theory is, we’ve got all these options find what work for every patient and direct them in that way you know even if hypnotherapy does not work on the average of the patient and it does not mean it won’t work for some, it worked for my best friend, would I recommended it no, but she quit and she’s been quit for 15 years or so. Okay, let us talk about this physiological behavioral is essential you know the pharmacotherapy while the clinical practice guidelines tell this at all patient is attempting to quit and should use effective medications for tobacco dependence treatment accept with contraindicated with specific populations where not so much that it’s not safe but there is insufficient evidence of effectiveness and that is pregnant woman, smokeless tobacco users, individual smoking less than ten cigarettes a day and adolescent okay. So those are the groups with their insufficient evidence says that it mean that it cannot be used but with appropriate precautions; someone talked briefly about the medication options I do when the time request and so we will get through this. We have five nicotine replacement therapy formulations and the very first one was the nicotine gum and Ohio pharmacy student at Ohio North are working in line at Ohio. The group that just got the applause, working and when Nicorette came on the market, I said God what a great idea and then after that it was the patch came out and then the lozenge those three are available without a prescription and not that they weren’t back then, they were prescription. But now we have nicotine nasal spray and also the nicotine oral inhaler which are on prescriptions and the transdermal nicotine patch all these they can get it over the counter as NicoDerm CQ. There is a prescription formulation that can be dispensed with the prescription and therefore it perhaps covered by insurance. So those of the five different NRT options then what I really like about these options is that you are not introducing a new chemical agent like you would be with the tablets that we will talk about it in a minute. However all of them are essentially equally effective. They are all effective and so what we see here though and the problem with the nicotine placement therapy is a cigarette is very rapidly increased the plasma nicotine after you smoke. We talked about this few moments ago and also moist snuff; it’s not as rapid, but it gets very high. Now these are the ones you can buy in front of the pharmacy, which has kind of the bane of my professional pharmacy existence. I’ve been working on that, and CVS is now tobacco free but all the nicotine replacement therapy products with lines at the bottom so they do not get this high and they do not work this quickly and so what is that mean to the patient well the satisfaction not being immediately relieved and so part of the counseling message for the patient visit is not going to act like a cigarette. You need to keep it on board and your system to prevent craving, to prevent withdrawal, not to treat withdrawal and that is something that seems to get lost and
almost every counseling interaction. The patients wait till they need it, then they take it, well that does not work, you know it is not going to work for you in that way. You know the beginning dose for some of these like the nasal spray, the inhaler, the lozenges and a the gum is a minimum of nine doses a day when they start one dose every 1-2 hours, and if that is not something the patient can do and adhere too, then it’s not a good option. Use the patch or use one of the tablets. So lots can be told to the patients about the medications, you know, even just to get them to read the box would be a good start, especially for the gum. They think you just chew gum. Well there’s a very specific way to chew it because nicotine is being released. It is not just chew it. It is a chew two part based on whether they feel a tingling which is the nicotine being released from that piece of gum. So I could talk for long time about the medications but I wouldn’t. So the other options here are Bupropion and Varenicline and so Bupropion is available as Zyban and a generic and Varenicline is only sold as Chantix. There is no generic and it has not gone through the time course to get a generic yet but these are all so very effective medications so this is the nice thing about this is oral dosing. Okay, and so where the other ones are not well. The lozenge and gum are but it is the different type of those. So here what we see is the graph that demonstrates the long term which is to find the six or more months quit rate for available cessation medications and these all the FDA group medication you can see here and I do not want you to look at just the yellow bars because these were active drug versus placebo that’s it. So, the population Varenicline looks to be the most effective and probably is to be honest but these were not head-to-head trials, so you really cannot compare it that way populations could be different, its to be a lot of other confounding factors but you know if you look across the blue bars you look pretty similar the control for the placebo group though and the Varenicline looks to be the most effective however you can’t really say that and look at the nicotine nasal spray, the problem without when the people do not want to stay on it because of the burn and who uses nasal spray is actually not a very popular product expect perhaps among mental health providers like use that product that has a more rapid on some action compared to all the other or so. So they are all effective and we should be using them and we should be recommending them and now in the clinical practice guideline although they recommend combination therapy so you could have a patch on, the nicotine patch and then use a lozenge piece of gum when you have situational cravings where you think you are going to want a cigarette and still can be fine with your nicotine levels. You saw the graph, you’ve got a lot of room to go up to get where you would be with cigarettes, so and some patient say I do not have the money for it in reality it is cheaper for most patient to use the medication that it is to smoke and so you know if the average pack of cigarette is 6 dollars and 18 cents which is the current figure for the United States and highly very fall by state but you know most of these are less than that per day assuming that you smoke a pack of cigarettes a day which is 20 cigarettes or so. These two are little higher Varenicline and the inhaler but it is very short term use you know it is for three months than you have done, so where if he smokes you are going to be paying that for the rest of your life, so huge difference.

So I do want to talk a little bit about some of the opportunities in home health care but first I have to say to maximize the success for any patient to quit smoking, interventions should – actually I shouldn’t say “should” – they must include comprehensive counseling and one or more medications with followup care. Okay, you’re going to increase your change of quitting if there is no followup care but if you do followup chances are much more likely. Okay, home health care provides a truly unique opportunity to catalyze on the windows of opportunity. The patients are being transitioned from different settings with followup care with frequent contacts, you know even minimal intervention just talking about how are you doing and what is your challenges there in the home setting could be huge in terms of helping the patients stay on track, helping to assess what their challenges will be at home, before they even go home. You for example modification we see down here, modifications of home environment what needs to be done to make sure that you can stay smoke free once you leave the hospital, so in your home it is deterrent to that, and establishing some rules people smoking outside, getting rid of ash trays, changing routines where you normally would smoke and I could spend hours and hours talking about this so there is so many opportunity if they are interesting because I have never smoked in my life but you know having counseled 70 patient’s over the year you here what works for all these individuals and so
everybody is different and for example one of the excuses for not using the medication the patient often say as well I do not have the money for that $50 for about the gum. Well, one of my student actually say why don’t they ask their friends and their family members needs to donate five dollars towards that first box so that would be paid for and then the money that they would save from not smoking, will go into a can and then they would pay their friends and the family members that, what a great idea no patient never came up with that but I use that all the time now in my lectures and when working with the patient; so I think some opportunity is really exist for this group for followup care for especially in a tobacco related disease but not just for that, but for people who are going to be in an environment with smoke, you know in a smoking environment whether they smoke or not. Establish formal hand-off protocol for cessation assistance, so what is happen, I mean how do you handle that, I am sure everybody is different across the country but when you, when a patient transitions from one setting to the home health home setting what is done in terms of transition related to tobacco association intervention is there even one, I do not know. I think in some places there are and in others there are not, and sometimes, somewhere in the middle in for most. So try to establish that, globalize it, make cessation followup a part of the transition, the hand-off protocol and it can be a formal continuation of inpatient cessation programs, you can refer to the quit line or other resources, whatever works for the patient, but how did we start the discussion, you know, so hearing your chart it shows that you were in a you were using the nicotine patch while you were inpatient, while you were in the hospital, let us talk about what our plans are, for when we get home. And so lots of opportunities here and it is quite shocking to me that this has not been a focus, really ever, that in my knowledge and the tobacco literature for home health care, so. I encourage you all to work together on this. And then the other thing is you know, it really is an opportunity to enhance response to treatments, so even if you think of cancer, you know, cancer is bad enough in itself and almost all cancers are associated with tobacco use. Does not mean that all caused by it most of them are, but the truth is surgery, radiation and chemotherapy all three of them are negatively impacted by tobacco use. And so what it that mean, so are career care doctor should be addressing this with patients and maybe some of them are, I know they do at MD Anderson, but you know some people say that all they already got cancer, why make it harder on them. You know what, if you are going through this crappy treatment, you feel awful and why would you want to maximize your chances right, so lots of opportunities related to that, and you know wound healing and you saw the data, it really does makes a huge difference in complications postoperatively and so big opportunity here. Okay so I was asked to present a little bit information about some resources that we have and this is the Rx for change program, it is based in UCSF, this is the website, you can see here, we have different versions and these can be used to train healthcare providers. You’ve got the 5 A’s; Ask-Advise-Refer for brief counseling; a Psychiatry version; Cancer Care Providers, which I developed; Cardiology Providers, which is Jodi Prochaska’s – that’ what I’m going to show you here in a minute; Mental Health Peer Counselors; and Surgical Providers. So it is a different versions... they are really all about the same; the only difference is that we focus a little more on the specific disease state. We also have Spanish language, in fact these folks that I'm working with now, done some Spanish translation that they share which is just wonderful, and this is like one big happy family with Rx for a change, a lot of people working together, all over the world and in all different disciplines and so it really makes me a difference I think in tobacco education world wide. So, on our webpage on the left, just some basic information. Here is the visitor navigation menu; here is the available versions. You can register on the website; it doesn’t cost anything. We share everything. We do not care what it is; you can have it for free. We want you to use it. You do have to register and you do have to agree to an end user license which basically says you are not going to use this for profit – you cannot sell it; you can’t go on the speaker circuit, making a living off of it, but it is a very generous license and it is really only, we only have it because we borrowed materials from other people and put it in our program, and we promised that we would have that condition that other people would not use their material for profit. So this is where you would log in at the top right and basically you know, I always, I’m a hockey fan, I’m a penguin fan and I always sign in as Sidney Crosby, little does he know, but you can, you would log in here but you do have to register like I said and once you get in, you get the content navigation and these are the different versions on the left, probably flipped them through pretty quickly but I do want time for questions, you can click on any of them,
you can click on the left, you can click over here and this is a brief description of them to access materials and then once you get in, so for example in the five A’s, we have teaching materials, we have case scenario through counseling this is more part of this is case scenario who is really useful if you have more of a workshop and you know you see this in class, we have a lot of videos segments that demonstrate appropriate counseling, some recommended reading and so, we also have some CE programs but we do not provide the CE units for but they are prepackaged so somebody wants to use that can be used, you can really take our materials if you want to do whatever you want them, you can pretty much shorten your talk whatever. So if you click on teaching materials that what you find here you know the power point slides, these are the different modules of our Rx for change, introduction epidemiology of tobacco usage, nicotine pharmacology principles of addiction, drug interactions with smoking which is actually really important nobody knows about. It is not nicotine interactions it is actually the smoking the combustion products that has some clinically significant interactions with medications especially for medications that used to treat patients with mental illness and then assisting patients with quitting, we looked two hours on that because it’s so important and then aid for cessation and this is the full module the core module which you could take six hours, you know we recommend six hours including counseling and so forth, but you know when your clinician already, people do much shorter, you do what you can. You know we got some optional modules, if you scroll down and then we got these handouts which were just translated into Spanish phrase and so these are very useful to guide counseling, tobacco cessation counseling guide sheet, withdrawal symptoms information which is good to hand out to patients. These are things you could expect and this is what you could do to alleviate them, when you quit smoking then we have this very important drug interaction with tobacco smoke tool that do any as drug interaction that is known. How it happened and extend to which is modify the level of that drug. Okay the concentration of that drug, different tools, tobacco use log, coping strategies, planning for change worksheet, this is actually our curriculum is used by GlaxoSmithKline for more than a decade. You know, none of the authors of the program ever taken a penny from tobacco and pharmaceutical industry but we share and anybody can use them as one thing that they liked about our program is that was not funded, it is funded by us. So they actually wanted us to develop something like this for use in doctor’s offices planning of change worksheet and we did that. And it was a really good idea, it a good addition. The other really important tool that we have as a pharmacologic product guide the third one from the bottom, which is summarizes all the medications, all the testing everything about it. Very, very useful, that’s probably the most heavily utilized piece of curriculum content that we have for folks. Now under the video segment section, I mentioned you know, lots of videos that you can use to demonstrate appropriate counseling sessions and these are all professionally done, these are professional actors, they have a producer you know so very good for different settings you know different stages of readiness to quit, different types of health care providers and so forth so lots of options. We also have what we call trigger tape, so for example this guy here on the very bottom left trigger tape taps says no I rather quit cold turkey and do it on my own. Well how do you respond to that, these are challenging things the patient say that like you go, okay what do I, so we used that to teach and this is an approach to trigger tape which is an approach is actually on words, teaching words. And so we have integrated this into our curriculum to make it more interactive for the audiences and I do not know about health care providers that because I don’t do formal assessments like I usually do with students, but they love it. They love all the videos and forty trigger tapes that scroll through and watch them. Now we have the CE programs as I mentioned but you know that this is just us putting things together to make it easier for other people. So it is all just a subset of the larger slide set. Okay so, I do want to stop. I promised I would give ten minutes and I have given eleven, so if there are any questions, I am happy to answer, and if there is any follow-up, if anybody has any ideas for how to integrate tobacco cessation into the home health care environment I would love to hear it and work with you.

Cindy Sun: So those of you are on the phone lines today we will be unmuting the lines so do take that as a warning so that you will mute your own line if you do not have a question, we do not want to eavesdrop on your call or your conversation. For those of you that do not have the phone line and you are using your computer, if
you open your chat window and send your questions you can send them directly to us or to all participants, and we’ll make sure we get them answered. So Misty, are the lines open?

**Misty Dyke:** Give me just one second.

**Cindy Sun:** Sure.

**Misty Dyke:** Okay, everybody is now unmuted.

**Cindy Sun:** Alright, we’ll start with the phone line. Does anyone have a question on the line today? If you do, you can jump on in I'll just take a moment here and for those of you who don't know, I’m a family nurse practitioner and I have been that for a while and I felt that was pretty well versed in tobacco cessation but I've got to tell you Karen you brought out quite a few good points, that I had and some I had forgotten but some I did not know and thank you for bringing forward the studies as well because that's fantastic, I think the first thing I really - I think we all need to remember especially at home health is that every puff of smoke where you said it brings up the blood pressure 20 mm just with smoking cigarettes so as we're in the home taking the blood pressure is something to consider; if your patient is actively smoking when you are taking the blood pressure which many are as they are actually smoking the pressure is going to be altered reading so as we’re moving forward with the preventative cardiovascular care in the home, blood pressure readings are critical really and that is the very good points to bring forward and thank you for that.

**Dr. Karen Hudmon:** Yes it is important and also an opportunity so even just asking the patient, have you given any thoughts and what you are thoughts about quitting. You are not in a way that is you know judgmental or feels threatening, you do not want your patient they come defensive; so one of the things that I would like to ask folks, do you ever plan to quit and if they say yes, then my followup question is always so know what is impeding you from quitting now instead of later, and the truth is, it’s not going to get easier to quit later than now so why not quit now and incur all this, you know how benefit sooner and most patients, that actually resonates with patients a lot, you know a very brief intervention sometimes can just be enough to push someone forward and it does not have to be you know they do not have to feel judge, it is just really asking question, what your thoughts about that? May I tell you what concerns may and we talk a lot about motivational interview and I do not know if this is the language, you know it is an approach is the way to talk with the patient not so much talk to the patient but we really need to be more of an advocate for everything especially for something like this and really now how can I and what you are thoughts about quitting and how can I be helpful, you know, it is a fair decision and I am here to help is suppose to I am here to tell you what to do.

**Cindy Sun:** This is a different approach to fully agree and just for those of you on the line and motivational interviewing is covered in the self management best practice and intervention package on the HHQI web site, because this is something that as you said. It is not just jargon that is the medical jargon be in turn around that the day. It is actually a technique that the evidence truly supports that as well as teach back and they join together for as you said not talking down but engaging the patient in how to be most effective as the clinician there actually going to tell us. We do have a few questions and start with the first one is asking that in working with the patients at home often pets play a big part. Are there any studies done on test in secondhand smoke? In terms of testing harm by secondhand smoke?

**Dr. Karen Hudmon:** Yes, there is. Although I am not up to date on the literature and that is actually an older literature and it is definitely and definitely impact them. In fact I have a friend who always tells the story when he does the training that he tried to get a woman to quit smoking for many, many years actually and she finally came
in and then she said I have quit now and what is going on. He said its Stacey, and so her dog that is, it’s true and that was the reason she quit smoking. You know and that’s what’s really important about talking now to the patient but with the patient it is understanding what is important for that and trying to correlate that if the reason to quit and so that is you know an important approach in our counseling and so yes absolutely it can be harm for the pets. It is harmful and I once went into the pet store I kid you not, there were birds who were so vulnerable and this was in Pittsburgh, in the South side of Pittsburg, I'm from Pittsburg, and I walked in because I love birds, obviously you know I have one who is tweeting throughout the call, and the woman was smoking in there, in the pet store, and I was just shocked. I said oh my God, this poor little bird is like 4 feet from you. It was awful, but yeah, it is harmful.

Cindy Sun: Personally, I think you showed great restraint from, like, not saying... [laughter]

Dr. Karen Hudmon: I did. My friend was very proud. He is my tobacco colleague that I do everything with, Frank Vitali; he was the greatest trainer on the planet for tobacco, yeah. Okay, next question.

Cindy Sun: Well that is really good question. Thanks for that, and another question that we have is, how do you talk with the spouse about smoking in bed and falling asleep when the individual denies that it’s even a dangerous problem?

Dr. Karen Hudmon: That is a good question I have never had that problem and I have never had that encounter to myself and how would I handle that. I would say, may I tell you what concerns me? I would first try to enter the conversation way that she did not feel threatened or he did not feel threat and so you know people do get the sense of about their smoking behavior as you know but if you come out it was a different approach that says, I have some very genuine concerns. May I tell you what they are? They are much more likely to be a receptive than if you just tell them. So that would be my first thing to enter the conversation in the way and that shows autonomy, not me telling you what to do, because the people do not want to be pointed out. So and then I would say here is my concern. I worry that you could potentially cause or whatever then tell him what concerns you and I think you will find that with this approach patients will be more likely to listen, now will it create change, it depends on the person. It is a really hard question to answer without actually knowing the situation here we are dealing with but I always try to go gentle with the patient is like that or fellows like that so I am not sure that is the best answer but that is how I would approach it and you know with that again there the patient who need to be, you know need to hear it in a firm way and I always give the example of my mother-in-law who smoked for 50 years and she would listen to my husband who has never smoked possibly cigarettes, she wouldn't listen to me anybody that when her doctor said to her, her endocrinologist she had developed diabetes and that if you wouldn’t quit smoking, I will no longer be your doctor. If you do not care about yourself then why should I. That was what got her to quit smoking. So everybody is different. It really just depends on the situation. You know that is not on the approach that I would ever use but you know what may be on some patient it would be the right one, now it just depends and that is what we are signing with as you mentioned in this the transition from the patient moving from the hospital into home health or from the physicians care into home health, the smoking or the tobacco use, transition information is sometimes not relayed. It is not high priority or so it seems and bringing it into the home the home health clinician, these are nurses and therapists who have worked with the patient though in their homes they know their birds or dogs, their animals and it might be the place that the patient will actually hear this information for the first time even though it’s been given that in all different technique and thanks for the information on the motivational technique because I think that that information from all clinician is transferrable not only with tobacco use, quit on everything and teaching that we work with and motivation is actually - the recommended strategy in the clinical practice guideline and this has been a quite a bit of work with case managers in motivational interviewing by Bruce Berger who used to be at Auburn University
and so there is lot of good training program through that. If one has not had that, I highly recommend it, it changed the way I talked to the patient completely

**Cindy Sun:** So that is the really great resource and we thank you for that and as well as everything on today’s call. We are coming up on the top of the hour so before we close I will just mention to all of the participants today, thank you for taking your time to join us. The next CardioLAN call will be one month from today as you did on March 19th at from 2 to 3 p.m. is not that do you remember that if you are not a CardioLAN number you will not receive the invitation. If this targeted, it is not ment to be selected but you do need to be a member in order to receive the webinar in the patient. If you have any questions about this, please contact us at HHQI and I am will be glad to help you with that. The content on next month call will be covering woman’s cardiovascular health. Looking at the prosperity and care looking between woman and men as far as symptoms and as well as treatment. Now, the patient as I mentioned they will be sent out the day before just like this one was so I do not panic if you do not receive it until the day before do make sure you do check your trash or your spam file because sometimes they do go in there accidentally and if you do not receive it just call us and let us know. We want to give a special shout-out or remind you actually that the HHQUI University is now open for class and some of the classes that will be coming up do include Tobacco Effects and Smoking Cessation, as well as Blood Pressure Control. So if you have not participated in this free continuing education for registered nurses, please feel free to do so at any time. It is now open, and this is accredited at a national level so the CEUs are yours, they are free, all you have to do is log in and take this and there is multiple classes and there are very short time period, so that you can do it because we do understand that in the home you are completely busy.

So with that we will say thank you to everybody, especially Dr. Hudmon for taking the time to present this information to us. We appreciate it, and we hope that every one has a great day. Good bye.