IMPLEMENTING TOBACCO CONTROL

into the PRIMARY HEALTHCARE SETTING

INDIAN HEALTH SERVICE TOBACCO CONTROL TASK FORCE

into the PRIMARY HEALTHCARE SETTING

IMPLEMENTING TOBACCO CONTROL

INDIAN HEALTH SERVICE TOBACCO CONTROL TASK FORCE

IMPLEMENTING TOBACCO CONTROL

INTO THE PRIMARY HEALTHCARE SETTING

Indian Health Service Tobacco Control Task Force
U.S. Department of Health and Human Services

Version 2

Acknowledgement

Trudy Griffin-Pierce, PhD (1950 -2009)

Associate Professor, Department of Anthropology, The University of Arizona

The Indian Health Service Tobacco Control Task Force and contributors to the *Implementing Tobacco Control into the Primary Healthcare Setting* Fieldbook wish to pay special tribute to Dr. Griffin-Pierce who passed away suddenly.

Dr. Griffin-Pierce is author of the Through Native Eyes introductions of the Fieldbook. Additionally, she selflessly contributed her original art work that introduces each Unit. She was of Catawba heritage with an unrelenting love of the Navajo culture nurtured since childhood and actualized by an adoptive Navajo family. She authored five published books about Native Americans and won awards for her artful publications. Dr. Griffin-Pierce was admired by her students and brought energy and spirit to every event involving the publication of this Fieldbook. We miss her presence as we revise this edition of the Fieldbook.....

TABLE OF CONTENTS

WELCOME MESSAGE

©Trudy Griffin-Pierce

WELCOME

Welcome to the Indian Health Service Tobacco Control Task Force Fieldbook. This fieldbook is a tool for the National Indian Health Service Tobacco Initiative Strategic Tobacco Plan. The ultimate goal is to work toward healthy American Indian and Alaska Native communities. We can only accomplish this multidisciplinary vision by working in partnership with Tribal and Urban Indian communities. Working together, we can create healthier communities and families.

Nathaniel Cobb, MD
Chair, IHS Tobacco Control Task Force

Megan Wohr, RPh
IHS Tobacco Control Specialist

NATIONAL TOBACCO INITIATIVE INDIAN HEALTH SERVICE, TRIBAL, AND URBAN HEALTH SYSTEMS

Despite the tragic health consequences of smoking, physicians and other healthcare clinicians often fail to assess and treat tobacco use consistently and effectively. For instance, recent studies report that only half of tobacco users who saw a primary care physician over a one-year period were asked about their tobacco use and advised to quit (Goldstein et al., 1997; Robinson, Laurent, & Little, 1995). Yet in surveys analyzed by the American Academy of Family Physicians (AAFP) Tobacco Cessation Advisory Committee, 70% of family physicians said that they ask their patients about tobacco use and 40% said that they take action to help patients quit (Theobald & Jaen, 2006). As the U.S. Public Health Service Clinical Practice Guideline comments, "[t]his failure to assess and intervene consistently with tobacco users exists in the face of substantial evidence that even brief smoking cessation treatments can be effective" (Fiore et al., 2008). The Clinical Practice Guideline continues by stating that tobacco use

> *"presents a rare confluence of circumstances: (1) a highly significant health threat; (2) a disinclination among clinicians to intervene consistently; and (3) the presence of effective interventions. This last point is buttressed by evidence that smoking cessation interventions, if delivered in a timely and effective manner, significantly reduce the smoker's risk of suffering from smoking-related disease. Indeed, it is difficult to identify any other condition that presents such a mix of lethality, prevalence, and neglect, despite effective and readily available interventions* (Fiore et al., 2008).

This fieldbook serves as a tool for the National Indian Health Service Tobacco Initiative Strategic Tobacco Plan. The plan is a reflection of a multidisciplinary vision for tobacco prevention and control within the Indian Health Service, Tribal, and Urban Indian programs. While preparing this plan, the Indian Health Service Tobacco Control Task Force team asked three primary questions:

- *How can the Indian Health Service serve its constituency on tobacco cessation, prevention, and control?*
- *What services and programs are missing?*
- *How can the Indian Health Service encourage a successful tobacco control environment among American Indian/Alaska Native people?*

These questions were within the current framework of the Indian Health Service, Tribal, and Urban Indian programs.

One of the **main foci** of this plan is to **establish tobacco use prevention and treatment networks**. These networks will help the Indian Health Service leadership to define the role it can play in contributing to eliminating tobacco use morbidity and mortality in American Indian/Alaska Native communities. The plan provides the opportunity for the Indian Health Service, Tribal, and Urban Indian facilities, as well as other federal partners and non-governmental organizations, to collaborate in tobacco control planning and implementation. It also presents a vision for how community participation in tobacco control can be fostered in a clinical setting, while incorporating not only treatment and clean indoor air policy, but also tobacco-free households. .

The core strength of this plan can be found in its **shared vision** with the public health environment, the clinical setting, and the American Indian/Alaska Native peoples at highest risk for tobacco dependence.

The ultimate goal of the Indian Health Service Tobacco Control Task Force is to work toward healthy American Indian/Alaska Native communities. The mission of this group, in partnership with American Indian and Alaska Native peoples, is to raise their physical, mental, social, and spiritual health to the highest level possible through prevention and reduction of tobacco-related diseases. We follow the guiding principles of being:

- Multidisciplinary
- Comprehensive
- Collaborative
- Inclusive
- Culturally and Community Sensitive
- Holistic
- Accessible

The purpose of the Indian Health Service Tobacco Control Taskforce is to:

Establish and maintain an Indian Health Service-wide infrastructure for the effective development, implementation, and evaluation of tobacco dependence treatment educational programs.

- Develop community-based programs and build relationships with existing tobacco prevention and education coalitions and alliances to enhance our ability to provide effective, affordable, state-of-the-art tobacco dependence treatment programs.
- Design systems and processes that will be self-sustaining by the end of the project period.

Action steps the Tobacco Control Task Force is taking to ensure success:

- Certifying individuals to deliver brief tobacco treatment interventions with all individuals who report using commercial tobacco.
- Utilizing a certification model that (1) is consistent with the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update,* (2) functions in concert with the Indian Health Service system, and (3) equips Indian Health Service personnel to build capacity in a "Train the Trainer" role.

- Establishing networks of tobacco dependence initiatives throughout the Indian Health Service, Tribal, and Urban Indian facilities, using a "Training of Trainers" capacity-building distribution model and encouraging certified instructors to offer intervention services certification to health and human service providers, worksites, schools, and community health influencers.
- Identifying, collecting, analyzing, maintaining, and reporting information on the current needs and resources for tobacco dependence treatment services in local communities and throughout the Indian Health Service, Tribal, and Urban Indian healthcare system.
- Developing tobacco dependence treatment program materials designed for "Training of Trainers" that are specific to the needs of American Indian/Alaska Native communities and their primary health influencers.
- Developing and implementing a system for delivering "Train the Trainer" workshops for communities interested in assisting others to quit tobacco through educational programs and evidence-based tobacco dependence treatment interventions.
- Implementing educational tobacco control workshops for tobacco dependence treatment programs, wellness programs, and tribal programs that target health and human service providers and the communities they serve.
- Evaluating the effectiveness of the proposed model by assessing process, impact, and outcome.

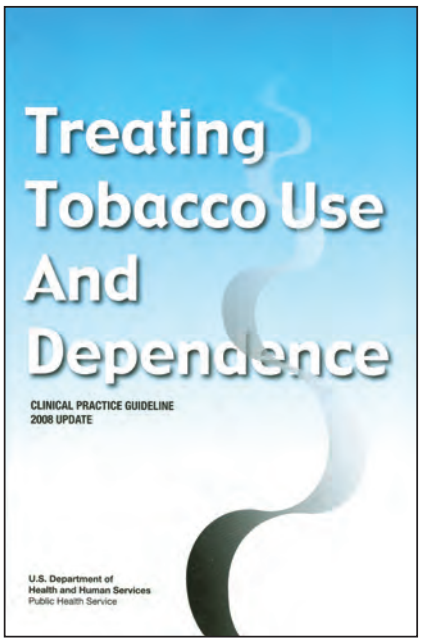
The content of the following units is modeled after several federal, state, and tribal efforts that have demonstrated success in implementing the National Cancer Institute's **Five A Model** and identifying tobacco dependent clients in health and human service settings. This fieldbook is an opportunity to link with your healthcare providers and develop evidence-based interventions that will assist American Indian/Alaska Native patients who are dependent on commercial tobacco to seek help in quitting. The Tobacco Control Task Force members have endeavored to provide you with the resources and informational support that you need to make that first contact. As a result, you will be building relationships and developing integrated systems with healthcare providers at all levels to identify individuals who use and/or who are dependent on commercial tobacco, thus creating the comprehensive support required to assist them in improving their health by abstaining from commercial tobacco use.

"The number one challenge in healthcare today is taking the science and changing it into a culturally competent message that changes behavior.

–Richard Carmona, M.D., M.P.H., F.A.C.S.
17th U.S. Surgeon General

U.S. Public Health Service Clinical Practice Guideline

The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* provides the framework of information and practice that you will find throughout the fieldbook. Based on a comprehensive literature review, the Clinical Practice Guideline offers recommendations to assist clinicians and non-clinicians in identifying individuals who use and/or who are dependent on tobacco for the purpose of delivering effective interventions (Fiore et al., 2008).



The major findings of the Clinical Practice Guideline support the Task Force objectives, and are as follows:

- Every person who uses commercial tobacco should be offered effective evidence-based tobacco cessation treatment at every encounter
- Clinicians should ask about tobacco and record the tobacco use status of **every patient**
- Brief tobacco dependence treatment, three minutes per visit, **is effective**
- Intensive treatment is more effective in producing long-term abstinence from tobacco
- Effective pharmacotherapies (i.e., non-nicotine and nicotine replacement therapy), clinician-delivered social support, and skills training are particularly effective components of tobacco cessation treatment
- Health and Human Service systems should make institutional changes to systematically identify and intervene with all tobacco users at every visit

(Adapted from Fiore et al., 2008)

"Desire and intention are the most dynamic of our faculties; they do work. They are the true explorers of the infinite, the instruments of our ascent to the Creator. Reason comes to the foot of the mountain; it is the industrious who will be urged by the passionate heart which climbs the slope.

– Evelyn Underhill

Each unit begins with a "Through Native Eyes" section. The purpose of these sections is to present American Indian/Alaska Native perspectives so that tobacco dependence treatment programs can be delivered in culturally respectful ways that reach American Indian/Alaska Native audiences. Anglo-American patients are used to being treated as individuals, but American Indian people feel isolation when they are singled out. This is why the most effective types of treatment are those that are community based. It is suggested that health and human service professionals make an effort to determine if a tribal wellness program exists in the community. If so, make tobacco dependence treatment an integral part of the program so that patients can be referred to the program for support.

Also, each unit ends with a "Reflection & Action" section for readers to reflect on the manual's content and focus on potential actions for addressing tobacco use in their facility or community.

Posters

Visual learning is a key motivator to use when conducting a tobacco dependence intervention. For this reason, it is suggested that posters addressing commercial tobacco abstinence in American Indian/Alaska Native communities be placed in prominent locations throughout examination and waiting rooms. Waiting periods

present an ideal time to teach patients through eye-catching posters about the risks of commercial tobacco and the rewards of being tobacco free.

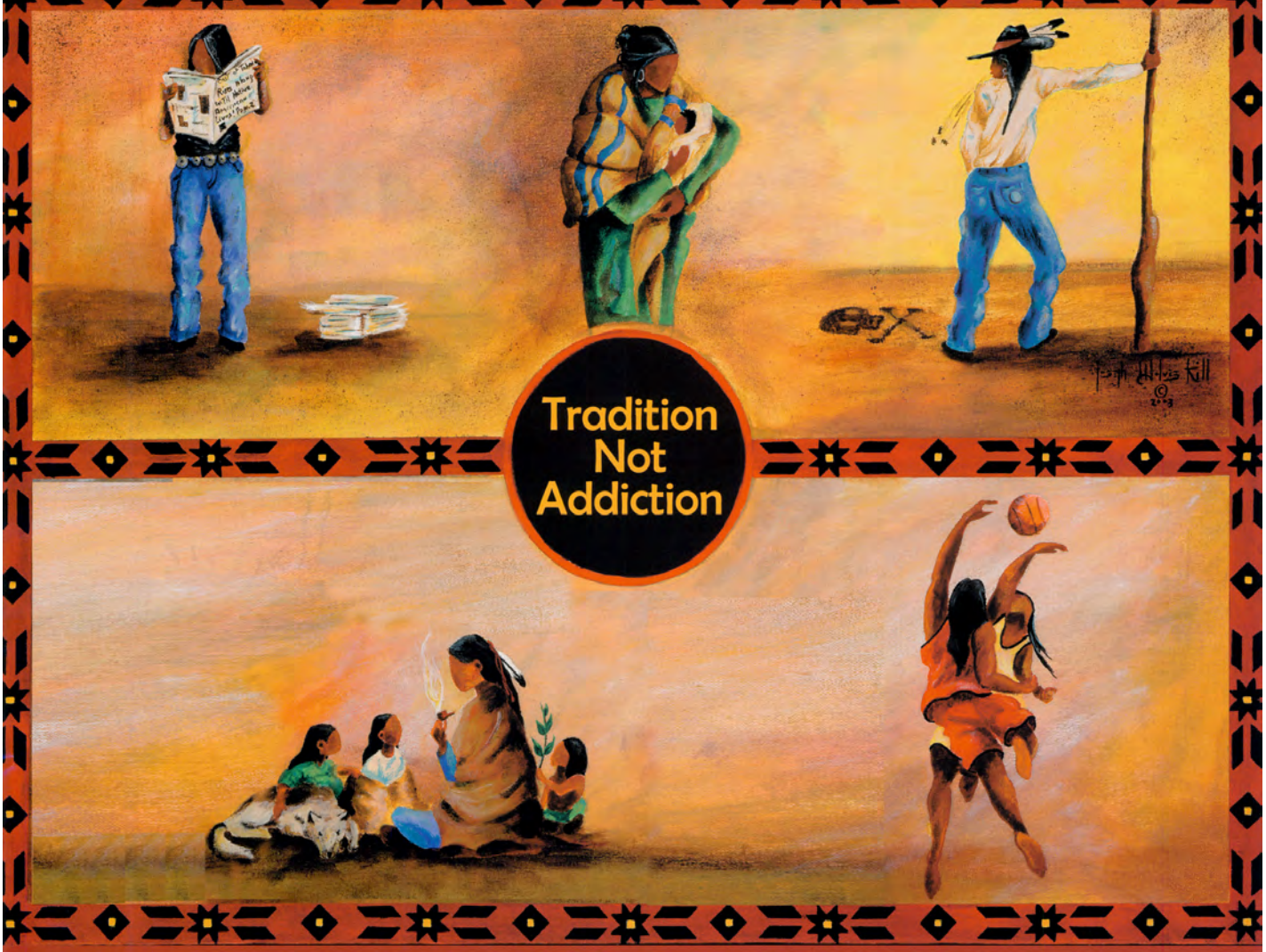
Posters have the potential to integrate commercial tobacco **INDEPENDENCE** as part of a healthy spiritual lifestyle based on traditional tribal values. Spiritual belief is a pervasive aspect of American Indian/Alaska Native cultures, although belief systems vary widely among tribal groups. The interconnections of all things means that humans, the Creator, and nature are closely related. This means that humans have a responsibility to show respect to other humans, the Creator, and beings in the natural world. Leading a whole and healthy life is the way the Creator intended for humans to live. Abstaining from commercial tobacco use shows respect for oneself, one's family, and the Creator.

Throughout this fieldbook, various posters are showcased to emphasize commercial tobacco abuse in the American Indian/Alaskan Native communities. In 1994 the IHS Cancer Prevention and Control Program sponsored a contest for Native artists to make tobacco control posters. Each IHS Area Tobacco Coordinator solicited entries from local artists, and chose the best from those submitted. Winners received a cash prize.

Suggested items to include on a patient education poster:

- *Impact of commercial tobacco use on family and community ("Stop for your children and the strength of your community").*
- *The survival of future generations of American Indian/Alaska Native peoples is dependent upon halting the use of commercial tobacco.*
- *Freedom from commercial tobacco is part of a spiritual/traditional way of life ("The Creator did not intend for us to smoke except in ceremonies").*
- *Breath is sacred and connects us with all living things ("Overall wellness depends on being free from commercial tobacco use, establishing an exercise routine, nourishing one's body with healthy food, and connecting to one's family").*

Embrace your culture, health and children.



End Tobacco Abuse.

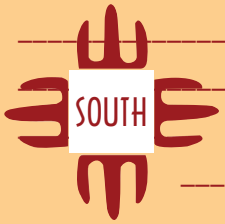
Community Tobacco
Education and Prevention Program
Inter Tribal Council of Arizona, Inc.

The Grant Cooperative Agreement Number U1A/CCU919253 from the Centers for Disease Control and Prevention (CDC) supports this poster. It's contents are solely the responsibility of the authors and do not represent the official views of CDC.

REFLECTION

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

TRADITIONAL AND COMMERCIAL TOBACCO

UNIT ONE

The use of traditional tobacco, whether smoked or chewed, has a spiritual and/or social role in American Indian culture–commercial tobacco use dishonors that role. Many American Indian tribes use tobacco in a sacred way: for ceremonies, hospitality, healing, and offerings. It was not intended to be used in the form of cigarettes or chewing tobacco for personal pleasure. In contrast to traditional tobacco, commercial tobacco is an extremely addictive drug. Daily chronic use has caused commercial tobacco to become a health hazard among American Indian/Alaska Native people.

The use of traditional tobacco plants for spiritual, ceremonial, social, and/or medicinal purposes goes back thousands of years. Most indigenous nations have traditional stories explaining how tobacco was introduced to their communities, many of which emphasize the sacred properties of the plant, containing both the power to heal, if used properly, and the power to cause harm, if used improperly.

The population of American Indians and Alaska Natives in the United States in the year 2008 was 4,861,963 (U.S. Census Bureau Population Estimates, 2009). There are **562** federally recognized American Indian/Alaska Native tribes, plus an unknown number of tribes without federal recognition (U.S. Bureau of Indian Affairs, 2009). Each tribe has its own culture, beliefs, and practices. Alaska Native is a term used to describe people of Athabascan, Tsimpsian, Tlingit, Haida, Eskimo, and Aleut descent. The sacred use of traditional tobacco is rare in Alaska Native populations.

Tribal groups along the Eastern seaboard, from the Algonquians and Iroquoians of the Northeast to the Seminoles of Florida, planted native tobacco along with other traditional plants, such as corn, beans, and melons. However, it was not until some time after 1614 that Englishman John Rolfe introduced Orinoco tobacco to Virginia. Colonists soon recognized the potential monetary gain associated with tobacco

farming. However, tobacco, like cotton, quickly degrades the quality of local soil, and thus requires large tracts of land to maintain viability. The resulting land grab pushed the indigenous peoples of these areas farther and farther westward (California Rural Indian Health Board, Inc. [CRIHB], n.d.).

American Indians of nearly all regions used tobacco pipes and for Plains Indian people, such pipes were among the most important of sacred objects. While tribes were guardians of elaborate pipes used only for special ceremonies, performed for reasons such as ensuring a successful bison hunt, healing, or marking the beginning of peace or war, individuals did own their own pipes. Pipes were usually made of a highly valued stone known as red pipestone (catlinite). American Indians also made pipes of other materials, including steatite, argillite, limestone, serpentine slate, soapstone, calcite, chlorite, and shale for the pipe bowl, with ash or sumac for the stem. Some special pipes were carved into ornate sculptured shapes (CRIHB, n.d.).

The Sioux Lame Deer described his feelings when he was allowed to smoke his people's Buffalo Calf pipe:

> *"I felt the pipe coming alive in my hand ... a power surging from it into my body, filling all of me.... When I smoked it I was at the center of all things, giving myself to the Great Spirit....*
>
> (Griffin-Pierce, 1995).

This historic and enduring relationship with traditional tobacco needs to be recognized and addressed when shaping meaningful, culturally respectful tobacco-related policies in American Indian communities that use traditional tobacco.

Tobacco Dependence As A Major Public Health Problem

> Imagine three Boeing 747s taking off each day and promptly crashing into each other, leaving no survivors and totaling up to 430,000 deaths each year. Would the airport authorities and the public remain quiet and complacent about the loss of human life that had occurred during this time? NO! Planes would be grounded and Boeing executives would be running for cover. Yet, each day [in the United States], the same number of people die due to tobacco use. Over 430,000 people die each year [from] tobacco-related deaths. In fact, in the time it took you to read the previous seven lines, approximately thirteen people lost their lives to smoking [tobacco] related diseases. These are shocking numbers, and the total deaths related to this addiction are expected to rise (University of Michigan Health System, 1998).

Commercial Tobacco

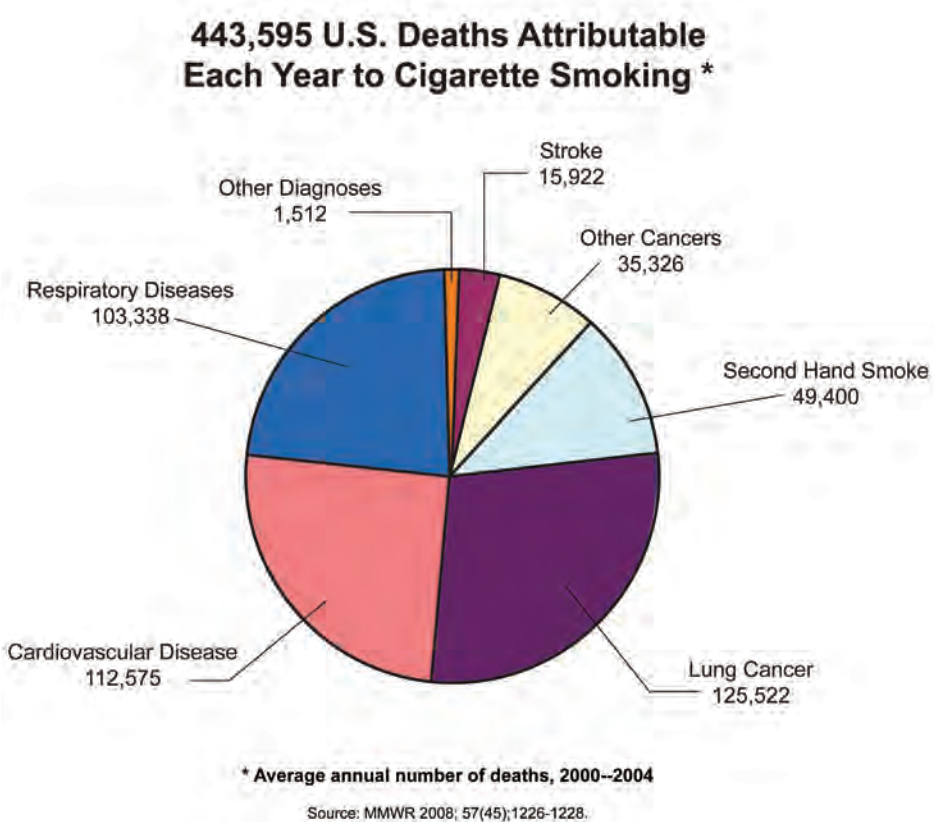
In this manual, the following nicotine-containing products are defined as commercial tobacco: cigarettes, cigars, pipe tobacco, snuff, and chew that have been cultivated, cured, manufactured, and sold by large corporations for commercial profit. *Unless indicated*, tobacco and tobacco use in this manual is referring to commercially manufactured tobacco.

The Dangers of Tobacco

Tobacco use is the chief preventable cause of illness and death in the United States. Tobacco kills 443,595 people in the United States each year (CDC, 2008).

REFLECTIONS

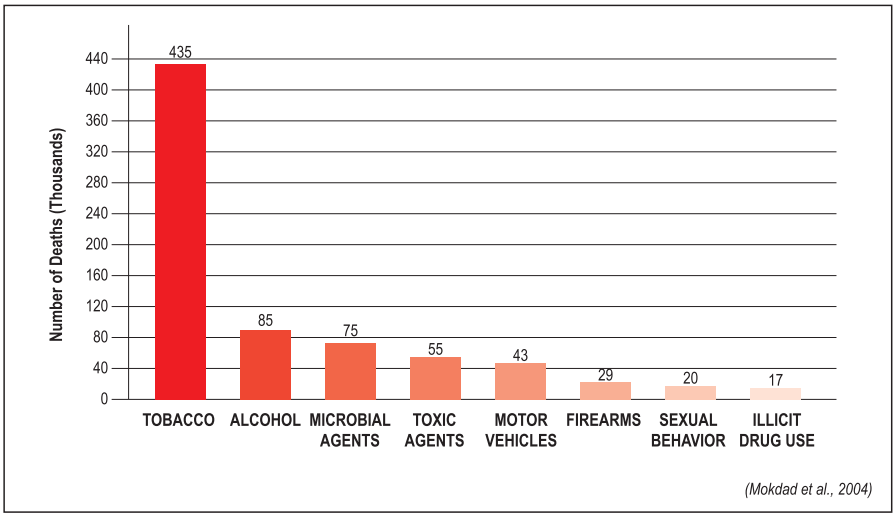
REFLECTIONS



(CDC, 2008a)

- **One in five deaths** in the U.S. is tobacco-related.
- Men who smoke lose on average 13.2 years of life and female smokers lose 14.5 years.
- **Smoking is a known cause of:** cancer, heart disease, stroke, and chronic obstructive pulmonary disease (CDC, 2002).
- Tobacco use is surprisingly widespread, given the health dangers it presents and the public's awareness of those dangers. In 2005, 20.9% of U.S. adults smoked cigarettes (CDC, 2006).
- The estimated smoking-attributable cost for medical care in the United States exceeds **$96 billion annually** (Campaign for Tobacco-Free Kids [CTFK], 2006a).
- The estimated cost of lost productivity due to smoking-related disability in the United States exceeds **$97 billion per year** (CTFK, 2006a).

Actual Causes of Death in the United States, 2000



Tobacco use kills significantly more people per year than any other form of preventable causes.

Smoking Prevalence Among U.S. Adult Ethnic/Racial Groups

U.S. Adult Ethnic/Racial Groups	Smoking Prevalence (%)	Men	Women
African American or Black	19.8	24.8	13.5
American Indian or Alaska Native	36.4	36.7	36.0
Asian	9.6	15.9	4.0
Hispanic or Latino	13.3	18.0	8.3
Native Hawaiian or Other Pacific Islander	–	–	–
White/Non-Hispanic	21.4	23.1	19.8

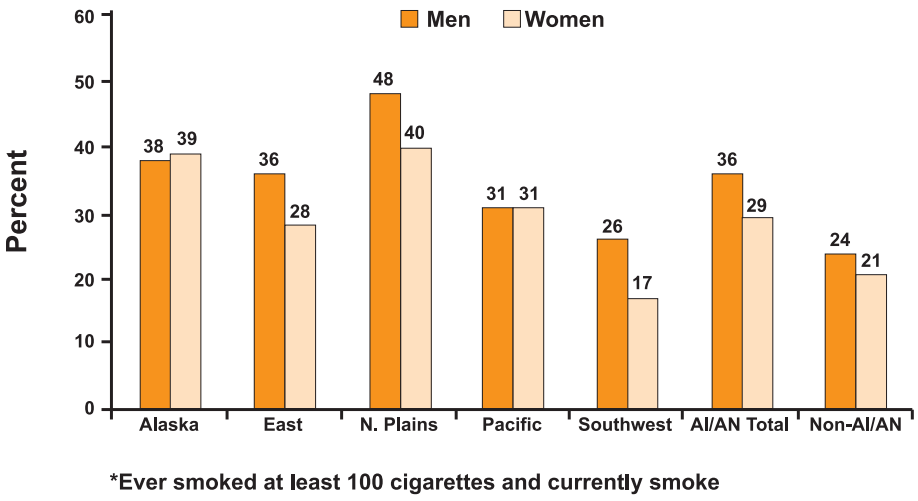
(CDC, 2007)

American Indian/Alaska Native groups have the highest reported tobacco use of any US ethnic group, with estimates ranging from 32%-40% (Morton et al., 2008).

REFLECTIONS

REFLECTIONS

Current Cigarette Smoking Among AI/AN Adult Populations by Region, *1997-2000



*Ever smoked at least 100 cigarettes and currently smoke

(Denny & Holtzman, 2000)

This data was collected from 36 states covered by the 12 IHS Area Offices from 1997 to 2000 through the Behavioral Risk Factor Surveillance System (BRFSS) (Denny & Holtzman, 2000).

There are *many resources* to help the cigarette smoker learn about the dangers of commercial tobacco and provide motivation to quit.

American Cancer Society: www.cancer.org/docroot/PED/ped_10_1.asp

American Lung Association, Smoking and AI/AN Fact Sheet: www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=35999

American Legacy Foundation: www.becomeanex.org

American Indian/Alaska Native Women's Health: www.womenshealth.gov/minority/AmericanIndian/smoking.cfm

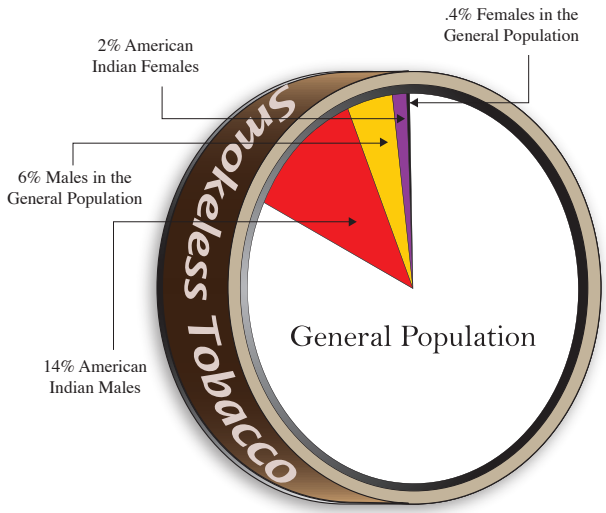
My Time To Quit: www.mytimetoquit.com

Stop Smoking Tips: www.stop-smoking-tips.com/reasons-quit-smoking-cigarettes.html

Chew Free: www.chewfree.com

Smokeless Tobacco

Fourteen percent (14%) of American Indian males and two percent (2%) of American Indian females use smokeless tobacco, as compared to just over six percent (6.0%) of males and four tenths of a percent (.4%) of females in the general population (CDC, 2007).



(CDC, 2007)

Nicotine in Smokeless Tobacco (Spit Tobacco)

Smokeless tobacco products generally have an average nicotine content of 7.11 mg/g to 11.04 mg/g (CDC, 1999). Smokeless tobacco users who dip or chew 8 to 10 times a day may be exposed to the same amount of nicotine as persons who smoke 30 to 40 cigarettes a day (CDC, 1999).

Peak nicotine levels with smokeless tobacco products usually occur within 30 minutes, with rapid absorption occurring within the first 10 minutes (Severson & Hatsukami, 1999). Holding a pinch of snuff in the mouth for 20–30 minutes yields nicotine levels 2 to 3 times the amount of nicotine delivered by a regular-size cigarette (United States Department of Health and Human Services [USDHHS], 1993).

REFLECTIONS

REFLECTIONS

Nicotine Absorption in Chewing

People who dip, chew, or smoke cigars and pipes absorb nicotine through the lining of the mouth (National Cancer Institute [NCI], 1998). An adult smokeless tobacco user averages 6 to 9 dips per day or approximately 2.6–3.8 tins per week (Hatsukami, Jensen, Boyle, Grillo, & Bliss, 1999). Iqmik chewed by some Alaska Natives is mixed with ash, enhancing the rate of absorption (Renner, Enoch, et al., 2005).

Tobacco used in these products is manipulated to enhance absorption (USDHHS, 2000; Douglas, 1997). To enhance absorption, sodium carbonate and ammonium carbonate are added to smokeless tobacco to increase the level of "free" nicotine in moist snuff by raising the pH level. Therefore, increasing the pH can increase the snuff user's nicotine absorption rate (USDHHS, 2000).

Consequences of Smokeless Tobacco Use

- Smokeless tobacco refers to snuff, chew, or spit tobacco that is used orally, but not smoked.
- The Surgeon General's Report, "Health Consequences of Using Smokeless Tobacco," concluded, "Oral use of smokeless tobacco represents a significant health risk and is not a safe substitute for smoking cigarettes" (USDHHS, 1986).
- Smokeless tobacco contains 28 cancer-causing agents (carcinogens). Smokeless tobacco use increases the risk of developing cancer of the oral cavity. Oral health problems strongly associated with smokeless tobacco use are leukoplakia and recession of the gums (CDC, 2005).
- A National Cancer Survey conducted from 1969 to 1971 showed that moderate users of smokeless tobacco are 4 times more likely, and heavy users are 7 times more likely, to develop mouth cancer than nonusers (Hoffmann, Harley, Fisenne, Adams, & Brunnemann, 1986; Severson & Hatsukami, 1999).

- Regular users of smokeless tobacco are more likely to develop:
  - Bad breath
  - Tooth staining
  - Tooth damage
  - Gingivitis (inflammation of the gum)
  - Gum recession (gum loss may lead to tooth and bone loss)
  - Leukoplakia and erythroplasia (white patches or sores in the mouth that may lead to cancer)
  - Various forms of mouth cancer
  - Atherosclerosis and thrombosis
  - Stomach and duodenal ulcer
  - Prostate cancer
  - Pancreatic cancer
  - Cervical cancer
  - Crohn's disease
  - Ulcerative colitis

  (Winn, 1997; Severson & Hatsukami, 1999; Mitchell, Sobel, & Alexander, 1999)
- Young smokeless tobacco users are 9 times more likely to develop gum recession than nonusers. They also have 6 times the risk of developing gingivitis and 2.4 times the risk of experiencing dental caries (Offenbacher & Weathers, 1985).
- The prevalence of leukoplakia (white patches that may lead to mouth cancer) is as high as 78% in daily smokeless tobacco users, as compared to 6.3% in nonusers of smokeless tobacco (Little et al., 1992). The severity of these lesions is associated with frequency of use, amount used per week, and number of years of regular use (Offenbacher & Weathers, 1985).
- Blood pressure and heart rate increase significantly when people use smokeless tobacco (Westman, 1995).
- Smokeless tobacco use leads to nicotine addiction (Severson & Hatsukami, 1999; Mitchell et al., 1999).
- Current use in the U.S. was estimated at 3.2% among adults in 2007 (SAMHSA, 2008).

REFLECTIONS

REFLECTIONS

- The 2005 National Survey on Drug Use and Health states, the prevalence of **previous or current smokeless tobacco use** is 18.4% in the total population, 32.3% of men and 5.3% of women having ever used smokeless tobacco (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006).

Smoke-Free Laws and New Products on the Market

As States enact smoke-free laws and the harmful health problems caused by commercial tobacco use are emphasized to the general public, "novel" nicotine replacement products for tobacco users are marketed as a means to reduce health risks to the user and those around them. Products that are being marketed include, but are not limited to:

- Electronic Cigarette or "E-Cigarette"
- Nicabate PRE-QUIT
- Nicotine Water
- Snus

Although these products are promoted as a means to reduce the health hazards of smoking, preliminary research indicates that the products may offer few health benefits and could introduce new risks (Buchhalter & Eissenberg, 2000; Cobb, Weaver & Eissenberg, 2009). Additionally, the products are unregulated, untested in this country and not approved by the Food and Drug Administration, which has sanctioned other nicotine-supplying substitutes such as patches and gum.

In a joint statement, the American Cancer Society Cancer Action Network, the American Heart Association, the American Lung Association and the Campaign for Tobacco-Free Kids blasted e-cigarettes for being "marketed towards young people, who can purchase them in fruit flavors and online, without having to verify their ages" (Leiby, R. 2009).

Previous or Current Smokeless Tobacco Use

Past Year, and Past Month among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2004 and 2005

Demographic Characteristics	Time Period					
	Lifetime		Past Year		Past Month	
	2004	2005	2004	2005	2004	2005
Total	18.6	18.4	4.1	4.3	3.0	3.2
Age						
12–17	7.1	7.1	4.3	4.4	2.3	2.1
18–25	21.4	20.8	8.0	8.5	4.9	5.1
26 or Older	19.6	19.5	3.3	3.5	2.7	3.0
Gender						
Male	32.3	32.3	7.7	8.1	5.8	6.1
Female	5.7	5.3	0.6	0.8	0.3	0.4
Ethnicity/Race						
White	22.5	22.3	5.1	5.3	3.8	3.9
Black or African American	10.2	10.4	1.6	2.1	1.3	1.6
American Indian/Alaska Native	34.9	35.1	6.7	10.4	4.2	8.5
Native Hawaiian/Other Pacific Islander	*	8.6	*	2.7	*	2.5
Asian	5.2	5.5	1.3	0.9	0.6	0.5
Two or More Races	23.4	16.9	3.8	3.9	3.0	2.7
Hispanic or Latino	8.1	8.8	1.4	1.8	0.8	1.0
*Low precision; no estimate reported.						

(Adapted from SAMHSA, 2006)

Environmental Tobacco Smoke (Second-hand Smoke)

Working or living in a smoke-filled environment can be almost as harmful as smoking. People who work in bars or casinos where smoking is allowed may be particularly at risk because of the daily exposure to environmental tobacco smoke.

REFLECTIONS

REFLECTIONS

Environmental Tobacco Smoke Is Toxic

Four thousand (4000) chemical compounds have been identified in environmental tobacco smoke; **200 are poisons** and more than **50 cause cancer** .

Cancer-Causing Chemicals *are extremely toxic*

- Formaldehyde
- Benzene
- Polonium-210
- Vinyl Chloride

Poison Gases *can cause death, affect heart and respiratory functions, burn throat, lungs, and eyes and cause unconsciousness*

- Carbon Monoxide
- Hydrogen Cyanide
- Butane
- Ammonia
- Toluene

Toxic Metals *can cause cancer, death, and damage the brain and kidneys*

- Chromium
- Arsenic
- Lead
- Cadmium

(USDHHS, 2006)

(UA Healthcare Partnership, 2007)

Major Conclusions of The Health Consequences of Involuntary Exposure to Tobacco Smoke

A Report of the Surgeon General, 2006:

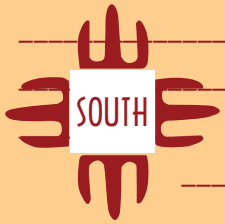
- Environmental tobacco smoke causes **premature death** and disease in children and in adults who do not smoke.
- Children exposed to environmental tobacco smoke are at an **increased risk for sudden infant death syndrome** (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and **slows lung growth** in children.
- Exposure of adults to environmental tobacco smoke has immediate adverse effects on the cardiovascular system and causes **coronary heart disease** and **lung cancer**.
- The scientific evidence indicates that there is **no risk-free level** of exposure to environmental tobacco smoke.
- Many millions of Americans, both children and adults, are still exposed to environmental tobacco smoke in their homes and workplaces despite substantial progress in tobacco control.
- Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to environmental tobacco smoke.
- Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate the exposure of nonsmokers to environmental tobacco smoke.

(USDHHS, 2006)

REFLECTIONS

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

TOBACCO DEPENDENCE TREATMENT

UNIT TWO

Asking patients about their use of commercial tobacco products can be a sensitive and uncomfortable encounter for both patient and clinician. Therefore, it is recommended that clinicians first ask patients for permission before reviewing the role of traditional tobacco and the health risks of commercial tobacco use.

A conversation about commercial tobacco products may lead to questions about traditional tobacco use. Be prepared by learning about the traditional cultural uses of tobacco by the people in the area in which you work.

The people of Zuni Pueblo in New Mexico have developed an innovative approach to alcohol and substance abuse treatment that can be tailored to tobacco treatment interventions. Part of the treatment program includes a 30-, 60-, or 90-day mandatory physical workout at the Zuni Wellness Program's gym. Zuni has extensive physical fitness programs for older American Indians. For more information, contact:

Indian Health Service, Eldercare Initiative
Zuni PHS Hospital, P.O. Box 467, Zuni, NM 87327
Phone: (505) 782-7357 FAX: (505) 782-7405
www.ihs.gov/MedicalPrograms/ElderCare

It is important to remember that something pleasurable cannot be taken away successfully without the substitution of something else. Exercise, clinician assistance, behavioral assistance, overall wellness, and community support are essential in successfully treating tobacco dependence.

For example, a sweat lodge program, if offered in the community, can be a useful tool for clinicians when assisting their patients. A sweat lodge is used in many American Indian cultures for purification. Thus, it is a unique and culturally appropriate adjunct to the treatment of tobacco dependence, because the sweat lodge experi-

ence provides a visceral whole-body experience of cleansing the entire body. The experience of "doing a sweat" is a spiritual, shared experience, which helps overcome the sense of isolation often felt by patients attempting to abstain from tobacco use, among other challenges. Feelings of isolation are replaced by a sense of community, as evidenced by the tribal songs and prayers that are spoken during a sweat lodge experience.

Making a Plan to Quit

In many American Indian/Alaska Native cultures, such as the Diné (Navajo), a project is undertaken in a series of four steps. Each step is associated with a direction:

represents thinking about the project, 

represents active planning of how the goal will be accomplished, 

represents initiating the project, and 

represents carrying through and continuing the project.

Four is a sacred number to most tribal people, which is why it feels comfortable to have plans presented to American Indian/Alaska Native people in **four steps**, with a **circular diagram** of the **four directions** and a **step associated with each of the directions**.

Talking Circle

The Talking Circle is used by many tribes to discuss important issues and to promote equality among participants. Equality is achieved by arranging the group in a circle, thus eliminating the superior position at the head of the table. Respect is established by allowing only one participant to speak at a time. To identify the speaker, participants pass around an object, such as a stone, feather, or basket. When the person holds the object, he or she is empowered to speak his or her own truth: in other words, that person's truest beliefs. The talking circle can be used as ongoing support through scheduled meetings or as an intervention to address the health risks of commercial tobacco use.

Screening and Assessment for Tobacco Use

The first step in treating tobacco use and dependence is to identify tobacco users. **This simple step increases the rates of clinician intervention, and can be an important motivator for smokers attempting to quit** (Fiore et al., 2008).

Hence, clinicians and healthcare systems are urged to use the healthcare facility visit for universal screening, assessment, and intervention. Specifically, every patient/client is asked if s/he uses tobacco **(Ask)**, all tobacco users are advised to quit **(Advise)**, and all tobacco users are assessed for their willingness to make a quit attempt **(Assess)**. These three steps, which are part of a five step model (called the **Five A Model** and fully described in this Unit), screens for current or past commercial tobacco use, and results in four possible responses:

- Patient/client uses tobacco and is willing to make a quit attempt at this time
- Patient/client uses tobacco and is unwilling to make a quit attempt at this time
- Patient/client once used tobacco but has since quit
- Patient/client never regularly used tobacco

Once a tobacco user is identified through these steps, the clinician determines the type and intensity of tobacco dependence treatment needed.

Levels of Intensity in Tobacco Dependence Treatment Interventions

The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* defines minimal, low-intensity (brief), and high-intensity (intensive) interventions in tobacco dependence treatment (Fiore et al., 2008).

REFLECTIONS

REFLECTIONS

Minimal Interventions

Minimal tobacco dependence interventions are defined as **being less than three minutes long with little to no significant personal interaction** (e.g., handing out informational brochures at a health fair). Minimal interventions may not have a significant effect upon clients/patients, but they are a low-cost method of reaching many people.

Low-Intensity Counseling (Brief Interventions)

The brief interventions practiced in low-intensity counseling are **3 to 10 minutes** in length and **require personal interaction** with the ultimate goal of assisting one or more individuals in quitting commercial tobacco products. There are two types of brief interventions, individual and group:

- Individual Brief Interventions are based on the **"Five A Model"** (Ask, Advise, Assess, Assist, and Arrange), first developed by the National Cancer Institute and later expanded upon in the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update*. Use of the Five A Model for brief interventions has been shown to be effective (Fiore et al., 2008).
- **Group Brief Interventions** are short presentations used to raise awareness of the health consequences of tobacco dependence and present the core components of a simple Quit Plan.

High-Intensity Counseling (Intensive Interventions)

Intensive interventions are **multi-session** treatment programs that are aimed at helping people quit using tobacco. The U.S. Public Health Service Clinical Practice Guideline stresses that intensive treatments must last at least **two weeks**, consist of sessions **longer than 10 minutes**, contain **four or more sessions**, have total contact time of **more than 30 minutes**, and be **scientifically proven effective** (Fiore et al., 2008).

Intensive interventions are facilitated by certified providers who assess an individual's willingness to quit; teach about health risks, benefits, and pharmacotherapy; and emphasize the importance of practical counseling and social support.

- There is a strong dose-response relationship between treatment effectiveness and the number of sessions, the session length, and the total amount of contact time.
- Higher-intensity counseling produces significantly higher quit outcomes than minimal or low-intensity counseling.
- Any contact time produces significantly higher quit outcomes over no contact, with 31–90 minutes producing the highest abstinence rates.
  (Fiore et al., 2008)

The Five A Model (Brief Interventions)

The research evidence and current best practice is clear–u**pon every contact, all clinicians should ask their patients if they use tobacco, and advise every person who uses tobacco to quit** (Fiore et al., 2008). Brief interventions can be implemented effectively by a wide range of health professionals (e.g. physicians, nurses, respiratory therapists, dentists, health educators, community health lay workers, pharmacists, etc.). The universal application of brief interventions in healthcare systems ensures that all tobacco users are identified and provided effective treatment.

Evidence-based tobacco dependence treatment interventions put this recommendation into action. **Evidence-based interventions include the following:**

- Applying the Five A Model, developed by the National Cancer Institute and recommended by the U.S. Public Health Service (Fiore et al., 2008)

REFLECTIONS

REFLECTIONS

» Integrating evidence-based theoretical models, including the Stages of Change Model (Prochaska & DiClemente, 1983) and Motivational Interviewing (Miller & Rollnick, 2002)

> *The Counseling and Behavioral Interventions Work Group of the United States Preventive Services Task Force (USPSTF) was convened to address adapting existing USPSTF methods to issues and challenges raised by behavioral counseling intervention topical reviews.... The task force concluded that no simple empirically validated model captures the broad range of intervention components across risk behaviors, but the Five A construct–assess, advise, agree, assist, and arrange–adapted from tobacco cessation intervention [ask, advise, assess, assist, and arrange] in clinical care provides a workable framework to report behavioral counseling intervention review findings* (Whitlock, Orleans, Pender, & Allan, 2002).

Not Stage Dependent (refers only to Ask and Advise)	
ASK	Ask about present & past use of tobacco and exposure to environmental tobacco smoke (vital signs)
ADVISE	Offer clear, strong, personalized advice to quit
ASSESS	Assess willingness to quit, using the Stages of Change Model
ASSIST	Provide assistance in quitting through stage-based interventions and motivational interviewing
ARRANGE	Arrange for follow-up and offer local and national resources

(Adapted from Heim, Strayer, Nadkarni, & Turner, 2004)

Intervention Flow Chart

Ask

» Ask if they use commercial tobacco using the multiple choice questions in Step 1 (over)

Current → No → Congratulate!

Current → Yes

Advise

» Encourage every person using commercial tobacco to quit in a clear, strong, personalized manner.

Assess

» Willing to set Quit Date within 30 days?

No

Yes

Assist

Unwilling to Quit

» Provide a *motivational intervention* using the 5 R's: Relevance, Rewards, Risk, Roadblocks and Repetition.

Arrange

» Remind person that you will ask in the future.

Assist

Willing to Quit

Assist with Quit Plan:

» Quit Date

» Support Persons

» Problem-Solving Resources

» Self-Help Materials

» Referrals to Intensive Services

Arrange

» Arrange for follow-up after Quit Date.

REFLECTIONS

REFLECTIONS

Ask

Ask about tobacco use at every encounter. Make identifying tobacco use a part of standard clinical practice. The U. S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* recommends institutionalizing a system to identify all tobacco users at every visit. For example, healthcare facilities can expand the collection of vital signs to include asking about tobacco use and exposure to environmental tobacco smoke. This procedure provides a useful way to ensure proper documentation of tobacco use and tobacco dependence treatment in the patient's medical record (Fiore et al., 2008).

Keep it simple. As a time-efficient and routine part of intake, use one or a combination of these questions:

- Do you smoke cigarettes?
- Do you chew tobacco?
- Have you ever smoked or used commercial tobacco products?
- What type of tobacco do you use?
- Does anybody in your house smoke or chew commercial tobacco?
- Are you exposed to environmental tobacco smoke elsewhere during your day?

Advise

In a clear, strong, and personalized manner, urge every patient who uses commercial tobacco to quit.

- Congratulate those who have quit.
- Congratulate those on a tobacco-free lifestyle, home, and environment.
- Give clear, strong, and personalized advice to quit:
  - **Clear:** Advise the individual to quit smoking or chewing completely.
  - **Strong:** Explain that quitting commercial tobacco use is the single most important way to protect themselves and their family.

- **Personalized:** Make advice relevant to the individual when explaining the benefits of quitting and the consequences of continued tobacco use.

- Motivate quit attempts by discussing the following:
  - Health effects and benefits of quitting for pregnant women, children, and families
  - Risks of smoking to fetal health
  - Risks of environmental tobacco smoke exposure to other children or family members
  - Current health issues
  - Cost of tobacco products
  - Personal appearance: effects of tobacco on hair, skin, clothes, and breath

Assess

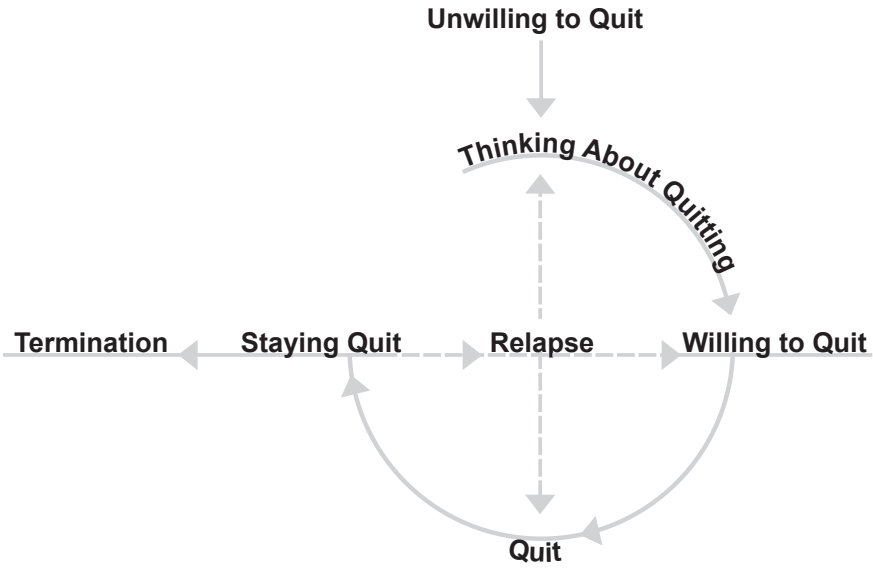
Determine the patient's willingness to make a quit attempt within the next 30 days using the "Stages of Change Model." (Prochaska, Redding, & Evers, 2002; DiClemente et al., 1991; Prochaska & DiClemente, 1983).

- **Ask**, *"Are you willing to set a quit date within the next 30 days?"*
  - If the patient clearly states that they are **unwilling to make a quit attempt within the next 30 days**, offer information to move the person toward thinking about quitting.
    - Move to the strategies outlined in the next section on **ASSIST/Unwilling to Quit.**
  - If the patient is **willing to make a quit attempt**, move to the strategies in the next section on **ASSIST/Willing to Quit.**
- Approximately 40% of people who use tobacco are unwilling to quit and 40% are thinking about quitting (Prochaska et al., 2002)

REFLECTIONS

REFLECTIONS

Approximately 20% of people who use tobacco are willing to quit (Prochaska et al., 2002).



(Adapted from Prochaska et al., 2002)

Detail of The Stages of Change Model		
Precontemplation	(Unwilling to Quit)	Has no intention to quit within the next 6 months
Contemplation	(Thinking About Quitting)	Intends to quit within the next 6 months
Preparation	(Willing to Quit)	Willing to set a quit date within the next 30 days
Action	(Quit)	Has quit using tobacco for less than 6 months
Maintenance	(Staying Quit)	Has remained tobacco free for more than 6 months
Termination	(Living Quit)	No longer giving in to urges and has total self-efficacy
Relapse*	(Relapse)	A return to regular tobacco use; may be less than, equal to, or greater than the beginning level of tobacco use

*Not part of the core construct Stages of Change
(Adapted from Prochaska et al., 2002)

Assist

Assist the individual to quit commercial tobacco. How you assist each individual depends on their willingness to set a quit date. If he or she is **unwilling to quit**, follow the Unwilling to Quit steps below, including **motivational interviewing** strategies using the **Five R's**. If he or she is **willing to quit**, follow the Willing to Quit steps that follow to develop a quit plan.

Unwilling to Quit

People who are unwilling to make a quit attempt at the time of the intervention may be ready the next time. With these individuals, communicate in a motivational manner.

Practice Motivational Interviewing Strategies

Motivational interviewing requires the clinician/non-clinician to develop five primary skills:

- **Express empathy.** Be non-judgmental; listen reflectively; accept ambivalence; see the world through the patient's eyes. Accurately understanding the patient's experience can facilitate change.
- **Develop discrepancy.** Help the patient perceive the difference between present behavior and desired lifestyle change. Patients are more motivated to change when they recognize that their current path will not lead them to their future goal.
- **Avoid argumentation.** Gently diffuse patient defensiveness. Confronting a patient's denial can lead to drop-out and relapse. When a patient demonstrates resistance to change, switch your strategies.

REFLECTIONS

REFLECTIONS

- **Roll with resistance.** Reframe patient's thinking/statements; invite patient to examine new perspectives; value patient as being his or her own agent of change.
- **Support self-efficacy.** Provide hope; increase patient's self-confidence in ability to change behavior; highlight other areas where patient has been successful.
  (Miller & Rollnick, 2002)

For more evidence-based practice and theory on Motivational Interviewing, visit www.motivationalinterview.org/sitemap.html and/or www.aztreattobacco.org.

Use the Five R's

The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2008) explains that effective advice in a tobacco dependence treatment intervention should include the **Five R's**:

- **Relevant** information
- Emphasis on **Rewards** and **Risks**
- Identification of **Roadblocks**
- **Repetition** at each encounter

Relevance

- Make the information **relevant** to the patient's situation.
- The greatest impact is achieved if it is **relevant** to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to abstinence).

Rewards

- Ask the patient to reflect on the potential **benefits** of quitting tobacco.
- Suggest and highlight those **benefits** that seem most relevant to the patient.

Risks

- Ask the patient to reflect on potential **negative consequences** of using tobacco.
- Address those **risks** that seem most relevant to the patient.

Roadblocks

- Identify and address **barriers** to quitting tobacco use.
- Barriers may include withdrawal symptoms, fear of failure, weight gain, lack of support, and depression.

Repetition

- **Repeat** the motivational interview every time the patient visits the healthcare setting.
- Inform the patient that you will **continue to ask** about his or her tobacco use and advise him or her to quit at each visit.

Examples:

- **Clear** – "The most important health decision you can make for you and your family is to quit smoking. I will help you! Cutting down while you are ill is not enough."
- **Strong** – "As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your current and future health."
- **Personalized** – Tie smoking to current health or illness, the social and economic costs of tobacco use, motivation level or willingness to quit, and the impact of smoking on children and others in the household: "Would you be willing to take a look at this brochure? It talks about smoking and respiratory illness. Smoking may trigger your daughter's asthma. Quitting will help."

REFLECTIONS

REFLECTIONS

Willing to Quit

People willing to make a quit attempt at the time of the encounter need assistance in developing a quit plan. Assist them by starting a Quit Plan, including the following steps:

STAR

- Set a quit date (ideally within 2 weeks)
- Tell family, friends, and coworkers and ask for support
- Anticipate challenges, including nicotine withdrawal symptoms
- Remove tobacco products from home and work environments
- Discuss **problem-solving methods** and skills for quitting, including the following:
  - Quitting through total abstinence
  - Learning from past quit experiences
  - Anticipating triggers or challenges
  - Avoiding alcohol use
  - Encouraging other tobacco users in the home to quit
  - Developing coping skills through the **Four D's** (Drink water, Deep breathe, Delay, and Do something else)
- Offer **social support**:
  - Provide encouragement
  - Communicate caring and concern
  - Encourage dialogue about the quitting process
  - Provide support through phone calls or letters
- Facilitate **support from friends, family, and coworkers**:
  - Help identify sources of support and practice requesting support from others
  - Discuss community resources and quitlines (1-800-QUIT-NOW)
  - Invite spouses, partners, and support people to quit-smoking sessions
  - Assign a "buddy system"
- Provide self-help materials

Arrange

Arrange for follow-up whenever possible. Follow-up may provide an invitation to talk about quitting in the future. It may be arranged for a specific time, such as when a patient returns to the health facility. It is particularly important to arrange follow-up contact with a patient who is making a quit attempt. Whenever possible, arrange the follow-up within a week after the patient's quit date.

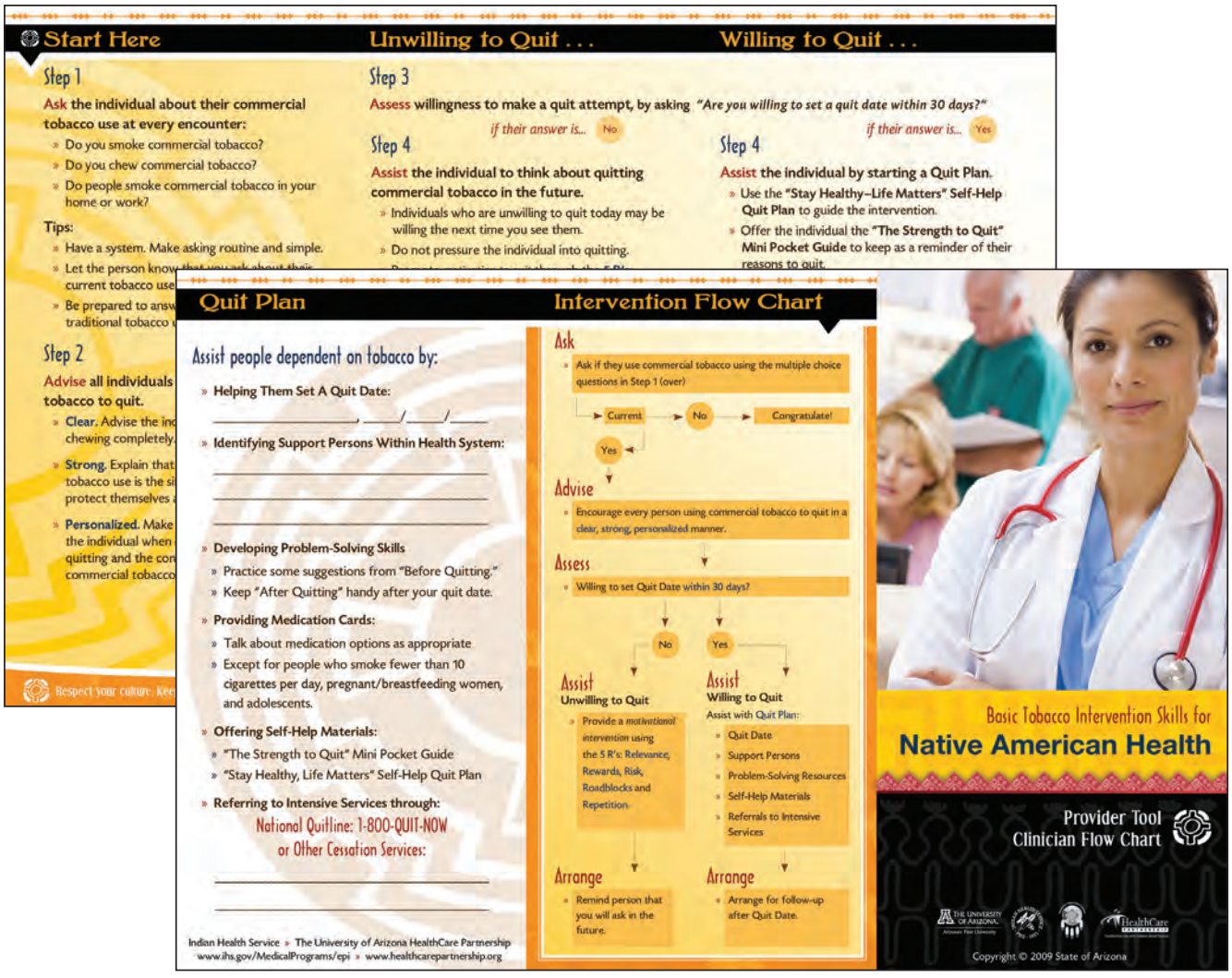
- Ask about tobacco use status.
- The first follow-up contact should occur **soon after the quit date**, preferably during the first week. The second follow-up is recommended within the first month after the quit date.
- Congratulate patients who are tobacco free.
- If commercial tobacco use has occurred, acknowledge any period of abstinence as a success; assess if use was a slip or relapse; if relapse has occurred, assess willingness to make a new quit attempt; and consider referral to more intensive treatment.
- Elicit **commitment** to abstinence.
- Remind that **slips** can be used as a learning experience.
- Identify problems and **anticipate challenges**.
- **Refer** to additional intensive help when indicated.
- **Document** your visit.

U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* Appendix C; Page 231. www.ahrq.gov/path/tobacco.htm#Clinic

REFLECTIONS

Brief Intervention Flow Chart

The Brief Intervention Flow Chart is a tool that outlines the recommended steps to take when providing brief interventions. The Flow Chart is divided into three panels to help you deliver brief interventions that match a person's willingness to quit tobacco.



(UA HealthCare Partnership, 2009)

Quit Plan

The Quit Plan can be used to quickly assist a patient who is willing to quit commercial tobacco use. It should **take no more than 10 minutes** to complete a Quit Plan. Even identifying a quit date and writing that date on the Quit Plan can be a motivator.

The parts of the Quit Plan are:

- Quit Date
- Names of individuals for social support
- Problem-solving resources
- Pharmacotherapy information
- Self-help materials
- Referrals to intensive programs or services

My Quit Plan	
Congratulations on your decision to quit using tobacco! Please follow the steps outlined below to make your personal quit plan.	
My Quit Date is	_____/_____/_____
My Support Persons	_____ _____
Problem-Solving Skills	**Ex-tobacco users find these tips useful:** » Practice some suggestions from "Before Quitting." » Keep "After Quitting" handy after your quit date. » Always carry your survival bag with you
Medication Information	Talk to your doctor or pharmacist about medication to help you quit.
Referrals to Intensive Services	For information call » National Quitline: 1-800-QUIT-NOW » Other cessation services: _____ _____ _____

(UA HealthCare Partnership, 2009)

REFLECTIONS

Abbreviated Fagerström Test for Nicotine Dependence

1. How soon after you wake up do you smoke your first cigarette?

Answer	Score
Within 5 minutes	3
6-30 minutes	2
31-60 minutes	1
After 60 minutes	0

2. On average, how many cigarettes do you smoke per day?

Answer	Score
10 or less	0
11-20	1
21-30	2
31 or more	3

Scoring

Nicotine Dependence Level	Total Score
Very Low	0-2
Low	3
Medium	4
High	5
Very High	6

Assessing Nicotine Dependence

An individual who is more dependent on nicotine may have greater difficulty in quitting tobacco products (Fagerström & Schneider, 1989), and may benefit more from intensive tobacco dependence treatment (Niaura & Abrams, 2002).

Simply asking a person if s/he uses tobacco may not be enough information to determine their treatment needs. A brief and effective assessment of a person's current tobacco dependence level can be performed using the **Fagerström Test for Nicotine Dependence** (Heatherton, Kozlowski, Frecker, & Fagerström, 1991).

- Time To First Cigarette
- Cigarettes Per Day

* *To see **full Fagerström Test for Nicotine Dependence**, go to page 53 in Unit 3, Intensive Interventions.*

Determination of Baseline Tobacco Use and Verification

Carbon Monoxide

Carbon monoxide (CO) is an odorless, tasteless, colorless, toxic gas that is harmful to the human body in high concentrations. Smoking and air pollution are the main causes of elevated CO levels in the human body. CO successfully competes with inhaled oxygen to deprive the body of the vital elements it requires to be healthy.

Carbon Monoxide Information		
Carboxyhemoglobin	» CO successfully competes with O2 to attach to the oxygen transporting hemoglobin. » CO binds with hemoglobin 200 times more readily than O2.	» This process creates carboxyhemoglobin, and due to decreased levels of O2, deprives vital organs and tissues of oxygen. » Heavy smokers may have up to 10% of their blood cells taken up by CO.
Measurement	» CO levels are measured in parts per million (ppm) or percent carboxyhemoglobin (%COHb). » Given one measurement (e.g., ppm) the other can be derived (e.g., %COHb).	» 1 ppm is equivalent to 1 milliliter (or cubic centimeter) in a cubic liter (or kiloliter).
Latency	» CO can remain in the bloodstream for up to 24 hours, with a half life of approximately 5 hours. » Concentrations are highest after smoking, increasing during the day with cigarette consumption.	» After 24 hours without smoking, a smoker would show the same CO levels as a nonsmoker in equivalent environments.
CO Values	» A typical puff of cigarette smoke yields 5% by volume CO. » The average smoker has a CO level of ~33 ppm. » CO levels in ambient air are ≤4 ppm.	» Toxicity generally begins at 95 ppm CO. » Cigar and pipe smokers have higher CO values, with some registering up to 90 ppm.

REFLECTIONS

REFLECTIONS

CO Monitors

CO Levels	
Nonsmoker	≤6 ppm
Danger Zone	7-10ppm
Smoker	11-15ppm
Frequent Smoker	16-25ppm
Heavy Smoker	26-35ppm
Heavily Addicted Smoker	36-50ppm
Dangerously Addicted Smoker	52ppm

(adapted from Farren et. al., 2004)

Carbon monoxide monitors are a simple way to measure a tobacco user's CO level. The test involves blowing into a small device through a disposable cardboard tube. The level of CO may vary according to how many cigarettes have been smoked, as well as how recently the person has smoked before the test is administered. The benefits of stopping smoking may be demonstrated by encouraging the tobacco user to blow into the monitor **24 hours** after quitting cigarettes. Within 24 hours of quitting, his or her level of CO will have dropped to the level of a nonsmoker. This is the **one tangible benefit** of stopping smoking that can be demonstrated objectively to the new former smoker–especially at such an early stage in the quitting process!

A CO monitor is also an effective educational tool for use in schools, prenatal healthcare facility, and presentations to the public on the dangers of smoking.

What Does It All Mean?
Heart
» Due to decreased levels of oxygen, the heart is forced to beat faster to transport sufficient levels of oxygen to the tissues and organs of the body. » In addition, the heart itself is at increased risk of damage due to the lack of oxygen caused by carbon monoxide.
Circulation
» Carboxyhemoglobin causes the blood to thicken and the arteries to become more permeable to cholesterol, creating fatty build-up. This results in high blood pressure and, consequently, increased risk of heart attack and stroke. » Hands and feet may become colder as a result of poor circulation.
Breathing
» Decreased oxygen levels cause smokers to feel out of breath while exercising or otherwise placing demands upon the respiratory system. » Due to increased respiratory demands, once effortless tasks (e.g., sitting and standing) will become ever more difficult for smokers to negotiate.

Cotinine

Cotinine is a metabolite of nicotine that can be measured in serum, urine, saliva, and hair. Cotinine is commonly used to establish a baseline and for clinical validation of tobacco use abstinence. Urinary cotinine "dipstick" tests are currently available.

People who chew tobacco and/or smoke cigars often have higher blood cotinine levels than cigarette smokers. Higher concentrations of toxic and carcinogenic compounds are found in smokeless tobacco and cigars than are found in cigarettes (Severson & Hatsukami, 1999; Baker et al., 2000; NCI, 1998).

REFLECTIONS

REFLECTIONS

Knowledge Is Not Enough

According to the Centers for Disease Control and Prevention (1993), more than 70% of smokers wish to quit (Fiore et al., 2008). Of those, the majority report quitting on their own. However, only about 7% achieve long-term success (Fiore et al., 2008).

The National Cancer Institute projects that if physicians assisted even 10% of their patients who use tobacco in quitting, the number of people who use tobacco in the United States would drop by an additional 2 million people annually (Fiore, Pierce, Remington, & Fiore, 1990).

Tobacco Free Nurses (2005) state: "If the 2.2 million working nurses in the U.S. each helped **one** person per year quit smoking, nurses would **triple** the U.S. quit rate".

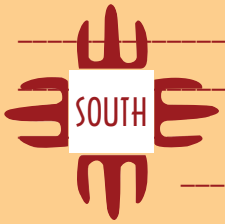
Brief tobacco interventions delivered by multiple persons (including both medical and non-medical persons) are more effective in helping people quit using tobacco than minimal interventions alone: 23.6% versus 10.8%, respectively (Fiore et al., 2008).

By delivering a stage-appropriate Five A Model brief intervention of approximately three minutes (*Ask, Advise, Assess, Assist* and *Arrange*), you have the potential of increasing a patient's likelihood of quitting tobacco by at least 60% (Fiore et al., 2008)!

You DO have a positive effect when you provide brief tobacco dependence treatment interventions, as described by the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update.*

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

INTENSIVE TOBACCO DEPENDENCE INTERVENTIONS

UNIT THREE

Peacemaker

"When the soul collects all its interior powers within, and when the body collects all its external senses and unites them to the soul, the Creator approaches and breathes into this union quietude and peace.

–Father Andrew Leonard Winczewski, O.S.B.

The Diné (Navajo) Nation has successfully used a traditional institution known as the Peacemaker Court to deal with disputes. This model can be adapted as an intervention model for tobacco dependence. The process begins by inviting all members of the patient's family, as well as anyone who has been affected by the patient's tobacco use, to join together with the person whose dependence has caused pain to others. The group then forms into a talking circle, establishing the equality of each member, including the person who uses tobacco.

The tobacco user's son or daughter may speak up and say, "I hate the way you smell when you smoke. I don't want to hug you or kiss you goodnight." The tobacco user's mother or father might say, "I worry about what will happen to you. I want you to live to be old and to carry on the stories. But when I hear that cough you always cough, I know that you will not be around to hear the wisdom I want to share with you. How will our traditions get carried on?"

A close friend might say, "What about the future generations of our people? Cancer that comes from smoking is killing more of us than white people ever did. And we are doing it to ourselves. This isn't the way the Creator meant for us to live. This is something under our control, something we can do to feel better and live healthier lives."

Intensive Tobacco Dependence Treatment Interventions

As currently defined by the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2008), an intensive tobacco dependence treatment intervention includes the following components:

Assessment	Assessments ensure willingness to make a quit attempt and can provide information useful in counseling (e.g., stress level, presence of comorbidity, nicotine dependence level).
Program Clinicians	Multiple types of clinicians are effective and should be used.
Program Intensity	Because of evidence of a strong dose-response relation, the intensity of the program should be: » Session length – longer than 10 minutes. » Number of sessions – 4 or more sessions. » Total contact time – longer than 30 minutes.
Program Format	Either individual or group counseling may be used. Proactive telephone counseling is also effective. Use of adjuvant self-help material is optional. Follow-up assessment intervention procedures should be used.
Type of Counseling and Behavioral Therapies	Counseling and behavioral therapies should involve practical counseling (problem solving/skills training) and intra-treatment and extra-treatment social support (see pages 56–57 of this fieldbook).
Pharmacotherapy	Every tobacco user should be encouraged to use pharmacotherapies as presented in this fieldbook, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations (e.g., pregnancy, adolescents). The clinician should explain how these medications increase smoking abstinence success and reduce withdrawal symptoms. Pharmacotherapy agents include nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, bupropion SR, and varenicline.
Population	Intensive intervention programs may be used with all tobacco users willing to participate in such venues.

(Adapted from Fiore et al., 2008)

Intensity of Treatment by Healthcare Professionals

Compared to no contact:

- Minimal contact (<3 minutes) increases quit rates by 30%
- Low-intensity counseling (3-10 minutes) increases quit rates by 60%
- High-intensity counseling (>10 minutes) increases quit rates by 130%

(Fiore et al., 2008)

Duration of Treatment

Total contact time and increased quit rates:

- 1–3 minutes 40%
- 4–30 minutes 90%
- 31–90 minutes 200%
- 91–300 minutes 220%
- >300 minutes 80%

(Fiore et al., 2008)

Number of Treatment Sessions

Compared to one or fewer sessions:

- 2–3 sessions increase quit rates by 40%
- 4–8 sessions increase quit rates by 90%
- More than 8 sessions increase quit rates by 130%

(Fiore et al., 2008)

REFLECTIONS

Common Elements of Practical Counseling (Problem Solving/Skills Training)

Practical Counseling Treatment Component (Problem Solving/Skills Training)	**Examples**
Recognize Danger Situations – Identify events, internal states, or activities that increase the risk of slip or relapse.	» Negative affect » Being around other tobacco users » Drinking alcohol » Experiencing urges » Being under time pressure
Develop Coping Skills – Identify and practice coping or problem-solving skills. Typically, these skills are intended to help cope with "danger" situations.	» Learning to anticipate and avoid temptation » Learning cognitive strategies that will reduce negative moods » Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure » Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention)
Provide Basic Information – Provide basic information about tobacco use and successful quitting.	» Any tobacco use (even a single puff) increases the likelihood of a full relapse » Withdrawal symptoms typically peak within 1–3 weeks after quitting » Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating » Tobacco use is addictive in nature

(Adapted from Fiore et al., 2008)

Common Elements of Intra-Treatment Supportive Interventions

Supportive Treatment Component	Examples
Encourage the patient in the quit attempt.	» Note that effective tobacco dependence treatments are now available » Note that one-half of all people who have ever smoked have now quit » Communicate belief in patient's ability to quit
Communicate caring and concern.	**Ask how patient feels about quitting:** » Directly express concern and willingness to help » Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings
Encourage the patient to talk about the quitting process.	**Ask about:** » Reasons the patient wants to quit » Concerns or worries about quitting » Success the patient has achieved » Difficulties encountered while quitting

(Adapted from Fiore et al., 2008)

Common Elements of Extra-Treatment Supportive Interventions

Supportive Treatment Component	Examples
Teach patient in support solicitation skills.	» Show videotapes that model support skills » Practice requesting social support from family, friends, and coworkers » Aid patient in establishing a smoke-free home
Prompt support seeking.	» Help patient to identify supportive others » Call patient to remind him or her to seek support » Inform patient of community resources such as hotlines and helplines
Arrange outside support.	» Mail letters to supportive others » Call supportive others » Invite others to treatment sessions » Assign patients to be "buddies" for one another

(Adapted from Fiore et al., 2008)

REFLECTIONS

Fagerström Test for Nicotine Dependence

The Fagerström Test for Nicotine Dependence can be used in a clinical and/or community tobacco dependence treatment setting as part of a the intervention.

Facilitators can use The Fagerström Test for Nicotine Dependence to assess clients' level of nicotine dependence as part of a single or multi-session tobacco dependence treatment program.

The Fagerström Test for Nicotine Dependence is also used on an individual basis with the tobacco user to:

- Establish a relationship between nicotine dependence and the severity of resultant withdrawal symptoms.
- Modify the intervention provided to increase the likelihood of successful long-term abstinence from cigarette smoking.
- Increase the tobacco user's awareness of certain negative aspects of being nicotine dependent.
- Determine evidence-based tobacco dependence treatment, including pharmacotherapy.

Fagerström Test for Nicotine Dependence		
Questions	**Answers**	**Points**
How soon after you wake up do you smoke your first cigarette?	» Within 5 minutes » 6-30 minutes » 31-60 minutes » After 60 minutes	3 2 1 0
Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in church, at the library, at the movies?	» Yes » No	1 0
Which cigarette would you hate most to give up?	» The first one in the morning » All others	1 0
How many cigarettes a day do you smoke?	» 10 or less » 11-20 » 21-30 » 31 or more	0 1 2 3
Do you smoke more frequently during the first hours after waking than during the rest of the day?	» Yes » No	1 0
Do you smoke if you are so ill that you are in bed most of the day?	» Yes » No	1 0

(Heatherton et al., 1991)

Scoring

The Fagerström Test for Nicotine Dependence (FTND) has five categories. The greater the score, the greater the likelihood of nicotine dependence. The point system is as follows:

Category	Score
Very Low	0 – 2
Low	3 – 4
Medium	5
High	6 – 7
Very High	8 – 10

REFLECTIONS

Who Uses the Instrument?

May be used by:

- Cessation facilitators
- Counselors
- Community health workers
- Dentists
- Nurses
- Pharmacists
- Physicians
- Psychologists
- Social workers
- Other allied health and human service professionals

Brief Test For Provider's Use

If time is an issue: (see **Abbreviated Test** on page 38)

- Question 1, Time to First Cigarette (TTFC)
- Question 4, Cigarettes per Day (CPD)
  (Heatherton, Kozlowski, Frecker, Rickert, & Robinson, 1989; Fagerström, Heatherton, & Kozlowski, 1990)

Quitting!

- Is not an act–it is a process
- Does not take an enormous effort of will–it takes organized planning and action
- Is facilitated by using a variety of strategies

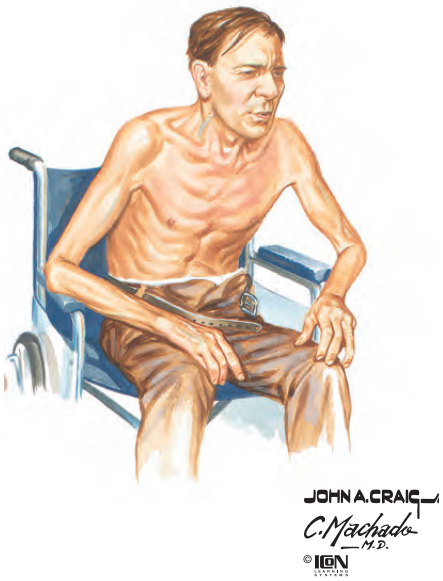
Why Can't I Just Quit?

The Three-Link Chain of Tobacco Dependence

The pathophysiology of tobacco dependence is complex and differs from person to person. A simple model, the "Three-Link Chain of Tobacco Dependence," can help providers remember that *biological, psychological,* and *sociocultural* factors contribute to tobacco dependence (Christen & Christen, 1994).

Biological Factors

- Tobacco use results in true drug dependence (on nicotine), which is comparable to the dependence caused by heroin, speed, and cocaine (Fiore et al., 2008).
- Specific gene variations may contribute to nicotine addiction (Volkow, 2006).
- Researchers have found that certain genes can predispose adolescents to tobacco addiction. For example, a gene called DRD2 partly determines whether an adolescent who takes a first puff on a cigarette will progress to regular smoking. Adolescents who carry one of the two known forms of the gene (A1) are more likely than those with the other variant (A2) to become daily smokers (Audrain-McGovern, Lerman, Wileyto, Rodriguez, & Shields, 2004).
- Nicotine affects essential brain structures associated with feelings of reward and arousal.
- Changes in brain structure and function persist long after the person stops using tobacco.



REFLECTIONS

REFLECTIONS

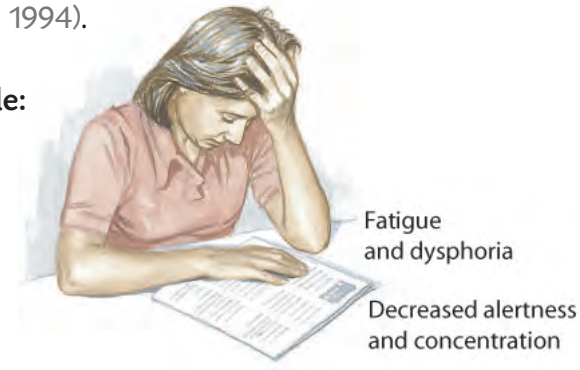
- The addictive power of nicotine may reinforce the learned behaviors that form tobacco-use patterns and make users more resistant to change.
- Craving for nicotine may be so intense that patients continue to smoke despite serious health consequences.

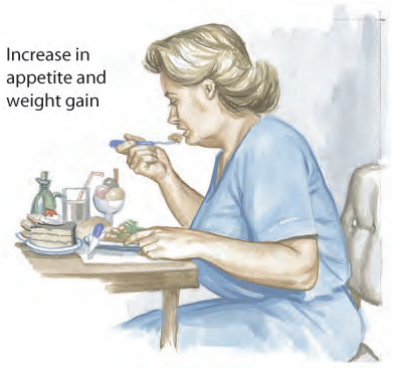
Withdrawal Symptoms

Withdrawal symptoms from tobacco are associated with both abrupt cessation and reduction in tobacco use. Withdrawal symptoms appear within hours of the last use of tobacco, are generally most severe within the first 2 weeks, and may reoccur in the form of cravings for months or even years (Hughes, 1994).

Withdrawal symptoms include:

- Depressed mood
- Insomnia
- Irritability, frustration, or anger
- Anxiety
- Difficulty concentrating
- Restlessness
- Decreased heart rate
- Increased appetite or weight gain (APA, DSM-IV, 1994)





Psychological Factors

- Conditioned drug-taking behaviors, reinforced by physical dependence, are thought to be central to the concept of addiction (USDHHS, 1988).
- Tobacco products are often used as a result of environmental cues. Lighting up or dipping becomes an automatic behavior. People may not even realize that they are using the product.

- Tobacco is used as a coping mechanism. People use tobacco to handle stress, or when they feel lonely, bored, happy, or angry.
- Nicotine may also be used to "self-medicate" underlying problems such as schizophrenia, depression, anxiety, attention deficit disorder, or stress (Saccho et al., 2005; Anda et al., 1999; Pomerleau & Pomerleau, 1984).

Coping Mechanism Cues

Tobacco is used as a coping mechanism to handle emotions, such as:

- Stress
- Loneliness
- Boredom
- Anger
- Depression
- Pain
- Anxiety

(Ferguson, 1987)

Environmental Cues

Tobacco use is triggered, or cued, by activities of daily living:

- Using the telephone
- Putting on makeup
- Driving a car
- Watching television
- Waiting for the school bus
- After a movie
- Having a cup of coffee
- After each meal
- Reading the mail
- Socializing at bars
- Taking a break at work

(Ferguson, 1987)

REFLECTIONS

REFLECTIONS

Sociocultural Factors

Tobacco plays an important role in our society. It may be part of identifying with a group, or a regular part of social activities or cultural practices (Christen & Christen, 1990).

Tobacco use becomes a part of many activities of daily living and rituals. This contributes to the difficulty of breaking the addiction (Fisher, Lichtenstein, & Haire-Joshu, 1993).

Smoking may be associated with pleasurable activities and feelings, or relief of unpleasant feelings.

Conditioning (Association)

- Social interaction
- Alcohol consumption
- Cultural practices

Cultural Backgrounds

When working with people from diverse cultural backgrounds, keep in mind:

- Age
- Behaviors
- Cultural norms
- Educational differences
- Family relations
- Language
- Learning styles
- Practices
- Religious beliefs

Treat tobacco addiction as a chronic disease.

Why Do I Smoke?

The *"Why Do I Smoke?"* scale is a validated instrument from the National Cancer Institute that is used as a self-test for people who smoke. It suggests alternative and substitute lifestyle changes that may support individuals in a successful quit attempt. People who use tobacco may do so to fulfill many different needs. Studies show that most people use tobacco for one or more of the following six reasons. Understanding these reasons will encourage tobacco users to look for a satisfying alternative.

Reasons for Smoking		
Stimulation	"Smoking gives me more energy"	» I smoke to keep from slowing down. (A) » When I'm tired, smoking perks me up. (G) » I reach for a cigarette when I need a lift. (M)
Handling	"I like to touch and handle cigarettes"	» I feel more comfortable with a cigarette in my hand. (B) » I enjoy getting a cigarette out of the pack and lighting up. ((H) » I like to watch the smoke when I exhale. (N)
Pleasure	"Smoking is a pleasure"	» Smoking cigarettes is pleasant and enjoyable. (C) » Smoking makes good times better. (I) » I want a cigarette most when I am comfortable and relaxed. (O)
Relaxation/ Tension Reduction	"Smoking helps me relax when I'm tense or upset"	» I light up a cigarette when something makes me angry. (D) » Smoking relaxes me in a stressful situation. (J) » When I'm depressed I reach for a cigarette to feel better. (P)
Craving	"I crave cigarettes; smoking is an addiction"	» When I run out of cigarettes, it's almost unbearable until I get more. (E) » I am very aware of not smoking when I don't have a cigarette in my hand. (K) » When I haven't smoked for a while I get a gnawing hunger for a cigarette. (Q)
Habit	"Smoking is a habit"	» I smoke cigarettes automatically without being aware of it. (F) » I light up a cigarette without realizing I have one burning in an ashtray. (L) » I find a cigarette in my mouth and don't remember putting it there. (R)

(NCI, 1993)

REFLECTIONS

Why Do You Smoke Scale					
Statement	Never 1	Seldom 2	Occasionally 3	Frequently 4	Always 5
A. I smoke to keep from slowing down.					
B. I feel more comfortable with a cigarette in my hand.					
C. Smoking cigarettes is pleasant and enjoyable.					
D. I light up a cigarette when something makes me angry.					
E. When I run out of cigarettes, it's almost unbearable until I get more.					
F. I smoke cigarettes automatically without being aware of it.					
G. When I'm tired, smoking perks me up.					
H. I enjoy getting a cigarette out of the pack and lighting up.					
I. Smoking makes good times better.					
J. Smoking relaxes me in a stressful situation.					
K. I am very aware of not smoking when I don't have a cigarette in my hand.					
L. I light up a cigarette without realizing I have one burning in an ashtray.					
M. I reach for a cigarette when I need a lift.					
N. I like to watch the smoke when I exhale.					
O. I want a cigarette most when I am comfortable and relaxed.					
P. When I'm depressed I reach for a cigarette to feel better.					
Q. When I haven't smoked for a while I get a gnawing hunger for a cigarette.					
R. I find a cigarette in my mouth and don't remember putting it there.					

(NCI, 1993)

Scoring

Add the scores for each category (reason for smoking). A score of 11 or more indicates an important reason for smoking, prompting the patient to identify alternatives to tobacco use and lifestyle changes. The higher the score (15 is the highest), the more important the reason. If a high score is obtained in more than one area, the quitting process may be more difficult.

Category	Score
Stimulation	A + G + M
Handling	B + H + N
Pleasure	C + I + O
Relaxation/Tension Reduction	D + J + P
Craving	E + K + Q
Habit	F + L + R
Never = 1 Seldom = 2 Occasionally = 3 Frequently = 4 Always = 5	

Stimulation

"Smoking gives me more energy"

Many people use tobacco like they use coffee: to help them wake up, get moving, and keep going when they feel worn out. The nicotine in tobacco, like the caffeine in coffee, is a stimulant. However, there are other ways to get more energy. When someone quits, he or she needs to find substitutes that stimulate.

Handling

"I like to touch and handle cigarettes"

This type of person gets physical pleasure from handling cigarettes and the rituals of smoking. It just "feels right" to have a cigarette in his or her hand or mouth. In fact, many people who smoke say they've gone back to smoking because "I had nothing to do with my hands." They may like to handle a cigarette, lighter, or matches, or watch the smoke. There may be other parts of the ritual of smoking that also foster dependence. Overcoming this obstacle can make it easier to quit smoking and remain smoke-free.

REFLECTIONS

REFLECTIONS

Pleasure

"Smoking is a pleasure"

Almost 2 out of 3 people who smoke say that they just plain enjoy smoking. When you associate smoking with "the good times," it can strengthen the addiction to nicotine. But it can be easier to quit when focusing on enjoying life without tobacco.

Relaxation/Tension Reduction

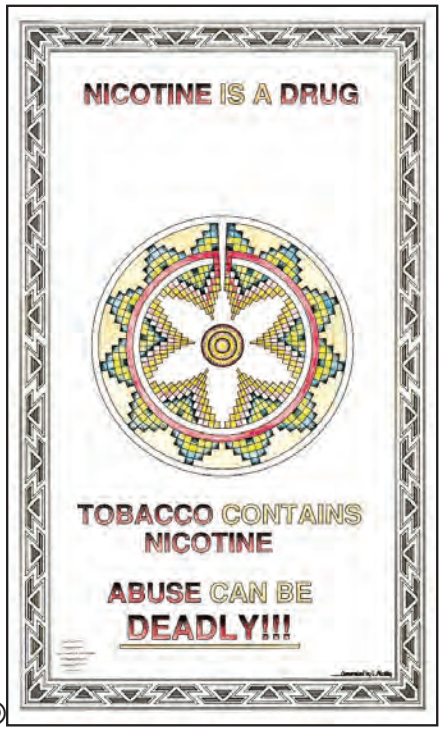
"Smoking helps me relax when I'm tense or upset"

Many people who use tobacco do so to help them through bad times. Some find it easy to stop when things are good, but tough when things go wrong. If someone has used cigarettes as a coping mechanism, finding another way to cope with stress can help that person stay quit.

Craving

"I crave cigarettes; smoking is an addiction"

Many people who use tobacco are addicted or "hooked" on the nicotine in tobacco. When they quit, many go through a withdrawal period. They may have both physical symptoms (feeling tired and irritable, headaches, and nervousness) and a psychological or emotional need for a cigarette. One ex-smoker compared his continued craving for cigarettes to the longing that one feels for a lost love.



Overcoming an addiction to tobacco is a tumultuous process. Nicotine addiction changes the brain, which makes addiction so difficult to overcome. When a

person is biochemically addicted, the body craves nicotine and becomes uncomfortable when the level of nicotine in the blood drops. The craving for another cigarette begins to build the moment that the last one is extinguished. However, with evidence-based treatments, people succeed in remaining free from tobacco. Often, individuals will have numerous quit attempts before a lifetime quit.

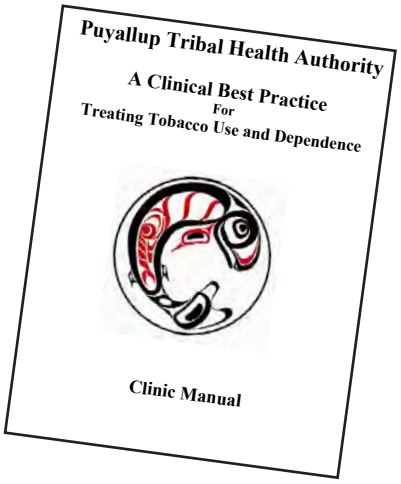
Habit

"Smoking is a habit"

This type of person who uses tobacco no longer gets much satisfaction from cigarettes. He or she smokes automatically. Chances are that only a fraction of the cigarettes smoked are enjoyed. Unlike people who smoke for pleasure, this person might not miss it very much if he or she stopped. The key is thinking through the smoking patterns and substituting alternative activities.

Validated Intensive Tobacco Dependence Treatment Programs Specific to American Indian/Alaska Native Community Members

Puyallup Tribal Health Clinic (PTHA) Intensive Intervention System



The Puyallup Tribal Health Clinic (PTHA) in Tacoma, Washington decreased smoking rates by 26% in a 6-year period after integrating the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence* into standard clinical practice. Healthcare facility visits for upper respiratory infections, coughs, and asthma decreased 60% over the same time period. Information on the healthcare facility system and accompanying programmatic materials is available by emailing nancy@eptha.com or by calling Nancy Meyer at 253-593-0232, ext 513.

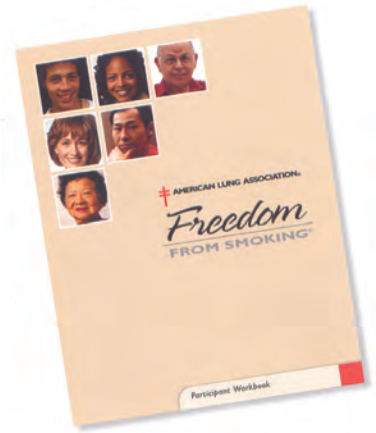
REFLECTIONS

REFLECTIONS

Second Wind: An Intensive Stop-Smoking Curriculum for American Indians/Alaska Natives

Second Wind is an intensive stop-smoking curriculum specifically designed for American Indian/Alaska Native people. Developed by the Muscogee Creek Nation Tobacco Prevention & Control Program, Second Wind provides basic information about smoking, practical counseling, problem-solving skills, and social support. For more information, contact the Muscogee Creek Nation Tobacco Prevention & Control Program at 1801 East 4th St., Okmulgee, OK 74447 or 1-800-782-8292, ext. 285. You can visit their website at www.theburningissue.org.

The American Lung Association offers a validated face-to-face Tobacco Dependence Treatment intensive program, *Freedom from Smoking*. For more information about the American Lung Association or to support the work it does, call 1-800-LUNG-USA (1-800-586-4872) or log on to www.lungusa.org.



(Reprinted with permission ©2007 American Lung Association)

The American Cancer Society also offers a face-to-face validated intensive program, *Freshstart*. You can contact the American Cancer Society at 1-800-ACS-2345 or visit www.cancer.org.

(Reprinted with permission © American Cancer Society)

Tracking Patient Progress and Outcomes to Evaluate Program Effectiveness

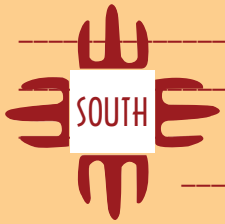
The **Electronic Health Record** (EHR) can support your program in documenting the progress of individuals who are willing to quit and are engaged in intensive services. Utilizing the system for encounter documentation and coding support (ICD and CPT), along with referral and tracking, will provide the information necessary to evaluate the effectiveness of your program interventions. Unit 9 also provides more information about the Government Performance and Results Act (GPRA) and various coding systems for tracking interventions.

The point-of-care data entry that the EHR offers ensures that you have the necessary data to assess the status of your patients' willingness to quit, quitting trajectory, and/or quit process outcomes. You can learn more about the **U.S. Department of Health and Human Services Indian Health Service Electronic Health Record** and how it can support your program with tobacco dependence treatment by going to www.ehr.ihs.gov or www.hhs.gov/healthit/ahic/materials/01_07/ehr/hays.ppt.

REFLECTIONS

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

SETTING UP A TOBACCO DEPENDENCE TREATMENT PROCESS IN YOUR FACILITY

UNIT FOUR

The Importance of Creating Change In Your System

Health and human service systems are under increasing pressure to address tobacco use in the healthcare setting as routine practice. National regulatory systems are requiring tobacco use intervention programs in healthcare systems because of their proven effectiveness in reducing healthcare costs. They also are encouraging improved community and workforce health and wellness. Employers and other purchasers are increasingly requesting services for members. The following regulatory and accrediting agencies are beginning to require that tobacco dependence be addressed:

- Joint Commission on Accreditation of Healthcare Organizations (JC)
- Government Performance and Results Act (GPRA)
- U.S. Centers for Medicare and Medicaid Services (CMS)
- Quality Control Auditors
- Patient and Family Education Protocols and Codes
- National Committee for Quality Assurance (NCQA)

Evidence also suggests that patients' overall satisfaction with healthcare facility visits is improved when tobacco use is addressed. Satisfaction increases with the intensity of services offered (Hollis, Bills, Whitlock, Stevens, & Lichtenstein, 1999).

In this unit, you are provided with essential information to implement a tobacco dependence treatment system of care. In the sections that follow, the standards for evidence-based care, and the key steps for implementing a tobacco dependence treatment system are described.

REFLECTIONS

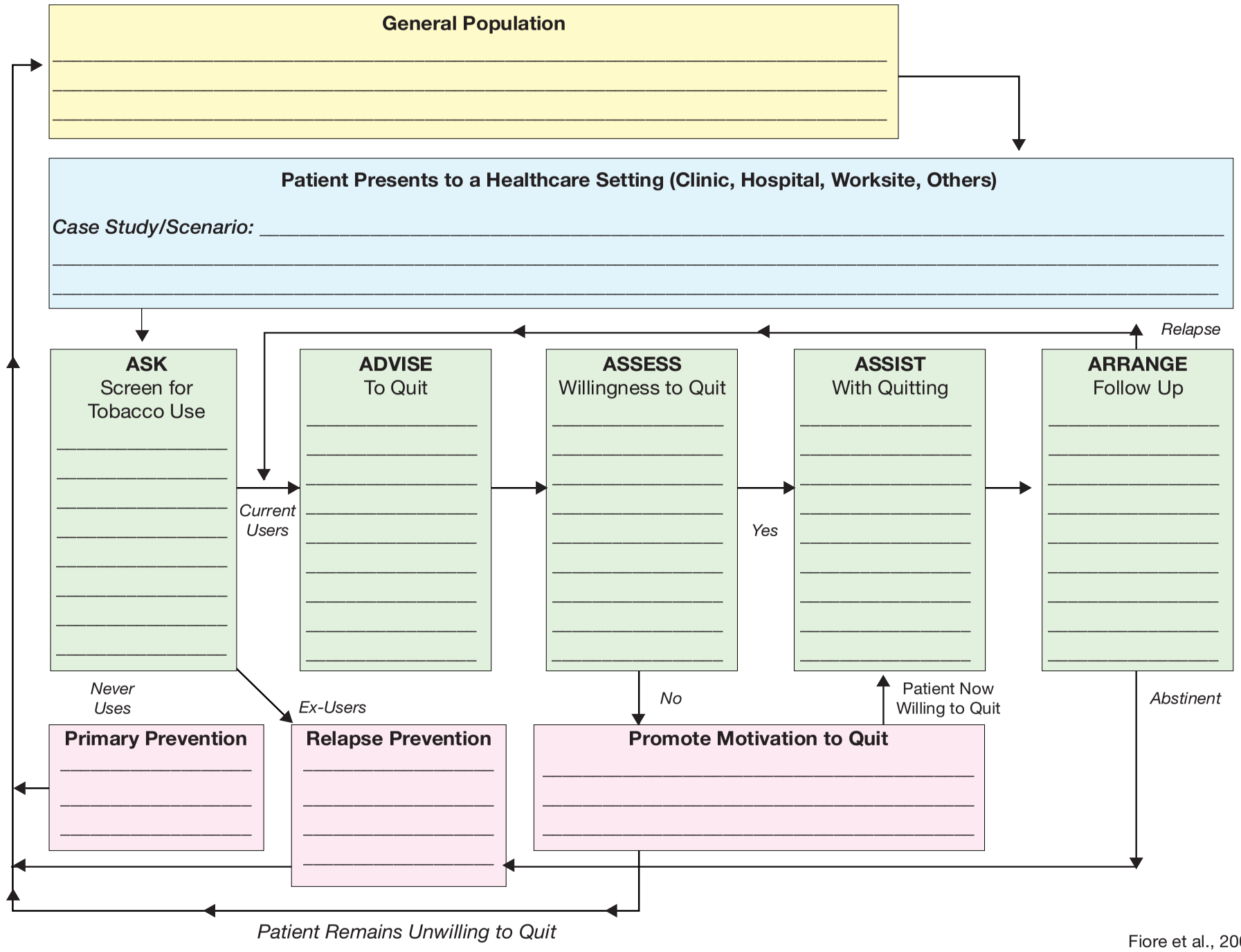
REFLECTIONS

Evidence-Based Standards of Care

A tobacco dependence treatment system of care may vary based on the needs and context of your healthcare facility, but all systems of care should incorporate the following standards in order to be effective:

- All patients have tobacco-use status reviewed and documented in the medical record as part of routine visits. A system reminds healthcare facility staff to complete the assessment.
- All tobacco users receive a brief motivational message from health and human service providers about the importance of tobacco independence.
- Patients ready to quit using tobacco receive practical counseling through the healthcare facility, along with appropriate pharmacologic adjuncts and follow-up.
- Referrals to more intensive programs are made when indicated.
- A quality assurance system sets goals, monitors tobacco treatment programs relative to those goals, and provides feedback to clinicians and to the health and human service system.
- Policies, education/training, and financial incentives support delivery of comprehensive quality cessation efforts (University of Michigan Health System, 1998).

Model for Treatment of Tobacco Use and Dependence: *On the lines provided, you can begin planning your program.*



Fiore et al., 2008

REFLECTIONS

Eight Steps to Develop a Tobacco Dependence Treatment Program

The **eight key** steps summarized below are described to assist you in designing a program specific to your healthcare center's needs and context.

1. Assess Knowledge and Attitudes of Your Staff

Develop a method to assess current knowledge, practices, and attitudes of healthcare center staff toward addressing tobacco use with their patients.

2. Design Treatment Program

Determine if your center will offer direct intensive treatment services or refer to local/state intensive evidence-based treatment programs and/or the National Quitline.

Focus on the treatment needs of your personnel first. Ensure that treatment includes both behavioral and pharmacotherapy options.

3. Staffing a Treatment Program

If on site intensive treatment will be provided at your center, decide how you are going to staff the program.

4. Screening for Tobacco Use

Work with healthcare providers (nurses, physicians, dentists, hygienists, community health aids, etc.) and healthcare center administrators to develop a system to screen and document tobacco use and exposure for all patients seen at every visit.

5. Healthcare Provider Education

Develop opportunities for healthcare providers to be introduced to the evidence-based **FIVE A Model** construct (*Ask, Advise, Assess, Assist, Arrange*) in order to screen and refer their patients to a tobacco dependence treatment program of their choice.

6. Treatment Program (Clinical) Protocol

Develop a protocol for treatment that details when, where, and how patients will receive treatment for tobacco dependence whether using a State or National Quitline or on site intensive tobacco dependence treatment. Implement a process system that has the full array of intake, counseling, referral, and follow-up components.

7. Program Evaluation

Develop a plan for program evaluation to track program progress (e.g. quit rates), successes, and to identify areas for improvement.

8. Sustainability

Develop a strategy to ensure that your systems change and protocols are institutionalized and self-perpetuating within the organization. Reimbursement for services is a key strategy.

Assess Knowledge and Attitudes of Your Clinical Staff

Purpose of Staff Assessment

An important first step to implementing a Tobacco Dependence Treatment Program is to conduct an assessment of healthcare center staff knowledge about tobacco addiction, abstinence from tobacco, treatment of tobacco dependence, and perceptions/attitudes toward the patient who is dependent on tobacco. This information is important for two reasons:

- It can help direct efforts in education and training for the clinical staff and administration. This includes identifying potential obstacles to implementing a program.
- A repeat assessment will be administered at some point in the future after the program is established. It will serve as a valuable means to assess changes in knowledge, attitudes, and system development since program initiation.

REFLECTIONS

REFLECTIONS

Format/Content

It is up to your program to choose the assessment format and content. An example of an assessment survey tool can be found at www.healthcarepartnership.org/IHS/facility_forms.html. This tool was developed specifically for this purpose by a team of experts in survey design. Feel free to modify it to fit the needs of your facility.

Target Population

However you choose to conduct the assessment, it is recommended that you sample a wide range of staff and healthcare providers **that interact with clients**. This includes persons such as nurses, physicians, dentists, hygienists, behavioral health specialists, and community health aides. Ideally, a re-assessment should be conducted in a year or at designated time intervals after program start-up to measure changes in staff practices, knowledge and systems change.

Designing a Treatment Program

Type of Treatment Services Offered

Base your tobacco dependence treatment program on clinically proven tobacco dependence treatment program guidelines, such as the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update.* Also, determine whether you will provide on site intensive tobacco dependence treatment or refer to local/state Quitline or community based services.

Examples of services that may be included in a tobacco treatment program are:

- Individual and/or group tobacco cessation counseling
- In-person or phone tobacco cessation counseling
- In-person or phone follow-up counseling
- Tobacco education
- Quitline access

Examples of persons that may be eligible for tobacco dependence treatment services in your healthcare facility are:

- Employees
- Inpatients
- Outpatients
- Visitors

An integral part of a successful tobacco dependence treatment program is the availability of free or low cost pharmacotherapy. Examples of first line recommended nicotine replacement therapies and non nicotine pharmacotherapy are:

- Bupropion SR (non nicotine replacement therapy also known as Zyban and Wellbutrin)
- Nicotine gum
- Nicotine inhaler
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine patch
- Varenicline (non nicotine replacement therapy also known as Chantix)

Tobacco Control Networking

There may be tobacco prevention and treatment resources throughout your state. Research other tobacco dependence treatment and prevention resources in your community and service area, such as www.lungusa.org and www.cancer.org. Develop formal and informal relationships as appropriate to enhance services, build a coordinated system of care for patients, and advertise and promote available treatment services.

REFLECTIONS

REFLECTIONS

Staffing a Tobacco Dependence Treatment Program

If you are providing intensive intervention services at your facility, you should determine what type of individual will provide tobacco dependence counseling and education. This individual may be a current member of your staff that will need to be trained in tobacco dependence treatment techniques, or an external individual that will need to be either contracted or hired. Allow enough time for a tobacco treatment specialist to be sufficiently oriented and educated in the theory and practice of tobacco dependence and evidence-based interventions before the initiation of your program. All individuals providing tobacco dependence treatment counseling to patients should have successfully completed or be willing to complete a Tobacco Treatment Specialist Program.

The University of Arizona HealthCare Partnership

The University of Arizona HealthCare Partnership is responsible for the instructional design, content, adaptation, graphic design, printing, materials distribution, program logistics, and evaluation of the Arizona Tobacco Dependence Treatment Continuing Education Programs. The Partnership was initially awarded a contract in 1998 to develop and test continuing education and certification models to meet the goals of the tobacco education and prevention arm of the Arizona Department of Health Services.

Continuing education and certification programs follow a stepped-care model and are organized accordingly:

Program	Instructor Program	Adaptations
Basic Tobacco Intervention Skills Certification	Basic Tobacco Intervention Skills Instructor Certification	» Maternal & Child Health » Medical & Allied Health » Native American Health » Hispanic/Spanish-Language
Tobacco Treatment Specialist Certification	Tobacco Treatment Specialist Instructor Certification	Online Learning Center & Library (English/Spanish): www.aztreattobacco.org
Tobacco Dependence Treatment Program for Health & Human Service Professionals	Speaker Orientation	Customized Presentations for Specialty Clinical Areas

Tobacco dependence treatment specialists are not defined by their professional affiliation or by the field in which they are trained. Rather, the specialist views tobacco dependence treatment as a critical professional role, has the requisite tobacco dependence intervention skills, and is often affiliated with programs offering intensive cessation intervention programs or services. Involving multiple types of providers in delivering evidence-based brief and intensive smoking cessation messages appears to enhance abstinence rates (Fiore et al., 2008).

The Indian Health Service Tobacco Control Task Force works closely with The University of Arizona HealthCare Partnership's Tobacco Dependence Treatment Continuing Education, Certification and Training programming. The University of Arizona program is a stepped-care certification model that recognizes differing contexts, intensities, and professional roles in the delivery of tobacco dependence treatment services and implements a "training-of-trainers" model to build sustainable capacity at the local level (adapted from Abrams et al., 1996). The model is based on the American Red Cross and the American Heart Association Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) certification models.

REFLECTIONS

REFLECTIONS

You can learn more about The University of Arizona programs at www.healthcarepartnership.org.

Included in The University of Arizona Tobacco Dependence Treatment stepped-care model is the **Treatment Specialist Certification**, specific to those individuals who deliver intensive interventions within the context of a nationally validated intensive treatment program. The Treatment Specialist program offers an Online Learning Center and Library as well as knowledge and skills-based practicum. More about this program can be obtained at www.aztreattobacco.org.

There are a variety of educational programs nationwide that provide educational opportunities to assure that those seeking assistance to abstain from tobacco receive evidence-based quality of care for tobacco dependence. The Association for the Treatment of Tobacco Use and Dependence (ATTUD) lists a sampling of programs at www.attud.org.

Patient Screening

> *"...The single most important step in addressing tobacco use and dependence is screening for tobacco use*
>
> *- U.S. DHHS Treating Tobacco Use and Dependence: 2008 Update*

Screen All Patients

Considering the extraordinarily high rates of morbidity and mortality due to tobacco use, it is imperative that we strive to ensure that ALL individuals who are dependent on tobacco are identified and offered assistance to quit. There are many ways to implement a commercial tobacco-user identification system.

Collaborate

The collaboration and support of your healthcare providers and facility administrators is essential for achieving the changes in your system that are required for tobacco dependence screening and treatment.

Strategies to encourage collaboration are:

- Provide information and education to providers and administrators so that they understand the devastating health effects of long term tobacco use and the importance of screening.
  - This can be accomplished in a variety of formats including presentations, meetings, or email blasts. Presentations on topics such as cost-effectiveness of treatment, rates of tobacco-user identification in the healthcare setting, health benefits of quitting, etc. can be established as a part of already established meetings.
- Identify key personnel, or a "champion provider" who is a natural advocate for tobacco use screening and intervention.
  - This is a provider who sees the everyday outcomes of chronic tobacco use or someone who has experienced tobacco related illness or death in their personal life.
  - This person can help facilitate communication between your program and healthcare staff.

Components of a Screening Tool

Screening for tobacco is very simple. It consists of the following:

- Ask if a patient uses commercial tobacco, or is frequently exposed to environmental tobacco smoke.
- If he or she uses commercial tobacco or is exposed, then determine if they smoke, chew, use both or are consistently exposed to environmental tobacco smoke.
- Sometimes a patient will be in the process of quitting (0-6 months quit), or have already quit (6 months or more).

REFLECTIONS

REFLECTIONS

Below is a sample paper-based screening tool used at the Alaska Native Medical Center (ANMC) in Anchorage Alaska and in several other tribal health organizations. All of the items in the screening tool equate to a health factor in the Resource and Patient Management System (RPMS) that can be easily coded.

Tobacco:						
None	Smoke	Chew	2ndhand	Quitting Now	Already Quit	
Education:						
Delivered	Y	N	**Referred**	Y	N	

Systems Change

The goal is to institutionalize this screening tool, or something similar, as part of an assessment procedure that will ensure or require that every individual is asked these questions. Examples include making the screening questions a part of an expanded "Vital Signs" box, including tobacco use status stickers on all charts, adding tobacco questions into computer chart-reminder systems, and/or on patient intake forms.

Another important step is to write the procedure and formalize the screening procedure within your organization. Some programs have done this via standing orders (see **Sample Physicians Form** section on page 120) or as a part of their policy and procedures manual.

Provider Education

Your treatment program will be largely dependent on healthcare provider referral of patients. To be successful, it is critical to provide educational opportunities for staff. These opportunities could be in the form of in-services, resource kits and/or presentations in the following areas:

- The burden of tobacco use in terms of morbidity and mortality for their communities

- Availability of effective treatment, behavioral and pharmaceutical
- Importance of screening
- Evidence of the Five A Model construct (a process to guide your intervention with persons who use tobacco, (see **Five A Model** on page 27)
- How to document interventions addressing tobacco use
- How and where to refer a patient for treatment
- How to code and bill for reimbursement of treatment for tobacco dependence

The Five A Model includes the major steps of a brief intervention for tobacco use in the healthcare setting. In three minutes or less you should be able to assess the patient's willingness to change, help them along to the next step in the process, and to provide a motivational message regardless of what stage of quitting tobacco they are currently at. These are the preliminary steps to assess whether a person is ready to be referred for treatment.

The Five A's Framework for Tobacco Use Intervention		
ASK	about tobacco use	Health Support Staff
ADVISE	all users to quit	Health Support Staff
ASSESS	willingness to quit	Health Support Staff
ASSIST	to increase willingness to quit *or* to access treatment	RN or Provider
ARRANGE	treatment and follow-up	Treatment Specialist/ Adjunct Health Support Staff

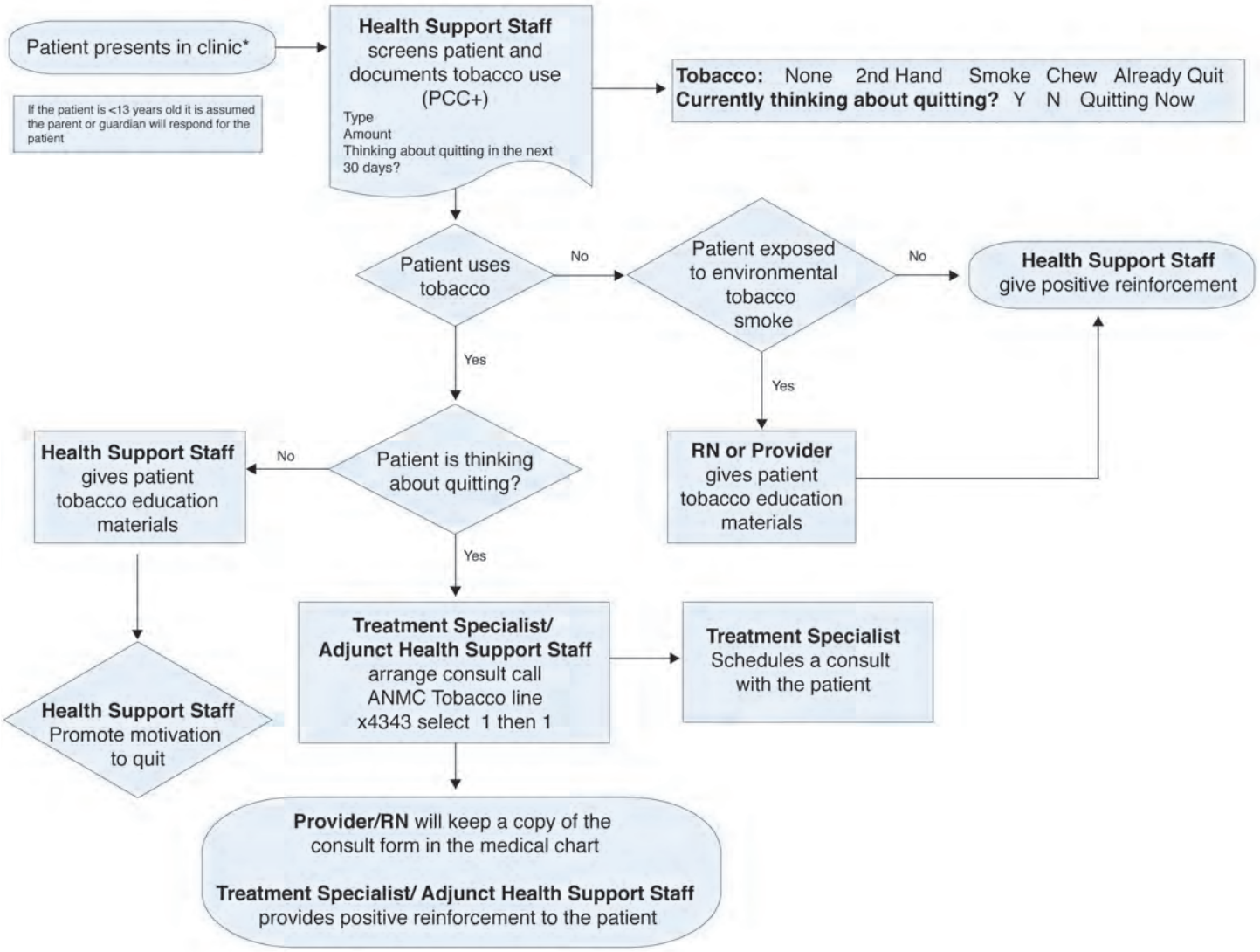
REFLECTIONS

REFLECTIONS

Treatment Protocol

A treatment protocol provides the general methods, structure, and systems by which your treatment activities will function. Patients should flow seamlessly into the "Treatment Protocol" from the "Screening Protocol." As you develop your program, it is suggested that you construct a formal document outlining this protocol. This document can assume any number of formats. Some tribal healthcare centers use this document to formally implement a tobacco dependence treatment program into healthcare facility policy, or for approval/acceptance by tribal councils, healthcare facility administration, and governing bodies. It is also a useful tool for orienting and teaching new staff. An example of a treatment protocol written for the Alaska Native Medical Center (ANMC) treatment program is shown on the following page:

Tobacco Screening and Referral Guideline for Alaska Native Medical Center (ANMC) Hospital Outpatients



ALASKA NATIVE MEDICAL CENTER

This guideline is designed for general use for most patients but may need to be adapted to meet the special needs of a specific patient as determined by the patient's provider.

REFLECTIONS

Referral

The treatment protocol should include a process for referral. The process should provide easy access to a tobacco dependence treatment program. If you are a healthcare facility, consider separate referral processes for patients (provider referral), visitors (potentially either provider or self-referral), and employees (self-referral). Establish a clinical protocol outlining the referral processes for these different components of the healthcare system, and make it accessible for providers within your facility.

Modes of Referral

The referral process to a tobacco dependence treatment program may be initiated through contact with a tobacco counselor via telephone, fax, EHR Consult or face-to-face encounters.

Referral Response

Once contacted for a referral, the tobacco treatment counselor will respond according to referral-specific protocol, which may vary for inpatients, outpatients, visitors, and employees. Examples of means of response for tobacco dependence treatment may include immediate point-of-care bedside counseling, immediate counseling in a private office or specialty healthcare facility exam room, counseling via means of a scheduled appointment, walk-in healthcare facilities and/or outreach health programs.

According to the U.S. Public Health Service, it is ideal for tobacco treatment counselors to deliver counseling to patients immediately upon receipt of a referral, as this allows counselors to capture "teachable moments," or "windows of willingness" to quit.

Location

Determine where in your healthcare facility tobacco dependence treatment services will be held. Examples may include: outpatient specialty healthcare facilities, inpatient hospital rooms, meeting rooms

throughout your facility, and/or a private tobacco dependence treatment office located on the healthcare facility campus. Identify the appropriate administrative decision-makers with which to discuss the allocation of space in your facility for an on site tobacco dependence treatment program. The location of your program relative to the healthcare center is a critical factor in developing a smoothly running referral system.

Tobacco Dependent Patient Intake for Counseling

After greeting your patient you can begin asking some general questions about tobacco use. First determine why the patient is in your office, and how you can help them. The patient may or may not be willing to try quitting. Language and techniques to help you to sensitively communicate, evoke information, and assist the patient can be cultivated by learning the methods and techniques as found in Motivational Interviewing (MI).

Counseling Patients Willing to Set a Quit Date:

You should enroll patients into the intensive treatment program only if they are willing to set a quit date within 30 days (or less than 30 days depending on your program protocol). Document all the information obtained. An example of a Patient intake form paper or electronic can be found at www.healthcarepartnership.org/IHS/facility_forms.html. The data will help you conduct your counseling session and to document your intervention. The session will typically take **30 minute**s to an hour to complete.

Counseling Patients Unwilling to Set a Quit Date:

If the patient is unwilling to set a quit date within 30 days, you will want to obtain and document:

- demographics
- tobacco type used
- amount of tobacco use
- willingness to quit

REFLECTIONS

REFLECTIONS

Then proceed with brief motivational interviewing (see **Motivational Techniques** on page 31) to encourage patient to quit. Also, provide tailored education materials and encourage the patient to contact the program or facility when they are interested in quitting. Be sure to give them contact information for the program. This will be considered an educational encounter and should be documented in the Resource and Patient Management System (RPMS).

Follow-up

Patient follow-up takes 5-15 minutes and can be conducted by phone or in-person. Your call for follow-up schedule (call log) can be created from an iCARE or external database. For the best quit rates, it is recommended to perform follow-up on the quit date and during weeks 1, 2, 3, 6, 12, 26, & 52 of the quit period for each patient. The minimum requirements for program evaluation suggest follow-up sessions at week 6, 12, 26, and 52. Research shows that weeks 1, 2, 3, 6 and 12 are especially crucial times when patients need support to remain abstinent. Follow-up, both attempted and completed, must also be documented in the *Resource and Patient Management System* (RPMS). An example follow-up form can be found at www.healthcarepartnership.org/IHS/facility_forms.html.

Relapse/Re-start

If a patient reports a slip or relapse either during a follow-up call or as a result of a call-in, employ motivational interviewing techniques to encourage remaining abstinent or considering a revised quit date within 7 days. Let the patient know that slips and relapses are to be expected during the quitting process. Most people **quit 9 - 11 times** before they are able to maintain long-term abstinence. If the patient is unwilling to set a new quit date they can be inactivated and invited to contact program at any time to re-enroll when they are willing to set a new quit date. If a year or more has passed since a patient was enrolled, and the patient wishes to make another quit attempt, re-enroll the patient and set a new quit date.

For Precontemplators & Contemplators (Unwilling, Thinking)

- Do not enter them into the full intervention program
  - Implement Five A Model (see **Five A Model** on page 27)
  - Deliver Brief Motivational Intervention: Attempt to move client closer to willingness
  - Provide Health Teaching
    - Verbal information
    - Written Material
- Follow Up
  - Patient is asked to contact program when he/she is ready to set a quit date to abstain from tobacco use. Continue to **assess** and **advise** at each encounter.

For Preparation or Ready for Action

- Enter client into Program
- Full Assessment & Counseling:
  - Complete Tobacco Use Questionnaire– Quit date is Mandatory
  - Provide Health Teaching in the context of a validated intensive tobacco dependence treatment program as provided by the American Lung Association, American Cancer Society and/or American Legacy Foundation:
    - Nicotine addiction education
    - Effects of tobacco use – smoking/chewing
    - Talk to patient about specific health problem(s) as it relates to his/her tobacco use
    - Patient and counselor discuss medication
    - Quitting techniques, i.e. making a plan, coping skills
    - Quit book/ quit guide delivered
    - Follow-up calls/ appointments scheduled with patient
    - Written education materials reviewed and discussed
  - New patient file created for clinic 94 *(Tobacco Dependence)* visit
  - Data is entered into Resource and Patient Management System (RPMS) for healthcare facility visit
  - Counselor documents progress note on the session

REFLECTIONS

REFLECTIONS

Billing:

- Complete the Charge Master form;
  - All the clients seen, including no charges
  - Tell patients that Beneficiaries will not be responsible for any fees. Non-beneficiaries will be responsible if their insurance will not cover services
- The following documents should be completed:
  - Tobacco Use Questionnaire or similar of intake instrument
  - Billing form
  - Progress notes
- Follow up:
  - Counselor calls client on quit date
  - Counselor calls client for brief supportive counseling sessions as needed, reassessing willingness and documenting progress note on every encounter.
  - Follow-up calls at 1, 2, 3, 6, 12, 26 and 52 weeks

Close File:

- When the 52 week follow up has been completed
- If patient is lost to follow-up, meaning cannot be reached via telephone, email, surface mail and does not present for health-care facility services (three consecutive intervals is the general rule)
- File status is changed to inactive, and moved to inactive file

Program Evaluation

A comprehensive plan for program evaluation is essential in order to track the progress and success of your program. Evaluation can help you to maintain a functional and effective tobacco treatment program by encouraging program staff to identify areas that need improvement, prioritize staff time and energy, and direct program resources. Specific personnel should be identified who are responsible

for the evaluation to help ensure that evaluation tasks are accomplished. If you have the resources, it may be helpful to obtain outside assistance to help you establish a plan and systems for evaluation measurement.

Evaluation is also important to attaining program fiscal sustainability. Evaluation data can be used to obtain and maintain grants as well as present "hard data" on enrollment and quit rates to justify your program to your administration and decision-makers.

Key evaluation measures used in tobacco dependence treatment can be obtained through the following sources: the **Government Performance and Results Act (GPRA) reports**, **iCARE**, and **patient medical records reviews**.

Evaluation Measures

- **Quit Rates**

  Participants in a tobacco dependence treatment program are considered quit if they have not used any form of tobacco in the last 7 days and/or the last 30 days.

  The "Point Prevalence" Quit Rate is the most typical standard measure used in evaluations of tobacco dependence treatment programs. This is usually calculated at 6, 12, 26 and 52 weeks after the patient's original quit date.

  - **Point Prevalence Quit**
    - 7 day Point Prevalence = No tobacco use in the last 7 days
    - 30 day Point Prevalence = No tobacco use in the last 30 days
  - **Continuous Quit**
    - No tobacco use since the initial quit date
    - Programs do not report this quit rate, as relapse is considered part of the quitting process and this rate is typically very low

REFLECTIONS

REFLECTIONS

Tobacco dependence, as chronic disease, has trends of relapses and remissions; therefore causing continuous Quit Rates to report low. Still, in order to achieve lifetime abstinence, these rates are important when assessing what interventions and treatments were used.

- Patient demographics

  This is information such as patient age, ethnicity, gender, etc. It can be obtained from RPMS reports.

- Systems Change

  Systems change evaluation measures determine how effective your program has been at implementing tobacco use screening, referral, and intervention for all of your patients. It also documents your centers efforts to sustain the program. This information can be obtained from:

  - The Government Performance and Results Act (GPRA) or RPMS Reports
  - Patient Medical Records (via a random chart review)

Sustainability

Reimbursement for services is an important part of program development and program sustainability. Work closely with your facility's billing department to determine the correct way to submit for reimbursement through third party payers including private insurers, Medicare and Medicaid.

Private Insurers

Some of your beneficiaries, as well as employees of your healthcare facility, may have coverage for tobacco dependence treatment services under their private insurance plans. Coverage will differ by insurance company, so you will need to research in order to identify the

main insurers for your patient population, then contact the individual companies to determine exactly what services are covered (counseling, medication, etc.). Places to look for this information include your benefits administration department, private insurance company websites and policy handbooks, and your healthcare center billing department.

If coverage is available, coordinate with your billing department to establish a system for documentation and reimbursement. If little or no coverage is available you can explore options to advocate for coverage of tobacco dependence treatment services and medications.

Medicare/ Medicaid Billing

Medicare billing for tobacco dependence treatment and some medications is available under defined circumstances. General codes are found in Unit 9 of this fieldbook. For more information refer to the Medicare website, www.medicare.gov/Basics/ClaimsOverview.asp or your facility billing department.

Medicaid also offers limited reimbursement for pharmacotherapy. Each state offers different coverage. Refer to your state resources to learn about coverage in your state.

HealthCare Settings Can Support Change

Primary healthcare takes place in many settings and involves the activity of a wide range of clinicians/non-clinicians. Evidence supports multiple interventions from multiple types of providers as an effective treatment for tobacco dependence (Fiore et al., 1996). Basic tobacco treatment intervention measures such as routine identification of tobacco users and advice from clinical staff to quit have not been widely implemented in health and human service systems (McAfee et al., 1995). Understanding the dynamics of clinical practice is important in identifying opportunities for change. **Evidence clearly demonstrates that health and human service providers DO make a difference!**

REFLECTIONS

REFLECTIONS

Seventy percent (70%) of tobacco users see a healthcare provider each year; more than 50% see a dentist (Fiore et al., 2008).

- Providers are likely to see patients at "teachable moments" when health issues are present
- Minimal interventions at the time of hospitalization result in favorable abstinence rates (8–54%) when compared with unassisted cessation rates of approximately 3% (Cohen et al., 1989)
- France, Glasgow, and Marcus (2001) suggest that cessation is enhanced when offered by a designated smoking cessation counselor as opposed to a general practitioner

Physicians as Health Influencers

- Patients report that physician advice is the single most important motivating factor
- As compared to no provider intervention, physician interventions increases quit rates by 120%
- Other health and human service provider (e.g., nurse, dentist, counselor, psychologist, pharmacist, health educator) interventions increase quit rates by 70% (Fiore et al., 2008)

Health and Human Service Providers Increase Quit Rates

- Advice to quit tobacco use by one healthcare provider increases quit rates by 80%
- Advice to quit tobacco use by two healthcare providers increases quit rates by 150%
- Advice to quit tobacco use by three or more healthcare providers increases quit rates by 140% (Fiore et al., 2008)

Summary: The Ideal Primary Care Setting and Real Life Examples

To end this Unit, we provide you with specific guidelines for creating an ideal primary care setting and some real life examples of healthcare facilities that have embarked on systems change.

The Ideal Primary Care Setting: Guidelines for Primary Care Clinicians

- Primary care organizations co-sponsor and promote clinician education in tobacco dependence treatment and prevention for providers, administrators, and clinicians.
- Primary care organizations support tobacco-dependent staff members in quitting.
- Self-help materials for tobacco-dependent patients and family members are provided free of charge in all exam rooms and waiting areas.

Administrators and clinical leaders adopt and implement policies and procedures consistent with standards of care recommended in the Public Health Service guidelines:

- Tobacco use is assessed and documented for all patients at each visit.
- A brief, personalized provider-mediated intervention is delivered and documented for each patient who uses tobacco at every visit.
- All patients interested in quitting are assisted in obtaining affordable, accessible tobacco dependence treatment services.
- Referrals to services are documented in the medical record.
- All patients who are making an attempt to quit receive information about pharmacological interventions and are offered evidence-based practical counseling.
- All patients who are attempting to quit receive follow-up.

REFLECTIONS

REFLECTIONS

Establish mechanisms to refer patients to intensive tobacco dependence treatment services:

- Develop a simple method for clinicians to refer patients to treatment services through the healthcare facility or through community-based programs.
- Enhance internal systems to allow clinicians to refer patients to intensive services in a timely manner, with sensitivity to the patient's willingness to quit.
- Identify and bring attention to local resources and quitlines to increase accessibility to patients.

Have a mechanism to develop and maintain the skill level of staff:

- Use Certified Tobacco Treatment Instructors to certify designated point-of-contact staff and other interested staff in Basic Tobacco Cessation Skills.
- Provide in-services for clinical staff on policies and procedures.
- Develop a Resource Kit and use presentation materials from the kit to teach clinicians evidence-based brief tobacco dependence intervention methods and techniques.

Support clinical staff during the change process:

- Provide self-help materials for exam rooms and monitor distribution.
- Update staff on progress and treatment service outcomes.
- Provide reminders and motivators to office staff.
- Assist in monitoring progress during implementation via simple chart audits and patient surveys.

Keep At It–it takes years to change systems:

- Limit the number of initial healthcare sites to make technical assistance manageable.
- Recruit internal champions who will assume part of the workload.
- Keep expectations for change reasonable.
- Teach and report back.

Real-Life Examples of Systems Change

Warm Springs Reservation IHS Clinic, Oregon

Each patient is screened for tobacco use and exposure by the triage staff using the Five A Model. Staff are also certified in Basic Tobacco Intervention Skills. Tobacco screening is documented in the Electronic Health Record (EHR). If a tobacco user is interested in quitting, an electronic referral is made to the Pharmacy Tobacco Cessation Program. Patients are contacted and scheduled into the healthcare facility and followed according to protocol. Patients are offered intensive intervention, nicotine replacement therapy and/or mitigation therapy. Additionally, patients are offered group counseling from the local Tribal Programs and referrals to the Oregon Quitline.

Phoenix Indian Medical Center Pharmacy Nicotine Cessation Clinic, Arizona

Patients enrolled in the pharmacy healthcare facility must be enrolled in an intensive cessation counseling program. Patients may self-refer or be referred to the Nicotine Cessation Healthcare facility by their medical provider.

The first pharmacy appointment is scheduled 7-10 days prior to the patient's decided quit date. The pharmacist conducts a physical assessment and interviews and assesses the patient in order to:

- Determine any contraindications for pharmacotherapy
- Provide patient specific education on medication therapy
- Provide first fill of medication

Patient follow up is based on the standard for "Best Practice" for Intensive Interventions as outlined in the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update.*

- At every encounter, patients will be interviewed for progress, medication side effects and therapy goals.

REFLECTIONS

REFLECTIONS

- The first refill visit should be within 2-4 weeks of initial pharmacy appointment to document blood pressure and assess the patient's tolerance to the medication.
- Subsequent refills are patient specific and may be processed in person or via telephone.

Documentation is done at each visit. The pharmacist notes side effects, behavior modification and the patient's progress and goals. Further education is provided.

"GEGO ZAGSWAAKEN" (Don't smoke) PROGRAM, Minnesota

Individuals can be self-referred or referred by their medical provider who will complete a referral form. The referral form includes name, address, telephone number and name of referring medical provider.

The smoking cessation program assists individuals interested in stopping the use of commercial tobacco by providing educational materials though the use of flyers, articles, and DVD's on the topics of nicotine, handling nicotine withdrawal symptoms, developing an individualized "quit plan", selecting appropriate pharmacotherapy such as the patch, gum, inhaler or Chantix and identifying individual smoking triggers while limiting the use of traditional tobacco to ceremonial and cultural use only.

Individuals are requested to complete the Fagerström Test for Nicotine Dependence as part of the intake process.

"Gego Zagswaaken" promotes smoke-free homes and cars by providing education on the harmful effects of environmental tobacco smoke and amount of carcinogens in cigarettes.

Pine Ridge Service Unit, South Dakota

Tobacco Cessation services at the Pine Ridge Service Unit are currently being provided on the brief intervention level through the Outpatient areas utilizing the Five A model. Triage staff Ask and Advise and document in the health factors & education codes. Providers continue the process by Advising again and Assessing willingness for quit attempt. If a patient is willing to quit, they are referred to intensive services..

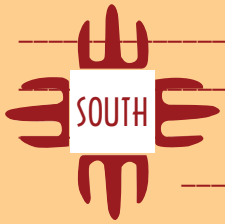
Intensive interventions are provided through the Pharmacy in Pine Ridge and Public Health Nursing in Pine Ridge and Wanblee. All nicotine dependence counselors (NDP) have completed training through the Mayo Nicotine Dependence Program. Trained staff accept cessation referrals from any clinical providers or client self-referrals and nicotine replacement therapies are available on the formulary at each site.

Client recall is individually determined by each NDP counselor utilizing the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* and community education/ intervention is done solely through the PHN department.

REFLECTIONS

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

PHARMACOTHERAPY

UNIT FIVE

It is a misconception that American Indians/Alaska Natives will not use medications. Opinions vary, just as they do in the Anglo-American population. Generational differences also exist, as do urban versus rural differences. The important thing is not to generalize, but rather to present the American Indian/Alaska Native patient with varied treatment options to see which he or she is comfortable with using. Be sure to stress that if the patient uses the patch, gum, lozenge, inhaler, spray, or non-nicotine replacement medication, he or she will not feel the same immediate feeling of reward as when smoking cigarettes or chewing tobacco. It is important to tell the patient what to expect so that he or she realizes that the medication is working. Otherwise, the patient may stop using the therapy and say, "It just didn't work for me." **Knowing what to expect is a key to success.**

REFLECTIONS

Pharmacotherapy for Treating Tobacco Dependence

General Considerations

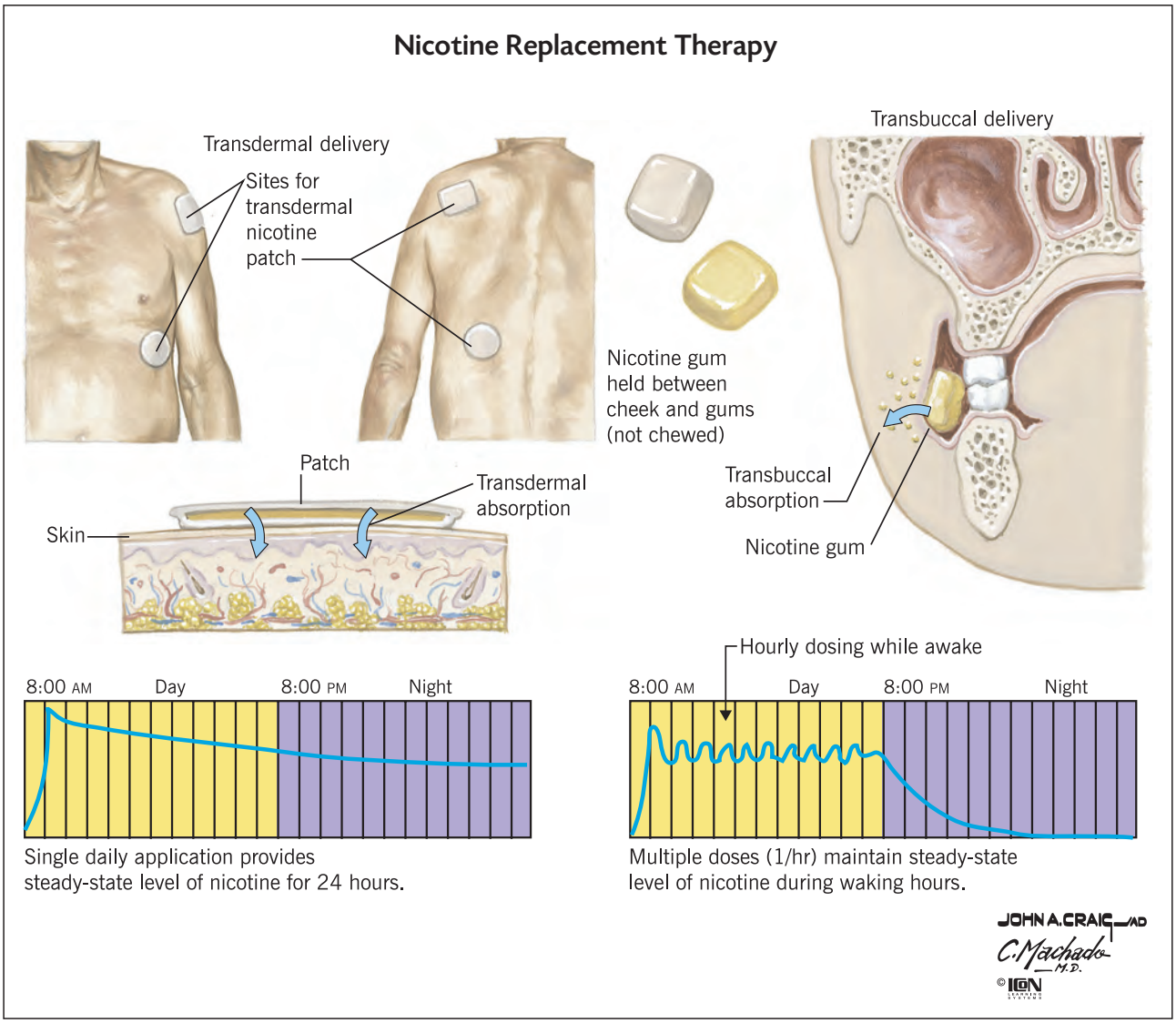
The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* recommends that all people trying to quit tobacco be encouraged to use effective medication for tobacco dependence treatment, unless they present with special circumstances. Those who fall into the categories below should consult with a physician to determine the appropriateness of pharmacotherapy to treat their tobacco dependence (Fiore et al., 2008):

- People who smoke less than 10 cigarettes per day
- Adolescents (under 18 years of age)
- Pregnant and breastfeeding women
- People with serious medical conditions (for example, recent heart attack, unstable angina, arrhythmia, or uncontrolled hypertension)
- **NOTE:** Tobacco users in any of these groups should consult with a physician before using pharmacological treatment (see **Special Circumstances** section on page 121 of this unit).

Why Encourage Pharmacotherapy?

- People who use tobacco treatment medications may double or possibly triple their quit rate (Fiore et al., 2008; Leischow & Cook, 1998).
- Pharmacotherapies are effective for a broad range of smokers, not just "heavy" smokers (Fiore et al., 2008).
- Pharmacotherapies are effective with low as well as high levels of psychosocial treatment intensity. Therefore, clinicians should recommend effective psychosocial treatments (such as practical counseling) in addition to pharmacotherapy to all patients for whom they are appropriate (Fiore et al., 2008).

The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* recommends **seven first-line medications** (nicotine gum, nicotine lozenge, nicotine patch, nicotine nasal spray, nicotine inhaler, bupropion SR and varenicline) and **two second-line medications** (clonidine and nortriptyline) to assist people attempting to stop smoking (Fiore et al., 2008).



REFLECTIONS

Nicotine Replacement Modes of Delivery

Nicotine replacement therapies (NRTs) deliver nicotine to the body, but the delivery method is different from that of cigarettes. This can result in a slower release of nicotine and in lower nicotine levels in the blood stream.

Nicotine replacement is absorbed either through the skin (nicotine patch) or through membranes in the nose or mouth (nicotine gum, inhaler, spray, and lozenge).

With these routes of administration, nicotine is absorbed slowly and transported to the brain in low, steady doses. This means that patients who use a nicotine replacement product will not get the same immediate feeling of reward that was part of their experience of smoking or chewing tobacco.

Patients who smoke absorb up to 90% of the nicotine in mainstream cigarette smoke. Mainstream cigarette smoke is the air drawn through a lit cigarette (Henningfield, Cohen, & Pickworth, 1993).

Each cigarette yields about 1 mg of nicotine; a pack contains 20 cigarettes. The normal adult daily dosage of nicotine is about 20 mg, or one pack per day (Henningfield et al., 1993; Benowitz, 1988).

Nicotine Replacement Dosing*

- 1 cigarette equals 1 mg of nicotine
- 1 dip chewing tobacco equals 3-4 mg of nicotine
- 1 cigar equals 10-20 mg of nicotine
- 1 bidi or kretek equals 2-3 mg of nicotine

*Adapted from Ford & Zlabek, 2005

First-Line Medications

Nicotine Replacement Medications

- Nicotine gum
- Nicotine patch
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine inhaler

Non-Nicotine Replacement Medications

- Bupropion SR (Zyban®)
- Varenicline (Chantix™)

The first-line medications listed are safe and effective pharmacological therapies for the treatment of nicotine dependence. Since not enough information exists to recommend one medication over the others (Fiore et al., 2008), the choice of a specific first-line medication must be guided by factors such as

- Previous patient experience with the medication
- Patient preference
- Patient characteristics (for example, history of depression or concern about weight gain)
- Presence of special circumstances or contraindications
- Clinician familiarity with the medication
  (Fiore et al., 2008)

REFLECTIONS

REFLECTIONS

Combination Tobacco Dependence Treatment Pharmacotherapy

Combinations of certain first-line medications have been shown to be more efficacious than a single form of nicotine replacement, and patients should be encouraged to use such combined treatments if they are unable to quit using a single type of first-line pharmacotherapy.

Effective combination medications are:

- Long-term (>14 weeks) Nicotine Patch + other NRT
- The Nicotine Patch + Nicotine Inhaler
- The Nicotine Patch + bupropion Sr
- The Nicotine Patch + Nortriptyline
  (Fiore et al., 2008)

The FDA has **approved only one combination** of tobacco dependence treatment pharmacotherapy for smoking cessation: the Nicotine Patch + bupropion SR (Fiore et al., 2008).

Varenicline is not designed to be used in combination with nicotine replacement therapies because of its nicotine antagonist properties (Fiore et al., 2008).

Clinicians should use their best judgement and consider the current evidence and patient preference before prescribing combination medications. Evidence indicates that combination pharmacotherapy may result in greater suppression of tobacco withdrawal symptoms than the use of a single medication (Sweeney et al., 2001). Patient preference may also play a role in prescription recommendations, because some combinations may produce more side effects and cost more than individual medications (Schneider et al., 2006).

Nicotine Gum *(Nicotine Polacrilex)*	
Nicotine gum was first approved by the FDA in 1984 and became available without a prescription in 1996. A person will need to stop using tobacco completely before using the nicotine gum.	
Dosage	The gum is available in 2 mg and 4 mg (per piece) strengths. The recommended dosages are: » < 25 cigarettes/day: 2-mg » ≥ 25 cigarettes/day: 4-mg » Weeks 1-6: 1 piece every 1-2 hours » Weeks 7-9: 1 piece every 2-4 hours » Weeks 10-12: 1 piece every 4-8 hours » No more than 24 pieces/day
Duration	Nicotine gum should be used on a fixed schedule (at least one piece every 1 to 2 hours) for 6 to 12 weeks, then tapered off.
Efficacy	Use of nicotine gum increases the odds of quitting by 80% as compared to placebo (Fiore et al., 2008).
Precautions	» Tobacco users in any of the special circumstances groups should consult with a physician before using nicotine gum. » Extensive dental work/dentures » TMJ disease » Stop use if signs of nicotine toxicity develop. Symptoms of nicotine overdose include nausea, vomiting, dizziness, weakness, and rapid heartbeat.
Side Effects	» Mouth soreness » Jaw ache » Hiccups » Nausea/vomiting » Headache » Indigestion Side effects usually transient and mild, often relieved by correcting chewing technique. These effects are generally mild, subside over time, and often can be alleviated by correcting the chewing technique.
Instructions for Use	**STOP ALL SMOKING** » Chew until peppery or minty taste released, "park" between cheek and gum 1-5 minutes, then repeat » Park in different areas of the mouth » Use one piece no longer than 30 minutes » No eating or drinking 15 minutes before and during use (decreases nicotine absorption) » Fixed dosing for 1-3 months may be more useful than ad libitum

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

Nicotine Patch *(Transdermal Nicotine System)*	
The nicotine patch was approved by the FDA in 1991 and became available without a prescription in 1996. A person will need to stop using tobacco completely before using the nicotine patch.	
Dosage	The type and strength of the patch should be selected according to individual patient characteristics, such as previous experience with the nicotine patch, body weight, number of cigarettes smoked per day, and medical history. **16 hour** » 15-mg x 6 wks, 10-mg x 2 wks, 5-mg x 2wks » Remove before sleeping » Only releases nicotine for 16 hours **24 hour** » 21-mg x 6 wks, 14-mg x 2 wks, 7-mg x 2wks » 22-mg x 4 wks, 11-mg x 4 wks » May remove CQ patch after 16 hours
Duration	The nicotine patch may be used for 10 weeks. After approximately 6 weeks of treatment, the patient may begin using a lower strength patch and then taper off by reducing the dosage every 2 weeks until the patch is discontinued completely..
Efficacy	Use of nicotine patch doubles the odds of quitting as compared to placebo (Fiore et al., 2008). There is no difference in efficacy between 16-hour and 24-hour patches.
Precautions	» Tobacco users in any of the special circumstances groups should consult with a physician before using the nicotine patch. » Extensive skin disease » Hypersensitivity to patch adhesive » Stop use if signs of nicotine toxicity develop. Symptoms of nicotine overdose include nausea, vomiting, dizziness, weakness, and rapid heartbeat.
Side Effects	» Cutaneous hypersensitivity » Headache » Sleep disturbances/insomnia/abnormal dreams (w/24-hr use) » Approximately 50% of patients using the nicotine patch will experience local skin irritation. Rotate patch sites to reduce skin irritation. Less than 5% of patients using the nicotine patch must discontinue use as a result of skin irritation.
Instructions for Use	**STOP ALL SMOKING** » After waking up on quit day, apply patch to relatively hairless area between waist and neck. » Apply new patch at start of each day » Rotate patch site to minimize local skin irritation » If sleep disturbance occurs with 24-hour patch, remove patch at bedtime or try 16-hour patch.

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

Nicotine Lozenge *(Nicotine Polacrilex)*	
The nicotine lozenge was first approved by the FDA in 2002. A person will need to stop using tobacco completely before using the nicotine lozenge.	
Dosage	» If smoke>30 mins after waking: 2-mg » If smoke<30 mins after waking: 4-mg » Weeks 1-6: 1 lozenge every 1-2 hours » Weeks 7-9: 1 lozenge every 2-4 hours » Weeks 10-12: 1 lozenge every 4-8 hours » Do not use more than 5 lozenges in 6 hours. » Do not use more than 20 lozenges per day
Duration	The patient should follow a 12-week schedule (lozenges should not be used for more than 12 weeks).
Efficacy	Use of the nicotine lozenge doubles the odds of quitting as compared to placebo (Shiffman et al., 2002).
Precautions	» Tobacco users in any of the special circumstances groups should consult with a physician before using the nicotine lozenge. » Stop use if signs of nicotine toxicity develop. Symptoms of nicotine overdose include nausea, vomiting, dizziness, weakness, and rapid heartbeat. » Contains phenylalanine 3.4-mg per lozenge
Side Effects	» Insomnia » Nausea » Hiccups » Coughing » Headache » Heartburn These effects are generally mild and self-limiting. If side effects do not subside, or if they increase in severity, patients should discontinue use and consult a physician.
Instructions for Use	**STOP ALL SMOKING** » Suck lozenge until fully dissolved (20-30 minutes). There may be a warm tingling sensation. The lozenge should be occasionally moved from one side of the mouth to the other until dissolved completely. » Consume only one lozenge at a time » No eating or drinking 15 minutes before and during use (decreases nicotine absorption)

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

Nicotine Nasal Spray	
The FDA approved the nicotine nasal spray in 1996 for prescription only. A person will need to stop using tobacco completely before using nicotine nasal spray.	
Dosage	A single dose of two sprays (one in each nostril) from the inhaler is equal to 1 mg of nicotine. » One dose = one 0.5-mg spray to each nostril (1-mg total) » Weeks 1-8: 1-2 doses/hour » Weeks 9-14: gradually reduce dosage and discontinue » Maximum: 40 doses/day (5 doses/hour)
Duration	Nicotine nasal spray may be used for 3–6 months.
Efficacy	Use of nicotine nasal spray nearly triples the odds of quitting as compared to placebo (Fiore et al., 2008).
Precautions	» Tobacco users in any of the special circumstances groups should consult with a physician before using nicotine nasal spray. » Severe reactive airways disease » People using nicotine nasal spray have the potential to become dependent; approximately 15–20% of patients report using nicotine nasal spray for longer periods than recommended. » Stop use if signs of nicotine toxicity develop. Symptoms of nicotine overdose include nausea, vomiting, dizziness, weakness, and rapid heartbeat.
Side Effects	» Moderate to severe nasal irritation in first few days of use (persistent sneezing, coughing, or runny nose and watery eyes) » Some irritation may persist for weeks » Nasal congestion » Throat irritation » Transient changes in taste and smell » People with a history of nasal irritation and sinus allergies should not use nicotine nasal spray. People who experience severe persistent sneezing, coughing, or runny nose and watery eyes after the first 2 days of using nicotine nasal spray should discontinue use and consult a physician.
Instructions for Use	**STOP ALL SMOKING** » The spray is best delivered with the head tilted slightly back » Avoid swallowing, sniffing, or inhaling during dosing to minimize side effects

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

Nicotine Inhaler	
The FDA approved the nicotine inhaler in 1997 for prescription only. A person will need to stop using tobacco completely before using the nicotine inhaler.	
Dosage	» One dose = one puff or inhalation » One cartridge delivers 4-mg nicotine over approximately 80 inhalations (about 3-5 cigarettes) » Weeks 1 to 12: 6-16 cartridges/day
Duration	Treatment is recommended for up to 6 months. Use should be tapered off gradually during the final 3 months of the treatment.
Efficacy	Use of the nicotine inhaler increases the odds of quitting by 150% as compared to placebo (Fiore et al., 2008).
Precautions	» Tobacco users in any of the special circumstances groups should consult with a physician before using the nicotine inhaler. » Stop use if signs of nicotine toxicity develop. The symptoms of nicotine overdose include nausea, vomiting, dizziness, weakness, and rapid heartbeat.
Side Effects	» Around 40% of patients using the nicotine inhaler will present with local irritation (redness and/or swelling) of the mouth and throat. » Coughing (Approx. 32% of patients) » Rhinitis (Approx. 23% of patients) These symptoms are generally mild and decrease in severity over time. People who experience severe mouth or throat irritation while using the nicotine inhaler should discontinue use and consult a physician.
Instructions for Use	**STOP ALL SMOKING** People should use the nicotine inhaler any time that they begin to experience a craving for a cigarette or begin to feel other withdrawal symptoms. » *To use the inhaler:* The plastic mouthpiece should be separated into its two parts. One nicotine cartridge should be placed into the mouthpiece. The mouthpiece should be reassembled, pushing the two parts back together to break the seal on either end of the cartridge. The patient should place the end of the mouthpiece in his or her mouth and inhale. » Each cartridge provides 20 minutes of active puffing–approximately 80 draws or about 300 shallow inhalations. » Decreased nicotine delivery in low ambient temperatures (<40F): keep cartridges in pocket to keep warm » No eating or drinking 15 minutes before use and during use (decreases nicotine absorption) » Best effects with frequent puffing

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

Bupropion SR (Zyban®)	
Bupropion SR is the first non-nicotine replacement drug approved by the FDA for smoking cessation (1997). It is available by prescription only. Mechanism of action is presumed to be mediated through dopaminergic and/or noradrenergic mechanisms.	
Dosage	The recommended dose is 150 mg once daily for 3 days. Dosage then increases to 150 mg twice a day for 4 days (after which the patient should stop all tobacco use) and continue at this level for the remainder of the treatment.
Duration	Treatment with bupropion SR is recommended for 7 to 12 weeks.
Efficacy	Use of bupropion SR doubles the odds of quitting as compared to placebo (Fiore et al., 2008).
Precautions	» Tobacco users in any of the special circumstances groups should consult with a physician before using bupropion SR. » Contraindications: history of seizure disorder, eating disorder, serious head trauma, current alcoholism or alcohol abuse, concurrent use of another form of bupropion, use of MAO inhibitor in past 14 days. » Bupropion allergy » Seizure risk: 1 out of 1000 users » Bupropion SR is not currently recommended as a tobacco cessation treatment for pregnant women and adolescents.
Side Effects	» Insomnia » Dry mouth » Shakiness » Rash If insomnia is problematic, physicians should recommend taking the first dose earlier in the morning, so that the second dose (8 hours after the first dose) occurs earlier in the day.
Instructions for Use	» Start treatment with bupropion SR 1-2 weeks before quit date » Continue 150-mg b.i.d. for 7-12 weeks after quit date » If insomnia marked, take PM dose in afternoon » Use alcohol only in moderation

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

Varenicline (Chantix™)	
Varenicline is a partial nicotinic acetylcholine receptor agonist. It was designed to bind to nicotine receptors in the brain and ease withdrawal symptoms in adult tobacco users. Varenicline blocks the effects of nicotine from cigarettes if the patient resumes smoking.	
Dosage	» Day 1 to Day 3: white tablet (0.5-mg), 1 tablet each day » Day 4 to Day 7: white tablet (0.5-mg), twice a day (1 in the morning and 1 in the evening) » Day 8 to end of treatment: blue tablet (1-mg), twice a day (1 in the morning and 1 in the evening) » Varenicline should be taken after eating with a full glass (8 ounces) of water.
Duration	Treatment with varenicline is recommended for 12 weeks. For patients who have quit smoking at 12 weeks, an additional 12 weeks of varenicline is recommended to further increase the likelihood of long-term abstinence (Tonstad et al., 2006).
Efficacy	Use of varenicline 3 times to nearly 4 times greater compared to placebo depending on which time point abstinence is assessed (Gonzales et al., 2006; Jorenby et al., 2006).
Precautions	» Tobacco users in any of the special circumstances groups should consult with a physician before using varenicline. » History of kidney problems or kidney failure » History of psychiatric illness » Advise patients and caregivers that the patient should stop taking varenicline and contact a healthcare provider immediately if agitation, depressed mood, or changes in behavior that are not typical for the patient are observed, or if the patient develops suicidal ideation or suicidal behavior. *Note:* Safety and efficacy not established in patients with serious psychiatric Illness.
Side Effects	» Nausea » Changes in dreaming » Constipation, Gas » Vomiting *Note:* Nausea was reported by approximately 30% of patients treated with varenicline 1 mg twice a day, with approximately a 3% discontinuation rate during 12 weeks of treatment. Nausea was generally described as mild or moderate and often transient. Patients who cannot tolerate nausea may have the dose lowered temporarily or permanently.
Instructions for Use	» Start varenicline treatment one week before quit date » Varenicline should be taken after eating with a full glass (8 ouces) of water

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

REFLECTIONS

Second-Line Medications

- Clonidine
- Nortriptyline

Second-line medications are pharmacotherapies for which there is evidence of efficacy for treating tobacco dependence, but which have a more limited role than first-line medications because:

- The FDA has not approved them for a tobacco-dependence treatment indication
- There are more concerns about potential side effects than exist with first-line medications

Second-line treatments should be considered for use on a case-by-case basis after first-line treatments have been used or considered (Fiore et al., 2008).

Clonidine	
Clonidine is appropriate as a second-line treatment for smoking cessation. Clonidine is not approved by the FDA for the treatment of tobacco dependence.	
Dosage	Doses used in various clinical trials have varied from 0.15–0.75 mg/day orally to 0.10–0.20 mg/day transdermal patch, without a clear dose-response relation to cessation.
Duration	Patients should begin taking clonidine shortly (3 days) prior to or on the quit date. Duration of treatment ranges from 3 to 10 weeks.
Efficacy	The use of clonidine doubles the odds of quitting as compared to placebo.
Precautions	» As an antihypertensive medication, clonidine can be expected to lower blood pressure in most patients. Monitoring blood pressure is therefore recommended during treatment. » Failure to gradually reduce dosage over 2–4 days before discontinuation may result in rebound hypertension.
Side Effects	The most commonly reported side effects of clonidine are dry mouth, drowsiness, dizziness, sedation, and constipation.
Instructions for Use	Initial dosing is typically 0.10 mg twice daily orally, or 0.10 mg/day transdermal patch. Increase by 0.10 mg/day per week as needed.

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

Nortriptyline	
Nortriptyline is appropriate as a second-line treatment for smoking cessation. Nortriptyline is not approved by the FDA for the treatment of tobacco dependence.	
Dosage	» Dosage begins 10–28 days before the quit date. » Initiate treatment at 25 mg/day, gradually increasing to 75–100 mg/day. Blood levels of nortriptyline may be monitored.
Duration	Duration of treatment in smoking cessation is approximately 12 weeks.
Efficacy	Use of nortriptyline triples the odds of quitting as compared to placebo.
Precautions	Use with extreme caution in patients with cardiovascular disease.
Side Effects	The most commonly reported side effects are sedation, urinary retention, light-headedness, dry mouth, blurred vision, and hand tremor.
Instructions for Use	Patients should begin taking nortriptyline 10–28 days before the quit date to allow the medication to reach a steady state in the blood.

(Adapted from Fiore et al., 2008; Physicians' Desk Reference [PDR], 2005; PDR, 2007)

SAMPLE PHYSICIAN ORDER FORM
TOBACCO DEPENDENCE TREATMENT

Tobacco Treatment Checklist

ASK about tobacco use:	❑ Review tobacco use history in chart ❑ Ask if currently use tobacco
ADVISE tobacco user to stop:	❑ Stop-smoking advice given: "I strongly advise you to quit smoking. It is never too late to turn your health around, and we can help you."
ASSESS readiness to quit:	❑ Willing to quit ❑ Thinking about quitting ❑ Unwilling to quit ❑ Relapse
ASSIST tobacco user to quit:	❑ Brief counseling: Reasons to quit, Barriers to quitting, Lessons from past attempts, Set a quit date if ready, Enlist social support
	❑ Medications (if appropriate): Nicotine Replacement (circle): patch gum nasal spray inhaler lozenge Other (circle): bupropion SR varenicline
ARRANGE follow-up:	❑ Refer to National or Local Quitline: _____ and the American Legacy Program: *Become an EX* www.becomeanex.org
	❑ Community-based stop-smoking programs

NOTE: Pharmacotherapies can double or triple a patient's chances of successful abstinence.

FIRST-LINE THERAPY

❑ **Nicotine Gum**

Chew one piece of gum every 1-2 hours or as needed. Do not use >24 pieces per day.

- ❑ 2-mg dose up to 24 pieces per day if patient smokes < 25 cigarettes per day
- ❑ 4-mg dose up to 24 pieces per day if patient smokes ≥ 25 cigarettes per day

❑ **Nicotine Patch**

Apply patch as soon as patient awakens each AM.
May remove at bedtime if patient experiences sleep disruption. Notify physician if localized skin reaction occurs.

- ❑ Three strengths: 21, 14, or 7 mg/24 hours per patch
- ❑ Two strengths: 22 or 11 mg/24 hours per patch
- ❑ One strength: 15 mg/16 hours per patch

❑ **Nicotine Lozenge**

Use one lozenge q 1 to 2 hours, weeks 1 to 6; one lozenge q 2 to 4 hours, weeks 7 to 9; one lozenge q 4 to 8 hours, weeks 10 to 12. Do not use more than 20 lozenges per day.

- ❑ First cigarette >30 minutes after waking: 2 mg lozenge
- ❑ First cigarette within 30 minutes after waking: 4 mg lozenge

❑ **Nicotine Nasal Spray**

One 0.5 mg delivery to each nostril (1 mg total). Initial dosing should be 1 to 2 doses per hour, increasing as needed for symptom relief. Minimum treatment is 8 doses/day and maximum limit is 40 doses/day or 5 doses/hour.

❑ **Nicotine Inhaler**

Administer 6 to 16 4-mg dose cartridges per day, instructing patient to drink only water for 15 minutes before and during inhalation. Best effects are achieved by frequent puffing.

❑ **Buproprion SR**

150 mg every AM PO for 3 days, then 150 mg PO b.i.d.
Do not give if patient is pregnant or lactating, has a history of seizures or eating disorder, is already taking another form of bupropion, or is on an MAO inhibitor within 14 days of use.

❑ **Varenicline**

0.5 mg every AM PO for 3 days, then 0.5 mg b.i.d. for 4 days, then 1 mg b.i.d.
Do not give if patient has history of psychiatric illness or if patient is pregnant or lactating. Adjust dose in patients with renal insufficiency.

AT DISCHARGE

- ❑ Prescription for bupropion SR 150 mg b.i.d. x 8 weeks.
- ❑ Order for Nicotine Replacement Therapy as above.
- ❑ Prescription for varenicline as directed x 12 weeks.

Physician Signature: _____ **Date:** _____

This sample order sheet may be used as a guideline to assist a physician or healthcare organization to recommend pharmacotherapy (if appropriate) and to refer patients who are dependent on tobacco to intensive services. It is not intended to replace internal processes of physician order development and approval.

(UA HealthCare Partnership, 2009)

Special Circumstances to Consider with Pharmacotherapy

The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* recommends that all tobacco users trying to quit be encouraged to use effective medications for cessation unless they present with special circumstances. Those who fall into the categories below should consult with a physician to determine the appropriateness of pharmacotherapy to treat their tobacco dependence (Fiore et al., 2008):

- Patients who smoke less than 10 cigarettes a day
- Adolescents
- Pregnant and breastfeeding women (insufficient evidence supports NRT use with pregnant women [Dempsey & Benowitz, 2002; Hotham, Gilbert, & Atkinson, 2005])
- Patients with serious medical conditions (for example, recent heart attack, unstable angina, arrhythmia, or uncontrolled hypertension)

Patients Who Smoke Less than 10 Cigarettes per Day

Clinicians should consider prescribing nicotine replacement products at a lower dose than recommended in patients who smoke less than 10 cigarettes per day (Fiore et al., 2008).

Adolescents

There is no contraindication to the use of first-line medications for tobacco dependence treatment in adolescents. However, consider the teen's stage of willingness to quit, body weight, and nicotine dependency level before selecting a dosage (Fiore et al., 2008). Adolescents will likely require lower dosages of medication than adults. Effectiveness of NRT has not been demonstrated effective in pediatric tobacco use prevention (Fiore et al., 2008).

REFLECTIONS

REFLECTIONS

Pregnant and Breastfeeding Women

Pharmacotherapy should be considered when a pregnant woman is otherwise unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of pharmacotherapy and potential continued smoking (UpToDate, 2009).

Cardiovascular Disease

Nicotine replacement therapy is not an independent risk factor for Cardiovascular Disease (CVD). Nicotine replacement therapy should be used with caution in patients with recent myocardial infarction, serious arrhythmias, and/or serious or worsening angina pectoris (Fiore et al., 2008).

As an antihypertensive medication, clonidine can be expected to lower blood pressure in most patients. Therefore, blood pressure should be monitored during treatment (Talwar, Jain, & Vijayan, 2004).

Failure to gradually reduce the dose over several days before discontinuation may result in rebound hypertension in hypertensive patients and relative hypoglycemia in patients with diabetes (Gourlay, Stead, & Benowitz, 2004).

Because of the risk of arrhythmias and changes in contractility and blood flow, nortriptyline should be used with extreme caution in patients with cardiovascular disease (Fiore et al., 2008).

Varenicline is not designed to be used in combination with nicotine replacement therapies, nor has it been studied in combination with other smoking cessation medications (Cahill et al., 2007).

History of Psychiatric Illness

In February 2008, the FDA added a warning regarding the use of varenicline. Specifically, it noted that depressed mood, agitation, changes in behavior, suicidal ideation, and suicide have been reported in patients attempting to quit smoking while using varenicline (Fiore et al., 2008). All patients being treated with varenicline should be observed for neuropsychiatric symptoms and advised to tell their healthcare provider if they experience any of these feelings.

There are three standard and validated measures of depression with which clinicians can monitor changes in mood and behavior in patients taking varenicline. The Hamilton Depression Rating Scale (HAM-D) is a 17 question survey that takes approximately 15 minutes to complete. This survey instructs participants to rate the frequency with which they experience typical symptoms of depression (anxiety, suicidal ideation, etc.). This scale is in the public domain and can be obtained in numerous locations free of charge. The following link contains the survey, background information, and instruction for administration.

Website Resource for the Hamilton Depression Rating Scale

http://www.psychiatrictimes.com/clinical-scales/depression/

Another traditional screening instrument for depression is the Beck Depression Inventory (BDI). This survey contains 21 questions. Participants are instructed to document the extent to which they experience typical symptoms of depression. Unlike the HAM-D, this survey is not in the public domain and can only be obtained from the publisher. Below is a link to the publisher's website, where the survey and administration instructions can be found.

Website Resource for the Beck Depression Inventory

http://pearsonassess.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8018-370&Mode=summary

REFLECTIONS

REFLECTIONS

The Reynolds Adolescent Depression Scale is a 30-item survey designed to measure the presence and degree of symptoms characterizing depression in adolescents. The survey and associated information can be obtained from the publisher's website below.

Website Resource for the Reynolds Adolescent Depression Scale

http://www.sigmaassessmentsystems.com/assessments/rads.asp

Precautions, Warnings, Contraindications, and Side Effects

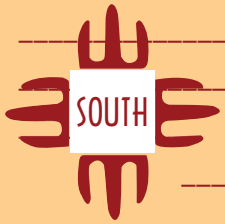
Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated, where there may be significant side effects, or for specific populations for which there is insufficient evidence of effectiveness.

	Nicotine Replacement Therapy (NRT)	Bupropion	Varenicline
Pregnancy	Compatible - Maternal benefit >>Embryo/Fetal Risk Contraindicated (with any use of tobacco)	Human Data Suggest Low Risk	No Human Data - Animal Data Suggest Low Risk
Breast feeding	No Human Data - Potential Toxicity	Limited Human Data - Potential Toxicity	No Human Data - Potential Toxicity
Cardiovascular Disease	NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those with serious arrhythmias, unstable angina pectoris, recent myocardial infarction, and/or uncontrollable hypertension.	Generally well tolerated; occasional reports of hypertension.	Not contraindicated.
Lung/COPD	**Nasal Spray:** should not be used in persons with severe reactive airway disease.		
Psychiatric disorders/ substance abuse disorders	**Nasal Spray:** highest dependence potential due to highest peak nicotine levels than other NRTs; 15-20% use for longer than recommended periods (6-12 months); 5% used the spray at a higher dose than recommended. **Nicotine Patch:** insomnia and/or vivid dreams.		Warning about depressed mood, agitation, changes in behavior, suicidal ideation, and suicide. Patients should discuss any history of psychiatric illness prior to starting the medication, and clinicians should monitor patients for changes in mood and behavior.
Seizures		Contraindicated in individuals with a history of seizures or eating disorders.	
Renal Disease			Precautions in patients with significant kidney disease (CrCl < 30 mL/min) or who are on dialysis.
Drug Interactions		Contraindicated in individuals who have used an MAO inhibitor in the past 14 days. Should not be combined with other forms of bupropion (duplication).	
Common Side Effects	**Gum:** mouth soreness, hiccups, dyspepsia, and jaw ache. **Inhaler:** local irritation in the mouth and throat (40%), coughing (32%) and rhinitis (23%). **Lozenge:** nausea, hiccups, heartburn; 4-mg dose has increased rates of headache and coughing (<10%). **Nasal Spray:** severe nasal irritation during first 2 days (94%) and after 3 weeks mild-moderate (81%); transient changes in smell and taste reported. **Patch:** local skin reactions (up to 50%) that are mild and self-limiting; occasionally worsen over time; use topical hydrocortisone cream or triamcinolone cream and rotate sites. Insomnia and/or vivid dreams.	Insomnia (35-40%) Dry mouth (10%)	Nausea (30%) Trouble sleeping Abnormal/vivid/strange dreams

(Adapted from Briggs, et.al., 2008; Fiore et al., 2008)

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

SPECIAL POPULATIONS

UNIT SIX

Guidelines for Intervening with Pregnant Women

> *"Smoking hurts your child. Future generations of American Indian people depend on you.*

Lakota women made elaborate beaded ceremonial robes to reflect *"the core of the Lakota life-way (wiconi) which is woman centered in the tipi (lodge or home). In traditional culture, the tipi rested upon the image of Ina Maka (Mother Earth).... The design elements are all symbolic representations of a woman's love and commitment to a Lakota woman's reason for being and belonging"*–Beatrice Medicine, Standing Rock Sioux (Williams, Wierzbowski, & Preucel, 2005).

When working with an American Indian community, it is important to understand the role that tobacco plays within the tribal culture of that community. In a biomedical approach, tobacco is portrayed as an addiction that requires total abstinence by those who smoke. However, a significant number of Native American nations consider traditional tobacco to be sacred and to be essential in ceremonial healing. Traditional tobacco carries prayers to the Creator, and, thus, is used by pregnant women in many tribes to bless and protect the unborn baby as well as the mother. Ceremonial tobacco use is very different from the recreational use of commercial tobacco, which is considered by American Indians to be inappropriate for expectant mothers.

Because the sacred use of traditional tobacco is an important part of pregnancy in many American Indian cultures, it is essential to present smoking cessation in a culturally appropriate manner. A good way to do this is to foster openness and respect for Native American cultural values, especially around the issue of tobacco. To implement cultural awareness:

- Emphasize the difference between the use of sacred tobacco and commercial tobacco, especially at this important life stage
- Ask about cultural beliefs of pregnant American Indian women in the population with whom you work
- Talk and be open with American Indian providers who are from the culture with which you work

> *"Every action should be taken with thoughts of its direct effects on children seven generations from now.*
>
> *–Cherokee saying*

See the national partnership to help pregnant smokers quit using tobacco: www.helppregnantsmokersquit.org/search.aspx?s=Native+American+Women.

Tobacco Use Among Pregnant Women in the U.S.

At least 10% of pregnant women in U.S. smoke (CDC, 2006b).

- Rates are consistently highest among:
- Young adult women aged 18 through 24 years
- Women with low income
- Women with lower levels of education
- American Indian/Alaska Native women (20.2%)
  (CDC, 2007)

Tobacco and Pregnancy

According to the U.S. Office of the Surgeon General, tobacco use is the most important modifiable cause of poor pregnancy outcomes among women in the United States. About 20%–30% of all low-birth-weight (sickly) births are attributable to tobacco use.

Compared with women who do not smoke:

- Women who smoke prior to pregnancy are about twice as likely to experience a delay in conception and have approximately **30% higher odds** of being infertile.
- Women who smoke during pregnancy are about **twice as likely** to experience premature rupture of membranes, placental abruption, and placenta previa during pregnancy.
  (CDC, 2007)

Babies born to women who smoke during pregnancy:

- Have about 30% higher odds of being born prematurely
- Are more likely to be born with low birth weight (less than 2500 grams or 5.5 pounds), increasing their risk for illness or death
- Weigh an average of 200 grams less than infants born to women who do not smoke
- Are 1.4 to 3.0 times more likely to die of Sudden Infant Death Syndrome (SIDS)
  (CDC, 2007)

REFLECTIONS

REFLECTIONS

If all pregnant women quit using tobacco during pregnancy, fetal and infant deaths would decrease by 10% (USDHHS, 2001).

Smoking Increases a Pregnant Woman's Risk Of

- Abruptio placenta
- Decreased fetal growth
- Ectopic pregnancy
- Placenta previa
- Placental abnormalities
- Premature birth
- Spontaneous abortion
- Stillbirth

(Fiore et al., 2008; USDHHS, 2001)

Smoking During Pregnancy Increases a Baby's Risk Of

- Dying from Sudden Infant Death Syndrome (SIDS)
- Cleft palate or cleft lip
- Development of childhood cancers
- Low birth weight (sickly baby)
- Small for gestational age (SGA)
- Abnormal lung development
- Alteration in architecture of the brain

(Fiore et al., 2008; USDHHS, 2001)

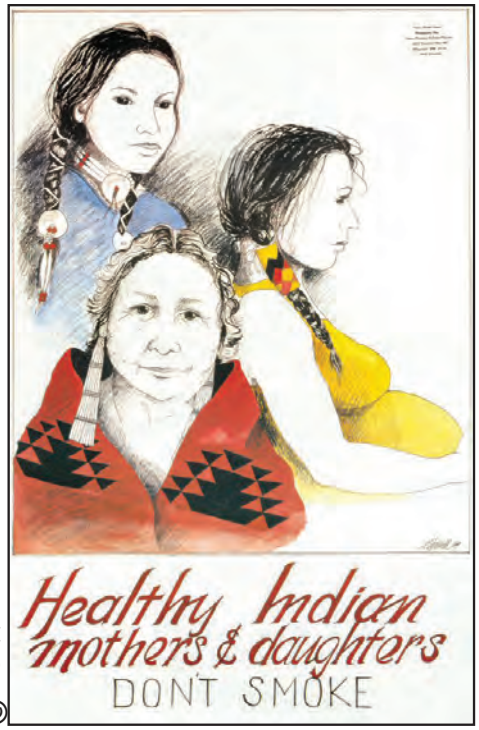
Pregnancy Is a Strong Motivation to Quit Smoking

Twenty-two percent to forty-one percent (22%–41%) of pregnant women quit spontaneously upon learning they are pregnant (Morasco, Dornelas, Fischer, Oncken, & Lando, 2006; Lumley, Oliver, Chamberlain, & Oakley, 2004; USDHHS, 2001). Providing continued support to pregnant women who quit on their own is important due to high rates of relapse since it has been estimated that 21%–35% relapse before delivery and 66%–90% relapse within one year postpartum (USDHHS, 2001, Lumley et al., 2004).

Successful Quitting in Pregnancy is Associated With

- Older age
- Being married
- Having a non-smoking partner
- Low smoking level prior to pregnancy
- Smoking initiation later in life
- Previous successful quit attempts
- Strong beliefs regarding harmful effects to the fetus
- Early prenatal care
  (USDHHS, 2001)

Public Health Service Guidelines for Intervening With Pregnant Smokers



Clinicians should offer interventions to pregnant women who smoke at the first prenatal visit as well as throughout the course of pregnancy.

Pharmacotherapy should only be considered if the potential benefits outweigh its risks.

Because of the risk to the pregnant woman who smokes and to her fetus, pregnant women should be offered extended or augmented psychosocial interventions (Fiore et al., 2008).

REFLECTIONS

REFLECTIONS

Adapting the Five A's to Intervene With a Patient Who is Pregnant

NOTE: *Smoke-Free Families and The National Partnership to Help Pregnant Smokers Quit offer numerous resources to help make the "Five A's" a routine part of prenatal care. These resources are described in the brochure, "Here's How You Can Help Your Pregnant Patient Quit Smoking." For more information, call (919) 843-7663 or email info@helppregnantsmokersquit.org.*

Ask

Ask the individual to choose the statement that best describes her tobacco use status:

- I have NEVER smoked, or have smoked FEWER THAN 100 cigarettes in my lifetime.
- I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
- I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
- I smoke some now, but I have CUT DOWN on the number of cigarettes I smoke since I found out I was pregnant.
- I smoke regularly now, ABOUT THE SAME as before I found out I was pregnant.

There are high levels of false self-reports regarding smoking status given by pregnant women, with up to 40% non-disclosure (Fiore et al., 2008).

Advise

Motivational messages (e.g., counseling and brochures) should be tailored to address tobacco use and pregnancy.

These messages should emphasize the impact of tobacco use on both the tobacco user and the unborn baby (Fiore et al., 2008).

Characteristics of Advice:

- **Clear:** "I think it is important for you to quit smoking now and I will help you."
- **Strong:** "As your clinician, I need you to know that quitting tobacco use is the most important action you can take to protect your health and the health of your unborn child."
- **Personalized:** "You've mentioned that you are worried about having a premature baby. Stopping smoking now is the best action you can take to reduce that risk."

Assess

Assess whether the patient is willing to make a quit attempt in the next 30 days and Assist accordingly.

- **Unwilling** to make a quit attempt, then:
  Assist by practical counseling using the 5 R's:
  - **Relevant** information
  - Emphasis on **Rewards** and **Risks**
  - Identification of **Roadblocks**
  - **Repetition** at each encounter
- **Willing** to make a quit attempt, then: Assist with a quit plan

Assist

Assist the patient in quitting.

The use of pregnancy-specific tobacco dependence treatment materials is twice as effective as non-specific/generic treatment materials in encouraging abstinence from tobacco in pregnant women (USDHHS, 2001).

Pregnant tobacco users should be encouraged to attempt quitting using educational and behavioral (problem-solving) interventions before pharmacological approaches. They should be strongly encouraged to quit throughout pregnancy because of the serious risks to the mother and unborn baby. Pregnant tobacco users should also be offered extended and augmented psychosocial interventions (Fiore et al., 2008).

REFLECTIONS

REFLECTIONS

Brief interventions should be used in addition to more intensive interventions.

Arrange

Arrange follow-up contact in person or by telephone, within 2 weeks and preferably during the first week of a quit attempt.

- Let the individual know that you are available when she is willing to quit.
- Inform the individual that because it is so important, you will continue to ask her about tobacco use.
- Congratulate success!
- Discuss continued abstinence at the post-partum visit because of high relapse rates.
- If relapse occurs, continue to refer to more intensive and/or a specialized program (Fiore et al., 2008).

Pharmacotherapy and Pregnant Women

Pharmacotherapy should be used during pregnancy only if the increased likelihood of abstaining from tobacco use, with its potential benefits, outweighs the risks of pharmacotherapy and potential continued smoking (Fiore et al., 2008; Hughes, Stead, & Lancaster, 2007).

* Note that there are no adequate and well-controlled studies on the use of bupropion in pregnancy.

Clinicians should:

- Consider monitoring blood nicotine levels to assess level of drug delivery.
- Consider prescribing medication at the low end of the dose range; alternatively, prescribe usual strength, but instruct patients using patch to remove at bedtime.
- Consider using intermittent (gum) rather than continuous (patch) drug exposure. *NOTE: Efficacy in pregnancy has not been tested; the relative ratio of risks to benefits is unclear* (Fiore et al., 2008).

Tobacco and Breastfeeding

It is important to encourage breastfeeding with mothers who smoke. In most cases, the benefits of breastfeeding outweigh the potential risks to the baby.

Recommendations for Breastfeeding Mothers Who Smoke

- Quit or reduce the amount of tobacco used
- Monitor infant's growth closely
- Breastfeed before smoking, not after
- Keep smoke away from baby
- Try to smoke outside and never smoke in enclosed spaces (e.g., cars, rooms in home)
- Tie a scarf around your hair while smoking. Remove after smoking and leave outside your home prior to handling the baby.
- Wash your hair frequently
- Wash your hands and change your clothes **after smoking** and **before feeding** the baby
- Take the Smoke-Free Home Pledge: call 1-800-513-1157

Nicotine from Tobacco Products in Breast Milk

- Nicotine levels in breast milk peak shortly after the woman smokes.
- About 1/3 of the nicotine in breast milk is absorbed by the baby.
- There are no uniform guidelines on how much tobacco use is "safe" for the breastfed baby of a nursing mother who smokes.
- Pregnant women who smoke breastfeed less frequently and for shorter periods of time than nonsmokers (Lumley et al., 2004).
- Smoking may decrease breast milk production.
- Cigarette smoking (5 per day) lowers prolactin hormone levels that are needed for breastfeeding (Salazar, Albala, Yanez, Seronferre, & Vio, 1995).
- Exclusively breastfed infants of mothers who smoke have lower growth rates compared to exclusively breastfed infants of non-smokers (Lande et al., 2003).

REFLECTIONS

Adolescent Tobacco Use

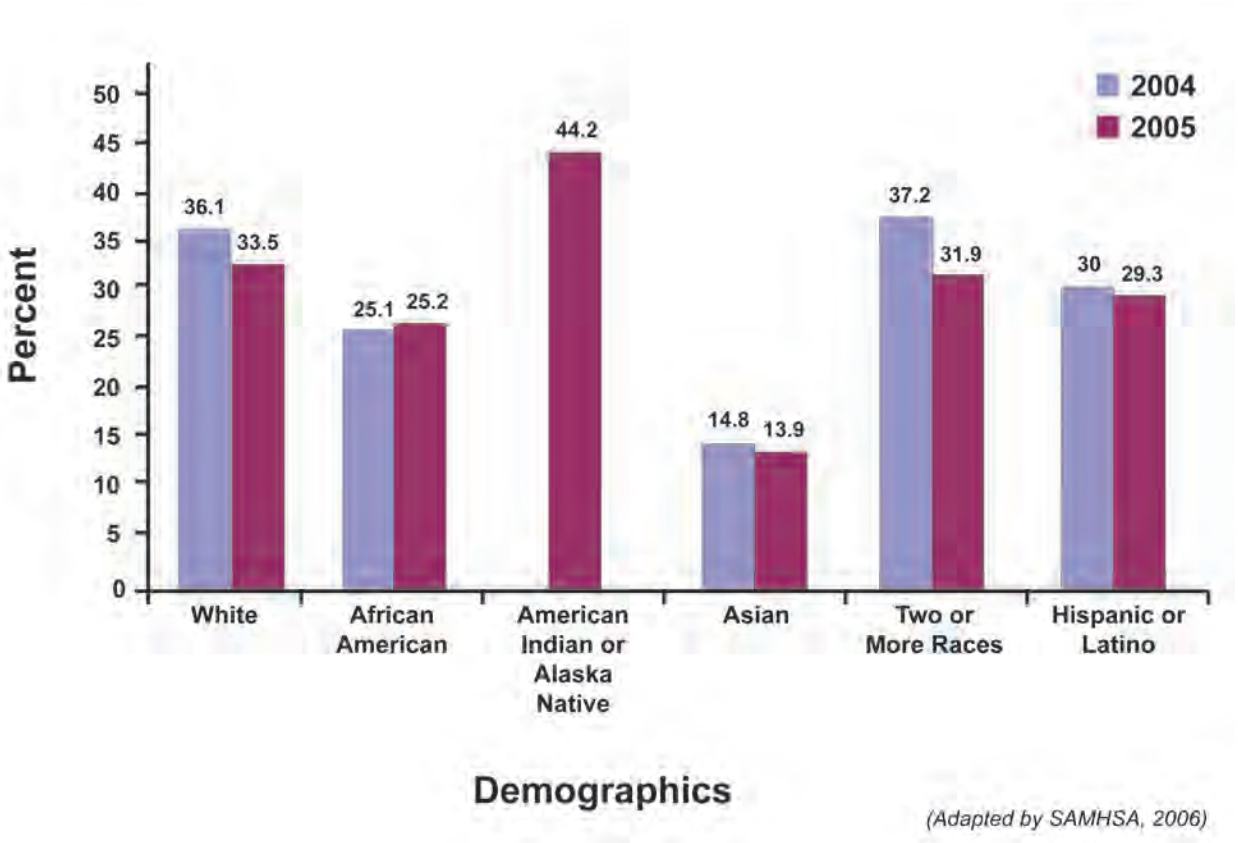
Risk-taking behavior and peer pressure are common among teenagers. Most individuals dependent on tobacco tried their first cigarette before the age of 18, so other activities, especially sports and sweat lodges (if applicable) need to be in place to counter the pressure to smoke. Smoking interferes with sports and a healthy, spiritually balanced lifestyle.

Trends in Teen Tobacco Use

According to Donna E. Shalala, PhD, Former Secretary of the U.S. Department of Health and Human Services, "Today, nearly 3000 young people across our country will begin smoking regularly. Of these 3000 young people, 1000 will lose that gamble to the diseases caused by smoking. The net effect of this is that among children living in America today, 5 million will die an early, preventable death because of a decision made as a child" (1997).

Tobacco Use Among Adolescents

Tobacco Product Use in Lifetime Among Persons Aged 12 to 17



- More than 6 million kids alive today will die of smoking-related illness if rates do not decline (CDC, 2008b).
- Each day more than 3500 youths try their first cigarette, and each day more than 1000 other youths under 18 years of age become regular, daily smokers (CDC, 2008b). That's 545,000 new underage daily smokers each year (CTFK, 2005).
- Nationwide, 20% (3.5 million) of high school students smoke cigarettes (CDC, 2008b).
- Seven (7) out of ten (10) young people who smoke report that they regret ever having started (Rankin, Jones, Basler, & Moore, 2006).
- Three (3) out of four (4) young smokers have tried to quit at least once and failed (Fiore et al., 2008).
- Addiction to nicotine in young people is not limited to smoking.

REFLECTIONS

- Among all high school seniors who have ever used spit tobacco, almost seventy-five percent (75%) began by the ninth grade (CTFK, 2006b).
- Eighty-three percent (83%) of American Indian 12th graders report lifetime cigarette use, as compared to 63% of non–American Indians (Beauvais, Jumper-Thurman, Helm, Plested, & Burnside, 2004).
- Forty-six percent (46%) of American Indian 12th graders report lifetime smokeless tobacco use, as compared to twenty-three (23%) of non–American Indians (Beauvais et al., 2004).
- In 2007, fourteen percent (14%) of high school students and 4% of middle school students were current cigar users (CDC, 2007).
- More than One-third of high school students who try smoking will become regular smokers before leaving high school (CDC, 1998).

Tobacco is a Gateway Drug

Nearly 80% of adults dependent on tobacco smoked their first cigarette as an adolescent. And of these adults dependent on tobacco 71% were daily cigarette users before age 18 (SAMHSA, 2006).

Youths who smoke are:

- Three times more likely to consume alcohol
- Three times more likely to smoke marijuana
- Four times more likely to use cocaine than youths who do not smoke cigarettes

(CTFK, 2002)

Factors Influencing Initiation

- Age at exposure
- Advertising
- Weight control
- Curiosity
- Depression
- Appearance and image concerns
- Peer, family, and social factors
- Psychophysiological response

A parent who smokes doubles the odds that their child will begin smoking. Both parents smoking increases the odds even higher, as well as increasing the number of years of their child's dependency on tobacco.

Anticipate Tobacco Use Among Youth

The National Cancer Institute encourages anyone working with children and adolescents to anticipate exposure to tobacco use and early experimentation with smoking or chewing tobacco. Beginning at age 10, children should be asked about environmental tobacco smoke and actual tobacco use at each encounter with a health provider (Manley, Epps, Husten, Glynn, & Shopland, 1991).

➲ **Anticipate** risk factors for tobacco use:

- Parents who use tobacco
- Friends who use tobacco
- Poor school performance
- Positive attitude about smoking

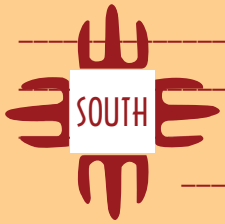
➲ **Ask** about tobacco use in the home

- The Guidelines recommend that Clinicians should strongly advise and that counseling has shown to be effective in treating adolescent smokers (Fiore et al., 2008).

REFLECTIONS

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

CHRONIC DISEASE AND TOBACCO RISKS

UNIT SEVEN

Comorbidities: Diabetes and Heart Disease

Elders are repositories of tribal traditions, stories, and skills such as basket making and beading. They need to be alive to carry on knowledge from previous generations. Once you have made contact with the tribal community and have given talks at the community center, make an appointment to give a presentation at the community senior center to speak specifically to the elders in the community about tobacco-related health issues. Do not lecture to them, but simply plant the seeds by presenting information on the additional risk that cigarette smoking contributes to the severity of diabetes and heart disease. Be sure to mention that their children and grandchildren depend on them to pass on wisdom from their elders.

Arrange for *Lii Biyiin (Horse Song)*, a 60-minute film by Norman Patrick Brown about diabetes prevention for American Indians/Alaska Natives. This film follows the life of Jack White, a traditional Navajo man who is diagnosed with diabetes and begins a difficult journey back to health. *Lii Biyiin (Horse Song)* was funded by the Indian Health Service and is available as a video from Four Directions Health Communications, Northern Navajo Medical Center, Shiprock, NM, (505) 368-6499. For a real-life scenario of the health consequences of diabetes and daily life, visit *Living a Life with Diabetes is Still a Life to be Lived* at: www.tribalconnections.org/health_news/secondary_features/diabetes3.html.

> *"Love your life, perfect your life, beautify all things in your life. Seek to make your purpose in the service of your people.... When you arise in the morning, give thanks for the food and for the joy of living.*
>
> *–Attributed to Chief Tecumseh*

REFLECTIONS

Prevalence of Tobacco Use and Diabetes

Smoking prevalence was reported to be significantly higher for diabetic AI/AN groups than for non-diabetic AI/AN groups, 29.8% and 18.8%, respectively (Morton et al., 2008).

Increased Risk of Developing Type 2 Diabetes

- The risk of developing Type 2 diabetes increases nearly 6 times for cigarette smokers with a family history of diabetes.
- Prevalence of Type 2 diabetes increases 1.5–2.7 times for current users of moist snuff as compared to non-users (Persson et al., 2000).
- In addition to age of onset, blood glucose monitoring, socioeconomic status, and health knowledge, smoking is one of the strongest predictors of poor metabolic control (Haire-Joshu et al., 1999).

Consequences of Tobacco Use

Hemodialyzed diabetic cigarette smokers show higher fibrinogen levels and have an increased systolic blood pressure reading. They also have a higher incidence of myocardial infarction (MI), and a decreased 5-year survival rate compared to nonsmoking patients on hemodialysis (Biesenbach & Zazgornik, 1996).

Persons with diabetes who smoke have:

- Poorer glycemic control and increased prevalence of microvascular complications (Chaturvedi, Stephenson, & Fuller, 1995)
- Increased risk of macrovascular complications and coronary artery disease
- Excess morbidity & mortality due to circulatory and cardiovascular disease
- Increased risk of nephropathy
- Increased risk of albuminuria by >20%

- Twelve-fold increased risk of neuropathy
- Increased risk of retinopathy and blindness (Haire-Joshu et al., 1999)

Tobacco and Insulin Resistance

Experimental findings suggest that smoking causes insulin resistance (Targher et al., 1997). This effect could be due to a stimulation of the sympathetic nervous system by nicotine (Persson et al., 2000).

Long-Term Damage

- Individuals with diabetes who smoke should be encouraged to quit as soon as possible in the course of the disease (Chaturvedi, Stevens, & Fuller, 1997).
- Smoking Cessation may lead to improvement in insulin sensitivity and to elevated levels of high-density lipoprotein cholesterol (Morton et al., 2008).

Prerequisites to Successful Treatment of Tobacco Dependence

Indian Health Service Standards of Care for Adults with Type 2 Diabetes can be downloaded at www.ihs.gov/medicalprograms/diabetes.

You will want to begin your interventions with a discussion of the following health issues:

- Weight gain
- Dietary adherence
- Beneficial effects of encouragement from physicians (Wakefield, Roberts, & Rosenfeld, 1998)

REFLECTIONS

REFLECTIONS

Heart Disease and Stroke

- Smoking is one of the causes of coronary heart disease, the leading cause of death in the United States.
- Cigarette smokers are 2–4 times more likely to develop coronary heart disease than nonsmokers.
- In 2005, mortality from coronary heart disease (CHD) was **445,687**, accounting for about 1 in every 5 deaths in the United States (American Heart Association, 2009).
- It is estimated that in 2009, 785,000 Americans will have a new coronary attack and about 470,000 will have a recurrent attack (American Heart Association, 2009).
- Smoking low-tar or low-nicotine cigarettes rather than regular cigarettes appears to have little effect on reducing the risk for coronary heart disease.
- Cigarette smoking approximately doubles a person's risk for stroke.
- The U.S. incidence of stroke is estimated at 795,000 cases per year, with a mortality rate of about 30% (American Heart Association, 2009; El-Saed, Kuller, Newman, Lopez, Costantino, McTigue, Cushman, & Kronmal, 2006).
- The risk of stroke decreases steadily after smoking cessation; former smokers have the same stroke risk as nonsmokers after 5 to 15 years.
- Cigarette smoking causes reduced circulation by narrowing the blood vessels (arteries).
- Smokers are more than 10 times as likely as nonsmokers to develop peripheral vascular disease.
- Smoking causes abdominal aortic aneurysm.

Tobacco & Oral Health

The oral health risks associated with tobacco use are often overlooked. Tobacco is a known cause of oral cancer and other conditions that negatively affect oral health. The considerable rise in the use of smokeless tobacco products during the last quarter of the 20th century, especially among American Indians/Alaska Natives, highlights the need for early identification of and intervention with patients presenting with tobacco use by healthcare providers.

Risks to Oral Health Caused by Tobacco Use

- Tobacco penetrates into tooth enamel and dental restorative materials, creating a brown to yellow staining of the teeth (USDHHS, 2000).
- Current users of smokeless tobacco are 4 times as likely as those who have never used tobacco to have one or more decayed or filled root surfaces (Tomar & Winn, 1999).
- The use of smokeless tobacco products may increase the risk of dental caries as a result of sweeteners added during the manufacturing process (Tomar & Winn, 1999; USDHHS, 2000).
- Abrasives contained in chewing tobacco can wear away portions of the occluding surfaces of teeth (USDHHS, 2000).
- Gingival recession is a common effect of smokeless tobacco. The gingiva may not regenerate after cessation (Spangler & Salisbury, 1995).
- Additional oral health tobacco-related conditions:
  - Snuff dipper's pouch
  - Smoker's palate (nicotinic stomatis)
  - Smoker's melanosis
  - Smoker's lip (burns)
  - Tooth loss
- Periodontal disease
  - Destructive periodontitis

REFLECTIONS

REFLECTIONS

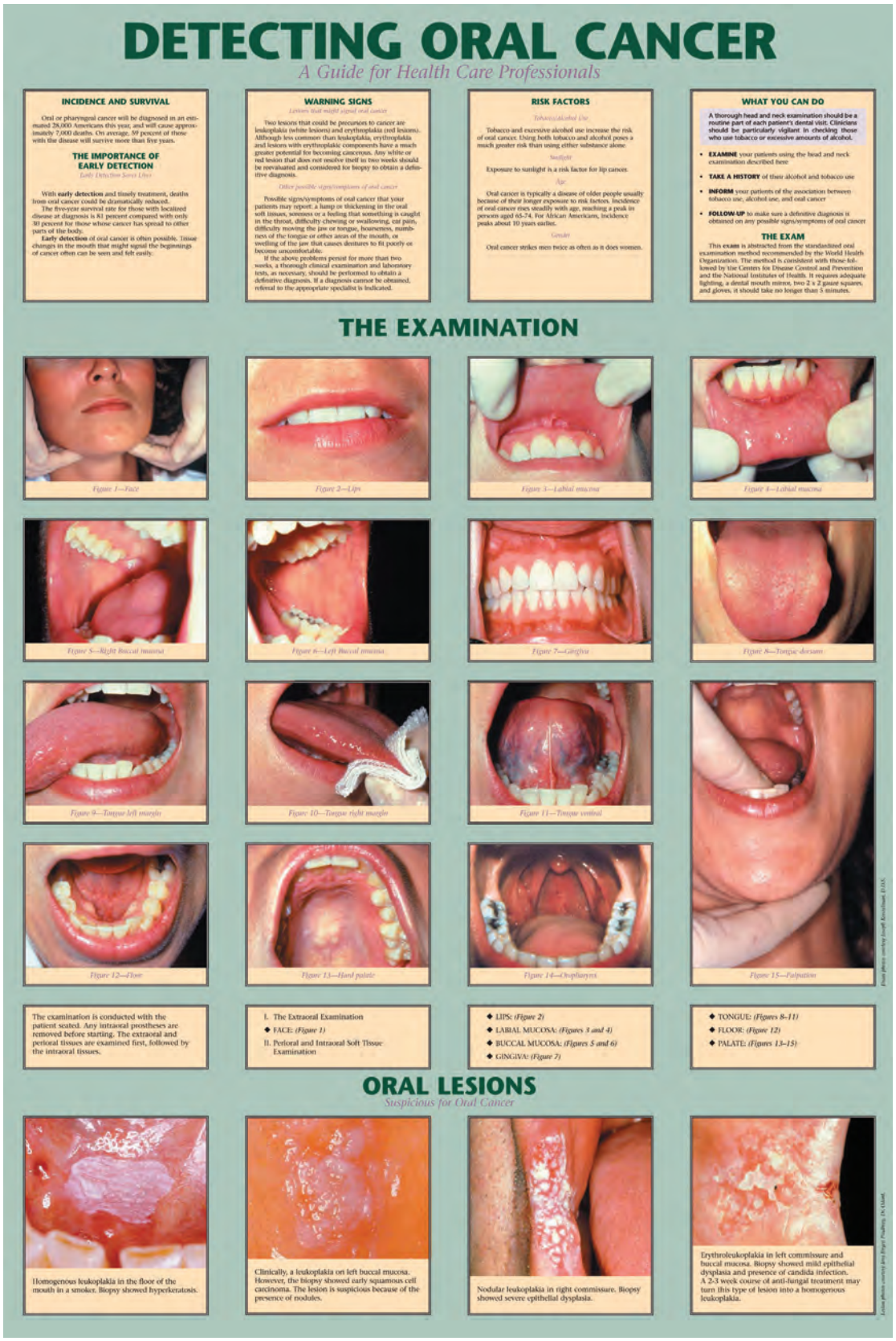
- Focal gingival recession with periodontal attachment loss
- Acute necrotizing ulcerative gingivitis (trench mouth)

- Gingival bleeding
- Halitosis (bad breath)
- Hairy tongue

(USDHHS, 2000; Mirbod & Ahing, 2000)

Mouth Cancer (Oral Cancer)

- There are several risk factors associated with the origin of oral cancer, but invariably, it can be traced back to past and present use of alcohol and **tobacco products**: cigarettes, cigars, pipes, and smokeless tobacco (Boffetta, Mashberg, Winkelmann, & Garfinkel, 1992; Silverman, 1990; USDHHS, 2000).
- Tobacco use and heavy alcohol consumption are the two principal risk factors, accounting for 75% of oral carcinomas (Gonsalves, Chi, & Neville, 2007).
- Tobacco has been established as a cause of oral cancer, and smokeless tobacco users have a substantially increased risk compared to nonusers (Tomar & Winn, 1999; NIH, 2006; Hatsukami & Severson, 1999; USDHHS, 1986).
- In comparison with nonsmokers, smokers have up to 10 times the risk of developing oral cancer or cancer of the pharynx (USDHHS, 2004).
- Oral cancer and pre-malignant lesions in the mouth are more common among users of **smokeless tobacco** (Ghosh, Shukla, Mohapatra, & Shukla, 1996; Winn et al., 1981).
- Leukoplakia (pre-malignant white patches or plaque on the oral mucosa) occurs 6 times more frequently in smokers than in nonsmokers: 23% versus 4% (USDHHS, 2000; Spangler & Salisbury, 1995).
- Leukoplakia appears in 40% to 60% of smokeless tobacco users in the area where the tobacco is held in the mouth, usually appearing within a few months of beginning regular use (USDHHS, 2000).



(National Institute of Dental and Craniofacial Research, 2006)

Mental Illness and Tobacco

It has been said that one cannot understand American Indian/Alaska Native perspectives without recognizing the unique relationship between Native people and the federal government. Historical events, such as forced attendance at boarding schools far from home, destroyed not only generational family ties, but also the transmission and strength of traditional cultures. As colonized people and as the most underserved minority in this country, American Indian/Alaska Native people experience intergenerational grief and anger as well as historical trauma related to post-traumatic stress disorder.

> *"Our ceremonies are the strength that sustain us.*
>
> *The birthing of a new child,*
>
> *The wedding of husband and wife,*
>
> *The teaching of the wise elder,*
>
> *The healing of those ill in body and mind.*
>
> *These and more are our ceremonies.*
>
> *They were our strength when everything was taken away,*
>
> *They will renew us in hard times ahead,*
>
> *They make us strong,*
>
> *They are our strength.*
>
> *– Cherokee healer*
> *From Listening with Your Heart: Lessons from Native America (Peate, 2003)*

Psychiatric Comorbidity and Tobacco Use

People with psychiatric conditions are twice as likely to smoke as the general population and to smoke more heavily than other smokers (Ranney et al. 2006). An analysis of data from the National Comorbidity Study (NCS) found that people with psychiatric disorders consume 44 percent of all cigarettes in this country. The high rate of smoking is an important factor in increased rates of physical illness and mortality in this group (Ziedonis et al. 2008).

Studies also have found that less than a quarter of patients with psychiatric diagnoses and tobacco dependence in outpatient healthcare facilities received tobacco dependence treatment counseling from their physicians, and only 1 percent of psychiatric inpatient smokers were assessed for smoking (Ziedonis et al., 2008).

Given these high smoking rates, people with psychiatric conditions should be provided with tobacco dependence treatments identified as effective in the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update*.

- Although psychiatric comorbidity places tobacco users at increased risk for slips or relapse, such individuals can be helped by tobacco dependence treatments.
- Nicotine withdrawal may exacerbate comorbid psychiatric conditions, although most evidence suggests that abstinence provokes minimal adverse impact (Fiore et al., 2008).

Schizophrenia

People with schizophrenia have higher rates of smoking (45%-88%) compared to the general population in both clinical and population based samples (Kalman et al.,2005). There may be shared genetic factors that determine vulnerability to both smoking and schizophrenia (Kalman et al, 2005).

REFLECTIONS

REFLECTIONS

For example:

- Increased dopamine from nicotine may be therapeutic for patients, as it may alleviate negative symptoms (Punnoose & Belgamwar, 2006).
- Tobacco use may also decrease neuroleptic-induced parkinsonism in people with schizophrenia (Dalack, Healy, & Meador-Woodruff, 1998).
- Psychosocial factors are also a contributing factor to the high rates, such as limited education, poverty, unemployment, and peer influence, coupled with the mental health treatment system that accepts and often condones smoking (Ziedonis, D. et al., 2008).

Depression and Tobacco Use

People diagnosed with major depression or clinically significant depressive symptoms have smoking prevalence estimates that range from 40%-60%. Individuals with a history of depression are 1.6 times more likely to smoke (Williams & Ziedonis, 2004). Thirty percent (30%) of patients seeking tobacco dependence treatment services may have a history of depression. (Ziedonis & Williams, 2003).

Research suggests that the relationship between depression and smoking may be bidirectional: depression increases the risk of smoking, and chronic smoking increases a person's vulnerability to depression. Shared genes may contribute to both of these vulnerabilities (Ziedonis et al., 2008).

The following findings from the research highlight the difficulties that individuals with depressive disorders may have when trying to quit:

- A history of major depression is predictive of difficulty abstaining from smoking. Persons with histories of major depression or anxiety disorders report more severe withdrawal symptoms.
- Attempting to quit tobacco use can trigger a depressive episode in those with a history of depression. Treatment for tobacco

dependence should be coordinated with the clinician providing medical care for depression.

- Patients with negative affect at pretreatment are less likely to achieve tobacco independence and more likely to slip or relapse (Brandon, Vidrine, & Litvin, 2007).
- Nicotine withdrawal symptoms include depressive symptoms. FDA-approved pharmacotherapies reduce withdrawal and can lessen depressive responses to quitting.

Bipolar Disorder

Few studies have been done on co-morbid smoking and bipolar disorder, but the prevalence rates from these studies are estimated to be a high of 60%-70% (Kalman et al, 2005). No studies have been done on the treatment of smoking in this disorder.

Anxiety Disorders

There is a wide variation of prevalence rates estimated among people with different types of anxiety disorders.

- Panic disorder has estimated smoking prevalence rates of 19%-56%.
- Obsessive-compulsive disorder has the lowest estimated rates of anxiety disorders with a range from 8% to 22%.
- Post-traumatic stress disorder (PTSD) has the highest estimated prevalence rates especially among combat veterans, 53%-66%. Also, among women diagnosed with PTSD related to physical and sexual assault, a smoking prevalence rate of 44% was found as compared to 26% of women without PTSD.
- Exposure to trauma (e.g. verbal, physical, or sexual abuse; divorce; incarcerated household member; substance abuse; mental illness) has found to be a significant risk factor for early onset of smoking.

  (Kalman et al, 2005)

REFLECTIONS

REFLECTIONS

Treatment of Tobacco Dependence in Individuals with Psychiatric Disorders

The same tobacco dependence treatment strategies recommended in this manual for the general population are recommended for use with people with co-morbid smoking and psychiatric disorders. Additional considerations for treatment are:

Psychiatric Medications

- Provide pharmacotherapies that target the underlying pathophysiology of the psychiatric disorder that may contribute to susceptibility for smoking.
- For individuals with depression, bupropion SR and nortriptyline, are also effective in treating depression. The clinician should assess whether or not the patient is using any other form of bupropion (Zyban®, Wellbutrin®) when considering use of bupropion SR to aid a patient in quitting smoking (Fiore et al., 2008).
- For individuals with schizophrenia, atypical antipsychotic agents such as clozapine has shown to be associated with a reduction in cigarette smoking. Also, atypical psychotic agents combined with a nicotine patch and bupropion have enhanced abstinence rates (Kalman et al., 2005).

Antidepressants and Neuroleptics

The clinician should recognize that tobacco use and/or tobacco cessation may affect the metabolism of individuals using psychiatric medications. Clinicians should closely monitor the level of effects of psychiatric medications in smokers making a quit attempt.

- Tobacco use may increase the rate of drug metabolism of psychiatric medications (Hughes et al., 2007).
- Cessation may cause increased plasma drug levels for some antidepressants (e.g., desipramine, doxepin) and neuroleptics (e.g., haloperidol, olanzapine) (Hughes et al., 2007).

Chemical Dependency and Tobacco

Chemically dependent people (e.g. addicted to alcohol or drugs such as cocaine, opioids, or marijuana) have smoking rates that are well above those for the average population, **exceeding 70 percent**. Chemically dependent individuals tend to be heavy nicotine dependent smokers. The risk of death is significantly higher for individuals with co-morbid addictions of alcohol and nicotine than for individuals who abuse only one of the above addictions (Ranney et al., 2006).

Considerations for Tobacco Dependence Treatment and Chemical Dependency

> *"The fact that a substantial proportion of alcohol-and opioid-dependent patients die of tobacco-related illness supports the assertion that smoking cessation services be rendered when these patients present to addiction treatment programs, as this offers a "teachable moment (Kalman et al. 2005).*

Multiple strategies such as nicotine replacement therapy in conjunction with counseling that follow the Public Health Service Guidelines are effective in treating tobacco dependence in patients with alcohol or other chemical dependencies.

- Although some substance abuse treatment providers argue that tobacco dependence treatment should be provided after the person achieves sobriety, evidence indicates that treatment for tobacco dependence can be provided concurrent with treating other chemical dependencies.
- Evidence indicates that tobacco dependence interventions do not interfere with recovery from chemical dependency.
- There is little evidence that patients with other chemical dependencies relapse to other drugs when they stop smoking (Fiore et al., 2008).

REFLECTIONS

Nutrition

Nutrition, exercise, and living a healthy lifestyle (without commercial tobacco, drugs, or alcohol) are all part of a traditional, spiritually-based lifestyle. However, American Indian/Alaska Native people who live in rural areas or on reservations may not have access to fresh fruit and vegetables because these items may not be stocked in the local stores, or, if stocked, may be expensive. For these reasons it is important to stay in touch with the community leaders who know what is going on and who support a wellness program. This is the key to the success of the Zuni wellness program: it was started and continues at a grassroots level.

Dietary Guidelines

There is a growing body of evidence which demonstrates that following a diet that complies with the **Dietary Guidelines may reduce the risk of chronic disease**.

Recently, it was reported that dietary patterns consistent with recommended dietary guidance were associated with a lower risk of mortality among individuals age 45 years and older in the United States (Kant, et. al., 2004).

(California Adolescent Nutrition and Fitness Program, n.d.)

Smoking Impacts Nutritional Health

Smoking negatively affects nutritional health status in several ways and is considered a nutritional risk. Commercial tobacco users tend to have a higher risk of chronic diseases including, heart disease, by increasing their cholesterol and lowering the amounts of "good cholesterol" High Density Lipoproteins (HDL). Women who use commercial tobacco have lower levels of calcium, increasing their risk of osteoporosis. Smoking also increases the occurrence of cancers in all parts of the digestive tract and a risk of stomach and intestinal ulcers.

Dietary Habits Accompanied with Tobacco Users are Different

Tobacco users may also have different dietary habits that affect their nutrition levels and ultimately their overall health (Preston, 1991). Tobacco users have lower vitamin A and C intakes, are less likely to take supplements and eat high fiber foods. The following table shows how vitamin and mineral uptake is affected in tobacco users.

Tobacco Use and Nutrition Physiology
Vitamin A
» Lower blood levels of beta carotene and vitamin A » Broken down at a faster rate » Related to current smoking, number of cigarettes daily, number of pack years » May need supplementation
Vitamin C
» Blood levels of ascorbic acid are 25%–40% lower in tobacco users » May need supplementation and/or increased intake of vitamin C–rich foods
Selenium and B12
» Chemical in tobacco (cadmium) decreases the bio-availability of selenium » Tobacco use lowers blood and tissue levels of B12, related to the detoxification of cyanide in tobacco smoke
Calcium
» Calcium levels are decreased » Estrogen and possibly other hormone levels are also decreased, which leads to osteoporosis later in life
Cholesterol Levels
» Smoking increases Low Density Lipoprotein (LDL) cholesterol » Smoking lowers High Density Lipoprotein (HDL) cholesterol

REFLECTIONS

Cessation and Weight Gain

The majority of smokers will gain weight after quitting smoking. Once a former smoker relapses and begins smoking at pre-quit levels, he or she will usually lose some, if not all, of the weight gained associated with quitting.

- Most gain fewer than 9 pounds (Abrams et al., 2003).
- Women tend to gain slightly more weight than men.
- The belief that little can be done about post-quit weight gain is difficult to address clinically because these beliefs are congruent with research findings (Fiore et al., 2008).
- Even if smokers do not increase their caloric intake upon quitting, they will gain some weight.

Major Weight Gain

- Occurs in a minority of those who quit; individuals may gain as many as 30 pounds (Shraim, Parsons, Aveyard, & Hajek, 2006).
- Effective methods to weight control are needed for smokers preparing to quit, especially if they are sedentary and overweight.

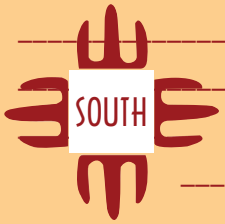
Prerequisites to Controlling Weight Gain AFTER Smoking Cessation

The clinician should:

- Acknowledge that quitting smoking is often followed by weight gain (note that the health risks of weight gain are small when compared to the risks of continued smoking).
- Recommend that individuals concentrate primarily on quitting smoking, not weight control, until ex-smokers are confident that they will not return to smoking.

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

EDUCATION, POLICY, COMMUNITY

UNIT EIGHT

Broadening the Reach

Successful treatment for tobacco dependence must have a broad buy-in at each level in the system. Commitment from decision-makers and opinion leaders in the community is essential for success. Linkage with the community through a wellness program that supports tobacco dependence treatment is a key to further integration of services and treatment. If such a wellness program does not exist, explore what you can do to help the community begin a program or to include wellness as part of an existing program. Be vigilant for individuals who support commercial tobacco control efforts and who are respected in the community. Engage their support in determining what works in reaching the community. Secure time on the schedule for the next community/tribal meeting (do not be discouraged if this takes a while) to speak about why addressing tobacco dependence is important to the health of the community. Solicit advice from the local leaders regarding the best way to approach this public health problem. Maintain your spirit and optimism; working with American Indian/Alaska Native communities begins by establishing a relationship and developing trust. Building trusting relationships takes time! Word will get around in the community about your intentions. It takes time for people to decide what they think about your cause and about your intentions. Once trust is established, community support will follow.

Systematically teach the patients who come to see you about the public health importance of living a life free from commercial tobacco. American Indian/Alaska Native patients indicate that doctors do not emphasize this health advice nor do they assess for commercial tobacco use during visits. One way for health and human service providers to remember to address commercial tobacco use is to refer to a **poster** on their office wall. As previously noted, the poster should be eye-catching

and integrate the message of being tobacco free as part of a healthy spiritual lifestyle based on traditional values. It is often more comfortable for an American Indian/Alaska Native patient to respond to a question like, "What do you think about what this poster has to say?" than to be confronted with personal questions that put him or her on the spot.

A discussion can proceed from questions about the poster, such as:

Clinician: "What do you think about this poster?"

Client/Patient: "It's a good idea to live that way."

Clinician: "Do you use commercial tobacco?"

Client/Patient: "Well, sometimes..."

Clinician: "Have you ever thought that using commercial tobacco keeps people from living healthy lives according to traditional values?"

Do not push, because this is considered to be rude and intrusive. Instead, take the perspective that you have planted the seed by giving the person something to think about. This is the respectful way to proceed. End by being sure that the person knows where to come for help if he or she desires it.

Health Teaching About the Importance of Tobacco Dependence Treatment through Grassroots Linkages

Leadership through Grassroots: Talk to the leaders you have linked with in the community about a plan to create a system that keeps community members healthy by abstaining from commercial tobacco use. Isolation is a major factor in morbidity and mental health problems for all people, but it is even more pronounced among American Indian/Alaska Native people because community is vital to a sense of well-being. Group identity and harmony, rather than individual achievement, are key values for

American Indian/Alaska Native people. This is why it is essential to enlist community efforts to establish a support network for people trying to abstain from commercial tobacco use. Remember that success depends on community cooperation, support, and leadership.

Make several presentations in the community, because people need time to think over what you discussed during your initial presentation. As a sign of respect for their community and elders, Native people are taught to remain quiet, to think before they speak, and to consult with family before acting. Other commonly held values among American Indian/Alaska Native people include group decision by discussion and consensus and longer contemplation of ideas after a presentation (Hendrix, 2006).

REFLECTIONS

Key Instruments for Community Change

It is important to remember that clinical tobacco dependence treatment does not occur in isolation. Both traditional and contemporary cultural norms in a community will determine whether people want to quit and what approaches will work. Key instruments to support community change include education and policy. Education can take the form of health curricula in schools, public service announcements in various media, presentations to local leaders, health fairs, and pow-wows. Counter-advertising campaigns have been quite effective in a number of states. Policy changes that have been shown to work include smoke-free building and campus laws, restrictions on youth access, and taxation.

Health Influencers as Conduits for Systems Change

Concerned persons within health and human service systems may be recruited as internal health influencers to support implementation of tobacco dependence treatment programs. Experience suggests that resources beyond those ordinarily present in the clinical practice setting are keys to initiating and developing tobacco dependence treatment services. It is important to support clinicians and non-clinicians by establishing efficient methods to refer patients to tobacco dependence treatment services and by providing the evidence-based system-wide interventions needed to develop and maintain the skill level of clinical staff. There are clinicians and non-clinicians (e.g. health educators and lay community health workers) who are responsible for health and lifestyle changes at the point of care. Often they spend more time with patients than a primary care provider does. These health influencers have the potential to assist in a system-wide integration of the prevention and treatment of tobacco dependence.

The Basic Tobacco Intervention Skills Certification program offers **fourteen (14) adaptations** addressing the nation's cultural diversity with respect to the needs of those who are dependent on and/or use commercial tobacco and are members of cross-cultural communities (Soloff et al., 2008). The Basic Tobacco Intervention Skills Certification programs have been reviewed by accreditation boards and are approved for a maximum of **4.0 contact hours** for **Continuing Medical Education** (CME) or **Continuing Education Units** (CEU) credits.

Continuing Education, Certification and Training

Continuing education, certification, and training are effective methods of introducing evidence-based tobacco dependence treatment methods and techniques. Utilizing educational venues, such as the University of Arizona HealthCare Partnership, to emphasize the importance of tobacco-free communities can set the stage for systems change. It is suggested that an evidence-based continuing education, certification, and training program would incorporate the following:

REFLECTIONS

Tobacco Dependence Treatment Education Programs

CONTENT of an Educational Tobacco Dependence Treatment Certification Program supports the recommendations of the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* and the USDHHS U.S. Interagency Committee on Smoking and Health's (ICSH) National Action Plan for Tobacco Cessation.

The Program incorporates a stepped-care capacity building model to build sustainable capacity at the local level. The model recognizes differing contexts, intensities, and professional roles in the delivery of tobacco dependence treatment services to:

1. Ensure that persons delivering tobacco cessation services have received education and certification consistent with current best practices referenced above and have demonstrated competency in core skills associated with these practices.
2. Enhance the capacity of communities to provide tobacco cessation services at multiple levels of intensity.
3. Promote at the community level, as well as the healthcare system level, self-sustaining networks for delivery of affordable, accessible, and effective cessation services.

Common Elements of Practical Supportive Counseling	» Provides basic information about tobacco use and quitting » Encourages patient in the quit attempt » Communicates caring and concern » Encourages patient to talk about the quitting process	
Common Elements of Problem-Solving Skills/Practical Counseling	» Basic information » Identification of danger situations » Coping skills	
Pharmacotherapy	» Nicotine Replacement Therapy: gum, patch, lozenge, inhaler, nasal spray » Over the Counter Medications: bupropion SR, varenicline	
Minimal Topics Set	» Tobacco-related statistics » Simple quit plan components » Slip & relapse » Relapse prevention » Levels of intensity in treatment interventions » Health consequences of tobacco use » Health consequences of ETS » Elements of follow-up	» Five A Model » Motivational interventions » Assessing nicotine dependence » Science of nicotine addiction (e.g., biological, psychological, and sociocultural aspects of tobacco dependence) » Assessing a client's willingness to quit (stages of change)
Minimal Skills-Based Demonstrations	» Intervening with individuals unwilling to quit, demonstrating **evidence-based** methods and techniques » Intervening with individuals willing to quit, demonstrating **evidence-based** methods and techniques	

U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* (Fiore et al., 2008)
Recommendation: All clinicians and clinicians-in-training should be trained in effective strategies to assist tobacco users willing to make a quit attempt and to motivate those unwilling to quit at this time. (Strength of Evidence = B)

National Action Plan for Tobacco Cessation (Fiore et al., 2004)
Recommendation 5: Invest in tobacco training infrastructure and education to ensure that all clinicians and non-clinicians in the U.S. have the knowledge, skills and support systems in place to intervene with their patients in helping them quit tobacco use.

The Tobacco Dependence Treatment Education Program is evaluated based upon the Model of Social Cognitive Learning Theory/Self-Efficacy and Theory of Planned Behavior. Critical predictors of behavior change include self-efficacy, knowledge, and skills competency.

General Principles of Information Dissemination to Gaining Interest

- Take advantage of existing meetings/venues or educational programs. It is often easier to secure time on an existing agenda than to recruit an audience for an additional meeting.
  - Grand rounds at hospitals are attended by physicians and mid-level providers, and are used for dissemination of clinical information related to patient care.
  - Staff in-service training at medical institutions is required; tobacco dependence treatment makes a timely topic.
  - Medical staff meetings can be challenging, as there are many competing agenda items; however, staff meetings are a good way to reach providers and to build consensus for implementation of new policies.
  - Quality assurance committee meetings are a strategic venue to discuss the implementation and monitoring of policies and procedures.
  - Mental health and substance abuse treatment settings can be an untapped, unique arena for impacting professional norms and increasing access to tobacco dependence treatment services among individuals diagnosed with a mental illness who use tobacco.
- Start early! It takes a long time to get on agendas for meetings or to set up a time for a presentation. Find champions and engage their support before giving a presentation.
- Have a concisely written description of the purpose, benefit, and time required for your presentation to use when you recruit your audience.
- Know your audience and gear your presentation and expectations accordingly.
- Keep presentations short and clearly state your desired outcomes.
- Know the science and research that supports your presentation. Be prepared to respond to challenges and questions.

REFLECTIONS

REFLECTIONS

- » Discuss costs and benefits of tobacco-free communities.
- » If you are just starting out, do your first presentations in places where you are known and respected.
- » Stay within your time lines.
- » Make compelling calls for action that will motivate participation in educational venues.

System-Wide Policies and Procedures

Aggressive policies and procedures are the template for the prevention and treatment of tobacco dependence in health and human service settings. In order to succeed, new procedures must be practical, make the best use of staff and clinician/non-clinician time, and be compatible with existing routines. It is the role of leadership to introduce models for implementation based on the U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* and to assist clinical staff in adapting those models to their healthcare facility or practice setting. Policies and procedures related to tobacco dependence treatment and prevention are routinely monitored through quality assurance.

Plan of Action: Tobacco-Free Campuses

The Division of Epidemiology and Disease Prevention provides an extensive Tobacco-Free Policy at www.ihs.gov/MedicalPrograms/Epi. You will want to refer to this as your guideline for establishing a tobacco-free campus.

The implementation of the U.S. Department of Health and Human Service Indian Health Service Tobacco-Free Policy is a component of a larger initiative to improve the health and wellness of employees, patients, and visitors.

Before full implementation of a tobacco-free environment initiative can occur, a clear plan must be designed that will encourage a

well-publicized and orderly transition for staff, patients, and visitors. It must be emphasized that a tobacco-free environment is designed to promote a healthy and safe place for staff, patients, and visitors. As the health and human service leadership works to accomplish the objectives of new policies and procedures, it is advisable to clarify that efforts toward becoming tobacco-free are not intended to denote "smoker-free" or "anti-smoker."

Clear and frequent communication regarding the organization's commitment to improved health should accompany the offer of tobacco treatment services.

A Tobacco-Free Campus

- Acknowledges the profound challenges that tobacco creates for the addictions treatment community.
- Establishes a leadership group or committee and secures the commitment of the administration.
- Develops a tobacco-free policy.
- Establishes a policy implementation time line.
- Conducts staff education and training.
- Provides treatment assistance for nicotine-dependent staff.
- Assesses and diagnoses tobacco dependence in patients and addresses this in treatment planning.
- Incorporates tobacco education into its patient education standard practice.
- Establishes ongoing communication with American Indian/Alaska Native people and community referral agents about these changes.
- Requires staff to be tobacco free during hours of employment.
- Establishes tobacco-free facilities and grounds.
- Implements tobacco dependence treatment throughout the organization and environs.

REFLECTIONS

REFLECTIONS

Tobacco-Free Campus Policy

Policy
(Company Name) _____ is promoting the wellness of our employees by incorporating a total tobacco-free campus, effective [date].

Purpose
The health hazards of smoking have been well documented as they impact both the smoker and the non-smoker who is exposed to environmental tobacco smoke. It is our intent to provide all employees with an environment conducive to good health and a productive atmosphere.

Applicable to
This policy is applicable to all employees, contractors, guests, and visitors while on the property or in any of our _____ based locations.
All employees, contractors, and visitors are prohibited from smoking cigarettes, pipes, cigars, and/or chewing tobacco on site at (Company Name) _____. On site is defined as inside all (Company Name) _____ facilities, as well as on the grounds and parking lots, and inside company-owned and personal vehicles on company property.
Employee noncompliance with the policy will result in disciplinary action, up to and including termination from employment. Human Resources will review all cases of noncompliance with this policy, and any action taken will be in accordance with established company policies and procedures.
Any questions regarding this policy should be referred to the appropriate Human Resources representative.

Smoke-Free Policy Date_____

A Model Plan for Staff to Implement These Changes Must Start With

- Including **all** staff as **authentic** partners
- Agreement on goals and timetable
- Careful planning and emphasis on education
- Establishment of policies and procedures
- Support at the top and a cooperative spirit
- An understanding that staff must be tobacco free during the hours of employment
- Using treatment (interventions and consciousness-raising, **not** coercion) when dealing with tobacco issues
- Taking pride in the policy
- Patience: keeping all eyes on the prize

The Components of a Model Timetable for Implementing Tobacco-Free Changes	
2 Years	Obtain cooperation, agreement, and support of administration and medical leadership and inform staff.
2 Years to 6 Months	Hold regular in-service education programs with staff, encourage staff who smoke to quit, develop policies and procedures (regarding violations, consequences, Nic Anonymous meetings, visitor restrictions [dress, smell], and staff restrictions).
6 Months	Initiate weekly tobacco education groups for patients and make available self-help materials for patients and staff.
5 Months	Increase intensity of staff education and support staff attendance at relevant conferences.
4 Months	Discuss imminent changes with other departments: admissions, housekeeping, security, maintenance, administration, and dietary, to ensure their support and cooperation.
3 Months	Policies and procedures finalized and accepted, staff members aware of the changes, smoking areas reduced in size, purchase a carbon monoxide monitor (detects patient CO levels in relationship to healthy levels).
2 Months	Unit medical director discusses plans with physicians; current patients are informed of changes and process feelings, begin a second weekly group on smoking cessation.
1 Month	Patients informed that smoking will be eliminated.
3 Weeks	Support department plans finalized: Dietary: provide carrot sticks, juices Housekeeping: deep cleaning Security: discourage entry of contraband; advise and refer based on policy and health warnings Maintenance: research smoke detectors in the bathrooms Activity Therapy: plan extra-morning exercise group Admissions: discuss smoke-free policy with all new patients and families prior to admission Pharmacy: order a supply of nicotine replacement therapies Medical/Nursing Staff: familiarize themselves with carbon monoxide monitor operation; practice Five A Model intervention; ensure placement of information and referral packets
2 Weeks	Begin informing new patients of the tobacco-free policy prior to admission and hold community meetings for patients to discuss policy.
1 Week	Be aware that problems can start (patient and staff discontent, staff question wisdom of policy).
Start Day	Collect all cigarettes and lighters

REFLECTIONS

Thinking in Action: Organize a Roundtable Session

As part of the strategic planning process for the creation of systems change, it can be helpful to hold roundtable sessions. These can be in the form of either large or small group discussions.

For A Large Group Discussion:

- Involve key opinion leaders within the health and human service organization.
- Identify tobacco prevention and treatment resources currently in place within the organization.
- As a team, create plans for linking with external/internal tobacco dependence treatment resources:
  - Health and human service professional continuing education, certification, and training
  - Face-to-face practical counseling and telephonic services
  - Pharmacotherapy aids and discounted medications

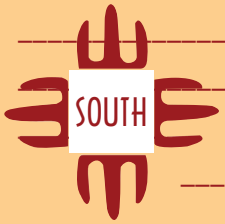
For A Small Group Discussion:

Break out into small groups with members of your work unit/team.

- Select a facilitator and a reporter for the group (may be the same person).
- Discuss what you currently provide to support tobacco-use prevention and/or treatment.
- Group-think activities that your unit/team can take on to improve tobacco treatment services, such as:
  - Listing three activities that the group agrees upon
  - Identifying next steps needed
  - Establishing a time frame to implement activities
  - Describing additional resources or education needed
  - Summarizing reports from small groups

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

GPRA, CODING AND BILLING

UNIT NINE

GPRA Overview

The Government Performance and Results Act (GPRA) is a federal law which requires federal agencies, including the Indian Health Service, to demonstrate effective utilization of funds toward meeting their missions. The law requires agencies to develop a 5-year Strategic Plan as well as submit an Annual Performance Plan and Report with budget requests. The Annual Performance Plan contains specific 1-year performance measures and goals. The Annual Performance Report describes how agencies measured up against performance targets set in the previous year's Performance Plan.

Indian Health Service (IHS) facilities are required to report on GPRA measures annually. The Resource Patient Management System (RPMS) software application provides automated local and area monitoring of clinical performance data and produces reports on demand for GPRA measures. The GPRA measures are designed to reflect important clinical areas in the categories of prevention and treatment. The IHS develops performance goals, or benchmarks, for each GPRA measure. The tobacco use assessment measure includes both screening for tobacco use as well as tobacco cessation intervention.

As of 2006, GPRA objectives include tracking the number of tobacco users referred to treatment. The goal of the GPRA is to improve effectiveness of government programs by collecting data on results, service quality, and customer satisfaction. Since the GPRA process will be tracking the referral of tobacco users to treatment programs in Indian Health Service and Tribal facilities, these data may be used as leverage to increase support for local cessation efforts. For more information, see www.ihs.gov/NonMedicalPrograms/PlanningEvaluation/pe-gpra.asp.

REFLECTIONS

REFLECTIONS

Impact of GPRA Measures on IHS Budget

Attaining goals on GPRA measures helps the IHS budget. National goals for these measures are to meet 82% of these GPRA measures. The annual goal is to maintain or improve the % met of the previous GPRA year. In addition, Service Units are advised to set and track local goals quarterly, and devise a working plan to improve.

Meeting or improving the annual GPRA measures determines the budget from Office of Management and Budget (OMB). When developing IHS budget allocations, the Office of Management and Budget considers the following metrics:

- **Meeting GPRA goals** and a comprehensive analysis from the Performance Assessment Rating Tool (PART)
- **Previous IHS budgets** and whether or not it has changed throughout the years. If the budget has changed, has it increased or decreased?
- **User Population:** the number of clients seen at least once in the past three years
  - Identify growth trends (increases, decreases, no changes)

WHAT DO THE NUMBERS MEAN?

GPRA measures are critical for evaluating trends over time, as well as comparing current figures to target numbers and local and national averages. **The overall outcome of improving GPRA measures is the improvement of quality patient care.**

Once a system-wide plan is established, it is important to address opportunities and challenges to the implementation of the tobacco use and dependence treatment model within health and human service settings. There are several considerations in planning that will help organizations to promote system-wide tobacco dependence treatment interventions with health and human service administrators, clinicians

and non-clinicians, and/or local communities. In order to achieve an interactive team systems approach, it is critical to examine all possible roles and expectations for service providers and all who are involved:

- Identify common opportunities and challenges for engaging health and human service systems and purchasers.
- Determine roles and expectations for community and regional affiliates and personnel.
- Create lists of existing and desired services and resources for marketing tobacco treatment to local health and wellness programs and human service systems.
- Initiate a planning process to engage at least one local resource and one primary care entity in tobacco dependence treatments (Annual Performance Plan and Annual Report with budget request).
- Identify funding accountability

Calculating GPRA Metrics

- General format is:
  - Numerator / Denominator = Percent Achieved
  - Target %: Establish baseline, maintain rate, increase rate (1%, 3%, 15%)

Measure Terminology

- **Denominator:** The total patient population being reviewed to determine how many of the total meet the definition of the measure.
  - Different measures have different denominators
    - Active Diabetic patients
    - Active Clinical female patients
    - User Population patients
- **Numerator:** The number of patients from the denominator who meet the logic criteria for a performance measure.
  - Patients with controlled blood pressure during the Report Period

REFLECTIONS

REFLECTIONS

- » Patients with LDL cholesterol during the Report Period
- » Patients with a Pap smear in the past 3 years

» **Performance Measure:** The combination of one denominator and one numerator.

- » Active Clinical patients 50 or older who have received or refused an influenza immunization during the Report Period
- » Performance Measure Rate: Calculated by dividing the numerator by the denominator
- » Note: Some performance measures are counts vs. rates, such as # of topical fluoride applications, dental sealants

Performance Measure Logic: The codes and conditions that are checked when determining if a patient meets the denominator and numerator definitions.

Tobacco Specific Measures Example

Tobacco Cessation/Intervention:

Denominator:

➲ **GPRA:** Active Clinical patients identified as current tobacco users prior to the Report Period, broken down by gender and age groups: <12, 12-17, 18 and older.

Numerators:

➲ **GPRA:** Patients who have received or refused tobacco cessation counseling or **received a prescription for a smoking cessation aid** during the Report Period. Documented by TO/SHS ed codes, clinic code 94, dental code 1320, CPT codes G0375-G0376-4000F.

- » Patients who refused tobacco cessation counseling via refusals to TO or SHS education codes

Patients identified during the Report Period as having quit their tobacco use. Identified via Previous Use Health Factors, POV code 305.13.

Reporting GPRA Metrics

Tobacco Specific Patient List

- Any user with the security key BGPZ MENU & BGPZ PATIENT LISTS will be able to run the reports. Ask your Site Manager to assign this key to you if you do not have it.
- IHS recommends all Area and site Quality Improvement staff, Compliance Officers, GPRA Coordinators, clinical staff, and other providers at the local facilities as well as Area Directors and any other staff involved with clinical quality improvement initiatives use CRS **to run their own reports**.

Improving Local Data

- **Patient List options in CRS:** These have the ability to create a template of patients for clinicians to focus on cessation efforts.
- **Generate list of patients** not meeting indicator requirements/ current users to case-manage for cessation.
- **Individual review/determine barriers:** Ask if you are documenting Health Factors & Education codes.
- **Evaluate local screening process:** Begin by asking who is triaging for Tobacco use and who is advising to quit and arranging assistance. Determine if these individuals are implementing the procedures correctly and if not, determine if there are more appropriate personnel for these activities.
- **Evaluate local documentation process:** Determine if your clinicians are familiar with Health Education codes specific to Tobacco. Also ask these clinicians if they are aware when a Current Tobacco user flows from Current Smoker→Cessation Smoker→Previous Smoker.
- **Implement new strategies:** Create or locate cessation E.H.R. templates or search for pre-printed PCC's from facilities providing cessation services.

REFLECTIONS

REFLECTIONS

Relationship Between GPRA and CRS

The IHS Director has designated the Clinical Reporting System (CRS) as the national tool for reporting of all GPRA clinical measures. The following details reporting requirements by facility:

- **Federal (IHS) facilities** are required to use CRS for GPRA reporting.
- **Urban facilities in the CAO** are required to use CRS for GPRA reporting.
- **Urban facilities in other Areas** are not required to use CRS; however, more are using it because CRS makes reporting easier.
  - **Tribal facilities** are not required to use CRS but are encouraged to use it.

Brief Overview of Clinical Reporting System (CRS) Version 8.0

- **Split into 2 separate reports:** *National GPRA report & Other Clinical Measures*
- **Patient Lists:** Reports will have patient lists where user can choose to include patients meeting the measure, not meeting the measure, or both
- **Area Aggregate Reports:** Available for both the National GPRA & ONM Reports
- **Quarterly Reporting:** Sites will be asked to export data for both the National GPRA and Other National Measures Reports

Coding and Billing Information for Tobacco Dependence Treatment

The U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* urged healthcare insurers and group purchasers to provide benefit coverage for effective counseling and pharmacotherapy. The report also urged insurers and purchasers to pay clinicians for providing tobacco dependence treatment, just as they do for treating other chronic conditions.

Advances in pharmacological and behavioral treatment for tobacco dependence, combined with evidence of the economic impact of successful smoking cessation treatment, provide the tangible belief that we will continue to reduce our nation's greatest preventable public health problem. New treatment intervention resources, such as the Internet and telephone quitlines, provide low-cost access to information and counseling, further fostering the belief that this health problem can be solved.

The tobacco-cessation reimbursement scenario is changing rapidly. There is a trend toward reimbursing tobacco dependence treatment interventions, as evidenced by regulatory and accrediting measures instituted by the following organizations:

- Joint Commission on Accreditation of Healthcare Organizations (JC) 2002, expanded smoking-cessation performance measures (www.jointcommission.org)
- U.S. Centers for Medicare and Medicaid Services 2002, implemented national Hospital Core Measures for five medical conditions (www.cms.hhs.gov)
- National Committee for Quality Assurance (NCQA) 2003, revised Health Plan Employer Data and Information Set (HEDIS®) smoking cessation measures (www.ncqa.org/somc2001/advise_sm/somc_2001_advise_sm.html)

REFLECTIONS

REFLECTIONS

- Medicare Part B 2005, expanded coverage to include intermediate and intensive smoking cessation counseling for inpatients and outpatients (www.medicare.gov)
- Medicare Part D 2006, included coverage of prescribed medications for tobacco cessation (www.medicare.gov)
- Government Performance and Results Act (GPRA) 2006, included tobacco dependence treatment (www.ihs.gov/NonMedicalPrograms/PlanningEvaluation/documents/2006%20National%20Summary (Public013007).pdf)

Joint Commission on Accreditation of Healthcare Organizations

In 2002, the Joint Commission on Accreditation of Healthcare Organizations (JC) standardized its core performance measures to compare actual results of care across hospitals. Assessment of performance measures now includes 1) identification of adult smoking history at the time of hospital arrival; 2) for adults diagnosed with acute myocardial infarction, congestive heart failure, and/or pneumonia, identification of history of cigarette smoking during the year prior to hospital admission; 3) documentation of principal or other ICD-9-CM diagnosis codes; and 4) retrospective review of administrative data and medical records. Minimum JC counseling requirements include the documentation of one of the following:

- Advising patients to refrain from smoking, whether or not currently smoking
- Requiring patients to view a smoking cessation video
- Providing patients with brochures on smoking cessation
- Providing patients with pharmaceutical cessation aids, such as the nicotine patch or bupropion SR

JC evaluates the quality and safety of care of more than 16,000 healthcare organizations. To maintain and earn accreditation, organizations must receive an extensive on-site review by a team of JC

healthcare professionals at least once every 3 years. The purpose of the review is to evaluate the organization's performance in areas that affect patient care. Accreditation may then be awarded based on how well the organization meets JC standards.

Centers for Medicare and Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) administer Medicare. Medicare is the nation's largest health insurance program, providing care to nearly 40 million Americans. The Health Insurance Program covers people 65 years of age and older, along with some people under 65 years of age.

Medicare Part B: Levels of Tobacco Counseling

Medicare Part B includes two new levels of tobacco cessation counseling–intermediate and intensive. This coverage is for patients who use tobacco and have a "disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or who [are] taking a therapeutic agent whose metabolism or dosing is affected by tobacco use" (Centers for Medicare and Medicaid Services [CMS], 2005). Medicare will pay for two quit attempts per year, both of which can include up to four face-to-face intermediate or intensive sessions (Theobald & Jaén, 2006). These sessions may occur in the outpatient or inpatient setting. CMS will not cover tobacco cessation services if tobacco cessation is the primary reason for the patient's hospital stay.

Medicaid

Medicaid is funded by federal and state sources. Medicaid provides health insurance for the poor. It is only available to low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. For more information concerning eligibility, visit www.cms.hhs.gov/MedicaidEligibility/01_Overview.asp.

REFLECTIONS

REFLECTIONS

Many Medicaid patients who use tobacco can obtain financial and medical assistance for tobacco cessation treatments. Thirty-six states, as well as the District of Columbia, now cover one or more treatments for tobacco dependence. To learn more about Medicaid coverage in your state, contact your state Medicaid agency (Theobald & Jaén, 2006).

Coding Information

Documentation for a Tobacco Dependence Treatment Visit

Documentation of tobacco dependence treatment can be a complex and confusing subject, but it can be broken down by following a few simple rules. Specific information about tobacco use is documented in the medical record for a number of reasons:

- To enable RPMS collection and data management to document the Five A's
- To document data elements to support billing for the services you provided

In addition to these reasons, documentation is important for performing quality assessment, improvement, and management. Standardization of documentation will assist in data sharing with other clinical information systems.

Documentation required by Resource and Patient Management System (RPMS)

Individual Cessation Visits

There is specific information that Resource and Patient Management System (RPMS) needs to organize patient information in the system. This enables RPMS to share that information with many packages and applications. RPMS requires three items when you add any information to a patient's record:

- Patient name/identifier
- Creation of a visit/encounter
- Purpose of visit: This is documented using an ICD9 code. The International Classification of Diseases–9th Revision–Clinical Modification (ICD-9-M) is the official system of assigning codes to diagnoses and hospital procedures in the United States. Even though you use an ICD9 code, a purpose of visit is not the same as a diagnosis - it just tells why the patient came in for the visit.

ICD-9-CM Diagnosis Codes for Tobacco Cessation

- 305.1 Tobacco Use Disorder
- 305.1 Tobacco Dependence
- V 15.82 History of Tobacco Use

For reimbursement, a patient's condition that is adversely affected by tobacco use must also be documented as the primary diagnosis AND/OR the metabolism or dosing of a medication being used to treat a patient's condition must be documented as being adversely affected by his or her tobacco use.

Billing Codes

Two Healthcare Common Procedure Coding System (HCPCS) codes may be used to bill for tobacco-use cessation counseling:

G0375 Tobacco-use cessation counseling visit; intermediate, greater than 3 minutes and less than 10 minutes.

G0376 Tobacco-use cessation counseling visit; intensive, greater than 10 minutes.

Claims for tobacco-use cessation counseling should be submitted with the appropriate diagnosis code (ICD-9-CM). Diagnosis codes should reflect the condition that is adversely affected by the use of tobacco or the medication that is affected by the use of tobacco.

REFLECTIONS

REFLECTIONS

Other ICD-9-CM Codes for Tobacco-Related Diseases Include:

989.84	Toxic effect of tobacco
786.00	Dyspnea
786.20	Cough
786.40	Abnormal sputum
465.90	Infection, upper airway
786.50	Chest pain
794.20	Reduced vital capacity
496.00	Chronic airway obstruction
492.80	Emphysema, obstructive
493.00	Asthma
491.20	Chronic obstructive pulmonary disease (COPD)

As of January 2006, Medicare Part D covers prescribed smoking cessation medications. Medicare requires public reporting of smoking cessation counseling for hospitalized patients with acute myocardial infarction, congestive heart failure, and/or pneumonia. In 2005, Medicare instituted a penalty of 2.0% reduction in annual payments for failure to report. Your local hospital's data can be viewed on the public reporting website at www.hospitalcompare.hhs.gov.

When Private Health Plans cover tobacco cessation counseling, physicians can bill for it using the ICD-9-CM code for tobacco dependence, 305.1, along with the appropriate Current Procedural Terminology (CPT) code.

CPT Codes for Tobacco Dependence Treatment

For private insurers, in cases where Tobacco Dependence Treatment is part of the initial or periodic comprehensive medicine examination:

99383 New patient (preventative well exam for 5-11 year olds)

99384 New patient (preventative well exam for 12-17 year olds)

99385 New patient (preventative well exam for 18-39 year olds)

99386 New patient (preventative well exam for 40-64 year olds)

99387 New patient (preventative well exam for 65 & over)

Individual Tobacco Dependence Treatment visits occurring in association with another medical condition:

99201 New Patient-Document the Evaluation and Management (E & M) code for the visit as appropriate (add a modifier* of 25 to indicate Tobacco Dependence Treatment)

Three Key Components:

- a problem focused history
- a problem focused examination
- straightforward medical decision making (usually 10" or less of face-to-face with patient)

99202 New Patient-(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment)

Three Key Components:

- an expanded problem focused history
- an expanded problem focused examination
- straightforward medical decision making (usually 20" of face-to-face with patient)

99203 New Patient-(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment)

REFLECTIONS

REFLECTIONS

Three Key Components:

- a detailed problem focused history
- a detailed problem focused examination
- medical decision making of low complexity (usually 30" of face-to-face with patient)

99204 New Patient-(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment)

Three Key Components:

- a comprehensive history
- a comprehensive examination
- medical decision making of moderate complexity (usually 45" of face-to-face with patient)

99205 New Patient-(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment)

Three Key Components:

- a comprehensive history
- a comprehensive examination
- medical decision making of high complexity (usually 60" of face-to-face with patient)

99211 Established Patient--(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment). "Usually the presenting problems are minimal. 5 minutes are spent performing or supervising these services."

99212 Established Patient--(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment)

Requires Two out of Three Key Components:

- a problem focused history
- a problem focused examination
- straightforward medical decision making (usually 10" or less of face-to-face with patient)

99213 New Patient-(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment)

Requires Two out of Three Key Components:

- an expanded problem focused history
- an expanded problem focused examination
- straightforward medical decision making (usually 15" of face-to-face with patient)

99214 New Patient-(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment)

Requires Two out of Three Key Components:

- a detailed problem focused history
- a detailed problem focused examination
- medical decision making of low complexity (usually 25" of face-to-face with patient)

99215 New Patient-(E & M) code for the visit as appropriate (add a modifier of 25 to indicate Tobacco Dependence Treatment)

Requires Two out of Three Key Components:

- a comprehensive history
- a comprehensive examination
- medical decision making of high complexity (usually 40" of face-to-face with patient)

* The modifier tells the payor (insurance companies) the physician or clinician provided significant separately identifiable evaluation & management service on the same day of other service (e.g. they came in for diabetes and the clinician addressed diabetes and also addressed the tobacco abuse) A sample code would be 99215-25.

Tobacco Dependence Treatment As Specific Counseling And/Or Risk-Factor Reduction Intervention:

99401 Preventive medicine–individual (approx. 15 minutes)

99402 Preventive medicine-individual (approx. 30 minutes)

99403 Preventive medicine-individual (approx. 45 minutes)

99404 Preventive medicine-individual (approx. 60 minutes)

REFLECTIONS

REFLECTIONS

Behavior Change Interventions, Individual

99406	Smoking & tobacco use cessation counseling visit: intermediate, greater than 3" up to 10"
99407	Intensive, greater than 10 minutes.
99411	Preventive medicine–group (up to 30 minutes)
99412	Preventive medicine-group (up to 60 minutes)
99078	Preventive medicine–physician education group (add a modifier of 25 to indicate Tobacco Dependence Treatment)

Psychiatric Therapeutic Procedures:

90804	Outpatient-Individual psychotherapy, approx. 20-30 minutes
90805	Outpatient-Individual psychotherapy, approx. 20-30 minutes with medical evaluation and management services.
90806	Outpatient-Individual psychotherapy, approx. 45-50 minutes
90807	Outpatient-Individual psychotherapy, approx. 45-50 minutes with medical evaluation and management services.
90808	Outpatient-Individual psychotherapy, approx. 75-80 minutes
90809	Outpatient-Individual psychotherapy, approx. 75-80 minutes with medical evaluation and management services.
90816	Inpatient Individual psychotherapy, approx. 20-30 minutes
90817	Inpatient Individual psychotherapy, approx. 20-30 minutes with medical evaluation and management services
90818	Inpatient Individual psychotherapy, approx. 45-50 minutes
90819	Inpatient Individual psychotherapy, approx. 45-50 minutes with medical evaluation and management services
90821	Inpatient Individual psychotherapy, approx. 75-80 minutes
90822	Inpatient Individual psychotherapy, approx. 75-80 minutes with medical evaluation and management services
90853	Other Group psychotherapy

Tobacco Dependence Treatment As Part Of An Oral Health Examination:

01320 Dental code

Indian Health Service Tobacco Use Patient Education Codes

TO- Tobacco Use Patient Education Codes	
TO-C	Complications
TO-CUL	Cultural/Spiritual Aspects of Health
TO-DP	Disease Process
TO-EX	Exercise
TO-FU	Follow-up
TO-HY	Hygiene
TO-IR	Information and Referral
TO-L	Literature
TO-LA	Lifestyle Adaptations
TO-M	Medications
TO-N	Nutrition
TO-P	Prevention
TO-QT	Quit
TO-S	Safety
TO-SHS	Second-Hand Smoke
TO-SM	Stress Management
-TO	Tobacco Education Topic
-SHS	Second-Hand Smoke Topic

REFLECTIONS

REFLECTIONS

Documenting Patient Education					
Education Code ▼		Provider Code ▼		Goal Set, Goal Met, Goal Not Met ▼	
TO – QT – G – 123 – 5min -				GS -	**Quit Date Set For:** *mm/dd/yy*
	▲ Level of Understanding Good, Fair, Poor, Refused		▲ Time (min)		▲ Free text comment

(From "Documentation of Tobacco Screening and Cessation Intervention," by M. Wachaca and C. Lamer. Copyright © 2006 by Indian Health Service. Adapted with permission of the authors. www.ihs.gov/NonMedicalPrograms/NC4 Documents/Tobacco2-06.pdf)

Billing Information

The ICD9/POV code is documented from the Resource and Patient Management System (RPMS) requirements and is an important piece for billing.

» CPT Codes (Current Procedural Terminology) are used to describe a medical service that is provided. Some example CPT codes that are specific for tobacco use disorder services are:

CPT Code	Definition
G0375	Tobacco-use cessation counseling visit; intermediate, greater than 3 minutes and less than 10 minutes.
G0376	Document the E&M code for the visit as appropriate (99201-99215)

There are no E&M codes specific for tobacco use disorder interventions. E&M codes should be documented for the visit depending on the level of service provided and the setting in which it is provided. The E&M code should also include a modifier of 25. This shows that the E&M service is a separately identifiable service from the smoking and tobacco-use cessation counseling service.

Quality Metrics

- Indian Health Service Reports - Clinical Reporting System (CRS) is the software utilized to electronically compile GPRA statistics. It is a program within RPMS for selection of quarterly reports and various measurement outcomes.
- Physicians Quality Reporting Initiative (PQRI) is a national evaluation that is conducted by CMS utilizing CPT codes to assess clinician interventions. There are two tobacco associated measures: (1) inquiry regarding tobacco use and (2) advising smokers to quit. The CPT codes used in this project include:

Measure	CPT Code	Definition
Inquiry regarding tobacco use	1000F and » 1034F or » 1035F or » 1036F or or 100F-8P	*Tobacco use assessed* » Current smoker » Current smokeless tobacco » Current non-smoker *Tobacco use not assessed/no reason noted*
Advising smokers to quit	G8455 and » 4000F or » 4001F or G8456 or G8457 or G8455 and » 4000F-8P	*Tobacco use cessation* » Tobacco use cessation intervention, counseling » Tobacco use cessation intervention, pharmacologic therapy *Smokeless tobacco user, not counseled to quit* *Tobacco non-user, not counseled to quit* *Smoker* » Not counseled, no reason provided

REFLECTIONS

REFLECTIONS

Bringing it all together.....

How the Five A's are Captured throughout the Documentation Process

Addressing the Five A's is an important part of reducing tobacco use dependence. These steps can be documented in Resource and Patient Management System (RPMS) using the following:

1. **Ask** all patients about smoking status and assess smoker's willingness to quit. Smoking status should be documented in the medical record. Document using the tobacco health factors:

Health Factor	Definition
Non-Tobacco User	Does not and has never used tobacco products
Current Smoker	Currently smokes tobacco (cigarettes, pipe, etc.)
Current Smokeless	Currently uses smokeless tobacco (chew, snuff, etc.)
Current Smoker and Smokeless	Currently uses both smoke and smokeless tobacco
Cessation Smoker	Is transitioning from a Current Smoker to a Previous Smoker. The time period between the stop date and the present date is less than 6 months.
Health Factor	**Definition**
Cessation Smokeless	Is transitioning from a Current Smokeless tobacco user to a Previous Smokeless tobacco user. The time period between stopping smokeless tobacco and the present date is less than 6 months.
Previous Smoker	Has quit smoking tobacco for 6 months or more
Previous Smokeless	Has quit smokeless tobacco for 6 months or more
Ceremonial Use Only	Uses tobacco for ceremonial or religious purposes only
Exposure to Environmental Smoke	Smoke Is exposed to environmental tobacco smoke at work or outside the home
Smoker in Home	Is exposed to environmental tobacco smoke at home
Smoke-Free Home	No exposure to tobacco smoke at home

2. **Advise** all smokers to seriously consider making a quit attempt using a clear and personalized message. Advice as brief as 3 minutes is effective. Document using patient education codes:

   TO - QT - G - XYZ - 5 min

   - "TO-QT" is the patient education code for "tobacco quit" and means that you advised the patient to quit, discussed that willingness and personal motivation are key components to quitting, reviewed the treatment, medication, and support options available to the patient/family, made referrals as appropriate, and review the value of frequent follow up and support during the first months of cessation.
   - "G" is the patient's level of understanding of the information:
     - **Good** - Verbalizes understanding, verbalizes decision or desire to change (plan of action indicated), or is able to return demonstration correctly (G)
     - **Fair** - Verbalizes need for more education, undecided about making a decision or a change, or return demonstration indicates a need for further teaching (F)
     - **Poor** - Does not verbalize understanding, refuses to make a decision or needed changes, or unable to return demonstration (P)
     - **Group** - Education provided in group and unable to evaluate individual responses (GR)
     - **Refused** - Refuses or declines patient education (R)
   - "XYZ" is the provider's initials or code of who provided the education.
   - "5 min" is the amount of time (in minutes) that was spent providing education.

3. **Assess** all smokers' willingness to make a quit attempt. If not yet ready to quit, offer motivational intervention using 5 "R's" – relevance, risks, rewards, roadblocks, repetition.

REFLECTIONS

REFLECTIONS

4. **Assist** those ready to make a quit attempt:

- » Set a quit date. Quit date abstinence is a strong predictor of long-term success
- » Give advice on quitting and provide supplementary materials
- » Prescribe pharmacologic therapy as appropriate

Steps 3 and 4 can be combined to document the patient's willingness to make a quit attempt and set a quit date as a goal added on to the education code documented in step 2 above.

If the patient is interested in making a quit attempt

TO - QT - G - XYZ - 5 min - GS - Quit Date set for Jan 1st

- » "GS" stands for goal set. In this case, the patient plans to quit tobacco use and has set a quit date for January 1st. The information following GS is an optional free text field in which you can enter brief pertinent information (up to 180 characters).

Provide additional materials, access to services such as Quitlines, and medication information as appropriate to assist in the quit attempt

TO - L - G - XYZ - 1 min	Tobacco literature (handouts)
TO - HELP - G - XYZ - 2 min	Tobacco Quitline information
TO - M - G - XYZ - 3 min	Medication education

If the patient is not interested in making a quit attempt

TO - QT - G - XYZ - 5 min - GNS - Not Interested Right Now

- » "GNS" stands for goal not set. In this case, the patient is unwilling or interested in quitting tobacco use. The information following GNS is an optional free text field in which you can enter brief pertinent information (up to 180 characters).
- » Provide and review additional written information to patients who are unwilling to quit and document using patient education codes. This may provide help to increase the patient's interest in attempting a quit attempt in the future.

TO - L - G - XYZ - 2 min	Tobacco literature (handouts)
TO - HELP - G - XYZ - 2 min	Tobacco Quitline information

5. **Arrange** follow-up either with phone call or office visit.

- » Prevent relapse by congratulating successes and reinforcing reasons for quitting
- » Assess any difficulties with pharmacologic therapy
- » Discuss sources for tobacco cessation treatment, refer to nicotine treatment program or other resource as available, and document using patient education codes:

  TO - IR - G - XYZ - 2 min Tobacco information & Referral

Healthcare providers interested in reimbursement for providing tobacco dependence treatment interventions must do so within the limitations of a system that does not yet universally reimburse for either brief or intensive interventions. Providers often work within less than ideal coverage. Pharmacotherapy may be covered, but counseling may not; patients may have to pay for their over-the-counter or prescription medications while accessing counseling from provider-referred resources. Clinical opportunities to address tobacco-related diseases arise when healthcare professionals review the results of tests such as:

- » Electrocardiography
- » Total leukocyte counts
- » Blood pressure measurements
- » Hematocrits
- » Auscultation of heart and lungs
- » Blood lipid studies
- » Blood coagulation studies
- » Serum alpha antiprotease measurements
- » Pregnancy tests
- » Dental examinations
- » Biological markers of tobacco exposure, such as carbon monoxide and cotinine, pulmonary function tests, and histopathological changes

REFLECTIONS

HEALTH FACTORS

ASK ABOUT TOBACCO USE AND EXPOSURE

Ask the patient:

- Do you use tobacco products (cigarettes, snuff, dip, etc)?
- Do you use tobacco products for cultural or religious purposes?
- Are you exposed to tobacco smoke at work?
- Does anyone use tobacco products in or around the home?

Health Factor*	Definition
Non Tobacco User	Does not and has never used tobacco products
Current Smoker	Currently smokes tobacco (cigarettes, cigars, pipe, etc)
Current Smokeless	Currently uses smokeless tobacco (chew, dip, snuff, etc)
Current Smoker and Smokeless	Currently uses both smoke and smokeless tobacco
Cessation Smoker	Is transitioning from a Current Smoker to a Previous Smoker. The time period between stopping smoking and 6 months.
Cessation Smokeless	Is transitioning from a Current Smokeless tobacco user to a Previous Smokeless tobacco user. The time period between stopping smokeless tobacco and 6 months.
Previous Smoker	Has quit smoking tobacco for 6 months or more
Previous Smokeless	Has quit smokeless tobacco for 6 months or more
Ceremonial Use Only	Uses tobacco for ceremonial or religious purposes only
Exposure to Environmental Tobacco Smoke	Is exposed to second hand smoke at work or outside of the home.
Smoker in Home	Is exposed to second hand smoke at home
Smoke Free Home	There is no exposure to tobacco smoke at home

*More than one tobacco health factor may be documented.

RESOURCES

Phone Numbers

American Lung Association Call Center
1-8666-QUIT-YES (1-866-784-8937) or
1-800-548-8252

Department of Health and Human Services
National telephone counseling quit line
1-800-QUITNOW (1-800-784-8669)
TTY 1-800-332-8615

Web Sites

CDC's Tobacco Information and Prevention Service
www.cdc.gov/tobacco/news/QuitSmoking.htm

NCI's Tobacco Information and Prevention Service
http://www.cdc.gov/tobacco/news/QuitSmoking.htm

American Lung Association – Tobacco Control
www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=22937

Smokefree.gov website sponsored by the NCI, CDC, and the American Cancer Society
www.ahrq.gov/path/tobacco.htm

Department of Health & Human Services:
www.surgeongeneral.gov/tobacco/

IHS Health Promotion and Disease Prevention:
www.ihs.gov/NonMedicalPrograms/HPDP/Index.cfm

American Academy of Family Physicians:
www.aafp.org/x27811.xml

Tobaccofree.org: www.tobaccofree.org/other.htm

Freedom From Smoking: www.lungusa.org/ffs/

Key Contacts

IHS Tobacco Control Task Force Chair: Nathanial Cobb (Nathaniel.Cobb@ihs.gov)

IHS Tobacco Control Lead Consultant:
Mary Wachacha (Mary.Wachacha@ihs.gov)

Documentation of Tobacco Screening and Cessation Intervention

INDIAN HEALTH SERVICE · PHS · 1955 ·

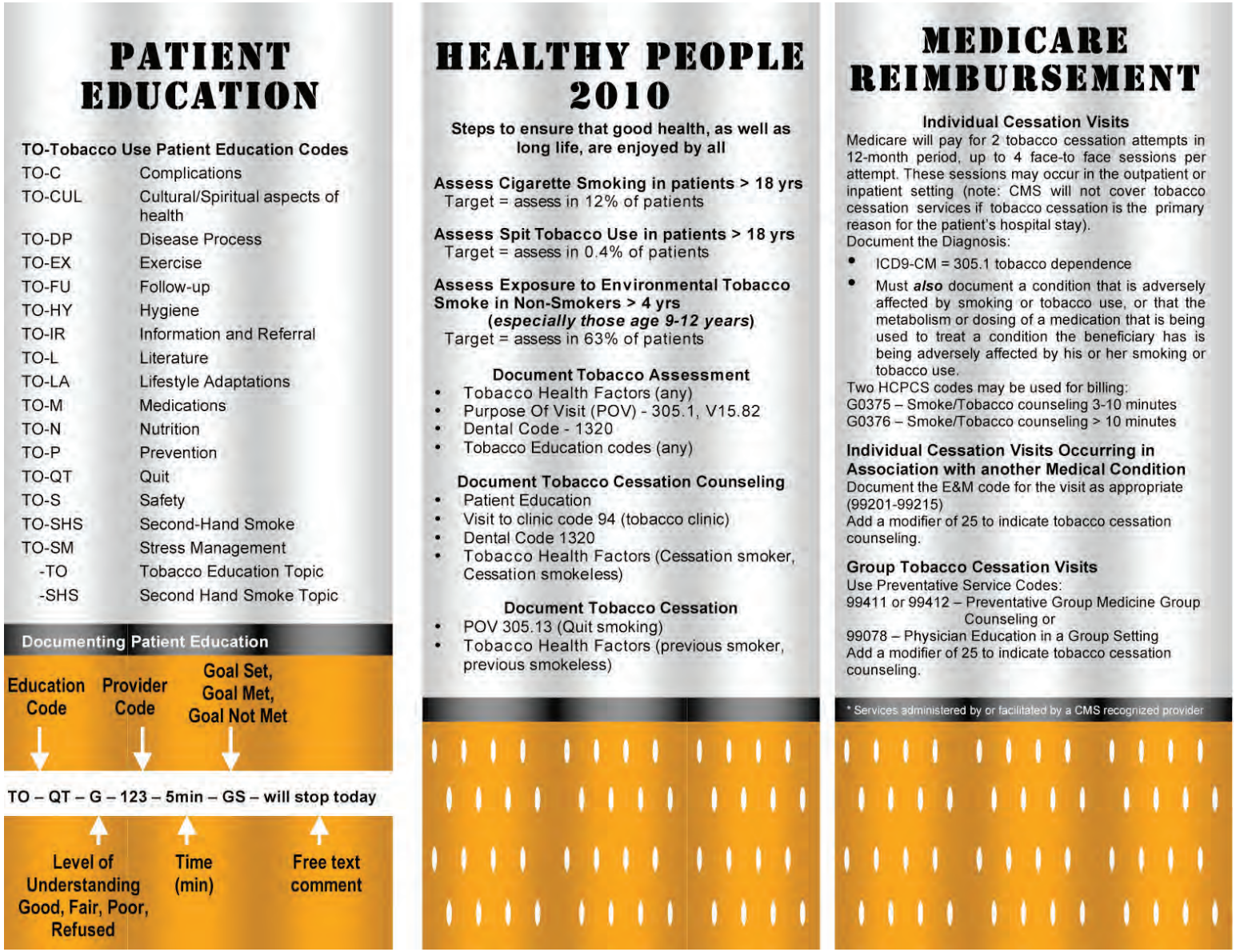
Five A's of smoking cessation counseling:

- **Ask about tobacco use**
- **Advise to quit**
- **Assess willingness to make a quit attempt**
- **Assist in quit attempt**
- **Arrange follow-up**

Last updated 8/1/2006

Developed by Chris Lamer, PharmD, BCPS, CDE
Cherokee, NC

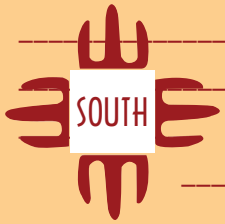
(From "Documentation of Tobacco Screening and Cessation Intervention," by M. Wachaca and C. Lamer. Copyright© 2006 by Indian Health Service. Reprinted with permission of the authors. www.ihs.gov/NonMedicalPrograms/NC4/Documents/Tobacco2-06.pdf)



(From "Documentation of Tobacco Screening and Cessation Intervention," by M. Wachaca and C. Lamer. Copyright© 2006 by Indian Health Service. Reprinted with permission of the authors. www.ihs.gov/NonMedicalPrograms/NC4/Documents/Tobacco2-06.pdf)

Action

THINKING – What information will help me to understand the health risks of commercial tobacco in my community?



PLANNING – What can I do?

INITIATING A PLAN – How will I do it?

EVALUATING AND MAINTAINING – How will I know that the program is working?

RESOURCE NOTES

RESOURCES

©Trudy Griffin-Pierce

National and International Quitlines and Cessation Programs

American Cancer Society (1-800-227-2345 or TTY: 1-866-228-4327)
(www.cancer.org/docroot/PED/ped_10.asp)

American Heart Association (1-800-AHA-USA-1 or 1-800-242-8721)
(www.americanheart.org)

American Legacy Foundation (1-800-4A-LEGACY)
(http://americanlegacy.org)

American Lung Association (1-800-LUNGUSA)
(www.lungusa.org)

Become An EX
Once you begin, you'll start to look at quitting not as one huge war but a series of small battles you can actual win. (www.becomeanex.org)

Great Start (1 -866-66-START)
Links pregnant women who smoke with telephone counselors who understand their special needs and concerns. (http://www.americanlegacy.org/2110.aspx)

Circle of Friends (1-800-243-7000)
Developed for women who smoke, Circle of Friends emphasizes support from family and friends. (http://americanlegacy.org/2108.aspx)

Bob Quits
This reality-based program provides online videos and diary excerpts following a 35-year-old New Yorker through his quit attempts. (www.bobquits.com)

Mary Quits
This program provides online videos and diary excerpts following a Washington, D.C. woman working through her quit plan. (www.maryquits.com)

Health Dialog
Some health plans and employers contract with Health Dialog to provide telephone counseling and other services. Check with your insurance provider or Human Resources department regarding participation. (www.healthdialog.com)

National Cancer Institute (NCI) (1-877-44U-QUIT or TTY: 1-800-332-8615)
http://www.cancer.gov/cancertopics/smoking

National Network of Tobacco Cessation Quitlines (1-800-QUIT-NOW)
The North American Quitline Consortium web site helps users find quitlines throughout North America and Europe. (www.naquitline.org)

Nicotine Anonymous
Nicotine Anonymous offers referrals for group support and recovery using the 12 Steps, as adapted from Alcoholics Anonymous, to achieve abstinence from nicotine. (www.nicotine-anonymous.org)

QuitNet
This online cessation program hosts the world's largest community of smokers and ex-smokers helping each other quit. (www.quitnet.com)

Quit Wizard
This web-based program offers personalized planning tools for quit attempts, as well as support materials to help loved ones quit. (https://quitwizard.makesmokinghistory.org)

Stop Tabac
This web-based cessation program is available in English, French, Chinese, German, Danish, Italian, Georgian, and Serbo-Croatian. (www.stop-tabac.ch/en/welcome.html)

University of Arizona HealthCare Partnership
Offering evidence-based continuing education & certification programs to address health risk behaviors with an emphasis on the treatment and early intervention of tobacco use and dependence. (www.healthcarepartnership.org)

You Can Quit Smoking Now! (1-877-44U-QUIT or TTY: 1-800-332-8615)
Sponsored by several government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the National Institutes of Health, this site offers cessation resources and referrals. (www.smokefree.gov)

Software for Handheld Computers

The National Cancer Institute's Handheld Computer Smoking Intervention Tool (HC-SIT) helps clinicians assist with smoking cessation counseling at the point of care. This software was developed in partnership with the Department of Family Medicine at the University of Virginia. (www.smokefree.gov/hp-hcsit.html)

Cardiovascular Health Resources

Cardi ovascular Health Program for Alaska Native Women
hpp.sagepub.com/cgi/content/abstract/6/4/472

Diabetes Resources

Awakening the Spirit: Pathways to Diabetes Prevention & Control
www.diabetes.org/communityprograms-and-localevents/nativeamericans.jsp

Educational Resources

Native Circle at Mayo
The Native CIRCLE is a resource center providing cancer-related materials to people involved in the education, care and treatment of American Indians and Alaska Natives. www.nativeamericanprograms.org/index-circle.html

Tobacco Education Clearinghouse of California
Over 400 tobacco education materials are available on this web site. (www.tobaccofreecatalog.org)

Elder Resources

Health and Health Care of American Indian and Alaska Native Elders
www.stanford.edu/group/ethnoger/americanindian.html

Native American Elders Health Care Series: The SHARE Project
http://learn.sdstate.edu/Share

National Resource Center on Native American Aging & University of North Dakota
www.med.und.edu/depts/rural/nrcnaa

Indian Health Service Resources

Indian Health Service
www.ihs.gov/MedicalPrograms/epi

Indian Health Service, Elder Care Initiative
www.ihs.gov/MedicalPrograms/ElderCare

The Indian Health Service Primary Care Provider
www.ihs.gov/PublicInfo/Publications/HealthProvider/provider.asp

Native Health Resources

National Congress of American Indians

www.ncai.org

Native American Cancer Research

www.natamcancer.org

Native Health Research Database

http://hsc.unm.edu/library/nhd

U.S. Public Health Resources

Surgeon General's Report on Health Consequences of Smoking (2006)

This site includes the Surgeon General's full report, summary, an animated slide show, and fact sheets. (www.cdc.gov/tobacco/sgr/sgr_2006/index.htm)

U.S. Public Health Service Clinical Practice Guideline:

Treating Tobacco Use and Dependence: 2008 Update. The Guideline offers behavioral and pharmaceutical techniques for treating tobacco dependence. (www.surgeongeneral.gov/tobacco)

U.S. Surgeon General Carmona's Testimony on Tobacco Harm Reduction

(www.surgeongeneral.gov/news/testimony/tobacco06032003.htm)

Rural Health Resources

California Rural Indian Health Board, Inc.

The California Rural Indian Heath Board, Inc. (CRIHB) was formed in 1969. It is a network of Tribal Health Programs that enables healthcare provision to member Tribes in California, focusing on the needs and interests of the Indians of rural California.

www.crihb.org

Smokeless Tobacco Resources

CDC's Smokeless Tobacco Fact Sheet

www.cdc.gov/tobacco/smokeless/index.htm

National Cancer Institute (NCI) Most Recent Fact Sheet on Smokeless Tobacco

www.cancer.gov/cancertopics/factsheet/Tobacco/smokeless

Youth Educational Resources

Campaign for Tobacco-Free Kids (CTFK)

CTFK serves as a resource for information on tobacco-related news reports, initiatives, and research findings. (www.tobaccofreekids.org)

Further Reading: Tobacco-Related Health Issues

Báezconde-Garbanati, L., Beebe, L.A., & Pérez-Stable, E.J. (2007). Building capacity to address tobacco-related disparities among American Indian and Hispanic/Latino communities: conceptual and systemic considerations. *Addiction, 102*(Suppl. 2), 112-122.

Beebe, L.A., Vesely, S.K., Oman, R.F., Tolma, E., Aspy, C.B., & Rodine, S. (2008). Protective assets for non-use of alcohol, tobacco and other drugs among urban American Indian youth in Oklahoma. *Maternal and Child Health Journal, 12*(Suppl. 1), 82-90.

Burgess, D., Fu, S. S., Joseph, A. M., Hatsukami, D. K., Solomon, J., & van Ryn, M. (2007). Beliefs and experiences regarding smoking cessation among American Indians. *Nicotine & Tobacco Research, 9*(Suppl. 1), 19–28.

Davis, S. M., Lambert, L. C., Cunningham-Sabo, L., & Skipper, B. J. (1995). Tobacco use: Baseline results from Pathways to Health, a school-based project for southwestern American Indian youth. *Preventive Medicine, 24*(5), 454–460.

Forster, J. L., Rhodes, K. L., Poupart, J., Baker, L. O., Davey, C., & American Indian Community Tobacco Project Steering Council. (2007). Patterns of tobacco use in a sample of American Indians in Minneapolis-St. Paul. *Nicotine & Tobacco Research, 9*(Suppl. 1), 29–37.

Gilliland, F. D., Mahler, R., & Davis, S. M. (1998). Non-ceremonial tobacco use among southwestern rural American Indians: The New Mexico American Indian Behavioural Risk Factor Survey. *Tobacco Control, 7*(2), 156–160.

Hiratsuka, V.Y., Loo, R., Will, J.C., Oberrecht, R., & Poindexter, P. (2007). Cardiovascular disease risk factor screening among Alaska Native women: the traditions of the heart project. *International Journal of Circumpolar Health, 66*(Suppl. 1), 39-44.

Horn, K., Noerachmanto, N., Dino, G., Manzo, K., & Brayboy,M. (2009). Who wants to quit? Characteristics of American Indian youth who seek smoking cessation intervention. *Journal of Community Health, 34*(2), 156-163.

Johnson, K. M., Lando, H. A., Schmid, L. S., & Solberg, L. I. (1997). The GAINS project: Outcome of smoking cessation strategies in four urban Native American clinics. *Addictive Behaviors, 22*(2), 207–218.

Reed, M.B., Burns, D.M. (2008). A population-based examination ofracial and ethnic differences in receiving physicians' advice to quit smoking. *Nicotine and Tobacco Research, 10*(9), 1487-1494.

Schumacher, M.C., Slattery, M.L., Lanier, A.P., Ma, K.N., Edwards, S., Ferucci, E.D., & Tom-Orme, L. (2008). Prevalence and predictors of cancer screening among American Indian and Alaska Native people: the EARTH study. *Cancer Causes Control, 19*(7), 725-737.

Wardman, D., Quantz, D., Tootoosis, J., & Khan, N. (2007). Tobacco cessation drug therapy among Canada's Aboriginal people. *Nicotine and Tobacco Research, 9*(5), 607–611.

Welty, T. K., Lee, E. T., Yeh, J., Cowan, L. D., Go, O., Fabsitz, R. R., et al. (1995). Cardiovascular disease risk factors among American Indians: The Strong Heart Study. *American Journal of Epidemiology, 142*(3), 269–287.

Further Reading: American Indian Cultures

Ballantine, B., & Ballantine, I. (Eds.) (1993). The Native Americans: *An illustrated history*. Atlanta, GA: Turner.

Beck, P.V., & Walters, A.L. (1977). *The sacred: Ways of knowledge, sources of life.* Tsaile, AZ: Navajo Community College Press.

Brown, J. E. (1982). *The spiritual legacy of the American Indian*. New York: Crossroad.

Brown, R.A., Adler, N.E., Worthman, C.M., Copeland, W.E., Costello, E.J., & Angold, A. (2008). Cultural and community determinants of subjective social status among Cherokee and White youth. *Ethnicity and Health, 13*(4), 289-303.

Cooter, R.D. and Fikentscher, W. (2008). American Indian law codes: Pragmatic law and tribal identity. *American Journal of Comparative Law, 56*(1), 29-74.

Erdoes, R., & Ortiz, A. (Eds.) (1984). *American Indian myths and legends.* New York: Pantheon.

Harjo, L. (2008). Place and Native American Indian history and culture. *American Indian Culture and Research Journal, 32*(4), 176-179.

Hill, T., Hill, R.W., Sr., & National Museum of the American Indian. (Eds.) (1994). *Creation's journey: Native American identity and belief.* Washington, DC: Smithsonian Institution Press.

Jones, M.D. and Galliher, R.V. (2007). Ethnic identity and psychosocial functioning in Navajo adolescents. *Journal of Research on Adolescence, 17*(4), 683-696.

National Museum of the American Indian. (1994). All roads are good: *Native voices on life and culture.* Washington, DC: Smithsonian Institution Press.

Nerburn, K. and Mengelkoch, L. (Eds.) (1991). *Native American wisdom.* San Rafael, CA: New World Library.

Rodriguez, J., Umana-Taylor, A., Smith, E.P., & Johnson, D.J. (2009). Cultural processes in parenting and youth outcomes: Examining a model of Racial-Ethnic Socialization and Identity in Diverse Populations. *Cultural Diversity and Ethnic Minority Psychology 15*(2), 106-111.

Szasz, M. C., & Ryan, C. (1989). American Indian education. In W. C. Sturtevant (Series Ed.) & W. E. Washburn (Vol. Ed.), *Handbook of North American Indians: Vol. 4. History of Indian-White relations* (pp. 284–290). Washington, DC: Smithsonian Institution Press.

Trafzer, C.E., Gilbert, W.S., & Madrigal, A. (2008). Integrating native science into a Tribal Environmental Protection Agency (EPA). *American Behavioral Scientist, 51*(12), 1844-1866.

Further Reading: American Indian/Alaska Native Health/Medical Issues

Brave Heart, M. Y., & Debruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*(2), 56–78.

Cohen, K.S. (2008). At the Canyon's edge: Depression in American Indian culture. *Explore-The Journal of Science and Healing, 4*(2), 127-135.

Coyhis, D. and Simonelli, R. (2008). The Native American healing experience. *Substance Use and Misuse, 43*(12-13), 1927-1949.

Csordas, T.J., Storck, M.J., & Strauss, M. (2008). Diagnosis and distress in Navajo healing. *Journal of Nervous and Mental Disease, 196*(8), 585-596.

Dennis, M.K. (2009). Risk and protective factors for HIV/AIDS in Native Americans: Implications for preventive intervention. *Social Work, 54*(2), 145-154

Dixon, M., & Iron, P. E. (2006). *Strategies for cultural competency in Indian health care.* Washington, DC: American Public Health Association.

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology.* Albany: State University of New York Press.

Feinstein, A. R. (1970). The pre-therapeutic classification of co-morbidity in chronic disease. *Journal of Chronic Diseases*, 23, 455–468.

Fletcher-Jantzen, E., Strickland, T., & Reynolds, C. (Eds.) (2000). *Handbook of cross-cultural neuropsychology.* New York: Kluwer Academic/Plenum Press.

Garroutte, E.M., Sarkisian, N., Goldberg, J., Buchwald, D., & Beals, J. (2008). Perceptions of medical interactions between healthcare providers and American Indian older adults. *Social Science and Medicine, 67*(4), 546-556.

Griffin-Pierce, T., Silverberg, N., Connor, D., Jim, M., Peters, J., Kaszniak, A., & Sabbagh, M.N. (2008). Challenges to the recognition and assessment of Alzheimer's disease in American Indians of the southwestern United States. *Alzheimers and Dementia, 4*(4), 291-299.

Howard, B. V., Lee, E. T., Cowan, L. D., Devereux, R. B., Galloway, J. M., Go, O. T., et al. (1999). Rising tide of cardiovascular disease in American Indians: The Strong Heart Study. *Circulation, 99*(18), 2389–2395.

John, R. (1996). Demography of American Indian elders: Social, economic, and health status. In G. D. Sandefur, R. R. Rindfuss, & B. Cohen (Eds.), *Changing numbers, changing needs: American Indian demography and public health* (pp. 218–231). Washington, DC: National Academy Press.

Manson, S. M. (2003). Extending the boundaries, bridging the gaps: Crafting *Mental health: Culture, race, and ethnicity,* a supplement to the Surgeon General's report on mental health. *Culture, Medicine and Psychiatry, 27*(4), 395–408.

Morton, D.J., Garrett, M., Reid, J., and Wingard, D.L. (2008). Current smoking and type 2 diabetes among patients in selected Indian Health Service clinics, 1998-2003. *American Journal of Public Health, 98*(3), 560-565.

Sheehan, A., Walrath-Greene, C., Fisher, S., Crossbear, S., & Walker, J. (2007). Evidence-based practice knowledge, use, and factors that influence decisions: Results from an

evidence-based practice survey of providers in American Indian/Alaska Native communities. *American Indian and Alaska Native Mental Health Research, 14*(2), 29-48.

Strauss, K. F., Mokdad, A., Ballew, C., Mendlein, J. M., Will, J. C., Goldberg, H. I., et al. (1997). The health of Navajo women: Findings from the Navajo Health and Nutrition Survey, 1991-1992. *The Journal of Nutrition, 127*(Suppl. 10), 2128S–2133S.

Tillman, L., Myers, S., Pockaj, B., Perry, C., Bay, R.C., & Al-kasspooles, M. (2005). Breast cancer in Native American women treated at an urban-based Indian health referral center, *American Journal of Surgery*, 190, 895-902.

U.S. Department of Health and Human Services (USDHHS), Indian Health Service. (2001). *Mental health: Culture, race, and ethnicity–a supplement to Mental health:* A report of the Surgeon General. Rockville, MD: US Department of Health and Human Services.

Whitbeck, L.B., Yu, M., Johnson, K.D., Hoyt, D.R., & Walls, M.L. (2008). Diagnostic prevalence rates from early to mid-adolescence among indigenous adolescents: First results from a longitudinal study. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(8), 890-900.

Whitbeck, L.B. and Crawford, D.M. (2009). Gestational risks and psychiatric disorders among indigenous adolescents. *Community Mental Health Journal, 45*(1), 62-72.

White, L. L., Goldberg, H. I., Gilbert, T. J., Ballew, C., Mendlein, J. M., Peter, D. G., et al. (1997). Rationale, design and methodology for the Navajo Health and Nutrition Survey. *The Journal of Nutrition, 127*(Suppl. 10), 2078S–2084S.

Wright, A. L., Naylor, A., Wester, R., Bauer, M., & Sutcliffe, E. (1997). Using cultural knowledge in health promotion: Breastfeeding among the Navajo. *Health Education & Behavior, 24*(5), 625–639.

National Network

Inter-Tribal Council of Michigan www.tobaccopreventionnetworks.org

2956 Ashmun St.
Sault Ste. Marie, MI 49783-3720
Phone is 906-632-6896
Fax is 906-635-4212
Contact: Lisa Kerfoot lkerfoot@itcmi.org

CDC Funded Tribal Support Centers

Black Hills Center for American Indian Health www.bhcaih.org

605 W. Desmond Street
Winslow, AZ 86047
Phone: 928-289-6483
Contact: Peter Nez pfnez@bhcaih.org

California Rural Indian Health Board www.crihb.org

4400 Auburn Blvd.
Sacramento, CA 95841
Phone: 916-929-9761
Contact: Jackie Kaslow jackie.kaslow@crihb.net

Indigenous Peoples Task Force www.indigenouspeoplestf.org

1433 E. Franklin Ave., #18A
Minneapolis, MN 55404
Phone: 612-721-0253
Contact: Sharon Day smarieday@aol.com

Southeast Alaska Regional Health Consortium www.searhc.org

222 Tongass Drive
Sitka, AK 99835
Phone: 907-966-8883
Contact: Andrea Thomas andreat@searhc.org

Tobacco Prevention Coordinator

Cherokee Nation
PO Box 948
Tahlequah, OK 74465
Phone: (918) 453-5617
Business Cell: (918) 316-4375
Contact: June Maher jumaher@cherokee.org

Tobacco Program Manager www.themuscogeecreeknation.com/healthsystem/TP.htm

Muscogee (Creek) Nation
116 North Grand Avenue
Oklahoma City, OK 74447
Phone: (918) 623-1189
Contact: Cynthis Tainpeah cynthia.tainpeah@creekhealth.org

TOBACCO CONTROL TASK FORCE MEMBERS

Alfreda Beartrack, MA

HP/DP Coordinator
Northern Navajo Medical Center
PO Box 160, Hwy 491 N
Shiprock, NM 87420
Phone: 505-368-6493
Alfreda.beartrack@ihs.gov

Rosalind Chorak, RPh

Chief Pharmacist
Catawba Service Unit
2893 Sturgis Road
Rock Hill, SC 29730
Phone: 803-366-9090
Rosalind.chorak@ihs.gov

Nathaniel Cobb, MD

Tobacco Control Chair
Chief, Chronic Disease Epidemiology
Division of Epidemiology and Disease Prevention
5300 Homestead Road, NE
Albuquerque, NM 87110
Phone: 505-248-4432
nathaniel.cobb@ihs.gov

CDR Jim Gemelas, RPh., NCPS

Clinical Applications Coordinator
Warm Springs Health & Wellness Center
PO BOX 1209
Warm Springs, OR 97761
Phone: 541-553-2174 ext 4216
James.Gemelas@ihs.gov

Carol Gourneau, MSW, LCSW

Hospital Social Worker
Belcourt Indian Medical Center
PO Box 160, 1 Main Street,
Belcourt, North Dakota 58316
Phone: 701-477-6111
carol.gourneau@mail.ihs.gov

Kari Johnson RN, PHN
TB Nurse Coordinator
Public Health Nursing
Pine Ridge IHS Hospital
PO Box 1201
Pine Ridge, SD 57770Z
Phone: 605-867-3141
kari.johnson@ihs.gov

LeeAnn Johnson, MPH
Health Promotion Specialist
Billings Area IHS
2900 4th Avenue North
P.O. Box 36600
Billings, MT 59107
Phone: 406-247-7118
Leann.Johnson@ihs.gov

Stacy Kelley, CTTS
Cancer Partnership Program Coordinator
A Program of the National Cancer Institute serving AK, ID, NV, OR and WA
Cancer Information Service - Northwest Region
Office of Alaska Native Health Research
Alaska Native Tribal Health Consortium
4000 Ambassador Drive, C-DCHS
Anchorage, Alaska 99508
Phone: 907-729-2927
sfkelley@anmc.org

Dayle Knutson, RN, BSN
Public Health Nurse
Wanblee Health Center
Wanblee, SD 57577
Phone: 605-462-6155
dknutson@abr.ihs.gov

Christopher C. Lamer, PharmD, NCPS, BCPS, CDE
LCDR, U.S. Public Health Service
Clinical Applications Coordinator/ Residency Program Director
Cherokee Indian Hospital
Hospital Road, Caller Box C-268
Cherokee, NC 28719
Phone: 828-497-9163 x 6363
chris.lamer@ihs.gov

Joe W. Law
Health Promotion Coordinator
Portland Area Office
1220 SW Third Ave., Suite 476
Portland, OR 97204
Phone: 503-326-6466
joe.law@ihs.gov

Marlene Poukka
Public Health Community Health Educator
Mille Lacs Band of Ojibwe
17230 Noopiming Drive
Onamia, MN 56359
Phone: 320-532-7812
marlenep@millelacsojibwe.nsn.us

Caroline Renner, MPH, CTTS
Nicotine Program Manager
4141 Ambassador Drive, Suite 118
Anchorage, AK 99508
Phone: 907-729-2925
ccrenner@anmc.org

Megan Wohr, RPh
LCDR, USPHS, Tobacco Control Specialist
IHS Division of Epidemiology
Phoenix Indian Medical Center
Centers of Excellence
4212 N 16th Street
Phoenix, AZ 85016
Phone: 480-216-4342
megan.wohr@ihs.gov

REFERENCES

©Trudy Griffin-Pierce

REFERENCES

Abrams, D.B., Niaura, R., Brown, R.A., Emmons, K. M., Goldstein, M.G., & Monti, P.M. (2003). *The tobacco dependence treatment handbook: A guide to best practices.* New York: Guilford Press.

American Heart Association. (2009). Heart disease and stroke statistics 2009 Update: A report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. *Circulation, 119,* e21-e181.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anda, R. F., Croft, J. B., Felitti, V. J., Nordenberg, D., Giles, W.H., Williamson, D. F., et al. (1999). Adverse childhood experiences and smoking during adolescence and adulthood. *Journal of the American Medical Association, 282,* 1652–1658.

Audrain-McGovern, J., Lerman, C., Wileyto, E. P., Rodriguez, D., & Shields, P. G. (2004). Interacting effects of genetic predisposition and depression on adolescent smoking progression. *American Journal of Psychiatry, 161,* 1224–1230.

Baker, F., Ainsworth, S. R., Dye, J. T., Crammer, C., Thun, M. J., Hoffmann, D., et al. (2000). Health risks associated with cigar smoking. *Journal of the American Medical Association, 284,* 735–740.

Beauvais, F., Jumper-Thurman, P., Helm, H., Plested, B., & Burnside, M. (2004). Surveillance of drug use among American Indian adolescents: Patterns over 25 years. *Journal of Adolescent Health, 34,* 493–500.

Benowitz, N. L. (1988). Drug therapy: Pharmacological aspects of cigarette smoking and nicotine addiction. *New England Journal of Medicine, 319,* 1318–1330.

Benowitz, N. L. (1999). Nicotine addiction. *Primary Care: Clinics in Office Practice, 26,* 611–631.

Biesenbach, G., & Zazgornik, J. (1996). Influence of smoking on the survival rate of diabetic patients requiring hemodialysis. *Diabetes Care, 19,* 625–628.

Boffetta, P., Mashberg, A., Winkelmann, R., & Garfinkel, L. (1992). Carcinogenic effect of tobacco smoking and alcohol drinking on anatomic sites of the oral cavity and oropharynx. *International Journal of Cancer, 52,* 530–533.

Brandon, T. H., Vidrine, J. I., & Litvin, E. B. (2007). Relapse and relapse prevention. *Annual Review of Clinical Psychology, 3,* 257–284.

Breland, A. B., Evans, S. E., Buchhalter, A. R., Eissenberg, T. (2002). Acute effects of Advance TM: a potential reduced exposure product for smokers. *Tobacco Control, 11*(4), 376-378.

Briggs, Gerald G., Freeman, Roger K., Yaffe, Sumner J. (2008). *Drugs in Pregnancy and Lactation: A Reference Guide to Fetal and Neonatal Risk.* Lippincott Williams & Wilkins, Edition: 8, revised.

Buchhalter, A. R., Eissenberg, T. (2000). Preliminary evaluation of a novel smoking system: effects on subjective and physiological measures and on smoking behavior. *Tobacco Control, 2,* 39-43.

Cahill, K., Stead, L.F., & Lancaster, T. (2007). Nicotine receptor partial agonists for smoking cessation. *Cochrane Database of Systematic Reviews,* Issue 1. Art. No.: CD006103. DOI: 10.1002/14651858.CD006103.pub2.

California Adolescent Nutrition and Fitness Program. (n.d.) *Native American food guide pyramid*. Retrieved June 15, 2007, from the U.S. Department of Agriculture National Agricultural Library web site: www.nal.usda.gov/fnic/Fpyr/NAmFGP.html

California Rural Indian Health Board, Inc. Tobacco Education and Prevention Technical Support Center. (n.d.) *Resource guide for assisting American Indian smokers to quit: Cultural competency guidebook.* Sacramento, CA: Author.

Campaign for Tobacco-Free Kids. (2002). *Smoking and other drug use.* Retrieved, date unknown, from www.tobaccofreekids.org/research/factsheets/pdf/0106.pdf

Campaign for Tobacco-Free Kids. (2005). *Smoking and kids.* Retrieved, date unknown, from www.tobaccofreekids.org/research/factsheets/pdf/0001.pdf

Campaign for Tobacco-Free Kids. (2006a). *State tobacco-related costs and revenues.* Retrieved, date unknown, from www.tobaccofreekids.org/research/factsheets/pdf/0178.pdf

Campaign for Tobacco-Free Kids. (2006b). *Smokeless tobacco and kids.* Retrieved, date unknown, from www.tobaccofreekids.org/research/factsheets/pdf/0003.pdf

Centers for Disease Control and Prevention. (1993). Physician and other health-care professional counseling of smokers to quit–United States, 1991. *Morbidity and Mortality Weekly Report, 42,* 854–857.

Centers for Disease Control and Prevention. (1998). Selected cigarette smoking initiation and quitting behaviors among high school students – United States, 1997. *Morbidity and Mortality Weekly Report, 47,* 386-389.

Centers for Disease Control and Prevention. (1999). Determination of nicotine, pH, and moisture content of six U.S. commercial moist snuff products–Florida, January–February 1999. *Morbidity and Mortality Weekly Report, 48,* 398–401.

Centers for Disease Control and Prevention. (2002). Annual smoking-attributable mortality, years of potential life lost, and economic costs–United States, 1995–1999. *Morbidity and Mortality Weekly Report, 51,* 300–303.

Centers for Disease Control and Prevention. (2005). *Smokeless tobacco fact sheet.* Retrieved January 20, 2006, from www.cdc.gov/tobacco/factsheets/smokelesstobacco.htm

Centers for Disease Control and Prevention. (2006a). Tobacco use among adults–United States, 2005. *Morbidity and Mortality Weekly Report, 55,* 1145–1148.

Centers for Disease Control and Prevention. (2006b). Births: Final data for 2004, *National Vital Statistics Reports, 55,* 1-102.

Centers for Disease Control and Prevention. (2007). Preventing smoking and exposure to secondhand smoke before, during, and after pregnancy, July 2007, 1-2.

Centers for Disease Control and Prevention. (2008a). Smoking-attributable mortality, years of potential life lost, and productivity losses --- United States, 2000--2004. *Morbidity and Mortality Weekly Report, 57,* 1226-1228.

Centers for Disease Control and Prevention. (2008b). Youth Risk Behavior Surveillance --- United States, 2007. *Morbidity and Mortality Weekly Report, 57,* 1-136.

Centers for Medicare and Medicaid Services. (2005, March 22). *Decision memo for smoking & tobacco cessation counseling.* Retrieved April 16, 2007, from www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=130

Chaturvedi, N., Stephenson, J. M., & Fuller, J. H. (1995). The relationship between smoking and microvascular complications in the EURODIAB IDDM Complications Study. *Diabetes Care, 18,* 785–792.

Chaturvedi, N., Stevens, L., & Fuller, J. H. (1997). Which features of smoking determine mortality risk in former cigarette smokers with diabetes? The World Heath Organization Multinational Study Group. *Diabetes Care, 20,* 1266–1272.

Christen, A. G., & Christen, J.A. (1990). What nicotine addiction and alcoholism teach us about other chemical dependencies. *Journal (Indiana Dental Association), 69*(6), 22–26.

Christen, A. G., & Christen, J.A. (1994). Why is cigarette smoking so addicting? An overview of smoking as a chemical and process addiction. *The Journal of Health Behavior, Education and Promotion, 18,* 17–24.

Cobb, C. O., Weaver, M. F., & Eissenberg, T. (2009). Evaluating the acute effects of oral, non-combustible potential reduced exposure products marketed to smokers. Tobacco Control, Online First, published April 2, 2009. doi:10.1136/tc.2008.028993.

Cohen, S., Lichtenstein, E., Prochaska, J. O., Rossi, J. S., Gritz, E.R., Carr, C. R., Orleans, C. T., Schoenbach, V. J., Biener, L., Abrams, D., DiClemente, C. C., Curry, S., Marlatt, G. A., Cumming, K. M., Emont, S. L., Giovino, G. A. & Ossip-Klein, D. J. (1989) Debunking myths about self-quitting. *American Psychologist, 44,* 1355–1365.

Dalack, G. W., Healy, D. J., & Meador-Woodruff, J. H. (1998). Nicotine dependence in schizophrenia: Clinical phenomena and laboratory findings. *American Journal of Psychiatry, 155,* 1490-1501.

Dempsey, D. A., & Benowitz, N. L. (2002). Risks and benefits of nicotine to aid smoking cessation in pregnancy. Drug Safety: *An International Journal of Medical Toxicology and Drug Experience, 24,* 277–322.

DiClemente, C. C., Prochaska, J. O., Fairhurst, S. K., Velicer, W. F., Velasquez, M. M., & Rossi, J. S. (1991). The process of smoking cessation: An analysis of precontemplation, contemplation, and preparation stages of change. *Journal of Consulting and Clinical Psychology, 59,* 295–304.

Douglas, C. E. (1997). Manipulation of cigarette production to cause and enhance addiction. *Lung Cancer, 18*(Suppl. 2), 5–6.

El-Saed A., Kuller, L.H., Newman, A.B., Lopez, O., Costantino, J., McTigue, K., Cushman, M., Kronmal, R. (2006). Geographic variations in stroke incidence and mortality among older populations in four US communities. *Stroke, 37*, 1975–1979.

Fagerström, K. O., Heatherton, T. F., & Kozlowski, L. T. (1990). Nicotine addiction and its assessment. *Ear, Nose and Throat Journal, 69,* 763–765.

Fagerström, K. O., & Schneider, N. G. (1989). Measuring nicotine dependence: A review of the Fagerström Tolerance Questionnaire. *Journal of Behavioral Medicine, 12,* 159-182.

Farren, C., Hill, L., Baker, T., Platts, R., BedFont Scientific, Ltd., & GASP Smoke Free Solutions. (2004). CO: *A smoker's guide to carbon monoxide, Smokerlyzers®, and stopping smoking.* [Brochure]. Rochester, Kent, England: BedFont Scientific.

Ferguson, T. (1987). *The no-nag, no-guilt, do-it-your-own-way guide to quitting smoking*. New York: Ballantine Books.

Fiore, M. C., Jaén C.R., Baker T.B., et al. *Treating Tobacco Use and Dependence: 2008 Update.* Clinical practice guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

Fiore, M. C., Croyle, R. T., Curry, S. J., Cutler, C. M., Davis, R. M., Gordon, C., et al. (2004). Preventing 3 million premature deaths and helping 5 million smokers quit: A national action plan for tobacco cessation. *American Journal of Public Health, 94,* 205–210.

Fiore, M. C., Pierce, J. P., Remington, P. L., & Fiore, B. J. (1990). Cigarette smoking: The clinician's role in cessation, prevention, and public health. *Disease-a-Month, 36,* 181–242.

Fisher, E. B., Jr., Lichtenstein, E., & Haire-Joshu, D. (1993). Multiple determinants of tobacco use and cessation. In C. T. Orleans & J. D. Slade (Eds.), *Nicotine addiction: Principles and management* (pp. 59–88). New York: Oxford University Press.

Ford, C. L., & Zlabek, J. A. (2005). Nicotine replacement therapy and cardiovascular disease. *Mayo Clinic Proceedings, 80,* 652–656.

France, E. K., Glasgow, R. E., & Marcus, A. C. (2001). Smoking cessation interventions among hospitalized patients: What have we learned? *Preventive Medicine, 32,* 376–388.

Ghosh, S., Shukla, H. S., Mohapatra, S. C., & Shukla, P. K. (1996). Keeping chewing tobacco in the cheek pouch overnight (night quid) increases risk of cheek carcinoma. *European Journal of Surgical Oncology, 22,* 359–360.

Goldstein, M. G., Niaura, R., Willey-Lessne, C., DePue, J., Eaton, C., Rakowski, W., et al. (1997). Physicians counseling smokers. A population-based survey of patients' perception of healthcare provider-delivered smoking cessation interventions. *Archives of Internal Medicine, 157,* 1313–1319.

Gonzales, D., Rennard, S. I., Nides, M., Oncken, C., Azoulay, S., Billing, C. B., et al. (2006). Varenicline, an alpha4beta2 nicotinic acetylcholine receptor partial agonist, vs sustained-release bupropion and placebo for smoking cessation. *Journal of the American Medical Association, 296,* 47–55.

Gonsalves, W. C., Chi, A. C., & Neville, B. W. (2007). Common oral lesions: Part II. Masses and neoplasia. *American Family Physician, 75,* 509–512.

Gourlay, S. G., Stead, L. F., & Benowitz, N. L. (2004). Clonidine for smoking cessation. *Cochrane Database of Systematic Reviews,* Issue 3. Art. No.: CD000058. DOI:10.1002/14651858.CD000058.pub2.

Griffin-Pierce, Trudy. (1995). *The encyclopedia of Native America.* New York: Viking.

Haire-Joshu, D., Glasgow, R. E., & Tibbs, T. L. (1999). Smoking and diabetes. *Diabetes Care, 22,* 1887–1898.

Hatsukami, D. K., Jensen, J., Boyle, R., Grillo, M., & Bliss, R. (1999). Characteristics of smokeless tobacco users seeking treatment. *Addictive Behaviors, 24,* 551–557.

Hatsukami, D. K., & Severson, H. H. (1999). Oral spit tobacco: Addiction, prevention, and treatment. *Nicotine & Tobacco Research, 1,* 21–44.

Heatherton, T. F., Kozlowski, L. T., Frecker, R. C., & Fagerström, K. O. (1991). The Fagerström test for nicotine dependence: A revision of the Fagerström Tolerance Questionnaire. *British Journal of Addiction, 86,* 1119–1127.

Heatherton, T. F., Kozlowski, L. T., Frecker, R. C., Rickert, W., & Robinson, J. (1989). Measuring the heaviness of smoking: Using self-reported time to the first cigarette of the day and number of cigarettes smoked per day. *British Journal of Addiction, 84,* 791–799.

Heim, S. W., Strayer, S. M., Nadkarni, M., & Turner, B. (2004, June 4). *Modular lifestyle intervention tool: A handheld tool to assist clinicians in providing patient tailored counseling at the point of care.* Slide presentation by the University of Virginia Health System at the Robert Wood Johnson Foundation Prescription for Health site visit, Virginia.

Hendrix, L. R. (2006). *Health and health care for American Indian and Alaska Native elders.* Retrieved June 10, 2006 from Stanford University Geriatric Education Center web site: www.stanford.edu/group/ethnoger/americanindian.html

Henningfield, J. E., Cohen, C., & Pickworth, W. B. (1993). Psychopharmacology of nicotine. In C. T. Orleans & J. D. Slade (Eds.), *Nicotine addiction: Principles and management* (pp. 24–45). New York: Oxford University Press.

Hoffmann, D., Harley, N. H., Fisenne, I., Adams, J. D., & Brunnemann, K. D. (1986). Carcinogenic agents in snuff. *Journal of the National Cancer Institute, 76,* 435–437.

Hollis, J. F., Bills, R., Whitlock, E., Stevens, V., & Lichtenstein, E. (1999). *Implementing tobacco interventions in real-world managed care settings.* Presentation at the 2nd Annual Conference Addressing Tobacco in Managed Care, San Diego, CA.

Hotham, E. D., Gilbert, A. L., & Atkinson, E. R. (2005). Case studies of three pregnant smokers and their use of nicotine replacement therapy. *Midwifery, 21,* 224–232.

Hughes, J. R. (1994). Nicotine withdrawal, dependence, and abuse. In *Diagnostic and statistical manual of mental disorders* (4th ed., pp. 109–116). Washington, DC: American Psychiatric Association.

Hughes, J.R., Stead, L. F., & Lancaster T. (2007). Antidepressants for smoking cessation. *Cochrane Database of Systematic Reviews,* Issue 1. Art. No.: CD000031. DOI: 10.1002/14651858.CD000031.pub3.

Indian Health Service. (2005). *FY 2005, 2006, 2007 GPRA measures.* Unpublished report.

Inter Tribal Council of Arizona, Inc. Community Tobacco Education and Prevention Program. (n.d.) *Tradition Not Addiction.* [Poster].

Jorenby, D. E., Leischow, S. J., Nides, M. A., Rennard, S. I., Johnston, J. A., Hughes, A. R., et al. (1999). A controlled trial of sustained-release bupropion, a nicotine patch, or both for smoking cessation. *New England Journal of Medicine, 340,* 685–691.

Kalman, D., Morissette, S.B., & George, T.P. (2005). Co-Morbidity of Smoking in Patients with Psychiatric and Substance Use Disorders. *American Journal of Addictions.14*(2), 106-123.

Kant A.K., Graubard B.I., Schatzkin A. (2004). Dietary patterns predict mortality in a national cohort: The national health interview surveys, 1987 and 1992. *Journal of Nutrition (J Nutr) 134:*1793-1799.

Lande B, Andersen LF, Baerug A, Trygg KU, Lund-Larsen K, Veierod MB & Bjorneboe GE (2003) Infant feeding practices and associated factors in the first six months of life: the Norwegian infant nutrition survey. *Acta Paediatr 92,* 152–161.

Leiby, R. (2009, April 29). Cigarettes go smokeless. Washington Post. Retrieved May 16, 2009 from http://www.washingtonpost.com

Leischow, S. J., & Cook, G. (1998). Nicotine and non-nicotine formulations for smoking cessation. In S.P. Arneric & J. D. Brioni (Eds.), Neuronal nicotinic receptors: *Pharmacology and therapeutic opportunities* (pp. 323–335). New York: Wiley-Liss.

Little, S. J., Stevens, V. J., LaChance, P.A., Severson, H. H., Bartley, M. H., Lichtenstein, E., et al. (1992). Smokeless tobacco habits and oral mucosal lesions in dental patients. *Journal of Public Health Dentistry, 52,* 269–276.

Lumley, J., Oliver, S. S., Chamberlain, C., & Oakley, L. (2004). Interventions for promoting smoking cessation during pregnancy. *Cochrane Database of Systematic Reviews,* Issue 4. Art. No.: CD001055. DOI: 10.1002/14651858.CD001055.pub2.

Manley, M., Epps, R. P., Husten, C., Glynn, T., & Shopland, D. (1991). Clinical interventions in tobacco control. A National Cancer Institute training program for physicians. *Journal of the American Medical Association, 266,* 3172–3173.

McAfee, T., Wilson, J., Dacey, S., Sofian, N., Curry, S., & Wagener, B. (1995). Awakening the sleeping giant: Mainstreaming efforts to decrease tobacco use in an HMO. *HMO Practice / HMO Group, 9,* 138–143.

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: *Preparing people to change addictive behavior.* New York: Guilford Press.

Mirbod, S. M., & Ahing, S. I. (2000). Tobacco-associated lesions of the oral cavity: Part I. Nonmalignant lesions. *Journal of the Canadian Dental Association, 66,* 252–256.

Mitchell, B. E., Sobel, H. L., & Alexander, M. H. (1999). The adverse health effects of tobacco and tobacco-related products. *Primary Care: Clinics in Office Practice, 26,* 463–498.

Mokdad, A.H., Marks, J.S., Stroup, D.F. & Gerberding, J.L. (2004). Actual causes of death in the United States, 2000. *Journal of the American Medical Association, 291,* 1238-1245.

Morasco, Benjamin J., Dornelas, Ellen A., Fischer, Edward H., Oncken , Cheryl & Lando, Harry A. (2006). Spontaneous smoking cessation during pregnancy among ethnic minority women: A preliminary investigation. *Addictive Behaviors, 31*(2) 203-210).

Morton, D.J., Garrett, M., Reid, J., and Wingard, D.L. (2008). Current smoking and type 2 diabetes among patients in selected Indian Health Service clinics, 1998-2003. *American Journal of Public Health,98,*560-565.

National Cancer Institute. (1993). *Why do you smoke?* (National Institutes of Health Publication 94-1822). Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health.

National Cancer Institute. (1998). *Smoking and tobacco control monograph no. 9: Cigars: Health effects and trends* (National Cancer Institute Monograph, National Institutes of Health Publication 97-4213). Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service.

National Institutes of Health. (2006). *Detecting oral cancer: A guide for health care professionals.* [Poster]. Bethesda, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research.

Niaura, R., & Abrams, D. B. (2002). Smoking cessation: Progress, priorities, and prospectus. *Journal of Consulting and Clinical Psychology, 70,* 494–509.

Offenbacher, S., & Weathers, D. R. (1985). Effects of smokeless tobacco on the periodontal, mucosal and caries status of adolescent males. *Journal of Oral Pathology, 14,* 169–181.

Peate, W. F. (2003). *Listening with your heart: Lessons from Native America.* Tucson, AZ: Rio Nuevo Publishers.

Persson, P. G., Carlsson, S., Svanström, L., Ostenson, C. G., Efendic, S., & Grill, V. (2000). Cigarette smoking, oral moist snuff use and glucose intolerance. *Journal of Internal Medicine, 248,* 103–110.

Physicians' desk reference. (2005). Montvale, NJ: Thomson Healthcare.

Physicians' desk reference. (2007). Montvale, NJ: Thomson Healthcare.

Pomerleau, O. F., & Pomerleau, C. S. (1984). Neuroregulators and the reinforcement of smoking: Towards a biobehavioral explanation. *Neuroscience and Biobehavioral Reviews, 8,* 503–513.

Preston, Alan (1991). Cigarette Smoking-Nutritional Implications, *Progress in Food and Nutrition Science, 15,* 183-7.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51,* 390–395.

Prochaska, J. O., Redding, C. A., & Evers, K. E. (2002). The transtheoretical model and stages of change. In K. Glanz, B. K. Rimer, & F. M. Lewis (Eds.), *Health behavior and health education* (3rd ed., pp. 99–120). San Francisco, CA: Jossey-Bass.

Punnoose, S., & Belgamwar, M. R. (2006). Nicotine for schizophrenia. *Cochrane Database of Systematic Reviews,* Issue 1. Art. No.: CD004838. DOI: 10.1002/14651858.CD004838.pub2.

Rankin, K. V., Jones, D. L., Basler, G. L., & Moore, B. T. (2006). *100% pure facts.* Retrieved, date unknown, from Texas Cancer Council, Dental Oncology Education Program web site: www.doep.org/Truth%20I.1%20for%20pdf.pdf

Ranney, L., Melvin, C., Lux, L, McClain, E., Morgan, L, Lohr, K. (2006). *Tobacco Use: Prevention, Cessation, and Control.* Evidence Report/Technology Assessment, Number 140. Prepared for Healthcare Research and Quality, U.S. Department of Health and Human Services, Publication No. 06-E015.

Renner, C. C., Enoch, C., Patten, C. A., Ebbert, J. O., Hurt, R. D., Moyer, T. P., et al. (2005). Iqmik: A form of smokeless tobacco used among Alaska natives. *American Journal of Health Behavior, 29*(6), 588-594.

Robinson, M. D., Laurent, S. L., & Little, J. M. (1995). Including smoking status as a new vital sign: It works! *Journal of Family Practice,* 40, 556–563.

Saccho, K. A., Termine, A., Seyal, A., Dudas, M. M., Vessicchio, J. C., Krishnan-Sarin, S., et al. (2005). Effects of cigarette smoking on spatial working memory and attentional deficits in schizophrenia: Involvement of nicotinic receptor mechanisms. *Archives of General Psychiatry, 62,* 649–659.

Salazar, G., Albala, C., Yanez, M., Seronferre, M., & Vio, F. (1995). Smoking effects on prolactin at the end of pregnancy. *Nutrition Research, 15,* 1599–1604.

Schneider, N.G., Koury, M.A., and Cortner, C., et al. (2006) Preferences among four combination nicotine treatments. *Psychopharmacology* (Berl). 187: 476-85. (PubMed)

Severson, H. H., & Hatsukami, D. (1999). Smokeless tobacco cessation. *Primary Care: Clinics in Office Practice, 26,* 529–551.

Shalala, D. E. (1997, November). *Prevention of teen smoking.* Testimony presented before the House Committee on Commerce, Washington, DC. Retrieved April 12, 2007, from the U.S. Dept. of Health and Human Services web site: www.hhs.gov/asl/testify/t971113a.html

Shraim, M., Parsons, A. C., Aveyard, P. N., & Hajek, P. (2006). Interventions for preventing weight gain after smoking cessation (protocol). *Cochrane Database of Systematic Reviews,* Issue 4. Art. No.: CD006219. DOI: 10.1002/14651858.CD006219.pub2.

Silverman, S., Jr. (1990). Etiology and predisposing factors. In S. Silverman, Jr. (Ed.), *Oral cancer* (4th ed., pp. 7–30). Atlanta, GA: American Cancer Society.

Soloff, L.A., Salazar, Z., Beita, O., Feng, C., Strayer, L.J., Sechrest, L. (2008). Promotores contra el tabaco en la frontera: eLearning Applications for culturally competent tobacco dependence treatment. *Hispanic Health Care International, 6*(3), 131-135.

Spangler, J. G., & Salisbury, P. L., III. (1995). Smokeless tobacco: Epidemiology, health effects and cessation strategies. *American Family Physician, 52,* 1421–1434.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings.* (NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.

Substance Abuse and Mental Health Service Administration, Office of Applied Statistics. (2008). *Results from the 2007 National Survey on Drug Use and Health: Detailed Tables.* (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

Sweeney, C.T.., Fant, R.V., and Fagerström, K.O., et al. (2001) Combination nicotine replacement therapy for smoking cessation: rationale, efficacy and tolerability. *CNS Drugs.* 15: 453-67. (PubMed)

Talwar, A., Jain, M., & Vijayan, V. K. (2004). Pharmacotherapy of tobacco dependence. *Medical Clinics of North America, 88,* 1517–1534.

Targher, G., Alberiche, M., Zenere, M. B., Bonadonna, R. C., Muggeo, M., & Bonora, E. (1997). Cigarette smoking and insulin resistance in patients with noninsulin-dependent diabetes mellitus. *The Journal of Clinical Endocrinology & Metabolism, 82,* 3619–3624.

Theobald, M., & Jaén, C. R. (2006). An update on tobacco cessation reimbursement [Electronic version]. *Family Practice Management, 13,* 75–78. Retrieved April 16, 2007, from www.aafp.org/online/en/home/publications/journals/fpm.html

Tobacco Free Nurses. (2005). *Helping smokers quit: A guide for nurses.* [Brochure]. Washington, DC: U.S. Government Printing Office.

Tomar, S. L., & Winn, D. M. (1999). Chewing tobacco use and dental caries among U.S. men. *Journal of the American Dental Association, 130,* 1601–1610.

University of Michigan Health System. (1998). *Smoking cessation.* Ann Arbor, MI: Author.

Up To Date Online, Inc. http://www.utdol.com

U.S. Census Bureau, Population Division. (2009). Table 3: Annual estimates of the resident population by sex, race, and Hispanic origin for the United States: April 1, 2000 to July 1, 2008 (NC-EST2008-03). Washington DC.

U.S. Department of Health and Human Services. (1986). *The health consequences of using smokeless tobacco: A report of the Advisory Committee to the Surgeon General* (NIH Publication No. 86-2874). Bethesda, MD: Author.

U.S. Department of Health and Human Services. (1988). *The health consequences of smoking: Nicotine addiction: A report of the Surgeon General* (DHHS Publication No. [CDC] 88-8406). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (1993). *Spit tobacco and youth: Additional analysis* (DHHS Publication No. OEI-06-92-00501). Washington, DC: Office of Inspector General.

U.S. Department of Health and Human Services. (2000). *Tobacco effects in the mouth* (NIH Publication No. 00-3330). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2001). *Women and smoking: A report of the Surgeon General.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

U.S. Department of Health and Human Services. (2004). *The health consequences of smoking: A report of the Surgeon General.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

U.S. Department of Health and Human Services. (2006). *The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General.* Atlanta, GA: U.S. Department of Heath and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

US Department of the Interior, Bureau of Indian Affairs. (2009). Available from: http://www.doi.gov/bia/index.html. Accessed May, 2009

Volkow, N. D. (2006). Map of human genome opens new opportunities for drug abuse research. *National Institute on Drug Abuse [NIDA]* Notes, 20(4), 3.

Wachaca, M., & Lamer, C. (2006). *Documentation of tobacco screening and cessation intervention.* [Brochure]. Cherokee, NC: Indian Health Service.

Wakefield, M., Roberts, L., & Rosenfeld, E. (1998). Prospects for smoking cessation among people with insulin-dependent diabetes. *Patient Education and Counseling, 34,* 257–266.

Westman, E. C. (1995). Does smokeless tobacco cause hypertension? *Southern Medical Journal, 88,* 716–720.

Whitlock, E. P., Orleans, C. T., Pender, N., & Allan, J. (2002). Evaluating primary care behavioral counseling interventions: An evidence-based approach. *American Journal of Preventive Medicine, 22,* 267–284.

Williams, J. M., & Ziedonis, D. (2004). Addressing tobacco among individuals with a mental illness or an addiction. *Addictive Behaviors, 29,* 1067–1083.

Williams, L. F., Wierzbowski, W., & Preucel, R. W. (Eds.). (2005). *Native American voices on identity, art, and culture: Objects of everlasting esteem.* Philadelphia: University of Pennsylvania Museum of Archeology and Anthropology.

Winn, D. M. (1997). Epidemiology of cancer and other systemic effects associated with the use of smokeless tobacco. *Advances in Dental Research, 11,* 313–321.

Winn, D. M., Blot, W. J., Shy, C. M., Pickle, L. W., Toledo, A., & Fraumeni, J. F. (1981). Snuff dipping and oral cancer among women in the Southern United States. *New England Journal of Medicine, 304,* 745–749.

Ziedonis, D. M., & Williams, J. M. (2003). Management of smoking in people with psychiatric disorders. *Current Opinion in Psychiatry, 16,* 305–315.

Ziedonis, D.., et al. (2008). Tobacco Use & Cessation in Psychiatric Disorders: National Institute of Mental Health Report. *Nicotine & Tobacco Research,* 1-25.

Indian Health Service Tobacco Control Task Force
U.S. Department of Health and Human Services

Indian Health Service Tobacco Control Task Force
U.S. Department of Health and Human Services