

KEEP IT SACRED



National Native Network
Technical Assistance Webinar

Lung Cancer Screening in Indian Country



Presented by:
Kris Rhodes, MPH
Chief Executive Officer
American Indian Cancer Foundation

- BAS, University of Minnesota Duluth, Community Health Education, 1992
- MPH, University of Minnesota School of Public Health Minneapolis, Public Health Administration & Policy, 2000

Lung Cancer Screening in Indian Country



Kristine Rhodes is an enrolled citizen of the Bad River Band of Lake Superior Chippewa and a Fon du Lac Reservation community member where she was born and raised. She earned a Master's of Public Health degree in Public Health Administration & Policy and a Bachelor's of Science degree in Community Health Education both from the University of Minnesota. She has worked on improving the health of American Indian health communities for the past two decades. Her work has included the development and evaluation of many tribal and urban tobacco control efforts. From 2000-2010 she coordinated multiple research projects with the American Indian Community Tobacco Projects at the University of Minnesota. She is currently the Executive Director of the American Indian Cancer Foundation an American Indian directed non-profit organization based in Minneapolis, MN.

Lung Cancer Screening in Indian Country



Presented by:

Abbie Begnaud, MD

Assistant Professor of Medicine

University of Minnesota

- MD, Louisiana State University Health Sciences Center in Shreveport, Louisiana, Medicine, 2006
- BS, University of Miami in Coral Gables, FL, Psychobiology, 2002

Lung Cancer Screening in Indian Country



Dr. Abbie Begnaud is a pulmonologist with an interest in lung cancer. She has completed specialty training in advanced diagnostic and therapeutic procedures pertaining to malignant disease of the chest. Dr. Begnaud joined the University of Minnesota faculty in August 2013. She collaborated to launch the University of Minnesota Health Lung Cancer Screening Program and continues to oversee all its activities. This program is recognized as a Center of Excellence by the Lung Cancer Alliance and meets recommendations of the National Comprehensive Cancer Network for lung cancer screening.

Lung Cancer Screening in Indian Country



Presented by:
Cynthia Langhorne
Lung Cancer Program Director
Caring Ambassadors Program

Lung Cancer Screening in Indian Country



Cindy Langhorne joined the Caring Ambassadors Program, Inc. in August of 2007 as the Lung Cancer Program Director. Ms. Langhorne brings over eighteen years of programmatic and managerial experience in the field of lung cancer advocacy and has been with public and private community stakeholders. Ms. Langhorne's compassion for lung cancer patients and their families and her dedication to improving the burdens of lung cancer one life at a time are extraordinary. Ms. Langhorne is a well-respected local, regional, and national advocate for lung cancer and issues that affect those living with or at risk for the disease. Ms. Langhorne is the Co-Chair of the Lung Cancer Action Network (LungCAN[®]) which is a collaborative group of 20 lung cancer advocacy organizations that have come together to raise public awareness about the realities of lung cancer.

Lung Cancer Screening in Indian Country



Presented by:
Patrick Roberts
Health Policy Fellow
National Native American AIDS Prevention
Center

Lung Cancer Screening in Indian Country



Patrick Roberts is a Native American of Hopi descent and functions as the Health Policy Fellow with the National Native American AIDS Prevention Center (NNAAPC) and Caring Ambassadors. Patrick has lived in the San Francisco Bay Area and has worked in the biotechnology industry and the university setting for over 25 years. He has previous experience advocating health needs in order to facilitate care of underserved populations through Kaiser Permanente San Francisco, Genentech, Inc., the University of California San Francisco (UCSF), and Acerta Pharma. As a Native American, Patrick felt he had to use his spiritual connection to aid in the assistance of HIV/AIDS and Hepatitis C communities and started donating his personal time by volunteering his service to local HIV/AIDS and LGBT organizations.

In 2016, Patrick returned to Denver, CO to apply his professional talents toward hepatitis C community outreach strategies to help improve the health and wellbeing and American Indian and Alaska Natives.

Faculty Disclosure Statement

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Faculty Disclosure Statement

- Funding for this webinar was made possible by the Centers for Disease Control and Prevention DP13-1314 Consortium of National Networks to Impact Populations Experiencing Tobacco-Related and Cancer Health Disparities grant. Webinar contents do not necessarily represent the official views of the Centers for Disease Control and Prevention.
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Accreditation

The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The IHS Clinical Support Center designates this live activity for 1 hour of *AMA PRA Category 1 Credit™* for each hour of participation. Physicians should claim only the credit commensurate with the extent of their participation in the activity. .

The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is designated 1.0 contact hour for nurses.

CE Evaluation and Certificate

- Continuing Education guidelines require that the attendance of all who participate be properly documented.
- To obtain a certificate of continuing education, you must be registered for the course, participate in the webinar in its entirety and submit a completed post-webinar survey.
- The post-webinar survey will be emailed to you after the completion of the course.
- Certificates will be mailed to participants within four weeks by the Indian Health Service Clinical Support Center.

Learning Objectives

By the end of this webinar, participants will be able to:

1. Examine the American Indian lung cancer burden
2. Utilize current and updated guidelines to appropriately screen for lung cancer in AI/AN patients
3. Identify evidence-based resources and effective strategies to reduce the burden of lung cancer



American Indian
Cancer Foundation®

Lung Cancer Screening in Indian Country

Presented with our partners at:

NNN, UMN, NNAAPC, Caring Ambassadors





American Indian
Cancer Foundation®

WEBINAR OVERVIEW

- Cancer Burdens in Indian Country & Tobacco Ways
 - Kris Rhodes, American Indian Cancer Foundation
- Lung Cancer Screening Guidelines
 - Dr. Abbie Begnaud, University of MN
- Cultural Context for Cessation
 - Patrick Roberts, National Native American AIDS Prevention Center
- Lung Cancer Screening Resources
 - Cindy Langhorn, Caring Ambassadors

The AICAF Story

American Indian Cancer Foundation (AICAF) is a national non-profit established to address tremendous cancer inequities faced by American Indian and Alaska Natives.



Mission:

To eliminate cancer burdens on American Indian families through education and improved access to prevention, early detection, treatment and survivor support.

Respect & Honor Cultural Teachings



We believe...

Native communities have the wisdom and the solutions to cancer inequities, but are often seeking the organizational capacity, expert input and resources to do so.

American Indian Mortality Data



In American Indian and Alaska Native communities across the United States, cancer is the...

**#1 Cause of Death
for Women**

-  #2 Heart Disease
-  #3 Unintentional Injury

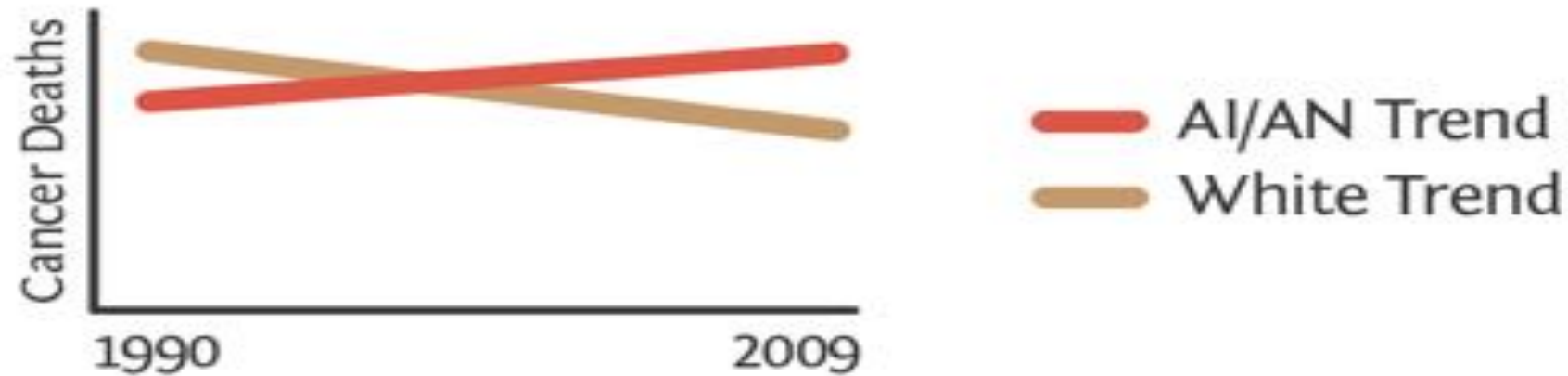
**#2 Cause of Death
for Men**

-  #1 Heart Disease
-  #3 Unintentional Injury

Source Data: White MC, Espey DK, Swan J, Wiggins CL, Ehemann C, Kaur J. *Disparities in Cancer Mortality and Incidence Among American Indians and Alaska Natives in the United States*. AJPH: June 2014, Vol. 104, No. S3: S377-S387.

American Indian Cancer Data

Cancer death rates for AI/AN increased over a 20 year span, while decreasing for Whites over the same time frame.



Source Data: White MC, Espey DK, Swan J, Wiggins CL, Ehemann C, Kaur J. *Disparities in Cancer Mortality and Incidence Among American Indians and Alaska Natives in the United States*. *AJPH*: June 2014, Vol. 104, No. S3: S377-S387.

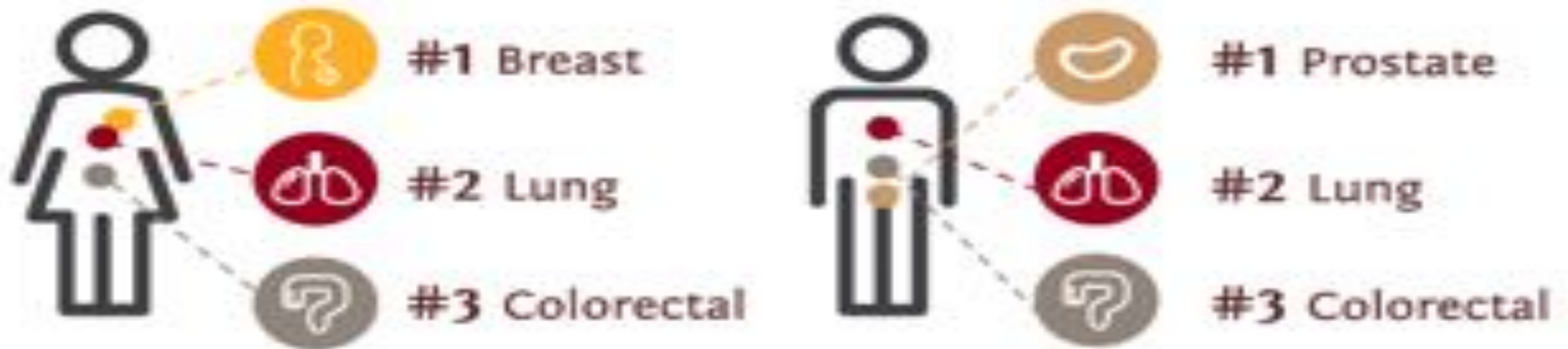
Distinct patterns in AI/AN cancer rates are observed across six geographic regions defined by the Indian Health Service.



Source Data: White MC, Espey DK, Swan J, Wiggins CL, Ehemann C, Kaur J. *Disparities in Cancer Mortality and Incidence Among American Indians and Alaska Natives in the United States*. *AJPH*: June 2014, Vol. 104, No. S3: S377–S387.

American Indian Cancer Data

The most commonly diagnosed cancers are...



Source Data: White MC, Espey DK, Swan J, Wiggins CL, Ehemann C, Kaur J. *Disparities in Cancer Mortality and Incidence Among American Indians and Alaska Natives in the United States*. *AJPH*: June 2014, Vol. 104, No. S3: S377-S387.

American Indian Cancer Data



Lung cancer is the leading cause of cancer death for men and women.

Other leading causes of cancer death are...



Prostate



Colorectal



Breast



Source Data: White MC, Espey DK, Swan J, Wiggins CL, Ehemann C, Kaur J. *Disparities in Cancer Mortality and Incidence Among American Indians and Alaska Natives in the United States*. *AJPH*: June 2014, Vol. 104, No. S3: S377-S387.

What Are The Leading Causes?



- Cigarette smoking and chewing tobacco
- Cigarette smoke exposure
- Radon exposure

Community & System Level Barriers

- Underfunded urban and tribal health care systems
- Lack of accurate population specific data
- High rates of poverty
- Poor access to health care due to low rates of health insurance
- Lack of culturally competent health care providers
- Limited availability of prevention programs, cancer screening and specialist care, especially in rural areas
- Unique historical trauma

Significant Challenges

Social Determinants

- Poverty
- Trauma
- Politics
- Inattention/Neglect
- Racism
- Inequity

Outcomes

- Health Disparities
- Education Inequality
- Generational Poverty
- Ongoing Racism
- Worsening Inequity
- Suffering and Death

How do we effectively address these complex issues?

Tribal resources for health equity?

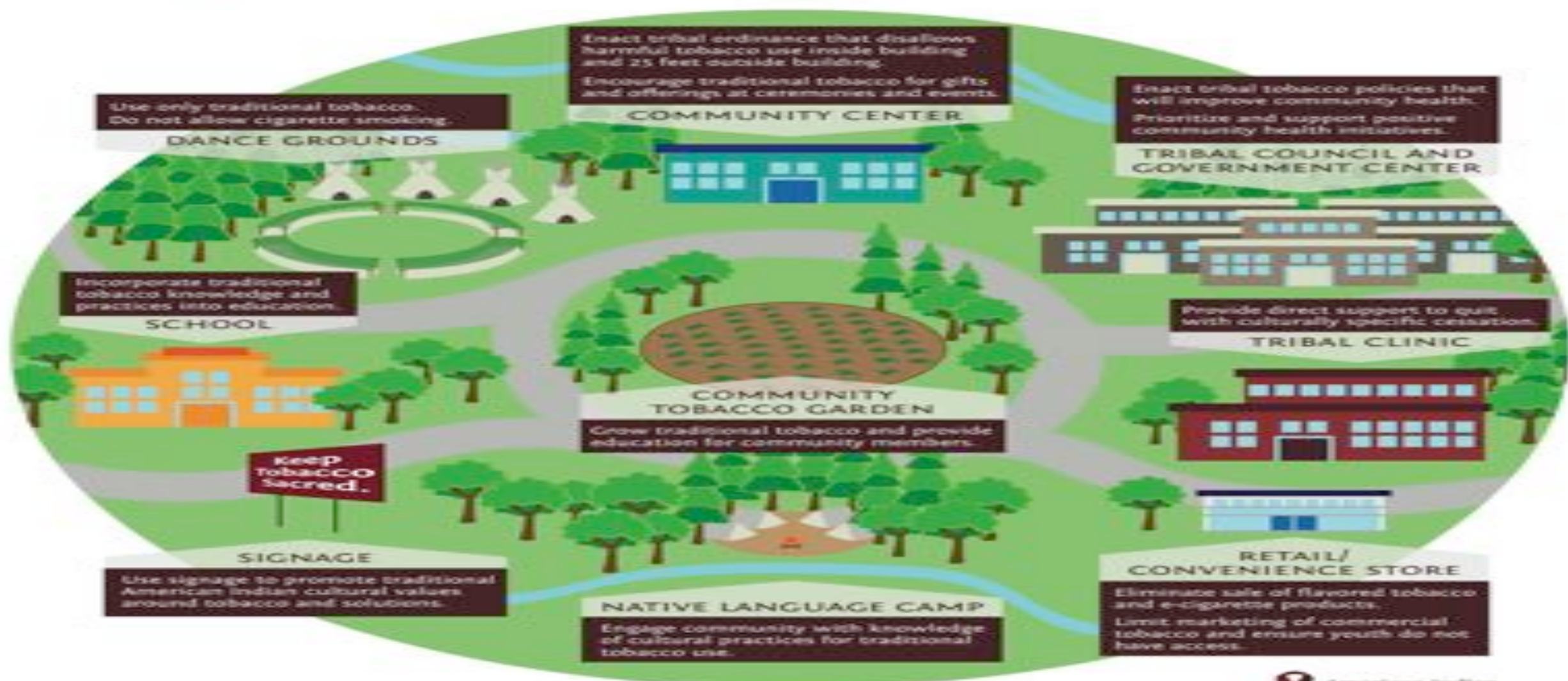


- Traditional teachings
- The voice of the community
- Tribal sovereignty
- Apply health in all policies framework to decision-making

SACRED TRADITIONAL TOBACCO FOR HEALTHY NATIVE COMMUNITIES

A BALANCED COMMUNITY FOR HEALTH

- ▶ Tribal leadership support & engagement
- ▶ Cultural connectedness & healing
- ▶ Community engagement
- ▶ Youth leadership & youth-led advocacy





American Indian
Cancer Foundation®

Tobacco in Indian Country



Smoking is a public health crisis for American Indian people

- Rates of current smoking among AI in MN (59% in 2012) exceed highest ever US smoking rates (42% in 1965)
- Smoking is linked to almost all health indicators and closely tied to leading causes of morbidity and mortality.
- *We must keep it in context:*
 - Trauma. Both historical and current
 - Stresses: racism, poverty, other systemic inequities, cultural separation
 - Historical repression of culture, extermination



Tribal Tobacco Teachings



“When it is used correctly, it has the power to bring good things and, like other medicines, if it is not used correctly, it has the power to bring harm.” Anishinabe Elder

What does tobacco mean to you?

- Traditional uses of tobacco
 - Spiritual
 - Medicinal
- Uses
 - Not always burned
 - Burned **but not inhaled**

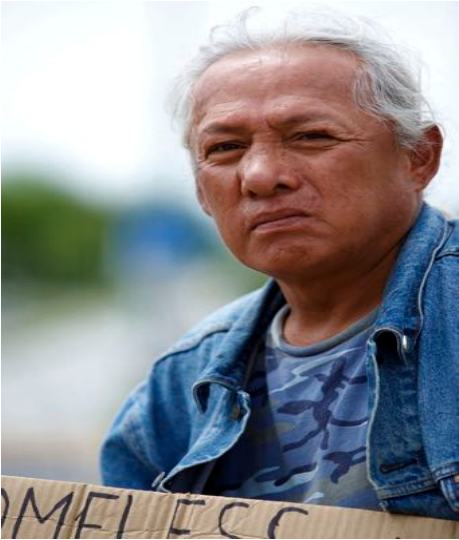


What is in your tobacco?

- Commercial tobacco is tobacco you buy in the store.
 - Loose tobacco
 - Cigarettes
- Traditional tobacco is usually not bought in the store.
 - Indian tobacco
 - Mixture that may not contain any tobacco



Why are AI tobacco issues so complex?



- Lack of religious freedom until 1978
- Cultural norms → commercial tobacco use in cultural practices and ceremonies
- Historical trauma → current issues and trauma
- Boarding schools → loss of culture
- Tribal economic issues → sales and casinos
- Cultural identity → imagery on tobacco products
- Social norms → more people smoke than don't



Take Away on American Indian Tobacco

- Protect and promote traditional tobacco use.
- Traditional tobacco use is not addictive tobacco use.
- Tobacco addiction is a symptom of many root causes.
- Tribes are sovereign nations and therefore state tobacco policy does not apply.
- Comprehensive tobacco control looks different in tribal communities.

Lung Cancer Screening Update

Abbie Begnaud, MD

Assistant Professor of Medicine

M Health Lung Cancer Screening Program Leader

Disclosure

- I am a paid consultant for Covidien (Medtronic)
- I will not discuss off label drug use

LUNG CANCER IS SCARY BUT THERE IS HOPE!

Objectives

1. Decide whom to screen – eligibility and shared decision making
2. Determine how to screen – Epic tools and ordering provider requirements
3. Manage screening results – nodule and incidental finding guidelines

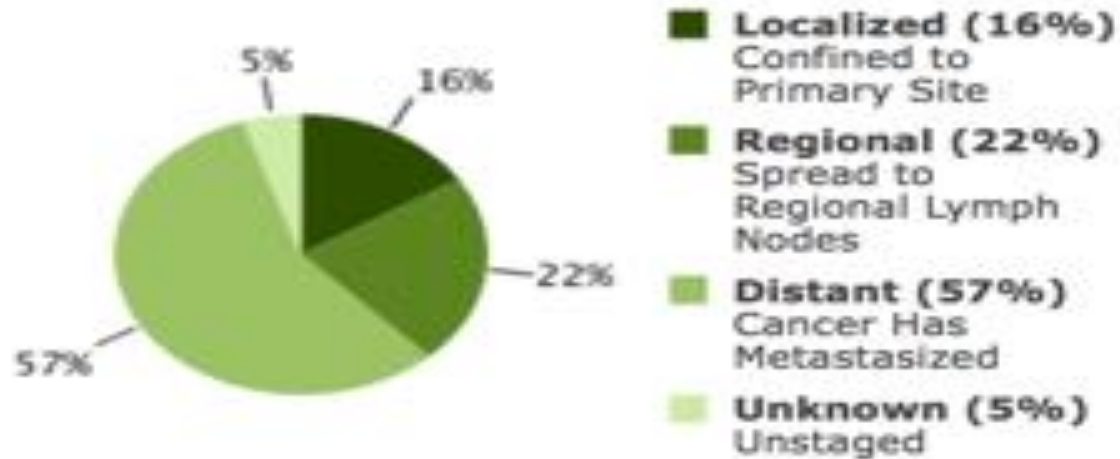
Evidence and Rationale for Lung Cancer Screening

DECIDING TO SCREEN

Stage at Diagnosis and Survival

Percent of Cases & 5-Year Relative Survival by Stage at Diagnosis: Lung and Bronchus Cancer

Percent of Cases by Stage



5-Year Relative Survival

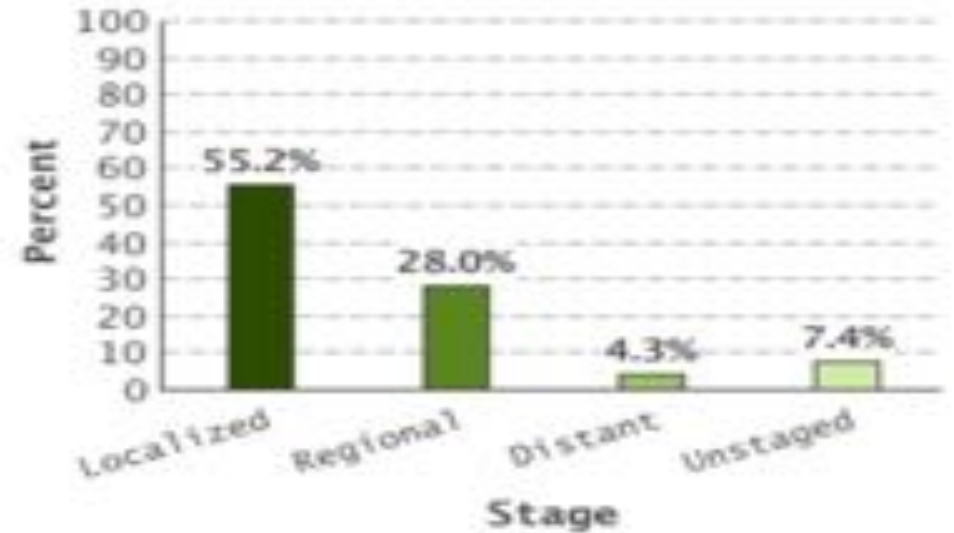
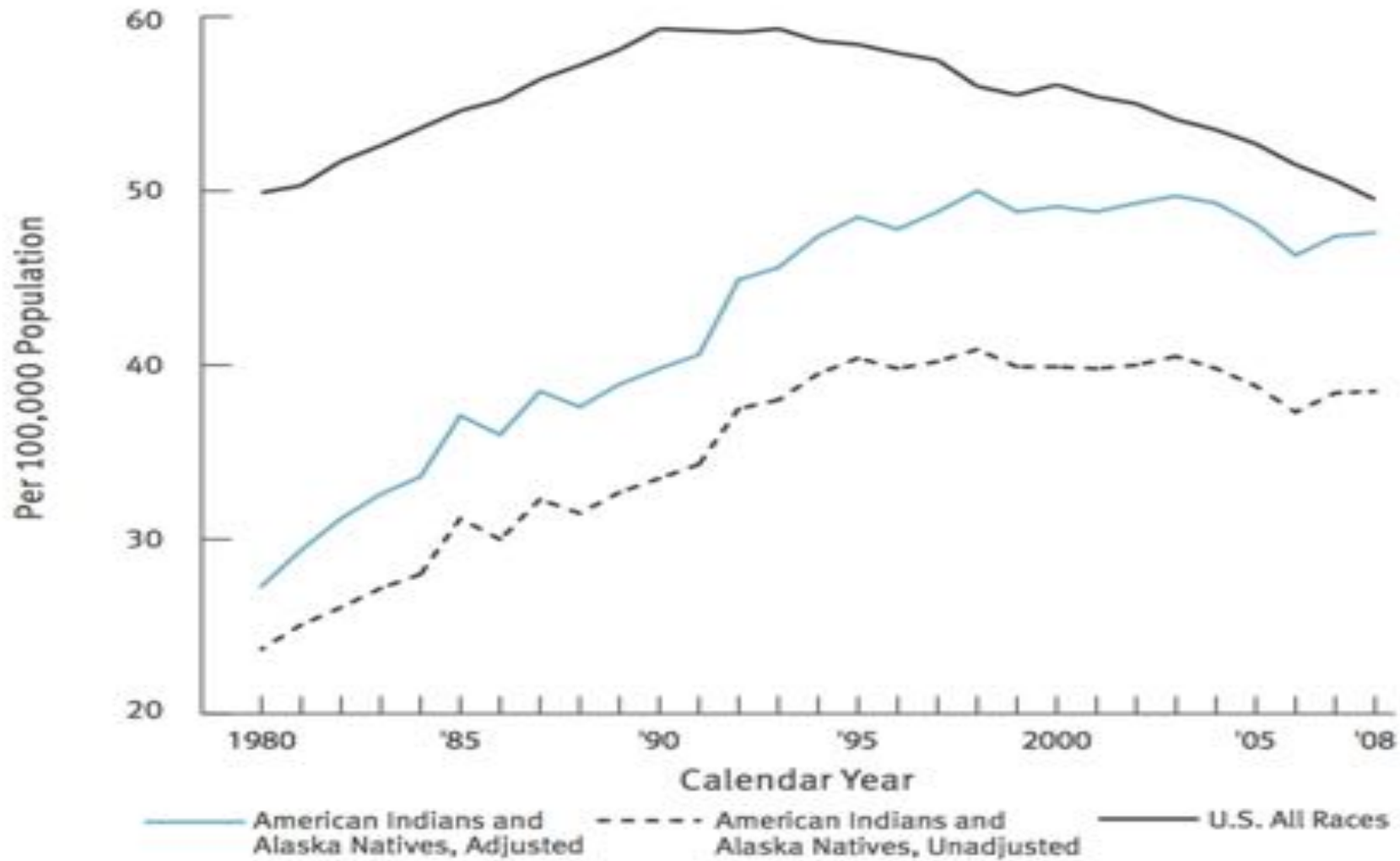


Chart 4.33

Age-Adjusted Lung Cancer Death Rates



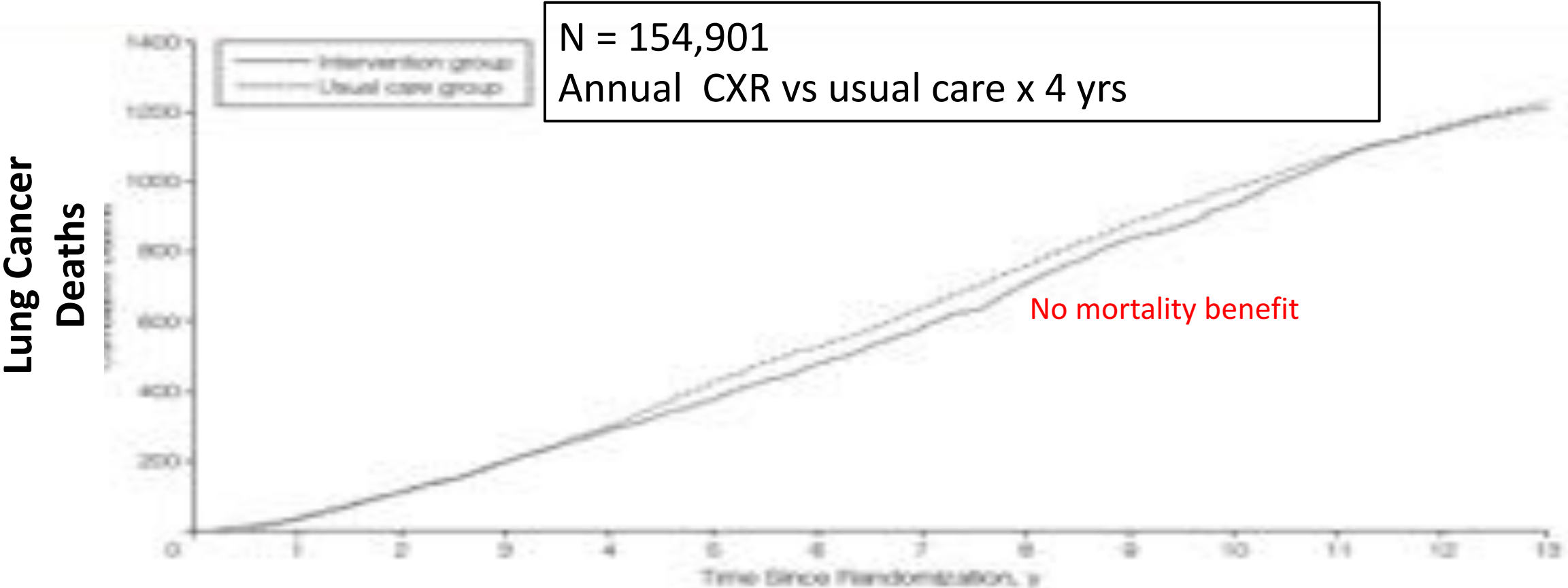
Overall Survival



Percent Surviving
5 Years

17.7%

Lung Cancer Screening with CXRs



Oken MM, et al (PLCO RCT), JAMA 2011;306:1865

But There is HOPE

- Multiple new treatments approved
- Newer treatments targeted to specific type of lung cancer, less toxic
- With early detection, we can shift the survival curve

National Lung Cancer Screening Trial (NLST)

- RCT, N > 53,000
- Ages 55 - 75 yr, ≥ 30 pack-yrs, quit < 15 yr ago
- Low-dose CT vs CXR annually x 3 yr, f/u 6 yrs
- Reduced lung cancer deaths
 - relative risk reduction: 20%
 - absolute risk reduction: 1.7% -> 1.4% (i.e., 0.3%)
- Reduced all-cause mortality (6.7% RRR)

Number Needed to Screen

Cancer Screening	NNTS to Prevent One Death from Specific Cancer
Lung CT	320
Breast (age 50-59, 60-69)	1339, 377
Colon (flex sig)	871

Cost per Quality Adjusted Life Year

Cancer Screening	Cost per QUALY (\$K)
Low Dose Chest CT ¹	81 K
Mammography ²	27-83 K
Colonoscopy at age 50 and 60 ³	62 K

1. Black WC, NEJM 2014;371:1793
2. Pataky R, J Cancer Policy 2014;2:97
3. Vijan S, Am J Med 2001;111:593

US Preventive Services Task Force

Annual Lung Cancer Screening with Low Dose CT for

- Age 55 - **80** yrs
- ≥ 30 pk-yr, and current smoker *or* quit the past 15 yrs
- Stop if
 - quit smoking >15 yrs
 - health problem that “substantially limits life expectancy or ability or willingness to have **curative lung surgery**”

B recommendation: The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

Benefits and Harms Experienced by People Ages 55–74 Who Were Screened for Lung Cancer With Low-Dose CT Scans Once a Year for 3 Years as Compared to Those Who Were Not Screened*

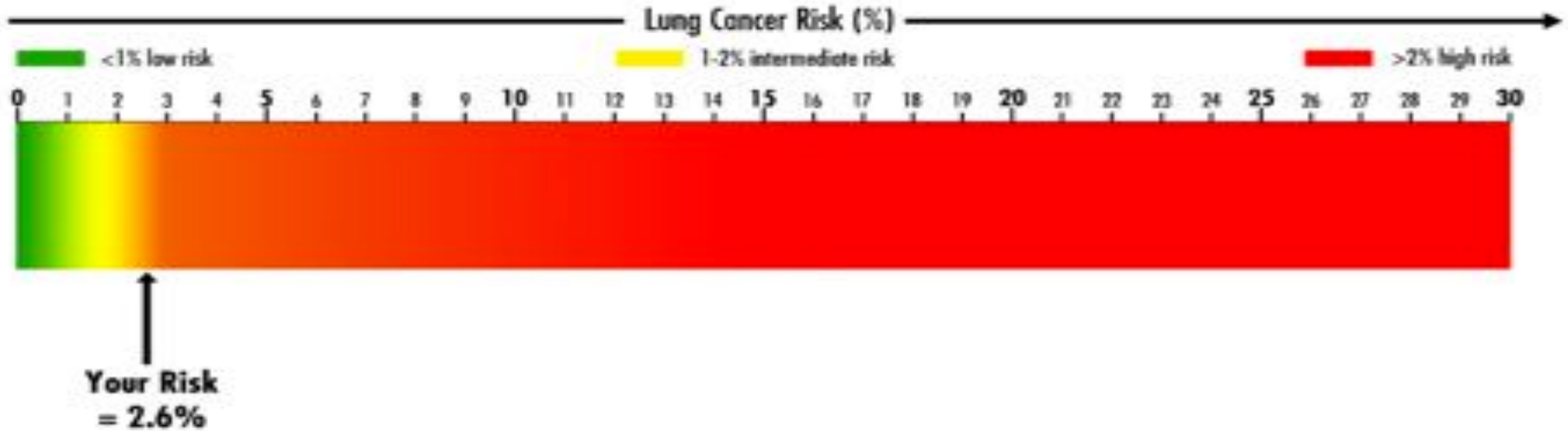


*The benefits and harms were measured after an average of 6.5 years.

The information in this graph was obtained from Patient and Physician Guide National Lung Screening Trial (NLST). See <http://www.cdc.gov/nchs/nlst/patphysguide>.

Not everyone places the same amount of value on these benefits and harms. Think about how you value the benefits and harms described in this picture.

Individual Risk Calculation



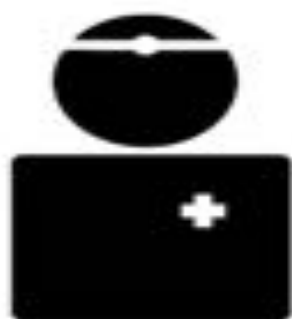
Compared to other people like you, there will be 5 fewer deaths out of 1000 in the next 6 years if you get screened.

Freely available web-based calculator. <http://www.shouldiscreen.com>

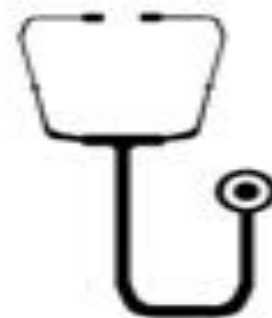
Accessed January 18 2016

Lung Cancer Screening

SHOULD I DO IT?



Given your age and smoking history, you are **not eligible** for screening according to the US Preventive Services Task Force criteria.



The chance of you developing lung cancer in the next 6 years is too low to be accurately measured. Talk to your doctor about screening if you are concerned about your risk for lung cancer as s/he will understand your situation best.

Lung Cancer Screening Decision Aids

- University of Michigan
 - <http://www.shouldiscreen.com>
- Memorial Sloan Kettering
 - <https://www.mskcc.org/cancer-care/types/lung/screening/lung-screening-decision-tool>
- American Thoracic Society
 - <https://www.thoracic.org/patients/patient-resources/resources/decision-aid-lcs.pdf>
- Lung Cancer Alliance
 - <http://www.lungcanceralliance.org/am-i-at-risk/what-do-i-need-to-know-about-risk/should-i-be-screened-for-lung-cancer.html>
- National Cancer Institute
 - <http://www.cancer.gov/types/lung/patient/lung-screening-pdq>
- Centers for Disease Control and Prevention
 - http://www.cdc.gov/cancer/lung/basic_info/screening.htm

Essential Elements of a Shared Decision Making Visit for Lung Cancer Screening

- Determination of beneficiary eligibility
- Discussion about:
 - Benefits and harms of screening
 - Follow-up diagnostic testing
 - Over-diagnosis
 - False positive rate
 - Total radiation exposure
- Decision aids utilized to promote decision support
- Counseling about:
 - Importance of cigarette smoking abstinence
 - Annual adherence; lung cancer screening is not a one time scan
 - Impact of comorbidities and ability or willingness to undergo diagnosis and treatment if something concerning is found

Before and after the CT screening exam

SCREENING IS A PROCESS

Shared Decision Making

LDCT screening exam

Smoking
Cessation

LungRADS/nodule
findings

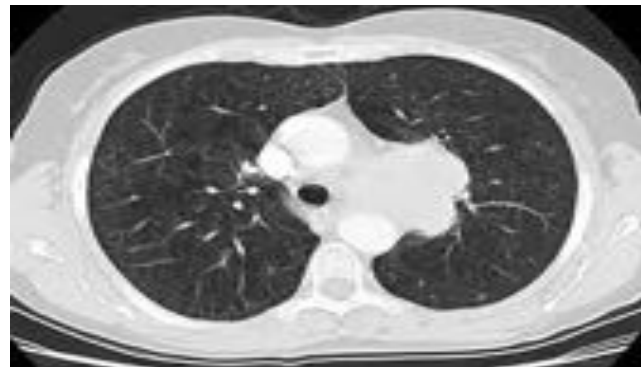
Incidental Findings

Culturally-specific
5 As

Shared decision making and screening CT order

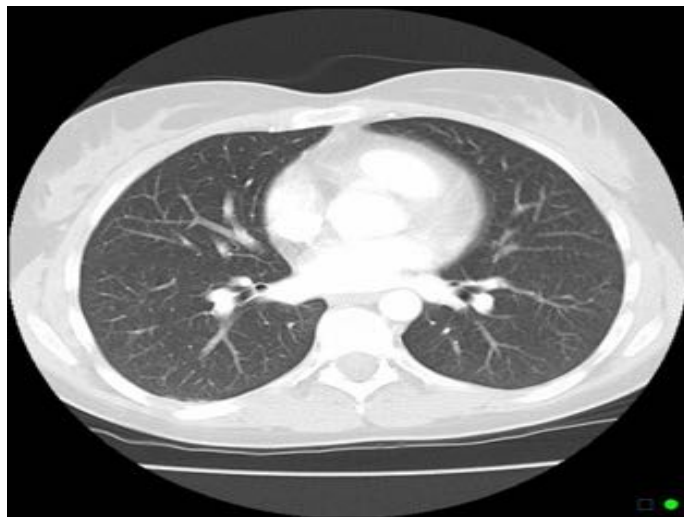


Low-dose CT scan

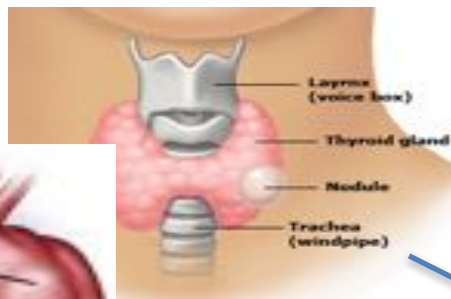


Suspicious mass LungRADS 4B

Normal CT – LungRADS 1



Incidental Findings



Additional testing may be indicated – ultrasound, MRI, etc.

Return to Annual Screening

Lung-RADS™ Initial LCS CT

Category	Description	Solid Nodules	Part Solid Nodules	Ground Glass Nodules	Management
0 Incomplete	Inadequate				Obtain additional CT images.
1 Negative	No nodules or definitely benign nodules.	None -OR- Nodule(s) w/specific calcifications: complete, central, popcorn, concentric rings. -OR- Fat containing nodules.			Continue annual screening with LDCT in 12 months.
2 Benign Appearance or Behavior	Nodules with a very low likelihood of becoming a clinically active cancer due to size.	< 6 mm	< 6 mm	< 20 mm	Continue annual screening with LDCT in 12 months.
3 Probably Benign	nodules w/ low likelihood of becoming a clinically active CA	≥ 6 to < 8 mm	≥ 6 mm total diameter w/ solid component < 6 mm	≥ 20 mm	6 month LDCT
4A Suspicious	Findings for which additional dx testing and/or tissue sampling recommended	≥ 8 to < 15 mm -OR- Endobronchial nodule	≥ 6 mm w/ solid component ≥ 6 to < 8 mm		3 month LDCT; PET/CT may be used if ≥ 8 mm solid component
4B Suspicious		≥ 15 mm	solid component ≥ 8 mm		
4X Suspicious	Category 3 or 4 nodules with additional features or imaging findings that increases the suspicion of malignancy	Features such as spiculation or enlarged lymph nodes			Chest CT, PET/CT and/or tissue sampling depending on probability* of CA & comorbidities. Consider PET/CT if ≥ 8 mm solid component.

Managing Incidental Findings

- Common (7.5% NLST)
- Will be deferred to ordering provider
- Not all have consensus guidelines
- Prior imaging must be reviewed
- Assess symptoms, risk factors

Consensus Guidelines

- Aortic aneurysm
- Visceral nodules
 - Liver, kidney, adrenal, thyroid

No Consensus Guidelines

- Coronary artery calcification
- Lymphadenopathy
- Interstitial lung abnormalities

Managing Incidental Findings – Visceral Masses

- Thyroid nodules
 - Best evaluated with ultrasound, if > 1.0-1.5cm
 - Increasing prevalence in older adults, malignancy rare
 - FNA often indeterminate leading to unnecessary surgery
- Adrenal masses
 - Consider biochemical evaluation (obesity, HTN, diabetes)
 - Smooth, low density < 4cm can be evaluated with subsequent LDCT
 - More dense than 10 HU, larger than 4 cm should be evaluated with adrenal protocol CT or MRI
- Liver
 - Smooth, low (< 20 HU) density requires no further workup in low risk person
 - Size > 1.5 cm, suspicious features requires MRI or contrast CT
- Kidney
 - Low (< 20) or high (> 70) density homogeneous lesions need no further eval
 - Size > 1 cm, irregular or intermediate density should have ultrasound, contrast CT or MRI

Managing Incidental Findings – Vascular Findings

- Aortic enlargement
 - No need for more definitive imaging
 - After initially noted, 6 month → annual surveillance
 - Surgical evaluation for thoracic aortic aneurysm, chronic dissection or pseudoaneurysm; growth > 0.5 cm/year or diameter > 5.5 cm of ascending aorta.
- Coronary artery calcification
 - Current guidelines do not suggest treatment of asymptomatic CAC in the absence of other risk factors such as diabetes.
 - In persons at intermediate risk (1-2%/year) for cardiovascular events, CAC may be useful to distinguish their need for aggressive risk modification

Managing Incidental Findings – Adenopathy

- Isolated mediastinal adenopathy rarely clinically relevant – no further eval recommended
- Cervical and axillary are more commonly seen in infections but in this population, may raise concern for head and neck/breast cancers
 - Consider follow up using non-ionizing radiation and core needle or excisional biopsy if persistent

Billing and Payment Guidelines

PAYING FOR SCREENING

Payment Guidelines

- IHS – Purchased Referred Care
- Private Pay Insurance – USPSTF Dec 2013
 - Covered for eligible persons annually
- Medicaid/Medicare – CMS memo Feb 2015
 - Covered for eligible persons annually
 - Face to face shared decision making required
 - Must be performed in approved imaging center

Payment Guidelines

- IHS – Purchased Referred Care
- Private Pay Insurance – USPSTF Dec 2013
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Payment Guidelines

- IHS – Purchased Referred Care
 - Level II Acute Primary and Preventive Care
- Private Pay Insurance – USPSTF Dec 2013
 - Covered for eligible persons annually
- Medicaid/Medicare – CMS memo Feb 2015
 - Covered for eligible persons annually
 - Face to face shared decision making required
 - Must be performed in approved imaging center

Billing Guidance – Medicare

- No patient co-pay(s) or deductible(s)- waived
- No telephone visits; must be face-to-face
- Counseling G0296 code must be “ordered”
- ICD-10 codes limited (Z87.891, F17.2)
- Cannot be billed with E&M without other indications or separate rationale
 - Use modifier -25 for separately identifiable E/M

National Native American AIDS Prevention Center



PATRICK ROBERTS

HEALTH POLICY FELLOW PARTNERED WITH

CINDY LANGHORNE

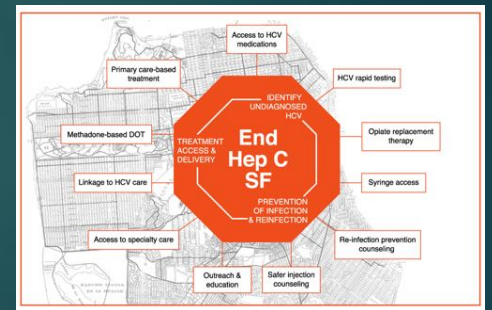
CARING AMBASSADORS PROGRAM

www.nnaapc.org

www.nnaapc-hcv.org



NNAAPC Advocacy Efforts Community Partnership



Indian Leadership for Indian Health

Lung Cancer Rates

A recent tribal tobacco use survey found that 59 percent of Minnesota's native people smoke. Nearly 3,000 people completed the questionnaire, making it the largest tobacco survey ever conducted among American Indians in Minnesota.

Lorna Benson, MPRNews



Photo Credit: Jennifer Simonson/MPR News

Lung Cancer



Leading Causes

- Cigarette smoking / tobacco chewing
- 2nd hand cigarette smoke exposure
- Radon exposure
- Low screening rates



Smoking Cessation

Tobacco Traditions

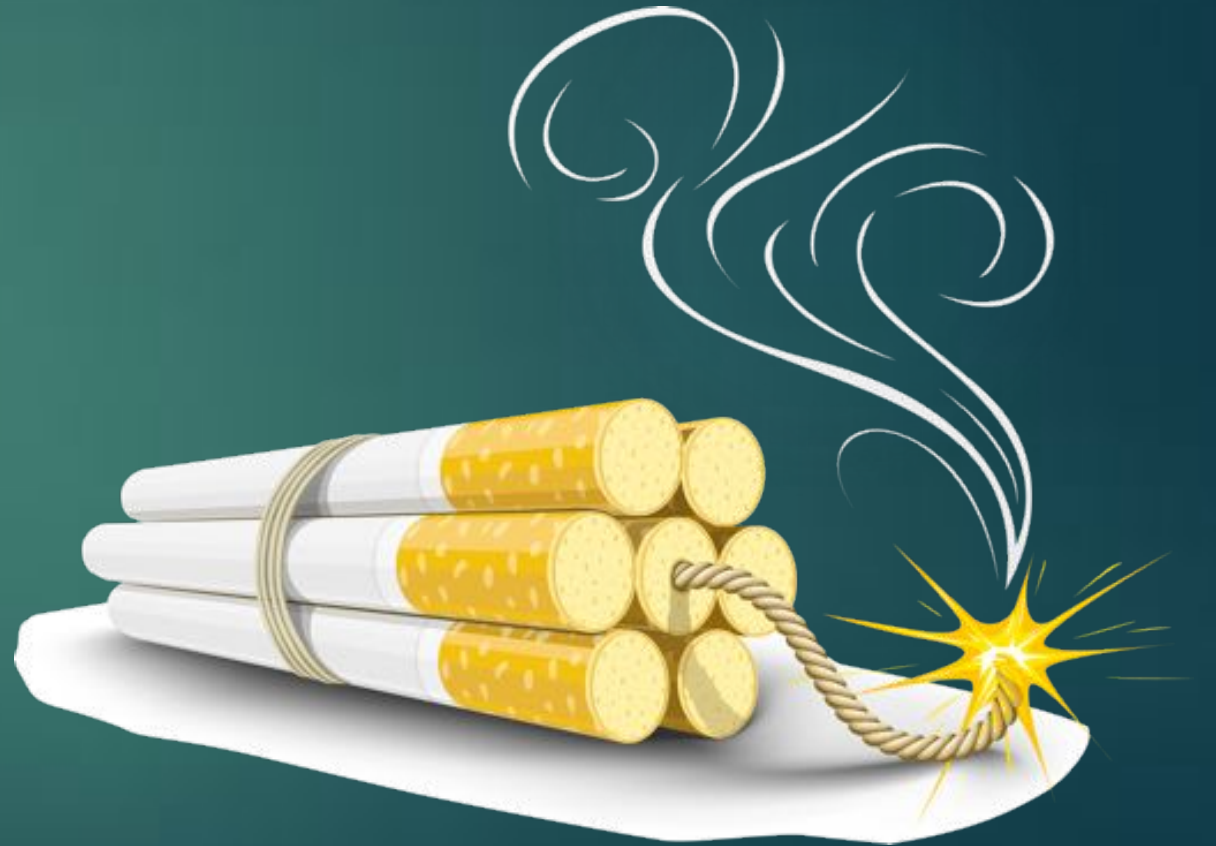
Within Our Native Communities,
Traditional Uses of Tobacco

- Gods gift to our people
- Offering sign of respect
- Prayer and in song
- Medicine



Smoking Cessation

WHY
QUIT?



Smoking Cessation

24 people
minute

Someone is
told they have
lung cancer



Smoking Cessation

70%

Of
Smokers
Want to
Quit

41% of smokers have
tried to quit for at
least one day in the
past year

Smoking Cessation

7,000
harmful
ingredients

ONE of
which is...
NICOTINE

Cigarettes contain tobacco and up to 7,000 other ingredients, including many that are harmful to our health.

Smoking Cessation

Nicotine

How Does Nicotine
Affect the Brain When a
Cigarette is Smoked?

Smoking Cessation

Nicotine

- Attaches to receptors in your brain (nicotinic *acetylcholine* receptor)
- Chemicals in your body are release (*dopamine*)
- Dopamine stimulates the “reward” center in the brain

Smoking Cessation

How to Quit?

The more you smoke, the more circulating nicotine is present and attaches to the nicotinic acetylcholine receptors

When you try to quit...

- dopamine levels drop
- receptors beg for more nicotine – withdrawal

Smoking Cessation

How to Quit?

Practical approaches to quit:

- Nicotine Replacement Therapy
- Transdermal Patch
- Short Acting Nicotine Replacements
 - Gum, Inhalers, Lozenge, Nasal Sprays

Smoking Cessation

How to Quit?

**Of the current American Indian Smokers in Minnesota...
Nearly 2/3 want to Quit Smoking but don't know where to start.**

Quit Connections
your path to
commercial tobacco cessation

PATCHES, GUM OR LOZENGES
Available over the counter

- Double your chances of quitting
- Provides a small amount of nicotine to help reduce cravings

BUPROPRION (ZYBAN, WELLBUTRIN) OR VARENICLINE (CHANTIX)
Prescription only

- Reduce nicotine withdrawal symptoms and tobacco cravings
- Bupropion can be combined with a patch
- Do not contain nicotine and are not addictive

COMBINATION OPTIONS
Increase your chances of quitting

- + Bupropion = 👍
- + Gum = 👍
- + Lozenge = 👍
- + Inhaler = 👍

COUNSELING & SUPPORT

- Telephone counseling
- Internet-based Programs
- Individual or Group Counseling
- Counseling + Medication is more effective than any one method alone

NASAL SPRAY OR INHALER
Prescription only

- Reduces tobacco cravings
- Nicotine nasal spray = medication that you spray into your nostrils
- Nicotine inhaler = medication that you hold to your mouth and inhale to combat cravings

TAKE ACTION! Talk to your doctor or cessation counselor about what cessation option works best for you.

For cessation options and support, Join Quit Connections on Facebook.

American Indian Cancer Foundation.

1

Within 20 Minutes: Blood pressure & heart rate decrease

2

8-12 Hours: Carbon Monoxide drops, blood oxygen returns to normal

3

2 Weeks to 3 Months: Improved circulation & lung function

4

1-9 Months: Lungs begin to regain normal function, including ability to clean & fight infection

5

1 Year: Risk of coronary disease is cut in half

6

5-15 Years: Risk of stroke reduced to that of a normal smoker

7

10 Years: Risk of cancer reduced, risk of lung cancer cut in half

8

15 Years: Risk of coronary heart disease is similar to non-smoker

If you think you have been smoking too long and it is too late to benefit from quitting, think again. The human body begins to recover quickly.



Benefits

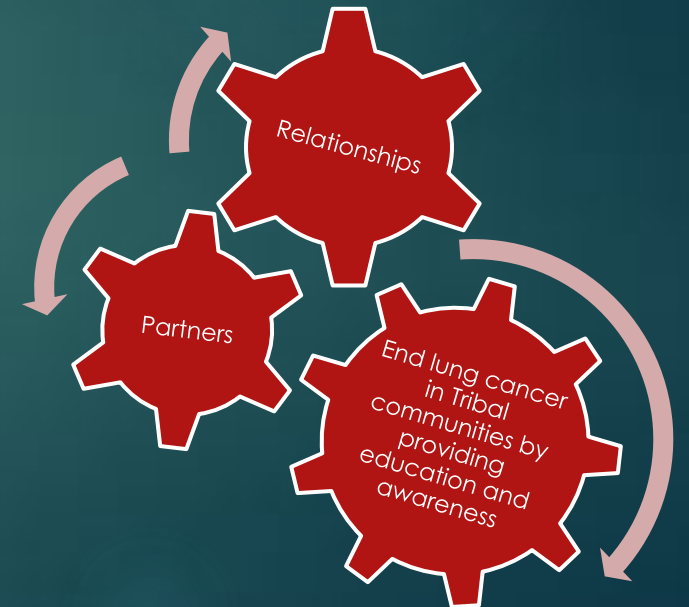
Smoking Cessation

Caring Ambassadors Lung Cancer American Indian/Alaskan Native (AI/AN) Awareness and Mobilization Program



BRING COMMUNITY PARTNERS TOGETHER TO ADDRESS

- BUILD STRATEGIC RELATIONSHIPS WITH RURAL AND URBAN TRIBAL LEADERS
- CREATE AWARENESS AROUND LUNG CANCER IN RURAL AND URBAN NATIVE COMMUNITIES
- RAISE AWARENESS ABOUT LUNG CANCER SCREENING



Caring Ambassadors Resources for Lung Cancer Patients

NOVEMBER 2016

NOVEMBER IS LUNG CANCER AWARENESS MONTH.

Caregiver CHOICES
An empowerment guide to help you navigate the journey together!

Lung Cancer CHOICES 3rd Edition
Diverse Viewpoints and Choices for Your Lung Cancer Journey

Two FREE Resources for Lung Cancer Patients and their Loved Ones!

WWW.CARINGAMBASSADORS.ORG

AICAF resources

- ▶ The American Indian Cancer Foundation has developed many culturally specific resources, including:
 - ▶ Lung cancer screening
 - ▶ Tobacco cessation
 - ▶ Traditional tobacco for health Native communities
- ▶ All resources can be found at AICAF's website: [AmericanIndianCancer.org](https://www.AmericanIndianCancer.org)

National Native Network Online

www.KeepItSacred.org



Facebook.com/KeepItSacred



Twitter.com/KeepItSacred



bit.ly/nnnlinkedin