Staff Education: Policy and Tobacco Treatment

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Education: Why the Policy

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- To create a safe and healthy environment for employees, patients and guests
- To model health behaviors or avoid tacit approval of bad behaviors by not doing anything
- To help create conditions for patients who must quit for procedures to feel supported
- Lower healthcare costs/clean up costs
- Increase productivity

Education: Why implement the policy

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- Enforcement
  - Security and supervisory staff need the help of staff to assist with enforcement
- Buy-in
  - Even most anti-smoke person may see policy as “picking on” smokers
- Institutional Pride
  - Being on the “cutting edge” of institutions

Policy Education: Attitudes to expect

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- Little push back from the majority of users
- Push back from concerned non-smokers about users ability to work with smoke-free conditions
- Push back from minority users about their loss of “rights”
- General concern about patients and families dealing with stress without the use of tobacco

Policy Education: Attitudes to expect

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- Concern or little support from physicians
  - Not to providing assistance to users but wanting to keep the happy patient
- Concern with nursing that “another job” will be forced upon them or unhappy patients
- Concern among clinical staff with intervening due to lack training in tobacco treatment
- Lack of service to assist the users who desire assistance to quit or to remain smoke-free while on property

Policy Education: Attitudes to expect

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- Security will become the smoking policy
- General concern of staff, patients, and guests smoking in bathrooms, interstitial spaces, etc.
- Expectation of explosive behavior of users denied place to smoke
- Expectation of “run away” cost for Nicotine Replacement Products (NRT) and other tobacco treatment products

Policy Education: Attitudes to expect

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- Concern about neighbors (residential areas)
- Concern about safety (city center areas)
- TJC and Type I errors

- What else?

Communication

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- Create the plan and then communicate it
- Key to this policy is communication –
  - In as many formats as possible
  - Less dependent on the electronic formats as those who need to hear this message the most may be the individuals least likely to use electronic communication
    - Trades groups, nursing, training physicians
- Important to avoid misconceptions about policy before or soon after implementing

Create Resources

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- Not only communicate why implementing the policy but expectations you have of staff
  - What do you want them to do?
  - What will you do to help them learn to do the new steps?
  - What can they depend on to offer?

Clinician Education –
For patients
For Enforcement

Clinician Training

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- PHS guidelines – If 75% of clinicians would routinely identify and assist users and achieved only a 10% long-term quit rate (6 months or more) – there would be 2 million new quitters each year
  - Some estimate quit rates of up to 30%
- 2006 data – 70% asked tobacco use status – 40% took action to assist with cessation

Clinician Training

University of Michigan Health System

- Patients who use tobacco may need time to prepare themselves before committing to stopping
- Children and youth may start to use tobacco if their abstinence is not reinforced
- Ex-users need support to stay tobacco-free
- Never-user adults need reinforcement never to start and encouragement to help others become tobacco-free

Clinician Training

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- Even when not ready to quit, patients whose PCP counseled about smoking reported being more satisfied with their care than patients whose physicians did not offer counseling
- Assisting patients in the cessation process, relapse stage, and ex-users stage is chronic disease service
- Patients in these stages require follow-up as they would for hypertension, diabetes, glaucoma, or any other chronic disease or condition

Clinician Training

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- 70% smokers say they want to quit
- 2/3 Americans see a physician at least once year
- Physicians site lack of or limited services and resources as barriers to intervening with patients
- Lack of patient motivation, limited coverage for services, and lack of reimbursement were also listed as additional challenges

Clinician Training

University of Michigan Health System

- Research has found clinicians refer more to treatment programs in areas where there is greater tobacco control programs
- Policies that guide clinician tobacco treatment roles also increase participation
- In places where tobacco use status was required, clinicians were more likely to intervene

Clinician Training

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- Clinician Training should include
  - Physicians
  - Nurses
  - NPs & Pas
  - RTs
  - Treatment team members
    - Everyone giving the same message

Keys to Improving Clinician Involvement

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- Information on resources and services for patients
- Reimbursement for treatment
- Documentation
- Availability of CMEs on tobacco treatment and behavior change
- Include tobacco treatment and behavior change curriculum in medical schools

Within the Hospital

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- Provide training opportunities for clinicians
  - Nicotine and nicotine addiction
  - Tobacco addiction
    - Physical, psychological, and social factors
  - Pharmacological interventions
    - Not just the meds but pros and cons to each med
    - Content of nicotine in tobacco products

Tobacco Addiction

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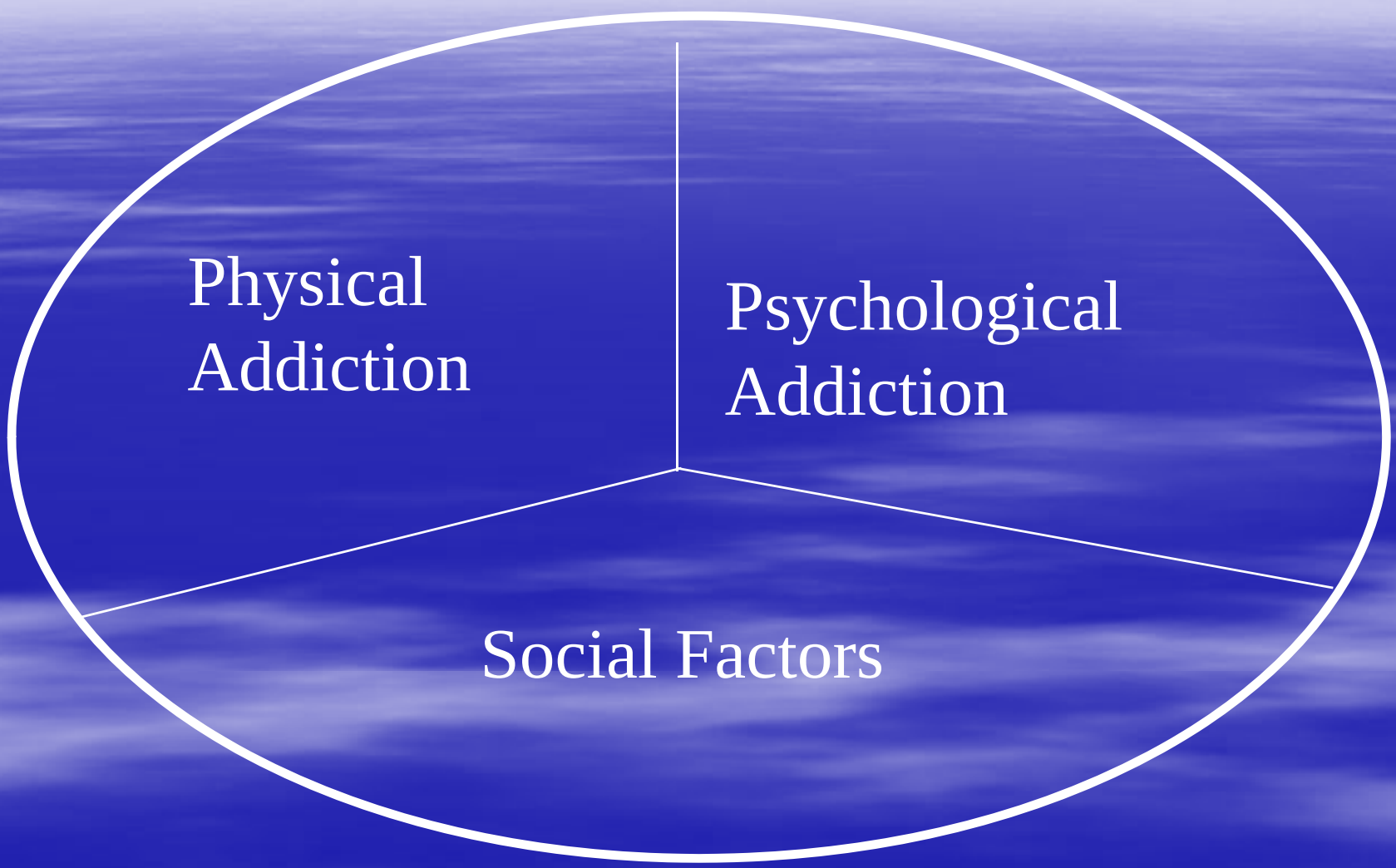

Psychological **Addiction**

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- Tobacco use is a learned behavior
- Tobacco use is a triggered behavior
- Tobacco use is an automatic behavior
- 45 - 55% smokers have underlying depressive disorder

Psychological Addiction

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Experts of a behavior -

20 cigs X 10 puffs per cig = 200 puffs/day

200 puffs X 365 days = 73,000 puffs/year

73,000 puffs/year X 20 years = 1,460,000 puffs

What have you done 1.5 million times?

Social Factors

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- Smokers know smokers
- Smoking an important part of socializing, especially at work sites
- Many smokers started smoking because of social factors as adolescents - Those reasons often continue to be present in adulthood

What is Nicotine?

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- The most common cause of drug addiction in the world
- Naturally occurring in the tobacco plant
- A colorless alkaloid that turns brown when burned
- Toxic levels 40-60mg; each cigarette delivers 1- 2mg
- Nicotine is absorbed through the mucosa, skin, and lungs

Nicotine Stimulates the release of Dopamine

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- Activates the α4β2 nicotinic receptors in the Ventral Tegmental Area (VTA)
- Dopamine is released at the Nucleus Accumbens (nAcc)
- Nicotine tolerance is related to the increased number of and desensitization of nicotine receptors in the VTA

Effects of Neurotransmitters & Hormones Released by Nicotine

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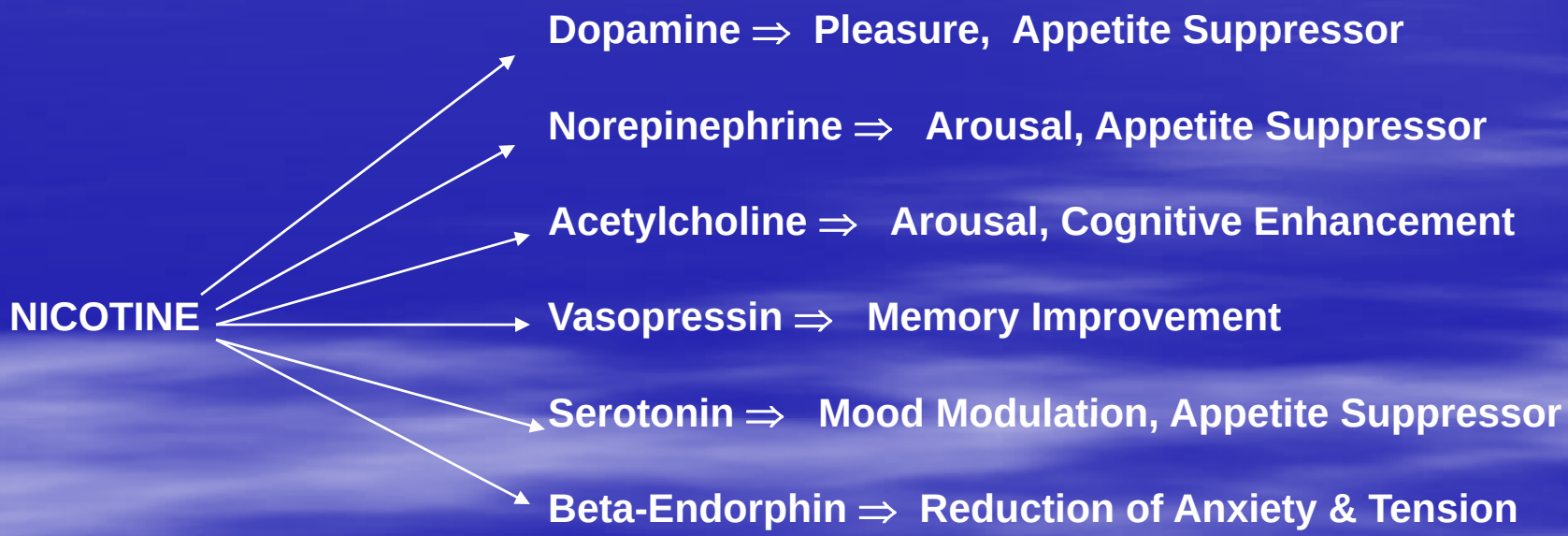

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Nicotine Metabolism

- Metabolized in liver to cotinine
- Nicotine half-life is 2 hours, cotinine is 20 hours
- Some individuals have more rapid metabolisms, leading to more cigarettes smoked per day and potentially earlier addiction as a teenager
- For example: males > females
  Caucasian > African American

Nicotine in Tobacco Products

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1 cigarette = 1 - 2mg (12 – 14 mg)

1 can spit tobacco = approx. 60 - 80mg
1 average size dip = approx. 3 - 5mg

1.5 ounce stogie = 12 - 24mg the same as a one pack cigarettes

1 Sweet and Milds = 5 – 6mg

Tobacco Cessation Aids – First line medications

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- Nicotine Gum
- Nicotine Patch
- Nicotine Spray
- Nicotine Inhaler
- Nicotine Lozenge
- Zyban (Bupropion)
- Chantix (Varenicline)

- Use of any cessation aid doubles quit rates

Clinician Training

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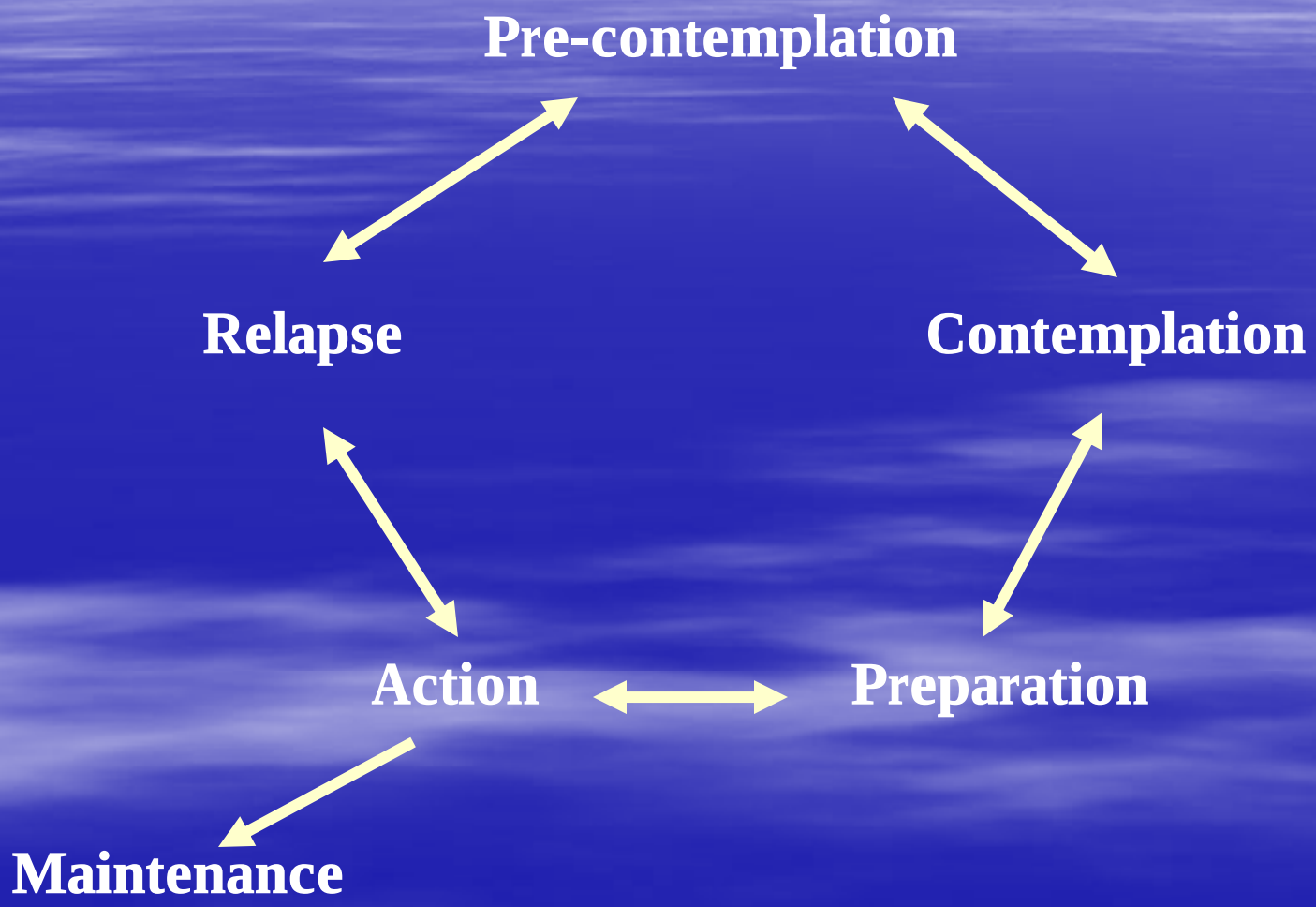
- Stages of Change Model
  - Learning to give a stage appropriate message rather than one message fits all
    - Happier patients / happier clinicians
- Brief bedside interventions
  - 5 A's – PHS Guidelines
  - MI – Confidence/Ability rules - Decisional Balance

Stages of Change Model



Within the Hospital

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- Create a expectation that tobacco treatment is part of standard care within the institution Develop resources
  - Order sets
  - Med cards
  - TTSs
  - Patient Education materials
  - Outpatient services
- Tobacco treatment medications on formulary

The Impact Training

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- Clinician confidence levels have been associated with behavior change and persistence despite obstacles

- Increased confidence post-training have led to new skills in the learner's personal value system and implementation into daily practice

Training's Objectives

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- Identify the clinician's role in tobacco prevention and cessation
- Screen for and assess tobacco use in patients
- Perform a brief intervention for tobacco cessation
- Incorporate a tobacco intervention program into the inpatient setting
- Describe resources for tobacco cessation assistance

Training's Barriers

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- Resistance to changing the role of acute care clinicians
- Lack of clinician education with cessation pharmacological aids
- Lack of accessibility to clinician training opportunities
- Lack of clinician reimbursement
- Lack of "counseling skills"
- Perception of a lack of time

Training's Desire Effect

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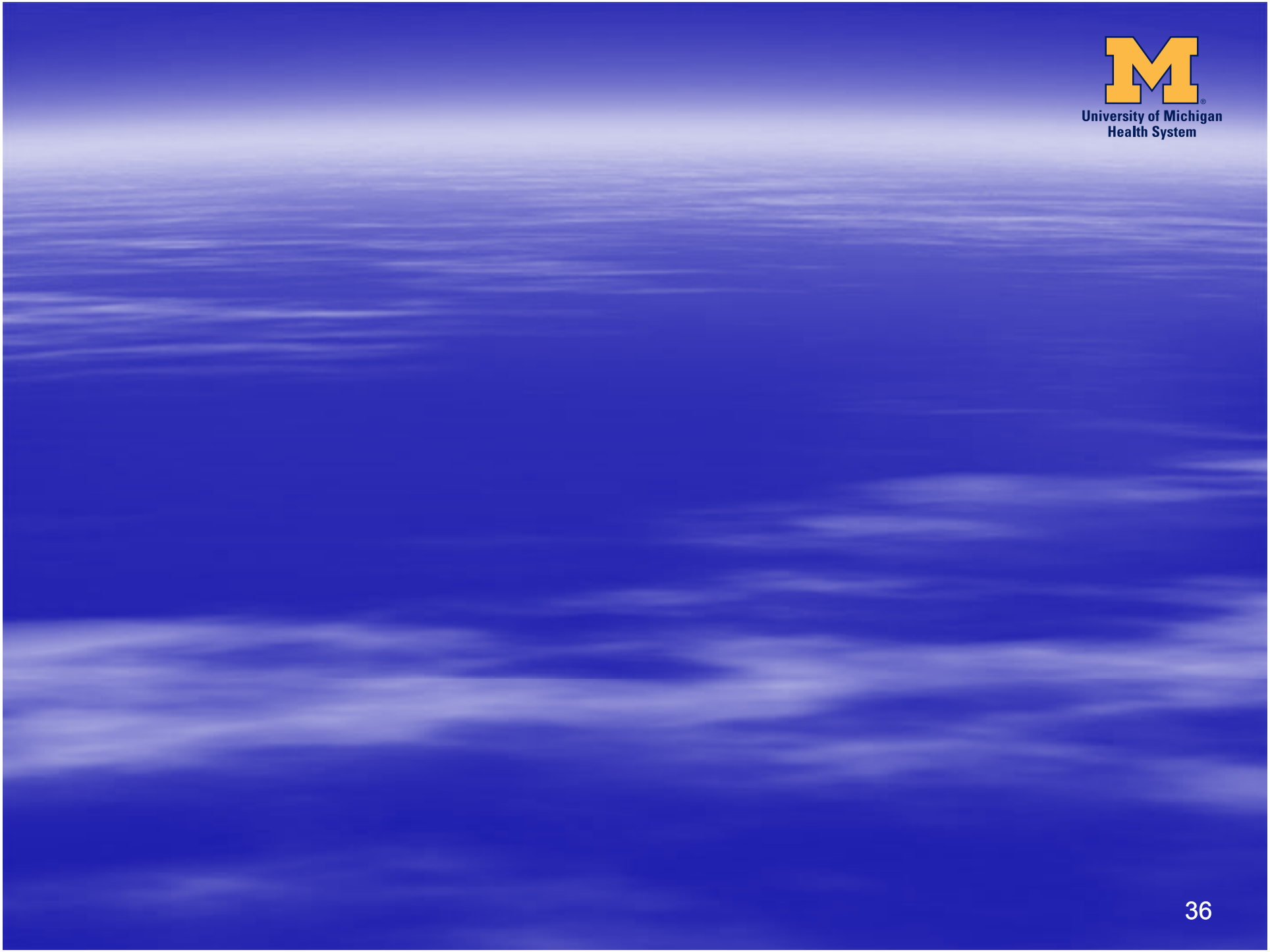
- Increased clinician activity in:
  - Identifying tobacco users
  - Discussing tobacco use
  - Advising cessation
  - Developing a quit plan
  - Prescribing tobacco cessation medications
  - Referring to intensive treatment program
  - Follow-up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