

Implementing an Effective Smoking Cessation Strategy in Medical Practice

HANDOUTS

Virginia Diabetes Council Meeting, 9/4/09

- Overview of the recommendations from the USPHS Clinical Practice Guideline, *Treating Tobacco Use and Dependence*
- Highlights of the changes in the most current revision of the USPHS Clinical Practice Guideline (2008 update)
- AHRQ Order Form (for USPHS clinician and consumer materials)
- Needs Assessment form for implementing the 5As and 5Rs
- Resources – where to find free/low-cost resources
- Drug Interactions information sheet (including insulin)
- ATTUD listserv messages re: stopping smoking & diabetes
- Medicare resources (CMS website links)
- Using an AARM approach
- Basic information about quitlines
- Overview of Quit Now Virginia quitline service
- Provider Information sheet & Fax Referral flow chart
- Quit Now Virginia materials order form
- Fax referral registration form

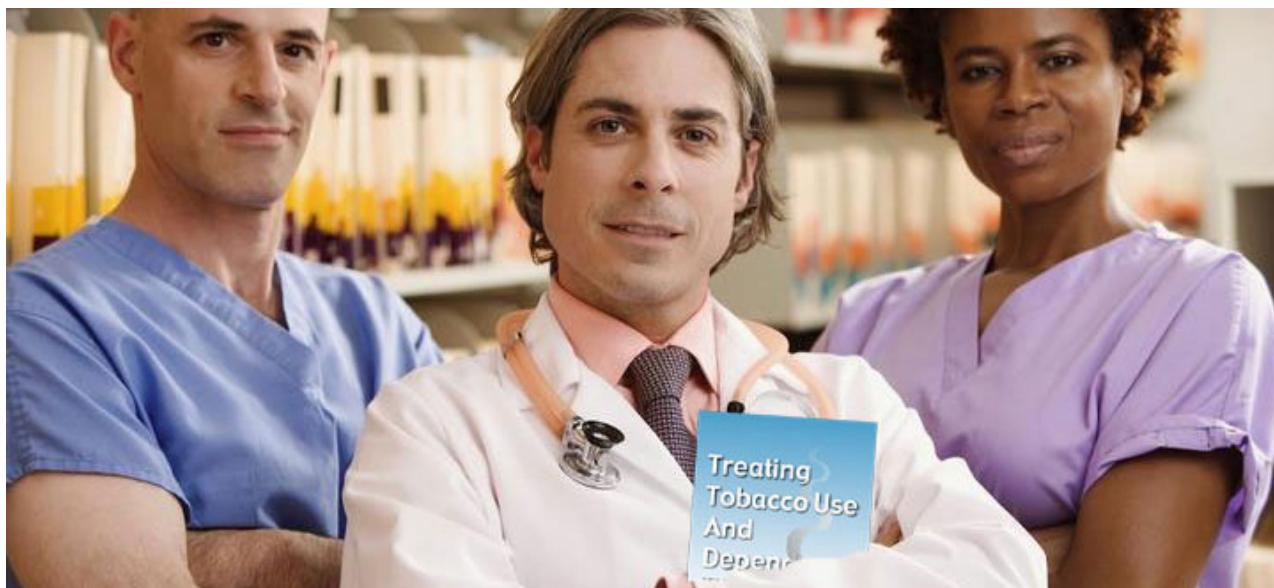
Treating Tobacco Use and Dependence: 2008 Update USPHS Clinical Practice Guideline

TEN KEY RECOMMENDATIONS

The overarching goal of these recommendations is that clinicians strongly recommend the use of effective tobacco dependence counseling and medication treatments to their patients who use tobacco, and that health systems, insurers, and purchasers assist clinicians in making such effective treatments available.

1. Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.
2. It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.
3. Tobacco dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in this Guideline.
4. Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in this Guideline.
5. Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt:
 - Practical counseling (problem-solving/skills training)
 - Social support delivered as part of treatment
6. Numerous effective medications are available for tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).
 - Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:
 - Bupropion SR
 - Nicotine gum
 - Nicotine inhaler
 - Nicotine lozenge
 - Nicotine nasal spray
 - Nicotine patch
 - Varenicline
 - Clinicians also should consider the use of certain combinations of medications identified as effective in this Guideline.
7. Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.
8. Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, both clinicians and health care delivery systems should ensure patient access to quitlines and promote quitline use.
9. If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivational treatments shown in this Guideline to be effective in increasing future quit attempts.
10. Tobacco dependence treatments are both clinically effective and highly cost-effective relative to interventions for other clinical disorders. Providing coverage for these treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans include the counseling and medication identified as effective in this Guideline as covered benefit.

What's New in the 2008 Clinical Practice Guideline: Treating Tobacco Use and Dependence



The U.S. Public Health Service has published the 2008 update to the Clinical Practice Guideline: *Treating Tobacco Use and Dependence*. Recommendations were based on evidence published in more than 8,700 peer-reviewed journal articles. Here's what's new or different from the previous edition published in 2000.

New Recommendations

- ☑ Quitline counseling is effective with diverse populations and has broad reach. Virginia Tobacco User Quitline callers on average are four times more likely to quit tobacco use than those who attempt to quit without treatment.
- ☑ The combination of counseling and medication is significantly more effective than either alone. When at all practical, both should be provided. However, medication should not be used when contraindicated—and is not recommended for pregnant women, light smokers, adolescent smokers or smokeless tobacco users. Otherwise, the pairing of coaching and medication should be routinely offered to patients trying to quit.
- ☑ This Guideline Update includes information on nicotine lozenges and varenicline. Seven medications are now approved by the FDA as safe and effective for tobacco-dependence treatment.
- ☑ Certain medicinal combinations have been shown to be effective:
 - Nicotine patch + other nicotine replacement therapy (nicotine gum, spray or inhaler).
 - Nicotine patch + bupropion SR.



New Emphasis

- ☑ Tobacco dependence is a chronic condition that often requires repeated intervention to achieve long-term abstinence. Many patients relapse several times before quitting for good. Clinicians should intervene using the recommended treatments in the Guideline Update, regardless of the smoker's past success.
- ☑ Recommendation for counseling is strengthened for:
 - Pregnant smokers.
 - Adolescents.
 - Spit tobacco users.
 - Light smokers. (Less than 10 cigarettes per day)
 - However, the Guideline does not recommend medication for these patients.
- ☑ For smokers with a history of depression, bupropion SR is significantly more effective than placebo.
- ☑ Quit-tobacco counseling and medication are effective with diverse populations, including: Racial and ethnic minorities; those of limited education or finances; patients with medical or psychiatric co-morbidities; LGBT patients.
- ☑ Healthcare policies and systems changes can significantly reduce barriers to treatment:
 - Tobacco-dependence treatment as a covered health-insurance benefit results in significantly more provision of treatment, more quit attempts and higher quit rates.
 - Clinician training, combined with a charting/documentation system, significantly increases rates of clinician intervention, and also improves patient quit rates.
 - Research supports the conclusion that investments in tobacco treatment are highly cost-effective.
- ☑ There are new strategies to increase interest in quitting among patients not willing to quit at the current time. Specific actions by providers can lead to increased motivation and quit attempts among these smokers.



For more on the Guideline, including full text, visit www.surgeongeneral.gov/tobacco
To order a free copy of the guideline from AHRQ: www.ahrq.gov/clinic/tobacco/order.htm

www.aptna.org

Adapted and reprinted with permission from UW-CTRI Quit Tobacco Series #13, July 2008



Ordering Information for Quit Smoking Products

Quit Smoking Products for Consumers

Call, mail, or fax the order forms below to:

AHRQ, P.O. Box 8547

Silver Spring, MD 20907-8547

1-800-358-9295

703-437-6922 (Fax)

Name:
Credentials/Title:
Organization/Company:
Address 1:
Address 2:
City, State, Zip:
Phone number:
E-mail address:
Credit Card Information:
Credit Card Type: Mastercard Visa
Card Holder's Full Name:
Credit Card Number:
Expiration Date:

Please send me the following publications:

Pub. No.	Title	Cost ¹	Quantity	Total
AHRQ 08-0050-2A	Consumer Guide, Help for Smokers and Other Tobacco Users (English)	100 free/\$12.50/25		\$
AHRQ 08-0050-2B	Consumer Guide, Help for Smokers and Other Tobacco Users (Spanish)	100 free/\$12.50/25		\$
AHRQ 03-0044	Hospital Card, Quitting Helps You Heal Faster (English/Spanish)	100 free/\$15.00/100		\$
AHRQ 02-0047	You Can Quit Smoking Card (English)	100 free/\$15.00/100		\$
AHRQ 03-0006	You Can Quit Smoking Card (Spanish)	100 free/\$15.00/100		\$

¹Payment may be made via credit card (Visa/Mastercard) or checks payable to PPIP. Additional shipping charges may apply for bulk quantities and for delivery to addresses outside of the United States.

Quit Smoking Products for Clinicians

Call, mail, or fax the order forms below to:

AHRQ, P.O. Box 8547

Silver Spring, MD 20907-8547

1-800-358-9295

703-437-6922 (Fax)

Name:
Credentials/Title:
Organization/Company:
Address 1:
Address 2:
City, State, Zip:
Phone number:
E-mail address:
Credit Card Information:
Credit Card Type: Mastercard Visa
Card Holder's Full Name:
Credit Card Number:
Expiration Date:

Please send me the following publications:

Pub. No.	Title	Cost ¹	Quantity	Total
AHRQ 08-0050-1	Clinical Practice Guideline: 2008 Update	1 free/\$1.00 ea		\$
AHRQ 08-0050-3	Pocket Guide, Helping Smokers Quit: A Guide for Clinicians	100 free/\$12.50/25		\$
AHRQ 08(09)-0091-A	Clinician Tear Sheet, Prenatal (English)	1 pad free/.50 ea		\$
AHRQ 08(09)-0091-B	Clinician Tear Sheet, Prenatal (Spanish)	1 pad free/.50 ea		\$
AHRQ 08(09)-0092-A	Clinician Tear Sheet, Primary Care (English)	1 pad free/.50 ea		\$
AHRQ 08(09)-0092-B	Clinician Tear Sheet, Primary Care (Spanish)	1 pad free/.50 ea		\$

¹Payment may be made via credit card (Visa/Mastercard) or checks payable to PPIP. Additional shipping charges may apply for bulk quantities and for delivery to addresses outside of the United States.

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Implementing Effective Smoking Cessation Strategies: “Needs Assessment”

WHAT	WHO	HOW	EDUCATION	MATERIALS
ASK smoking status	Receptionist? Intake nurse?	Clipboard form in lobby? Part of vital signs?	Simple instructions?	Questionnaire? Amend current form?
ADVISE cessation (clear, strong, personal)	RN? NP? PA? MD?	During exam? (document in chart)	Read Guideline? Take online course(s)?	Clinical Practice Guideline? Use Internet?
ASSESS Interest in quitting, readiness to quit	RN? NP? PA? MD? (staff designated as smoking cessation “Specialist”?)	During exam? (document in chart)	Read Guideline? Take online course(s)?	Clinical Practice Guideline? Use Internet?
ASSIST setting up a quit plan (pt ready to quit)	RN? NP? PA? MD? Health Educator? (staff “Specialist”?) Quit Coach?	Counsel? Refer to Quitline or local program/Specialist? Give self-help resources?	Read guideline? Simple instructions (for referrals)? Take online course(s)? Provide staff training?	Clinical Practice Guideline? Quitline materials? Web resources? CTRI provider training manual?
ARRANGE follow-up	RN? NP? PA? MD? Health Educator? (staff “Specialist”?) Quit Coach?	At next visit? Refer to Quitline or local program/Specialist? Refer to PCP/clinic?	Simple instructions?	Quitline materials? Web resources? Letter/postcard (develop)?
MOTIVATE (pt not ready to quit)	RN? NP? PA? MD? Health Educator? (staff “Specialist”?)	Do the 5 R’s? Refer to Quitline/Specialist? Use print resources?	Read guideline? Simple instruction (for referrals)? Take online course(s)? Provide staff training?	Clinical Practice Guideline? Quitline materials? Web resources? CTRI provider training manual?
PREVENT RELAPSE quit within year	RN? NP? PA? MD? (staff “Specialist”?) Quit Coach?	Counsel? Refer to Quitline/Specialist? Give self-help resources?	Read guideline? Simple instruction (for referrals)? Take online course(s)? Provide staff training?	Clinical Practice Guideline? Quitline materials? Web resources? CTRI provider training manual?

Implementing Effective Smoking Cessation Strategies: “Needs Assessment”

WHAT	WHO	HOW	EDUCATION	MATERIALS
ASK smoking status				
ADVISE cessation (clear, strong, personal)				
ASSESS Interest in quitting, readiness to quit				
ASSIST setting up a quit plan (pt ready to quit)				
ARRANGE follow-up				
MOTIVATE (pt not ready to quit)				
PREVENT RELAPSE quit within year				

RESOURCES

ONLINE COURSES FOR PROVIDER EDUCATION/TRAINING

Treating Tobacco Use and Dependence

<http://cme.medscape.com/viewprogram/8840>

Tobacco Use and Dependence: An Updated Review of Treatments

<http://cme.medscape.com/viewarticle/583425>

2A and R Brief Tobacco Intervention

<http://www.2aandr.org>

American Academy of Family Physicians CME Webcasts

1) *Conduct and Get Paid for Tobacco Cessation Group Visits*, 2) *Beyond the Guidelines: Advances in Tobacco Cessation Treatment and Payment*, 3) *Become a Tobacco Aware Practice: Using an Organizational and Team-based Approach*, and 4) *Treating Tobacco Dependence*.

www.aafp.org/online/en/home/clinical/publichealth/tobacco/cme/webcasts.html

Pharmacotherapy for Nicotine Dependence

1.0 Category 1 CME credit is available for reading this online journal article and taking the test (valid until September 1, 2006):

<http://caonline.amcancersoc.org/cgi/content/full/55/5/281>

PROVIDER TRAINING MANUALS AND MATERIALS

Treating Tobacco Use and Dependence: Practical Strategies to Help Your Patient Quit (with video/CD) – CTRI provider training manual

www.ctri.wisc.edu/HC.Providers/healthcare.Hospital.Packet.htm

Rx for Change: Clinician-Assisted Tobacco Cessation (requires registration, but there is no cost): <http://rxforchange.ucsf.edu/>

Cease Smoking Today Toolkit for educators and providers, including a Role Modeling Video titled “Patient with Diabetes” (requires registration, but there is no cost)

www.ceasesmoking2day.com

California Diabetes Program (cAARd) - Toolkit and Continuing Education program

<http://www.caldiabetes.org/>

USPHS MATERIALS

To order hard copies: www.ahrq.gov/clinic/tobacco/order.htm

To download and print: www.surgeongeneral.gov/tobacco

Helping Patients with Diabetes Quit Using Tobacco (guideline from Utah)

www.tobaccofreeutah.org/diabetes%20educators%20CE.pdf

PATIENT EDUCATION MATERIALS

Agency for Healthcare Research and Quality (AHRQ)

USPHS publications available from AHRQ at no cost. Call 1-800-358-9295 or fax an order form: www.ahrq.gov/clinic/tobacco/order.htm

Tobacco Cessation--You Can Quit Smoking Now!

Downloadable USPHS consumer materials in pdf format (including low-literacy and Spanish versions): www.surgeongeneral.gov/tobacco

You Can Control Your Weight as You Quit Smoking (downloadable)

<http://win.niddk.nih.gov/publications/PDFs/quitsmoking.pdf>

Tobacco & Diabetes brochure in English and Spanish (downloadable)

www.tobaccofreeutah.org/healthcare-diabetes_ed.htm

QUIT NOW VIRGINIA – free state quitline

Information can be accessed from the Virginia Department of Health Tobacco Use Control Project website: <http://www.vahealth.org/cdpc/TUCP/QuitNow.htm>

Free quitline brochures and Quit Cards (English & Spanish) available from VDH-TUCP at (804) 864-7874 or contacting APTNA (order form in packet). Sample copy of Quit Now Virginia booklet available from quitline. To request one – call 1-800-Quit Now

Local cessation resources: the quitline keeps a database of local programs. Patients can call 1-800-Quit Now to find one in their area.

Audio recordings of real quitline calls can be accessed from the quitline vendor's website at: www.freeclear.com/quit-for-life

A “1-800-Quit Now” video that is very positive and encouraging and focuses on calling the quitline can be downloaded (to play in clinic lobbies or via closed circuit TV, etc.) from: <http://1800quitnow.cancer.gov/multimedia.aspx>

QUITLINE FAX REFERRAL

Available to Virginia clinics/practices, especially those serving Medicaid and uninsured patients. There is no cost but registration is required. Participants may register with APTNA (as the VDH-TUCP liaison partner organization) by contacting Janis Dauer at 757-858-9934 or jdauer@aptna.org

ATTUD (www.attud.org): Association for the Treatment of Tobacco Use and Dependence membership allows access to the listserv (national network of experts)

APTNA (www.aptna.org): links to additional resources for providers (including more online courses, clinician toolkits and manuals, patient education materials, etc.)



DRUG INTERACTIONS WITH SMOKING

Many interactions between tobacco smoke and medications have been identified. Note that it is the tobacco smoke -- not the nicotine -- that causes these drug interactions. Tobacco smoke may interact with medications through pharmacokinetic or pharmacodynamic mechanisms. Pharmacokinetic interactions affect the absorption, distribution, metabolism, or elimination of other drugs, potentially causing an altered pharmacologic response. The majority of pharmacokinetic interactions are the result of induction of hepatic cytochrome P450 enzymes (primarily CYP1A2). Pharmacodynamic interactions alter the expected response or actions of other drugs. The amount of tobacco smoking needed to have an effect has not been established and the assumption is that any smoker is susceptible to the same degree of interaction.

DRUG/CLASS	MECHANISM OF INTERACTION AND EFFECTS
Pharmacokinetic Interactions	
Alprazolam (Xanax)	<ul style="list-style-type: none"> ▪ Plasma concentrations decreased up to 50% among tobacco smokers.
Caffeine	<ul style="list-style-type: none"> ▪ Increased metabolism (induction of CYP1A2); clearance increased by 56%. ▪ Caffeine levels may increase after cessation.
Chlorpromazine (Thorazine)	<ul style="list-style-type: none"> ▪ Decreased area under the curve (AUC) (36%) and serum concentrations (24%). ▪ Smokers may experience less sedation and hypotension and require higher dosages than nonsmokers.
Clozapine (Clozaril)	<ul style="list-style-type: none"> ▪ Increased metabolism (induction of CYP1A2); plasma concentrations decreased 28%.
Flecainide (Tambocor)	<ul style="list-style-type: none"> ▪ Clearance increased by 61%; trough serum concentrations decreased by 25%. ▪ Smokers may require higher dosages.
Fluvoxamine (Luvox)	<ul style="list-style-type: none"> ▪ Increased metabolism (induction of CYP1A2); clearance increased by 25%; decreased plasma concentrations (47%). ▪ Dosage modifications not routinely recommended but smokers may require higher dosages.
Haloperidol (Haldol)	<ul style="list-style-type: none"> ▪ Clearance increased by 44%; serum concentrations decreased by 70%.
Heparin	<ul style="list-style-type: none"> ▪ Mechanism unknown but increased clearance and decreased half-life are observed. ▪ Smokers may require higher dosages.
Insulin	<ul style="list-style-type: none"> ▪ Insulin absorption may be decreased secondary to peripheral vasoconstriction; smoking may cause release of endogenous substances that antagonize the effects of insulin. ▪ Smokers may require higher dosages.
Mexiletine (Mexitil)	<ul style="list-style-type: none"> ▪ Clearance (via oxidation and glucuronidation) increased by 25%; half-life decreased by 36%.
Olanzapine (Zyprexa)	<ul style="list-style-type: none"> ▪ Increased metabolism (induction of CYP1A2); clearance increased by 40–98%. ▪ Dosage modifications not routinely recommended but smokers may require higher dosages.
Propranolol (Inderal)	<ul style="list-style-type: none"> ▪ Clearance (via side chain oxidation and glucuronidation) increased by 77%.
Tacrine (Cognex)	<ul style="list-style-type: none"> ▪ Increased metabolism (induction of CYP1A2); half-life decreased by 50%; serum concentrations threefold lower. ▪ Smokers may require higher dosages.
Theophylline (Theo Dur, etc)	<ul style="list-style-type: none"> ▪ Increased metabolism (induction of CYP1A2); clearance increased by 58–100%; half-life decreased by 63%. ▪ Levels should be monitored if smoking is initiated, discontinued, or changed. ▪ Passive smoking (secondhand smoke) also increases the clearance. ▪ Maintenance doses are considerably higher in smokers.
Tricyclic Antidepressants (TCAs) (imipramine, nortriptyline, etc)	<ul style="list-style-type: none"> ▪ Possible interaction with TCAs in the direction of decreased blood levels, but the clinical importance is not established.

Pharmacodynamic Interactions	
Benzodiazepines (diazepam, chlordiazepoxide)	<ul style="list-style-type: none"> ▪ Decreased sedation and drowsiness. ▪ May be caused by central nervous system stimulation by nicotine.
Beta-blockers	<ul style="list-style-type: none"> ▪ Less effective antihypertensive and heart rate control effects. ▪ May be caused by nicotine-mediated sympathetic activation.
Opioids (propoxyphene, pentazocine)	<ul style="list-style-type: none"> ▪ Decreased analgesic effect; tobacco smoking may increase the metabolism of propoxyphene by 15–20% and pentazocine by 40%. ▪ Higher dosages necessary in smokers. ▪ Mechanism unknown.
Oral contraceptives	<ul style="list-style-type: none"> ▪ Increased risk of cardiovascular adverse effects (e.g., stroke, myocardial infarction, thromboembolism) in women who smoke and use oral contraceptives. ▪ Risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over age 35 years.
Adapted from Zevin S, Benowitz NL. Drug interactions with tobacco smoking. <i>Clin Pharmacokinet</i> 1999;36:425–438.	

The rate of absorption of insulin after subcutaneous injection is affected by subcutaneous blood flow. Nicotine causes cutaneous vasoconstriction. One study demonstrated a 113% decrease in the extent of insulin absorption during cigarette smoking and a 30% decrease in the 30 min after smoking. However, it is unclear how this translates into clinical effects. There is some evidence that smokers require more insulin compared with nonsmokers, on the other hand, there does not seem to be a significant difference in glycemic control between smokers and nonsmokers.

(From "Drug Interactions with Tobacco Smoking: An Update" by Shoshana Zevin and Neal Benowitz in *Clin Pharmacokinet* 1999 Jun; 36 (6): page 434)

ATTUD listserv posting on **Stopping Smoking & Diabetes**

-----Original Message-----

Sent: 08/27/2009 4:01 PM

To: ATTUD@LISTS.UMDNJ.EDU

I am conducting a monthly ex-smokers support group. Three out of 7 people in the group are diabetics. The man reports that his blood-sugar levels have decreased after a month of being quit and still using an inhaler. The two women have reported that their levels have increased after 2 months of being quit. One is still on the patches and the other is not using any other kind of stop smoking medication. All report very little changes in eating habits and take insulin.

Can someone reference comprehensive resources on quitting smoking and diabetes?

Thanks,

Gloria

RESPONSES

1) My understanding is that in general, nicotine inhibits insulin secretion, thereby resulting in some increase in blood sugar levels. In non-diabetics, the level of increase is fairly small.

The first case you describe makes sense. The inhaler is a low-dose delivery device, so one might expect less inhibition of insulin release, and thus decreased sugar levels. The first female case you describe also seems reasonable as the patch delivers a higher dose of nicotine (I'm assuming 21mg) so perhaps there is a some impact here, particularly for a diabetic individual. Simply quitting without using any meds in the last case seems unlikely to increase sugar levels, unless there are other changes in meds / diet / activity you are not aware of.

I'll leave this to those of you who know more about these complex physiological processes to better informed ideas.

Thanks,

Tom

2) Try to find Zevin and Benowitz (maybe someone has a copy) and there are later studies too. Basically, they reported stopping smoking alters concentrations of other medications. This is attributed to the change in *metabolism of the tar* and NOT nicotine. So even with replacement, there is still a problem and patients should be monitored and have medications adjusted. I recall offhand an example, that in patients taking theophylline, levels increased (out of therapeutic window) when quitting smoking and needing adjusting.

Hope someone can get these papers for you.

Nina

3) As it has been explained to me by our physician trainer the issue is somewhat different for insulin. Nicotine itself seems to raise glucose levels because it impairs cellular responsiveness to insulin. Therefore even NRT would have some effect – although the actual level of nicotine

would make a difference. So, if the inhaler is only delivering very low levels of nicotine then insulin responsiveness would improve and glucose levels would go down. In our training we recommend:

- Nicotine patch to help maintain steady levels of nicotine and therefore better regulation of glucose
- Increase monitoring of glucose levels during cessation – with the expectation that changes will occur.

Sorry – don't have access to citations right now.

Denise

4) The stress of cessation could, by itself, increase glucose levels. Individuals with diabetes can find it more difficult to control their diabetes when under stress or have an infection. Of course, it is difficult to manage the diabetes when using tobacco also, due to the adrenaline rush which releases glucose and many tobacco products add sugar to the tobacco...

I would evaluate alcohol consumption and carbohydrate consumption. We know that individuals going through cessation might increase their craving and consumption of carbohydrates, due to the serotonin elevations with these foods.

Below are a few links for the American Diabetes Association website:

<http://www.diabetes.org/type-1-diabetes/stress.jsp>

<https://www.diabetes.org/food-nutrition-lifestyle/lifestyle-prevention/check-up-america/cua-glucose.jsp>

<http://www.diabetes.org/type-1-diabetes/alcohol.jsp>

Hopes this helps.

Gaylene

5) Good morning, my experience matches closely that of Denise, with diabetes and tobacco treatment. The changes in blood sugar can be variable and influenced by many factors such as diet and activity. Many people change what they are eating- how often, snacks, new foods, amounts etc. Some people change their activities as well. We encourage at least daily and or more often monitoring of blood sugars while on NRT. Checking daily blood sugars for some or checking blood sugars more often than usual may be a new pattern also so comparing usual blood sugar patterns can be revealing for usual vs new levels. Changes in blood sugar and improvements of blood sugars for some can be an incentive for not smoking or using tobacco.
Rebecca

6) I am still waiting for replies from colleagues but want to get this correction to the listserv before weekend:

- Nicotine is involved in insulin. I am sorry for the error in my too-quick response to the query earlier.

- For other categories of medications (anti-depressants, theophylline, caffeine, etc.), there appear to be changes in levels of those medications *when quitting* related to stopping the metabolism of the tar *per se*. I will continue to double-check that (in case I have misunderstood this) and I am trying to get a copy of Zevin & Benowitz in PDF form to send to ATTUD.
- Re: insulin, diabetes, smoking, nicotine, I attach a paper Dr. Benowitz sent - Eliasson, 2003 (see conclusion, gum comment).

Again, pardon the misinformation. Hope this helps.

Nina

ATTACHMENT (Cigarette Smoking & Diabetes, Eliasson 2003)

7) Thanks to Denise - here is the article to which I was referring. I hope I understood it correctly.

There was also a poster NCI sent to pharmacies (I had a copy once) listing the categories of medications affected by stopping smoking. I am trying to find that.

Hope this helps.

Nina

ATTACHMENT (Drug Interactions with Tobacco Smoking: an Update, Zevin and Benowitz, 1999)

8) Sorry that I did not think to distribute this before but here is a table from Rx for Change. These materials are readily available at no cost with a simple agreement (which ATTUD has). I suggest you check out the website <http://rxforchange.ucsf.edu/>.

Thank you Nina for ensuring that this was a thorough and accurate discussion.

Denise

ATTACHMENT (Rx for Change: Drug Interactions with Smoking)



Search CN

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[CMS Home](#) > [Medicare](#) > [Smoking Cessation](#) > Overview

Smoking Cessation Overview

Smoking is the most preventable cause of disease and death in the U.S. People who continue to smoke after the age of 65 have a higher overall risk of disease and death than those who quit. Smoking contributes to and can exacerbate heart disease, cancer, stroke, lung disease, hypertension, diabetes, osteoporosis, macular degeneration, and cataracts. It can also interfere with the effectiveness of medications that many older adults take, including insulin.

In March 2005, CMS determined that there was sufficient evidence to support Medicare coverage for smoking and tobacco use cessation counseling for beneficiaries who have smoking-related illnesses, or who are taking medications that are affected by tobacco use. Medicare's prescription drug benefit will also cover smoking cessation treatments prescribed by a physician beginning in January 2006.

This section provides information regarding Medicare's smoking and tobacco use cessation counseling benefit, resources to support providers in the delivery of counseling, and organizations promoting cessation to older adults.

General Facts:

- An estimated 9.3% of people ages 65 and older smoke cigarettes.
- Approximately 440,000 people die annually from smoking related diseases, and 300,000 of those deaths occur in people ages 65 and older.
- One study estimated that Medicare spends about 10% of its total annual budget on treating smoking-related illnesses--approximately \$24 billion in 2001.
- There are significant benefits to quitting smoking, even after 30 or more years of smoking. Lung function and circulation begin to improve soon after quitting. Smokers who quit have cardiovascular mortality rates similar to those of non-smokers, and this benefit is unrelated to age or the time elapsed since quitting. In one study, older smokers who already had coronary artery disease improved their survival and risk of heart attack by quitting.
- Older adults who smoke have been shown to be more successful at quitting than younger smokers.

What Medicare covers:

Medicare covers 2 types of counseling:

- Intermediate cessation counseling is 3 to 10 minutes per session; and
- Intensive cessation counseling is greater than 10 minutes per session.

Medicare will cover 2 quit attempts per year. Each quit attempt may include a maximum of 4 intermediate or intensive counseling sessions, with the total annual benefit covering up to 8 sessions in a 12-month period. The health care provider and patient have the flexibility to choose between intermediate and intensive counseling.

To be eligible to receive this benefit, a beneficiary must have a condition that is adversely affected by smoking or tobacco use, or that the metabolism or dosing of a medication that is being used to treat a condition the beneficiary has is being adversely affected by his or her smoking or tobacco use.

In addition, Medicare Part D will also cover smoking cessation treatments prescribed by a physician beginning in January 2006. However, over-the-counter treatments, such as nicotine patches or gum, will not be covered.

Other helpful information:

In addition to Medicare's smoking cessation counseling benefit, the Department of Health and Human Services launched a national telephone counseling quitline for all smokers in the U.S. The toll free number 1-800-QUITNOW (1-800-784-8669, TTY 1-800-332-8615) is a single access point to the National Network of Tobacco Cessation Quitlines. Callers are routed to a state-run quitline for assistance. If there is no state-run quitline, they are routed to the National Cancer Institute's quitline.

Downloads

There are no Downloads

Related Links Inside CMS

[Prevention - General Information](#)

SOURCE: <http://www.cms.hhs.gov/SmokingCessation/>

Downloadable MLN Publications from CMS:

Smoking and Tobacco-Use Cessation Counseling Services

(Brochure for healthcare professionals)

www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf

Quick Reference Information: Medicare Preventive Services

(Includes HCPCS/CPT Codes)

www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

**AA
RM**



AARM Your Patients in their Fight to Beat Tobacco!

A_{SK}

- During clinical visit – this is a teachable, *reachable* moment
- Have you smoked/used tobacco in the past 12 months? When was the last time you smoked or used tobacco, even just a puff/pinch?

A_{DVISE}

- Advise quitting in a clear and strong manner
- Point out specific, personal risks of continued smoking/tobacco use
- Identify specific, personal benefits of quitting, such as:
 - Enhanced treatment efficacy
 - Improved quality of life
 - Lower risk for recurrence
 - Lower risk for second primary tumor
 - More money to pay bills/use for vacation
 - Pleasing family/friends
 - Being proud house/clothes won't smell bad
 - Setting a good example
- Appeal to emotions rather than intellect (feelings are more related to contemplation to quit than cognitions)

R_{EFER}

- Strongly encourage use of effective treatments (counseling/medications) vs. quitting cold-turkey
- Increase their self-confidence/sense of self-efficacy, be supportive
- Urge them to contact the free state quitline for help (1-800-Quit Now)
- Refer family/other household members who smoke/use tobacco

M_{EDICATE}

- Individualize pharmacotherapy
- Encourage adequate medication regimen (dose and duration)
- Consider combination medications for those with greater degree of addiction, history of relapse

Tobacco Quitlines

at a glance

What are tobacco quitlines?

Tobacco quitlines are telephone-based tobacco cessation services. Since the late 1980's, quitlines have been established in many countries around the world. Most are accessed through a toll-free telephone number and provide callers with a myriad of services including educational materials, referral to local programs, and individualized telephone counseling. Counselors assist callers by answering questions about the cessation process and by helping develop an effective plan for quitting.

Reactive quitlines only respond to incoming calls. Proactive quitlines handle incoming calls and also follow up the initial contact with additional outbound calls in order to help prevent relapse. In some cases, when written consent is obtained by a provider, the contact is entirely proactive. *Proactive telephone counseling has been shown to have a profound effect on the probability of success and in maintaining long-term abstinence.*

Where are they available?

Most European countries, Australia, Canada and the United States have established publicly financed quitline services. There are also quitlines in South Africa and in some Asian and Latin American countries. In addition, some employers and private health insurers have established quitlines for their employees and members. Many new quitlines have been set up in recent years, as evidence of their efficacy has become more solid and as tobacco control programs worldwide have grown more sophisticated.

Why have quitlines become popular?

Quitline services are easy to access and free to users. Traditionally, tobacco users have had to overcome various barriers in accessing cessation services, including:

- Sporadic availability of programs, both geographically and over time
- Transportation difficulties
- Childcare responsibilities
- Financial cost of participating.

Quitlines reduce these barriers by allowing tobacco users to access service from their own homes at a time that is convenient for them and usually at no cost. Partly for these reasons, surveys have shown that tobacco users are much more likely to use a telephone-based service than face-to-face programs.

Because it provides services over the telephone, a quitline can serve a large geographic area from a centralized base of operations. As a result, unlike traditional cessation programs in which it is common for participants to have to wait until a group forms, quitlines are able to staff for year-round operation, often with extended hours of business and multilingual capabilities. Quitline services have the potential to reach large numbers of tobacco users including low income, rural, elderly, uninsured and racial/ethnic populations who may not otherwise have access to cessation services.

Practical considerations

The range of services provided: Quitline callers have a wide range of expectations, and most quitlines offer a correspondingly wide range of services. Adult smokers wanting help to quit are the most common callers, but there are also those who are not yet ready to quit, or who have already quit. There are smokers of cigarettes, cigars, and pipes, and callers who use chewing tobacco or other smokeless tobacco. There are callers of all ages, including minors, and callers who speak different languages. In all of these categories, there are those who want counseling and those who just want printed information or referral. Some callers have particular needs such as learning more about smoking while pregnant, or quitting tobacco while managing a psychological condition such as bipolar disorder or schizophrenia. There are non-tobacco-users calling on behalf of friends and family members, and health care professionals or other community members trying to decide whether to refer their patients, students, and neighbors. Comprehensive quitlines develop protocols, resources, and staff training to address each of these situations.

Evidence-based structured protocols guide the flow of counseling sessions and remind counselors of topics considered to affect quitting success. Counselors using clinically validated protocols help clients to:

- Clarify and enhance motivation to quit
- Boost self-efficacy for quitting
- Identify situations that will trigger an urge to use tobacco and plan effective strategies for getting through them without tobacco
- Identify ways to get social support
- Commit to a quit date, often with counselor follow-up for accountability and extra support.

Supporting quitlines

The main reason quitlines have proliferated is that there is strong evidence of their efficacy. A quitline can help to normalize cessation and eliminate disparities in tobacco use or access to treatment. Dental hygienists are natural partners for quitlines and can play a major role in increasing their utilization. Providers who ask all patients whether they use tobacco, advise quitting, and refer to quitlines for comprehensive cessation counseling can have a profound impact on patient health.

Overview of *Quit Now Virginia*

Quit Now Virginia is the state quitline managed by the Virginia Department of Health Tobacco Use Control Project (VDH-TUCP) and funded by a grant from the Centers for Disease Control and Prevention (CDC). The quitline was launched in November 2005 and the service itself, the telephone counseling and print materials, are provided by a vendor, Free & Clear. Vendor selection was accomplished by TUCP through a competitive bidding process. Free & Clear is a highly specialized tobacco treatment provider with contracts to provide quitline services to health plans, employers (including health systems), and government organizations (including other state governments), all over the USA.

Quit Now Virginia provides free, evidenced-based, individualized counseling by highly trained and educated Quit Coaches. The Quit Coaches provide an assessment, assistance in developing a quit plan, helpful informational materials tailored to the caller's needs, and follow-up calls. They also provide TUCP with regular reports containing call and service data and an annual service evaluation report. Healthcare providers may refer patients and others to the state quitline at any time simply by giving them information about the service and letting them know they can access the free quitline by calling 1-800-QUIT NOW (1-800-784-8669). The hearing impaired can call a separate TTY line at 1-877-777-6534.

Any resident of Virginia age 18 and older (and pregnant teens on Medicaid or uninsured) may call and request personal cessation services. In addition, any Virginia resident may call to seek advice about assisting a family member or loved one, clinicians and helping professionals may call for a consult with staff regarding how to assist patients or clients, and callers can also find out about local community resources.

Services (counseling and print materials) are available in English and Spanish, there is no limit to the number of times anyone can call, and calls are answered live from 8:00 a.m.-Midnight every day (after midnight, callers can listen to topic-specific messages and/or leave a message for a callback). All tobacco users ready to quit within 30 days will receive a comprehensive counseling intervention and more intensive treatment services are available to Medicaid/uninsured callers who want to quit and prefer enrolling in a multiple session service that includes counselor-initiated calls.

Quitline counseling interventions consist of either a single call session or a multiple call program:

A “One-Call Intervention” is generally a 30-40 minute session consisting of:

- Quit Coach assessment of caller’s:
 - Tobacco use history
 - Previous quit attempts and relapse
 - Life experiences that may affect the quit attempt
- Quit Coach stressing the importance of planning for a quit attempt and offering the caller counseling to help develop a plan that will work for that particular tobacco user
- Quit Coach encouraging the caller to call the quitline any time for additional help and support.

A “Four-Call Intervention” is a more intensive, multiple session program:

- If the caller is eligible, the Quit Coach will offer the Four-Call program to the participant during the initial one-call intervention
- The Four-Call program allows the participant to receive four additional calls, initiated by the Quit Coach, over the next several months
- These calls usually take place around the time of the quit date and provide the caller with practical strategies for successfully quitting
- Quit Coaches will help callers enrolled in the Four-Call program with:
 - Ongoing urges to use tobacco
 - Reviewing medication usage (if applicable)
 - Identifying methods that participants may use to increase their support from family and friends.
- Four-Call program participants are also eligible to call the quitline on their own anytime for additional help and support (in addition to and/or between scheduled calls from the Quit Coach).

The fax referral pilot project is intended to link the state quitline directly to potential quitters with the help of the healthcare provider. By fax referring motivated patients, tobacco users will not need to take the first step in calling the quitline.

Quit Now Virginia Fax Referral
PROVIDER INFORMATION



What is the *Quit Now Virginia* Fax Referral?

The Fax Referral is the patient's direct link to the state tobacco user quitline.

Quit Now Virginia provides **free** information and coaching by telephone to anyone 18 years and older who wants to quit smoking or chewing tobacco. The counseling offered by the quitline combined with medication prescribed by healthcare providers gives the patient the best chance of quitting successfully.

With the Fax Referral, tobacco users no longer have to take the first step in calling the quitline--a Quit Coach will proactively contact the tobacco user to provide assistance after the fax referral form has been completed and signed. The quitline will also send materials tailored to your patient. All services are **free**.

How does the Fax Referral work?

The Fax Referral gives tobacco users the option of having a Quit Coach contact them to provide an individualized quitting intervention. When a clinician or helping professional addresses tobacco use during a clinic visit, he or she gives the tobacco user the option of having a Quit Coach contact the patient directly to help with quit attempt planning, strategies for coping with urges and stress and obtaining social support.

***Quit Now Virginia* does not provide medication** but will provide the counseling component of an intervention. It is up to the clinician to prescribe or recommend the medication that, combined with counseling, gives the patient a four times greater chance of quitting tobacco use.

After the patient gives informed consent, the signed form is faxed to the quitline. A Quit Coach then contacts the tobacco user, within 48 hours of receiving the form, to begin the intervention. The quitline is available to individuals in a variety of languages.

Who should be fax referred to *Quit Now Virginia*?

Not all patients are appropriate for the Fax Referral. They should be ready to make a serious quit attempt within 30 days and be willing to receive a proactive call from the quitline. Other patients may be better served by receiving quitline materials and encouragement to call when they are ready.

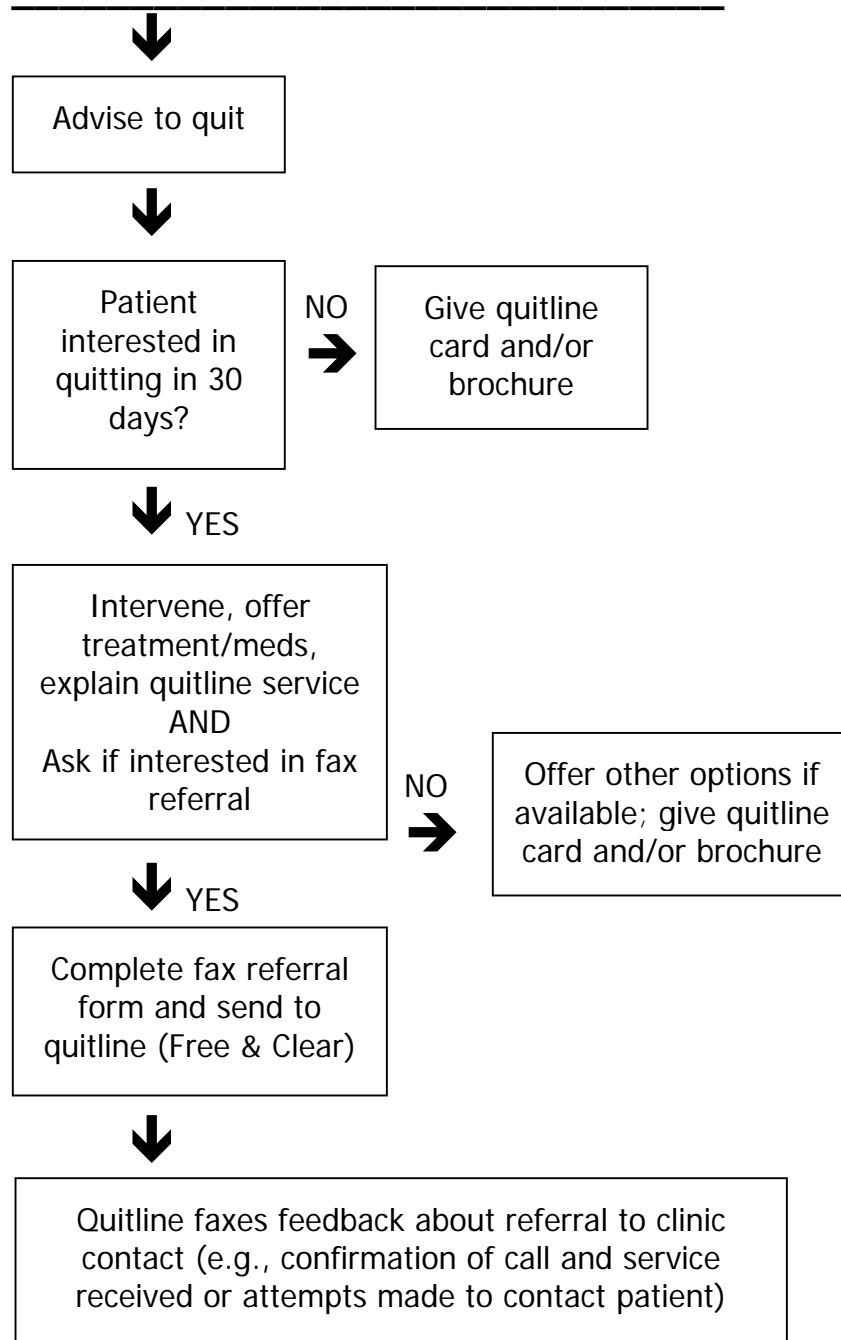
Is the Fax Referral data confidential?

Yes. By providing consent, tobacco users agree to have the quitline contact them and share the intervention results with the healthcare provider. The contact person will be informed whether a coach was able to reach the tobacco user and an intervention was provided. The consent does not authorize the release of any personal information to other parties. The quitline complies with all HIPAA regulations.

For more information, contact Janis Dauer at 757-858-9934 or jdauer@aptna.org

QUITLINE FAX REFERRAL FLOW CHART

Take patient's vital signs and ask about tobacco use.
Patient smokes or chews tobacco:



REQUEST FOR *QUIT NOW VIRGINIA* MATERIALS

Order Form – Please fill in your information below (PRINT):

Name: _____

Clinic Name: _____

Shipping Address: _____

Phone: _____ Fax: _____

Email address: _____

✓	Materials	Desired Quantity	Maximum Per Order
	Quitline card, English		100
	Quitline card, Spanish		50
	Quitline 8.5x11" poster, English		15
	Quitline 8.5x11" poster, Spanish		10
	Quitline brochure, English		100
	Quitline brochure, Spanish		50

Please fax or mail your request to APTNA:

Janis Dauer, Program Manager
3557 Chesapeake Blvd #1
Norfolk, VA 23513
Fax: 757-858-8464

Please allow 2-4 weeks for delivery - For larger quantities or earlier delivery, please contact Janis Dauer at 757-858-9934. Subsequent orders may be sent if/when your supply runs out.

**Clinic-Based Smoking/Tobacco Use Cessation Initiative
with Quitline Fax Referral
REGISTRATION FORM**

Goal: Reach as many low SES (uninsured/Medicaid) smokers/tobacco users as possible who are ready to make a quit attempt, in order to reduce tobacco use among this disparate population.

Strategies:

- Recruit as many clinics as possible
- Provide required materials
- Require minimal follow-up
- Facilitate integration of cessation intervention into routine practice

PROTOCOL - Ask-Advise-Assess-Refer

Ask = identify smokers/tobacco users

Advise = give clear, strong and personal advice to quit

Assess = ascertain if ready to make a quit attempt within 30 days

Refer = refer to state quitline (1-800-QUIT NOW)

- Give quitline cards (patient calls on his/her own)
- Fax refer to quitline when appropriate (Quit Coach calls patient)

(Please PRINT clearly - all information is *required*):

Clinic Contact Person:

Position/Job Title:

Clinic Name:

Clinic Location (address):

Contact Person's Phone number:

Contact Person's Email:

MAIL/FAX/E-MAIL THIS FORM TO:

Janis Dauer, APTNA

3557 Chesapeake Blvd #1, Norfolk, VA 23513

jdauer@aptna.org

Fax# 757-858-8464 (Questions? Call 757-858-9934)

