Ready or Not... Here it Comes: Treating Tobacco Use

1 Ready or Not... Here it Comes

Heart Health Now!
The North Carolina Cooperative for AHRQ's EvidenceNOW
Advancing Heart Health in Primary Care

Ready or Not... Here it Comes
Treating Tobacco Use

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Welcome by Adam Goldstein, MD, MPH

This is Dr. Adam Goldstein. I’m a practicing family physician and professor of Family Medicine at UNC North Carolina, and I direct the University of North Carolina’s nicotine-dependence program. Welcome to Part 2 of our Tobacco Treatment Webinar. This particular Webinar is entitled, “Ready or Not, Here it Comes”, and we’re going to talk about tobacco use treatment that can improve the care of your practice, and patients, and help you provide more successful outcomes.
Let’s dive in with a case. Our first case is a 55-year-old man who has coronary artery disease and is asymptomatic after successful stent placements six months ago. He smokes just over a pack a day with the first one within five minutes of waking, and he quit smoking for two weeks with a 14 mg nicotine patch after his stent, but “was a bear to live with” until he relapsed. He is here for follow-up with you, and when asked, tells you he is interested in trying to quit again.
What is the optimal evidence-based answer? Would you fax a referral to the Quit Line for counseling and nicotine-replacement therapy recommendations? Would you counsel for three minutes and give a prescription for nicotine gum 2 mg prn for six weeks? Would you counsel for 10 minutes, make a follow-up appointment in two weeks, and give a prescription for nicotine patch 21 mg, plus nicotine lozenge 4 mg for 12 weeks?

The last one is the optimal evidence-based answer. The other two would be OK, but they’re not optimal. Today’s Webinar will tell you why.
Our objectives are to review effective – and what I would say are the most effective – counseling strategies to increase success in tobacco-use treatment. We also will talk about the most-effective medications approved for tobacco cessation including combination medications. Finally, we want to talk about how we can improve your skills in tobacco-use treatment coding and billing, how to create those win-wins for you, your patient, and your practice. The bottom line is we can and we must do better. This webinar will help you do that.
We start by understanding that tobacco-dependence really is a two-part problem. It has physiological aspects, and behavioral aspects. And most of these are operative in most patients. The physiologic is the addiction to nicotine. And that’s where our medications are most effective. We want to prevent withdrawal. However, the behavioral treatment is also quite important. How? Because patients are using cues hundreds, if not thousands, times a week that help reinforce tobacco dependence. And if we don’t enlist them in behavior change, we will have less success. So, therefore, our treatment must address both the physiologic and the behavioral aspects. And today’s Webinar will do both.
7 Clinical Practice Guideline Recommendation: 5As

We already talked about the Five A’s of clinical-practice guidelines. And you learned about Asking, Advising, Assessing, and Arranging. Today we’re talking about the Assist, the medication and the counseling. How do we do it? How do we it better?
First, let’s understand that counseling alone is effective when we include evidence-based counseling. The abstinence rate goes from about 2.5% when you don’t do anything (people who could quit on their own with no help) to over 14% at the end of a year. Counseling is effective. Medication is also effective. When we just give medications alone, we can increase the quit rate to almost one-in-five. However, when we combine medication and counseling, together they’re more effective than either alone. We get closer to a third of our patients that can ultimately quit smoking within a year. This is outstanding. So, a take-home pearl is: Assist all patients to make a quit attempt by offering optimal counseling and medications.
What about those patients who maybe are motivated, but not as much as they should, to quit? How can we help them increase their motivation? Well, we only have to do two things: We can increase the change talk so that they’re ready to change rather than accepting the status quo, and we can decrease resistance.
How do we do these things? Well, we can assist the change talk by asking open-ended questions. We want to understand better by asking them to share with us the experience of smoking. What’s most difficult for them to quit? What do they enjoy about smoking? What do they like about not smoking? What would be different if they were tobacco-free? Help them establish, what are their life goals and values as it relates perhaps to quitting? And how does that goal fit in with their desire to be healthy, maybe see their grandchild grow up, save money? These things can help motivate people to change.
We can also help them with concrete counseling strategies, evidence-based strategies for three things. First, we can help them problem-solve, strategies to deal with their triggers. Because if they’re smoking a pack a day, that can be 20 times a day they’re putting a cigarette in their mouth which is related to perhaps stress, habit after a meal, when they wake up in the morning, on their way to work, all these things will need alternate strategies, things that are one-minute or two minutes so we can help them think about take a deep breath, five of them. We can have them drink a full glass of water. Other ways of handling stress, exercise, mindfulness, muscle relaxation; these are ways of problem solving. Patients need help. We can help them provide it.

We can also do two other things. One, provide social support in the treatment setting. We can do this with our clinic nurse, with our clinic laboratory receptionist. Everyone in the clinic on the same page saying, “It’s important. I see you’ve quit. Way to go! We’re here to help you.” We can also do it by mobilizing social support outside the treatment setting with family, and friends, the Quit Line, other resources. If we do these three things, we are going to be providing optimal cessation counseling.
12 Decreasing Resistance

How do we decrease the resistance they may face? Well, it’s the things that we already know to do as family doctors and primary care clinicians. We reflect back to patients and offer support with statements like, “We know you’re tired of people trying to get you to quit. We understand that.” “Even if medication didn’t help you before, perhaps a different medication can help you now.” “We know quitting can be difficult.” “It sounds like you’re overwhelmed with other things in your life. I’m here to help you when you are ready.”
We know the medications are effective, because they do help decrease withdrawal symptoms: the craving, the irritability, the depression that can start for many people certainly within an hour of quitting their last cigarette. So, we want to encourage use by all patients attempting to quit smoking unless there are contraindications.

See website at: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html
There are seven first-line medications. Five are nicotine-replacement therapy. Then there’s also Bupropion and Varenicline. And we do let our patients know that the pharmacotherapy can double the quit rates.
The most effective cessation medications are the combination therapies, as well as a single mono therapy. If we have a combination nicotine patch, a long-acting patch that achieves a steady state up to 24 hours, and the nicotine gum, lozenge, nasal spray or inhaler, we can get quitting up to 30 percent of our patients. The odds are much higher than other combinations with the exception of Bupropion and nicotine-replacement therapy. We also know that a mono therapy, Varenicline, achieves as very high outcomes. These are, again, more than the other outcomes listed, though the others can be effective.
16 Nicotine Replacement Therapy (NRT)

We do combine the long-acting nicotine patch with the combination nicotine-replacement therapy with the short-acting, either the over-the-counter gum, lozenge, or the prescription inhaler, or nasal spray.
NRT: Advantages

The advantages are that we’re providing the nicotine, which is addictive but no toxic than other carcinogenic agents. We’re not introducing a new drug. We can provide flexible and individualized dosing and provide gradual reduction. We might attenuate the weight gain during treatment, and there’s much lower addiction potential. Most patients tolerate this with minimal side effects.
How much nicotine do we give? Well, it depends on how many cigarettes per day they use. If they smoke a pack a day, 20 cigarettes, and average cigarette could have about 2 mg of nicotine. This can be 40 mg of nicotine. So, we can see if we’re giving a 14 mg patch, we could be up to 26 mg of nicotine undertreating them. A lot of patients need more nicotine-replacement therapy than we’re currently giving.
So, patients will self-dose nicotine with their cigarettes, and we can instruct them how to self-dose nicotine replacement therapy to control the withdrawal symptoms. We can say, take a 2 or 4 mg nicotine lozenge ad lib every time you feel like you need to have a cigarette. We can be assured that they will not overdose on nicotine. They don’t do it with cigarettes. They won’t do it with nicotine replacement therapy. Some patients may need more nicotine-replacement therapy for longer periods of time. We tend to stop it way too quickly. And reducing the dosing only after they’re tobacco free for four to six weeks, then every two weeks thereafter, because we want to ensure that we do not stop it too soon, otherwise they’ll relapse.
For patients who have tried NRT and “It didn’t work.”

What if they tried it, and it didn’t work? Were they using it correctly? Instead of chewing the gum like a piece of gum, were they parking it after one or two chews in their mouth, feeling the tingling with the gum? Did they quit and then relapse? Maybe they weren’t getting enough nicotine. If so, they could try again. Try the higher dosing if they cut down but didn’t quit. What about taste? There are new flavors of nicotine gum like cinnamon, and mint, and cherry. The taste and texture have improved significantly. Lots of options.
Bupropion, it’s available generic. It’s very inexpensive. You can combine it with nicotine-replacement therapy, and it can also attenuate the weight gain during treatment. There are precautions. There are common side effects to the central nervous system, headache, dry mouth, insomnia, weight loss. Contraindications: hx of seizure, recent ETOH/benzo withdrawal. Buproprion has Black Box Warning for possible neuropsychiatric events. The length of therapy, again, three months minimum. May be continued as needed to help them stay off tobacco.
Varenicline is the advantage, is the first drug that was made specifically for smoking cessation. It has the highest abstinent rates of any monotherapy, and it blocks nicotine. Thus it decreases the pleasure in smoking. Patients say, “I really just don’t feel like having a cigarette. I don’t get that buzz.” There are many precautions. The common side effects of central nervous system, nausea, insomnia, headache, and vivid dreams. It does have a black box warning for history of psychiatric illness, suicide, ideation, and attempt. And patients with severe renal impairment may need dose adjustment. But it can be used with a wide variety of different medications with very little drug interactions, and frequently if you start low and go slow, you can avoid some of the side effects. So, we want to give these patients when we’re giving them Varenicline a minimum of three months. In six months they will have higher outcomes and success rates. So, again, we keep them on it if they’re doing well.
Which medication to recommend? Certainly effectiveness as we’ve already mentioned. And the contraindications: They may not be able to take the medication. Insurance coverage is also important, because you don’t want the patient to get to the pharmacy and find they have a large copay when they could have gotten another medication for free. And, finally, their preference and prior experience are important. If they had a friend or family member that did really well on Varenicline, it’s probably going to do well for them. Conversely, if they had a friend that didn’t do well on Varenicline, it may not be the right medication for them. These things are all things to consider.
Another pearl is that pharmacotherapy can be effective even if patients aren’t ready to quit. The randomized control trials show patients will often reduce smoking while they’re receiving the nicotine-replacement therapy or Varenicline and achieve abstinence rates double over control. We give medications for people who have high blood pressure even if maybe they’re a little ambivalent, because we know it helps them. The same can be true for smoking cessation.
25 Billing: Medicare & Private Insurance

We can also bill for this, and you can get more income from your practice. If you counsel for 3-10 minutes or counsel for greater than 10 minutes, two different codes, depends if the patient is symptomatic or asymptomatic, and the reimbursement that’s listed; and the practice facilitators can help you set up and track how you create a win-win for your patients and your practice.

See website at: http://www.ctri.wisc.edu/HC.Providers/healthcare_codes.htm
A lot of our patients are using electronic cigarettes and vape pens. What do we tell them in our nicotine-dependence program? Well, we say they’re not FDA approved. The evidence base on their effectiveness is very weak. These are unregulated. The long-term safety of these products is not known. And if patients are using and want to use them, we ask about their willingness to try the FDA-approved cessation medications whose safety data is known and they’re regulated. We continue to assess and treat tobacco use and provide support.
Let’s end with our second case. A 66-year-old woman with COPD comes to the clinic for follow-up. She smokes from 1-to-2 packs of cigarettes a day for 40 years, and she’s thinking about quitting. She feels anxious when she can’t smoke, and she tried nicotine patches in the past, and she has a friend that quit successfully with Varenicline, and her husband also smokes. Sound familiar?
Which of the following actions are optimal evidence-based options? Tell her she must quit, or she’ll die and see her back in a week to see if she’s successful. Assist her with counseling and offer combination nicotine replacement therapy or Varenicline, with follow-up in four weeks. Tell her to call the Quit Line and get two weeks of patches free. Well, we wouldn’t tell her she’s going to die, but we could use either of other two options. If we tell her to call the Quit Line and get free patches, we’d still have to do evidence-based counseling. We also have to follow up with her.
Summary

In summary, patients expect us to access tobacco use and to assist them with quitting. They want our support, guidance, and advice. They can cut down and quit better today than ever before. Our unique expertise truly makes a difference. I want to thank you on behalf of the Webinar team for listening in to this Webinar, Treating Tobacco Use.
Congratulations on Completing the Module

Click Exit at top right of screen

Please review the attachments and begin the next course.
31 The Evidence Team

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