

Provider Feedback Forum on Smoking and Tobacco Use Cessation

December 6, 2007
Sheraton Atlanta Hotel
Atlanta, Georgia

**Department of Veterans Affairs, Veterans Health Administration
Public Health Strategic Health Care Group**

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Overview and Summary

On December 6, 2007, the Public Health Strategic Health Care Group (PHSHG) convened the Provider Feedback Forum on Smoking and Tobacco Cessation. The primary purpose of the forum was to obtain feedback from frontline providers about their experiences in conducting smoking and tobacco cessation programs for patients receiving care from the Veterans Health Administration (VHA). PHSHG sought this input in order to help determine priority areas for ongoing and future program and policy efforts.

VHA health care providers were invited to submit applications to participate in the forum. In selecting participants, PHSHG sought a representative cross section of frontline providers. While approximately half the participants were mental health providers, other disciplines, including medicine, nursing, pharmacy, and social work were represented (see Appendix A). Participants came from facilities across the country in both urban and rural settings, reflecting the diversity of VHA sites.

The forum addressed five major topic areas:

- Implementation of evidence-based tobacco use cessation interventions;
- Special populations;
- Pharmacy issues;
- Smoke-free policies; and
- Current resources and future opportunities.

For each topic area, participants were asked to identify: 1) what is working well; 2) areas that might require improvement or increased attention; and 3) how the VA Central Office can better support efforts to provide tobacco cessation services (see Appendix B).

Cross-Cutting Themes

In the discussion of the five topic areas, several cross-cutting themes emerged.

Inadequate Staffing and Resources

Across each of the five topics, one issue emerged repeatedly—the lack of adequate staffing and resources for tobacco cessation programs. The vast majority of participants carried out their tobacco cessation responsibilities in addition to other duties. Some programs were the result of the work of local “champions,” who may be fulfilling these responsibilities in addition to other clinical responsibilities, without protected time for tobacco cessation clinical activities. Another issue raised was succession; who will take over these programs when “champions” leave or retire. In addition, without dedicated staff, it is difficult to obtain dedicated resources. This makes it extremely challenging to provide services and obtain educational materials and resources. Finally, several participants opined that without a designated, funded tobacco cessation coordinator on the organizational chart, VHA was failing to recognize the importance of tobacco cessation programs for veteran patients. Participants expressed the need for dedicated tobacco cessation staff and/or protected time and resources as a means to formalize and institutionalize tobacco cessation programs and to meet the needs of more patients, especially returning Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans.

Expand the Target Population for Tobacco Cessation Services

When considering the target population for tobacco cessation services within VHA facilities, participants believed that it is important to go beyond patients to include family members (e.g., spouses) and importantly, staff. Participants reported that patients frequently wanted to quit with their spouses. While many programs allowed spouses to participate in support groups, VHA cannot provide nicotine replacement therapy (NRT) to non-patients. Many programs also provide services for staff but once again, unless they are veterans, they cannot receive NRT. Addressing smoking among staff members is important if VHA facilities are to become smoke free.

OIF/OEF veterans were identified by participants as an emerging population in need of smoking and tobacco use cessation services. It was shared that anecdotal reports suggest that the prevalence of tobacco use during the deployment to Iraq may be as high as 50 percent. Promoting smoking cessation among the population of returning OIF/OEF veterans now provides an opportunity to prevent the serious health problems that could develop in the future if these veterans continue to smoke or use tobacco products.

Improve Accessibility to NRT and Other Pharmacological Treatments

Participants expressed frustration about the difficulty of obtaining NRT and other pharmacological treatments for nicotine addiction. Many NRTs are available over the counter, yet policies related to access vary widely across Veterans Integrated Services Networks (VISNs) and even within VISNs, and may contradict national policies that encourage access to NRT and other smoking cessation medications. Policies related to the prescription of varenicline (Chantix) also vary. Participants reported that pharmacy-related issues can make it very difficult to be responsive to patient needs and that access

issues related to pharmacotherapy often undermine patients' efforts to quit. Participants suggested that other health care professionals should be able to prescribe treatment, especially for NRTs that are available as over-the-counter medication, since tracking down a primary care provider or someone else to write a prescription for a patient can be extremely time consuming, and can represent a barrier to access.

Need to Change Existing Culture Related to Tobacco Cessation Services

Finally, given the high rate of tobacco use among VHA's patient population and the significant health consequences resulting from tobacco use, participants expressed the need to change the culture within VHA to make tobacco cessation and prevention of tobacco-related diseases a higher priority. While some may argue that the success rate for tobacco cessation programs is very low (i.e., like all addictions, nicotine addiction is a chronically relapsing condition) failure to aggressively address this problem among patients, veterans, and active duty personnel constitutes a missed opportunity that will negatively impact the health of VHA patients for years to come. Characterizing tobacco use as an addiction issue, where relapse is frequent, and not solely as a prevention issue, might help to change the mindset of many providers and medical administrators who think that smokers should "just quit" and that ongoing support is not necessary.

The following report discusses the many issues explored during the forum.

1. Implementation of Evidence-Based Tobacco Use Cessation Interventions

Participants identified service delivery issues that limit their ability to implement effective tobacco cessation programs.

Access to Services. Patients experience various barriers in accessing care.

Transportation is a major issue for patients in both urban and rural areas—patients are

reluctant to travel to attend support services and appointments, both due to the expense and the time factor. Participants suggested multiple approaches that can be used to address this. These include use of telephone quitlines, telemedicine, walk in services, and on-line or Web-based support programs. There are limitations to these approaches. The quality of telephone and videoconferencing services can be inadequate and there can be limitations to the content that can be posted on websites, especially at the VISN level; also, not all veterans may be able to access the Internet. Creating partnerships with other community partners, such as state telephone counseling quitlines or local health departments and community-based organizations, can help to increase access to services for patients.

Staff Training. While dedicated staff are necessary to coordinate the tobacco cessation program, staff at all levels must be involved in the process if the program is to be a success. Ongoing training for providers is essential to ensure that providers know how to raise the issue of tobacco cessation with patients and properly refer the patient to services. Participants stated that there are many tools that have been developed. For example, checklists can walk physicians through the issues to cover with patients and correct dosing levels. One participant cited ***Rx for Change***, a clinician-assisted tobacco cessation training program based on the U.S. Public Health Service clinical practice guideline for treating tobacco dependency, which shares training materials on-line at no cost (<http://rxforchange.ucsf.edu/>).

Integration into Care. Participants identified the need to better integrate tobacco cessation within the treatment received by patients. They stated that all providers within a facility should be raising the issue of tobacco cessation with patients and that the

subject should be incorporated into both intake and discharge as a standard part of the process—and not an afterthought that may or may not be carried out. In addition, participants suggested that tobacco cessation be linked to other behavioral programs such as weight loss (e.g., MOVE), stress management, and substance abuse treatment.

Importance of behavioral therapy. Many patients see NRT and other pharmacological treatments as “quick fixes.” However, expert participants cautioned that only approximately 15 percent of smokers can quit using medication alone—the rest will need some level of behavioral counseling. In addition to helping patients quit, behavioral therapy can promote better long-term outcomes. Some participants opined that addressing behavioral issues and providing coping skills, such as stress management training, may help to prevent relapse. There were also a number of participants who stated that approaches such as motivational interviewing and contingency management (i.e., use of incentives) should be explored and incorporated as appropriate.

Selected Suggestions from Participants

- My Health_eVet could be used for tobacco cessation activities (e.g., posting information, online courses, listserves, chat rooms, etc.).
- Explore ways to promote tobacco cessation to patients when they are at facilities receiving care. Motivational videos to promote messages about the importance of quitting could be shown in waiting rooms and audio messages played while patients are holding on the telephone. Informational kiosks with computers could walk patients through the quitting process and provide other interactive educational opportunities.

- Engage and train providers who are interested in becoming involved with tobacco cessation activities and find ways to acknowledge their involvement (e.g., commendation letters to supervisors, small gifts, etc.).
- Offer training to a wide range of providers representing various disciplines (e.g., primary care, pharmacy, specialty care, mental health, etc.) and levels (e.g., physicians, physician assistants, nurses, etc.) throughout facilities. Mandating a minimum level of training for all staff should be considered. Training could take a variety of forms, such as attending grand rounds or on-line training. As stated above, *RX for Change* was cited as an example of a training program.
- Convene a nicotine research group to identify effective tobacco cessation services for VHA patient populations. This might involve analysis of existing VHA data. Participants also suggested conducting a meta-analysis of existing research. The findings could be used to identify evidence-based approaches, which could be made available to providers.
- Explore greater use of tools such as carbon monoxide (CO) monitors, which can be used to document that patients have stopped smoking.

2. Special Populations Issues

As with any behavioral intervention, tobacco cessation efforts must be tailored to the needs of the target population—tobacco users—and the subpopulations within that population. Participants identified many subpopulations in need of tobacco cessation services and stressed the need to tailor services to the needs of specific populations. For example, individual counseling sessions may be most appropriate for patients with severe

mental illness as these individuals may be too disruptive for or not amenable to group sessions.

Special Populations <i>(Identified by Participants)</i>	
<ul style="list-style-type: none"> • Active duty personnel • Acute coronary syndrome patients • Chronic pain patients • Chronic psychiatric care patients • Female veterans • Hepatitis patients • HIV patients • Home-based primary care patients • Homeless veterans • Hospitalized patients • In-patient spinal cord patients • Late-stage tobacco users • Long-time tobacco users • Low-income patients 	<ul style="list-style-type: none"> • Multi-diagnosis (alcohol, drugs, mental illness, etc.) patients • Nursing home patients • Obese patients • OIF/OEF veterans • Racial/ethnic minority patients • Seriously mentally ill patients • Substance users in out-patient settings • Transplant patients • VHA employees • Veterans with chronic conditions (e.g., diabetes, COPD, pulmonary patients) • Veterans with Post Traumatic Stress Disorder (PTSD)

A major barrier to the provision of tobacco cessation services that was identified by participants is provider perceptions. For example, providers on a psychiatric unit may be reluctant to encourage tobacco cessation because they believe patients may leave or may become more agitated if they are not allowed to smoke. Providers in nursing homes and hospices may believe that it is pointless to encourage end-stage patients to quit smoking. There is also a misperception that smoking helps some patients to manage their condition, such as those suffering from PTSD or those in substance abuse treatment.

Selected Suggestions from Participants

- Incorporate harm reduction approaches, such as getting patients to smoke less, for patients who are not ready to quit.

- Peers who have successfully quit can serve as educators and provide support to patients.
- Continue promoting the integration of tobacco use cessation services into mental health and substance use disorder treatment.
- Ongoing relapse prevention support for patients should be provided (e.g., monthly follow-up meetings for those who have been through the cessation program).

3. Pharmacy Issues

Most participants reported that there are limitations on who could can prescribe treatment within their facility and on what can be prescribed. However, most reported that some form of treatment was available to patients on an immediate basis. They also reported that pharmacists play important roles in many of their programs.

Participants reported many barriers related to obtaining treatments for patients. In some VISNs, special drug requests are required, which delay patients' access to NRT. Participants also identified access to combination therapy (i.e., patches along with gum/lozenges) as a major challenge in providing effective treatment to patients.

While some of the access issues participants identified were related to policies within the facility or on the part of the pharmacy, others were related to provider education—they simply do not know how to prescribe treatments or are unavailable to do so. For example, providers may prescribe too low a dosage of NRT. Also, because there can be limits on who can prescribe NRT, even those that are available over the counter, patients may have to wait until they can get an appointment with a provider who is able to write a prescription. For patients new to the VA, there are often long waits until their first appointment, which can result in significant delays in initiating treatment. As with many

prevention interventions, patient readiness and motivation are essential elements of treatment. Not being able to accommodate patients when they request treatment can result in many lost opportunities. Some participants shared that their sites had resolved, or improved, NRT access issues by the development of standard NRT order sets for use in the Computerized Patient Record System (CPRS).

Varenicline

A number of issues were raised regarding the use of varenicline. Participants reported good results with varenicline and that patients are very receptive to treatment. The vast majority of participants reported that a non-formulary request was required for varenicline. The drug is on the national formulary but it is not a first-line medication and is restricted for use only after patients have failed with either the patch or bupropion. Participants noted that recently an FDA safety warning has been issued concerning varenicline and possible suicidal ideation. This is a serious concern given the population served by VHA and that participants in the varenicline clinical trials did not reflect the VA's patient population. The VHA Pharmacy Benefits Management's Center for Medication Safety (VA MedSafe) is collecting data on adverse events related to varenicline and has an ongoing program to monitor for safety.

Patients are requesting varenicline—as a result of direct-patient marketing; many patients are aware of varenicline and want “the pill.” However, given the safety considerations, many primary care providers are reluctant to prescribe it. Also, some participants reported that pharmacies are not following Pharmacy Benefits Management (PBM) guidelines, creating barriers to patients receiving varenicline.

Providers also expressed their concerns that given the mental health issues among special populations such as psychiatric patients and OIF/OEF veterans, careful monitoring is required when prescribing varenicline. Participants agreed that there are many unknowns associated with this drug and providers need to be educated about potential side effects and emphasize to their patients that they must be aware of potential adverse side effects and call their providers in the event they occur. Several participants suggested that one strategy might be to prescribe less than the full course of treatment (12 weeks), which would require patients to return for evaluation. However, it was noted that if a primary care provider prescribes varenicline, it may not be possible for the patient to schedule an appointment within 12 weeks.

Several participants reported that varenicline is a difficult drug to administer to patients due to varying doses. While a starter pack is available, which makes dosing easier for patients, VHA does not make this available to patients. Some participants noted that failure to provide the starter pack has resulted in inaccurate dosing on the part of patients. Given the possibility of adverse reactions, participants believed that VHA should take steps to make sure that patients receive the correct dose of varenicline when it is prescribed.

Selected Suggestions from Participants

- PBM should emphasize the national recommendations and requirements for NRT and varenicline prescription and encourage their adoption at the local level.
- Tools are needed to assist providers in prescribing proper doses for both NRT and varenicline (e.g., automated order sets, quick orders).

- Explore ways to allow tobacco cessation experts who are not physicians to prescribe treatments (e.g., under a standing order with a co-signer).
- Monitor adverse effects in patients on NRT to establish incidence (i.e., for comparison with varenicline).
- Additional safety and efficacy studies on varenicline should be conducted in VHA patients.

4. Smoke-Free Policy Issues

Smoke-Free Policy for VA Health Care Facilities

VHA Directive 2003-035, July 1, 2003

It is VA policy that each VA health care facility must establish and maintain a smoking area in a detached building that is accessible, heated, and air conditioned; and that this detached building must meet the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements for ventilation.

The full policy is available at:

http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=264

As a result of a law passed by Congress in 1991, VHA facilities must provide specific areas where patients and staff can smoke. Prior to passage of the law, VHA was making great progress in moving toward smoke-free facilities.

Currently, there is great variability across VHA facilities in terms of the degree to which smoking takes place within each facility. Various factors contribute to the amount of smoking that takes place within a facility. These include: leadership and culture within the facility, prevalence of smoking within the patient population, and attitudes of staff toward smoking.

Leadership from top administrators within a facility is critical for promoting a “smoke-free” culture. This leadership can translate into fewer areas where smoking is permitted by patients or employees, enforcement of rules on where smoking is allowed, limited access to tobacco products, and accessibility of tobacco cessation programs for patients and staff. For example, some participants reported that smoking within their facilities can only take place in a single shelter. Others reported that there are numerous areas within their facilities that are designated as smoking areas including enclosed inner courtyards.

One strategy suggested by participants was the formation of work groups to address the issue of smoking within the facility. Work groups should include important stakeholders such as representatives from environment of care, public safety, unions, and patient care. These groups can make recommendations regarding smoking within the facility and play a role in the implementation of policies that promote a healthy work and patient environment.

Strategies for Addressing Staff Needs

Some of the resistance to smoke-free facilities comes from staff. The issue is two-fold; 1) staff who smoke want to be able to continue to smoke within the facility, and 2) some staff fear negative responses on the part of smoking patients who will no longer be able to do so (e.g., increased agitation).

Participants discussed the need to make tobacco cessation services available to staff to reduce the number of smokers within a facility. Participants reported that some facilities allow employees to attend tobacco cessation classes and continuing education

credit is provided (with supervisor's approval). Some facilities also provide NRT at reduced cost to employees.

Participants emphasized the need for support from leaders within the facility, especially when engaging in negotiations with unions. During such negotiations, it is important to emphasize that a smoke-free workplace is a workplace safety issue and the dangers of secondhand smoke to employees. Participants noted that a research and policy group at the Dana-Farber Institute, led by Dr. Elizabeth Barbeau, has reported empirical findings that support efforts to collaborate with unions as a means to promote smoking cessation.

In enforcing smoking restrictions, participants suggested using both “carrots and sticks.” For example, one participant suggested establishing a break room for non-smoking staff since there is a perception that smokers often get more break time than non-smoking staff. Encouraging public safety staff to write citations for smoking outside of designated areas was also suggested.

Finally, participants reported that in some communities VHA facilities are surrounded by several other smoke-free facilities. As a result, the VHA facility becomes a magnet for smokers—with smokers from other facilities coming to the VHA facility to smoke. It was suggested that the directors of these facilities contact the directors of the other facilities and request their assistance in addressing this problem to reduce additional secondhand smoke exposures.

Selected Suggestions from Participants

- Identify smoke-free facility best practices.

- VHA and local facilities should work collaboratively with unions to gain their support for smoke-free workplaces.
- VHA should issue national directives on: 1) where within facilities smoking can take place; and 2) eliminating all remaining sales of cigarettes to inpatient populations within facilities.
- VHA should develop guidelines for facilities identifying how to get as close to smoke-free as possible while still adhering to current Federal law.
- Develop talking points on the dangers of secondhand smoke, which could be used in discussions with administrators and unions.

5. Current Resources and Future Opportunities

Participants identified resources that they have found valuable in their work in promoting tobacco use cessation.

Preceptorships on the Integration of Smoking Cessation into Mental Health

Services. Many of the participants participated in preceptorships that have been conducted by the Seattle/Puget Sound Mental Illness Research, Education, and Clinical Center (MIRECC), the Center of Excellence in Substance Abuse Treatment and Education (CESATE), and the PSHHG in the past. These training opportunities provided valuable information and skills and allowed participants to serve as trainers when they returned to their facilities. A series of ongoing conference calls, a Website, and email groups provide ongoing support and technical assistance to participants following the conclusion of the training. Participants noted that the last time the program was offered, it was limited to mental health and substance use disorder professionals. Expanding it to other service providers (e.g., extended care, geriatrics, and rehabilitation) could increase

the range of providers involved in tobacco cessation services and the integration of tobacco cessation into additional clinical services.

Partnerships. Partnering activities exist and many participants reported taking advantage of them. State and local health departments are important partners. For example, one participant links patients who do not want to travel for tobacco use cessation support group sessions to similar services in their communities that are provided by the local health department. Another reported that the state health department provides free NRT and varenicline via a state telephone quitline. Other potential partners include the Centers for Disease Control and Prevention (CDC), which provides on-line training materials, and national and community-based non-governmental organizations that advocate for smoke-free communities.

Resources. The Website for CDC's Office on Smoking and Health (<http://www.cdc.gov/tobacco/osh>) provides a wide range of on-line resources and evidence-based practices. Participants recommended that a nationally coordinated campaign could result in more consistency across materials. Now, materials are drawn from a variety of sources, which can prevent a coherent approach.

Opportunities

As stated previously, participants stressed the need for stronger mandates from the VA Central Office that would require facilities to maintain comprehensive tobacco cessation programs. Participants stressed that dedicated staff and resources for tobacco cessation services are key to implementing and sustaining effective programs.

Participants also identified other ways that VA Central Office can provide support for tobacco cessation programs.

Certification and Competencies. A number of participants stated that as with other clinical areas, perhaps certification of tobacco treatment specialist and the identification of core competencies would help to ensure the delivery of high quality and effective services. Participants stated that direction would be needed from the VA Central Office—either by endorsing a program or developing its own program. One participant noted that the Mayo Clinic conducts a certification program.

Identification of Self-Study Modules. Providers in the field need access to training resources. However, it can be difficult to assess the quality of such resources. One approach would be for VA Central Office to vet self-study training modules and promote these resources to providers.

Identification of Evidence-based Practices. Focusing on evidence-based practices could serve to standardize treatment. A set of treatment guidelines could provide a “menu” of evidence-based practices from which patients and providers could select the most appropriate form of treatment. A number of participants talked about the usefulness of the VA/DoD Clinical Practice Guidelines.

Tracking Outcomes. Many tobacco cessation programs do not track outcomes, which makes it difficult to demonstrate that programs are effective. Participants recommended that standardized outcome measures should be identified and data collected across programs. One approach would be for the VA to include questions related to tobacco cessation in their regular patient surveys. Another approach would be to use stop codes and performance measures to track outcomes.

Engaging “Champions.” There is a need to recruit and train providers who can champion tobacco cessation activities within facilities. Pharmacists can play an

important role in this process as they see a large numbers of patients, work in various settings, and are generally trusted by other providers and patients. It is also important to involve leaders, such as VISN directors. For example, VA Central Office could conduct a meeting on tobacco cessation for VISN directors. Surveying VISN directors on their perceptions of tobacco cessation programs could provide valuable insight on how to enhance their support for these programs.

Provide Networking Opportunities. Many of the participants reported feeling isolated in their work and thought more interaction with their peers in other facilities would be beneficial. A conference for staff working in tobacco cessation programs was suggested. A listserv promoting the exchange of information among tobacco cessation program professionals was also suggested.

Appendix A: Participant List

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Appendix B: Agenda and Discussion Questions

Provider Feedback Forum on Smoking and Tobacco Use Cessation Thursday, December 6, 2007 Sheraton Atlanta Hotel Georgia Hall 4 & 5, 1st Floor

Agenda

- 7:30 a.m. **Registration and Continental Breakfast**
- 8:00 a.m. **Welcome** and Review of Meeting Goals
Dr. Ron Valdiserri, Chief Consultant PSHHG
- What is working well?
 - What are areas for improvement?
 - How can VACO help?
- 8:10--8:30 **Introduction** of Participants
Group
- 8:30--10:00 **Session I:** Implementation of Evidence-Based Tobacco Use
Cessation Interventions
Dr. Ron Valdiserri, Facilitator
- 10:00--10:15 Break
- 10:15--11:30 **Session II:** Special Population Issues
Dr. John Davison, Facilitator
- 11:30--12:00 Break and Pick-up Boxed Lunch
- 12:00--1:15 **Session III:** Pharmacy Issues (Working Lunch)
Dr. Larry Mole, Facilitator
- 1:15--2:30 **Session IV:** Smoke-Free Policy Issues
Dr. Kim Hamlett-Berry, Facilitator
- 2:30--2:45 Break
- 2:45--3:45 **Session V:** Current Resources and Future Opportunities
Dr. Ron Valdiserri, Facilitator
- 3:45--4:00 **Closing:** Final Thoughts and Adjourn
Group

SESSION I: IMPLEMENTATION OF EVIDENCE-BASED TOBACCO USE CESSATION INTERVENTIONS

1. What's working well in the clinical area of smoking and tobacco use cessation in VA?
2. What is needed to increase veterans' access to smoking cessation care at your site?
3. What are the top 3 things that you think are needed to increase the level of assistance to veterans who want to quit smoking?
4. What are some of the current local and system barriers to achieving this goal?
5. What resources, policies, or tools might be helpful to improve care in this area?

SESSION II: SPECIAL POPULATION ISSUES

We know that there are clinical populations in care in VA who smoke at much higher rates and who may be much more difficult to treat. Also, in the wider field of tobacco control, there has been a fair amount of discussion about the "hard to treat" smokers and how best to reach them.

1. What clinical populations would you identify as needing additional assistance or specially tailored programs to help address their tobacco cessation needs?
2. What barriers (patient-related, provider-related, and/or system-related) have you or others encountered in trying to meet the needs of these special populations?
3. What best practices do you think need to be implemented to meet their needs? What best practices in this area that have been successful at your site or at other clinical sites?
4. What have been some of your experiences in trying to incorporate treatment for tobacco use into routine care for mental health patients?

SESSION III: PHARMACY ISSUES

1. At some sites, pharmacy issues such as restrictions on prescribing nicotine replacement therapy (NRT) or smoking cessation medications have been a challenge. What, if any, pharmacy issues continue to be a challenge at your site or in your VISN?
2. What has been your experience with newer smoking cessation medications, such as Varenicline?
3. What assistance, policies, or resources would you find helpful from either the Public Health Strategic Health Care Group or the Pharmacy Benefits Management Strategic Health Care Group to address pharmacy issues or needs related to smoking cessation care?
4. At some sites, pharmacists have played an active role in smoking and tobacco use cessation care. What pharmacy best practices have worked well at your site?

SESSION IV: SMOKE FREE POLICY ISSUES

1. What smoke-free policy issues or challenges do you have at your site? What has been done locally to address these issues? What is needed to help sites with smoke-free policy issues?
2. How does the smoke-free policy of your facility compare with others in your community?
3. Do staff or patients voice any concerns about exposure to second-hand smoke?
4. Do employees at your site express any concerns about access to smoking cessation services? What smoking cessation services are available for employees at your site?
5. What support, policies, etc. do you need from VACO in this area?

SESSION V: CURRENT RESOURCES AND FUTURE OPPORTUNITIES

1. What materials are you currently using to support your work in this area?
2. How helpful have you found the current website and provider materials to be?
3. What else is needed?
4. Are there opportunities that we could be making better use of in the area of smoking cessation? What are some untapped opportunities or teachable moments you would identify for including messages about smoking and tobacco use cessation?
5. What other health care professionals or staff should we be approaching or partnering with to improve tobacco use cessation in VHA?