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Action TO QUIT
Advancing Tobacco Cessation Policy

Follow-up Q&A from the ActionToQuit August 19, 2014 Webinar
"Progress Toward A Tobacco-Free Military"

Speakers: Dr. Jonathon Woodson, Assistant Secretary of Defense for Health Affairs
Colonel John Y. Oh, Chief of Health Promotion, Air Force Support Medical Agency
Captain Joseph G. McQuade, Medical Director of Public Health, Naval Hospital Jacksonville
Colleen Haydon, Program Manager, Project UNIFORM
Moderator: David Zauche, Partnership for Prevention

Follow-up Q&A responses: Colonel John Y. Oh, Chief of Health Promotion, Air Force Support Medical Agency

What are your projections in removing nicotine products from commissaries, exchanges and other tobacco retailers on military bases?	*Tobacco products are currently sold at military exchanges and most commissaries. There has been recent criticism that the marketing and sales of tobacco products in military exchanges and commissaries conflicts with messages of health, fitness, and resilience communicated by the Department of Defense leadership. A policy review is currently in progress, and DoD leadership will decide what changes, if any, will be implemented to military exchange and commissary policies.*
Given reductions in health promotions funds, what are some free marketing resources?	*www.ucanquit.org is the DoD tobacco counter marketing website called Quit Tobacco - Make Everyone Proud. In its eighth year, QTMEP is funded by TRICARE and serves as a self-help resource as well as a center for military tobacco cessation POCs to order and receive cessation educational materials from an inventory of forty-two unique items ranging from posters, stress balls to dental floss. They are all provided at no cost to the POCs.*

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Does the NH Jacksonville cessation program include cigarettes, cigars, smokeless tobacco and e-cigarettes?	*We cover all forms of tobacco use. We have had some success with use of varenicline for oral tobacco use. We have used oral tobacco substitutes for some patients. Our Wellness staff is trained to use these products.*
What levels of Providers are positioned at the Wellness Center to do refills?	*We have a Wellness RN who writes for the refills and the clinic champion can countersign for the RN.*
Do you find there are many barriers to prescribing medications, especially Chantix to active duty?	*Aviators, aviation mechanics, sonar techs on submarines, and nuclear trained staff may not be prescribed Chantix without a formal waiver. These patients do have problems accessing this first line medication. It is an issue that I know the medical officer for nuclear reactors has on his agenda and currently there is not much hope for a resolution.*
How will this work in a Primary Care Medical Home clinic model?	*First tobacco using patients are identified at vital signs. The PCM orders medications and delivers counseling. Then the PCM places a consult to the Wellness Clinic. Here the patients receive behavioral support/phone messaging, follow-up reminders and attain medication refills.*
Are tobacco using patients given NRT at admission since the facility is smoke-free?	*Tobacco using patients are provided with whatever medication the providers who are following them in house choose to try. Many patients do well on Chantix as inpatients; others use NRT or remain abstinent with no medications. We no longer take patients out to smoke.*

How do you meet the need of active duty members who cannot attend classes or individual sessions?	*We encourage all patients to follow up with Wellness for one-on-one or group classes but if they cannot attend we follow them with the letters and audiocare messaging. Since 2006,we do not make it mandatory for the patients to be seen at Wellness and attend classes in order to be started on a medication.*
SARP numbers were low - can you comment on that?	*I had been providing the intake physical exams for the SARP program and consulting these patients as they were seen. The number of patients who have required physical exams has decreased due to policies where the physical exams are done more at their parent command before they leave. We consult those who decide to quit while in residential care with us. Those who have PCMs elsewhere are consulted to their local clinic.*
It seems to me like there is not enough time for any empanelled PCM working in the PCMH teams to do the work that needs to be done for this program. PCMs need to be in clinic seeing their patients, and this program seems like a resource/provider working with the PCMH teams that doesn't have the time limitations of being an active PMCH provider?	*I am a PCM who is fully empanelled and I agree it takes much time to counsel every tobacco user. I built the system to enable a consult to be written for every patient I see who may desire to quit. Wellness center RNs can follow the patient up with behavioral support. The patient gets gentle reminders auto-generated in the mail and on their phones to provide support in their quit journey. We try to take some of the burden of follow-up off the provider's plat by providing needed refills via the Wellness center.*
Is the stitch in time in AHLTA? Is the medical home port via CHCSII/AHLTA, Carepoint?	*The Stitch in Time is a locally created and locally generated document to remind our clinical staff of the preventive measures a patient may need as they are seen at the point of care. It pulls data from the same databases that Carepoint, CHCS and AHLTA use and is up to date (as of midnight the night before. In addition, it is more granular than the Carepoint system allowing for patient by patient identification. It can identify those who have not had their feet examined if they are diabetic or those who have not got their pneumovax if they are asthmatic,*

	diabetic or a smoker. If it is coded correctly it will appear accurately on the reminder. If the codes weren't used, or the care was not actually paid for, e.g. VA system, the data will be inaccurate. I grade that data quality at about 85%. It is never perfect but it is good enough to catch many colonoscopies, mammograms, foot exams and pneumovaxes that would otherwise have been missed.
Do any MTFs concentrate on teaching Behavior Changes? Learning how to cope without using so much Medication?	*Our Wellness staffs are trained in behavioral support as tobacco facilitators. We offer the medication allowing the full spectrum of help to be provided to every tobacco user. Some patients need very little support to quit, some take medications multiple times before they finally quit.*
21ST CENTURY SAILOR is demanding tobacco cessation programming for ALL DoD including Reserve Community. What budget line item can they order prescriptions for the Reservists.	*I am not sure as to budget lines, but we provide medications to our enrolled patients who we know we will be able to follow-up with behavioral support and monitor for adverse events. We are reluctant to take on reservists drilling here for the weekend, or patients from town who may be seen in our ED or inpatients who we can't follow up as outpatients.*
General Comments.	*I hope you all learned something about our program that you may be able take back to your own programs. It has been a push to keep the program alive and running, requiring much communication with the command leadership, providers and ancillary staff. It has required working closely with our pharmacists, public affairs officers, and IT staff to remain focused as a unit on tobacco cessation as a real goal. The best thing we did was to remove the smoking gazebos from around the hospital building, and create ways to consistently encourage providers to take action for tobacco users desiring to quit at every patient encounter. Wellness staff turnover has hurt us, and makes it a priority to have a clinical champion with some continuity at the command to create the sustainability necessary to keep the program moving.*

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Are there any recommendations any of the presenters can give on how a local public health department or coalition can partner with a base or National Guard post on tobacco prevention/cessation efforts?	*My strongest recommendation is to do your research and be culturally appropriate in working with an installation, Guard or Reserve unit. Local public health departments or coalitions have a lot to offer. The approach that seems to work best is to find out what services the base or unit(s) has currently. Once you know that (or even if you aren't able to figure that out) find a contact on base or in the Guard/Reserve unit and go from there. The most important thing for a public health department or coalition to remember in partnering with a base or Guard/Reserve unit is that we are all on the same team. Each member of the team has something to offer while trying to achieve the same goal.*
Is Project Uniform only in CA?	*Project UNIFORM is funded through the State of California. That said, we have worked with many other states to assist in their military-civilian partnerships to address tobacco use. Also, we are always happy to respond to emails or speak on the telephone. To reach us visit our website www.projectuniform.org.*