American Association for Respiratory Care's

Continuing Care & Rehabilitation

September / October 2002 Bulletin

NLHEP Guidelines are a Natural for You!

by Gretchen Lawrence, BA, RRT, FAARC, NLHEP liaison to the AARC

As a member of the Continuing Care and Rehabilitation Section, you probably work closely with patients with chronic lung disease every day. For you, using the National Lung Health Education Program (NLHEP) guidelines in everyday practice is a "natural" - something that can and should be incorporated into your care plans, not only to help stem the tide of chronic lung disease in this country, but to avert numerous other smoking related diseases as well.

For example, did you know that:

- Smoking is listed as a significant factor in stroke, cancer, and heart disease?
- At least 20% of smokers will develop airflow limitations that will impact their quality of life?
- Spirometric abnormalities predict all-cause mortality?

The NLHEP guidelines strongly suggest that the first line of defense is a good offense - and that the primary care physician (PCP) is in the best position to identify and treat these patients early in the course of their disease, many times long before they present with symptoms. The evaluation process begins with a few simple questions:

- Are you 45 or older and/or have a smoking history or environmental exposure?
- Do you have a chronic cough, sputum production, and/or shortness of breath?

Continued on page 3

Section Connection

GET IT ON THE WEB:
Help the AARC increase its efficiency by signing up to receive the Bulletin via the section homepage on the AARC web site (www.aarc.org). To change your option to the electronic Bulletin, send an e-mail to: mendoza@aarc.org.

JCAHO ACCREDITATION REPORT:
Please consider sharing information about your most recent site visit by filling out the form on the AARC web site found at the following link: www.aarc.org/members_area/resources/ jcaho.asp.

SECTION LISTSERVE:
Start networking with your colleagues via the section listserve. Go to the section home page on www.aarc.org and follow the directions to sign up.

Evidenced-Based Treatment of Tobacco Dependency

by Linda White, CRT, RCP, Baylor University Medical Center, Dallas, TX

Tobacco use, particularly smoking, remains the number one preventable cause of disease and death in the United States.[1] Can you identify any other condition that presents such a mix of lethality, prevalence and neglect, despite effective and readily available interventions?[2] Do you, as a health care provider, offer evidence-based tobacco cessation treatments to your patients who use tobacco? Do you address tobacco dependency with your patients during each clinic visit or hospitalization?

All health care professionals should play an important role in tobacco cessation, both by modeling non-tobacco use behavior themselves and by helping patients stop using tobacco products. Despite the fact that tobacco use is responsible for more deaths annually than AIDS, alcohol, motor vehicle collisions, murder, illicit drugs and suicide combined, most health care providers lack adequate training to effectively treat nicotine addiction behavior.[3,4] The former surgeon general, C. Everett Koop, made this statement, "Every doctor and nurse, health plan purchaser and medical school in America should make treating tobacco dependence a top priority."

Until formal educational programs heed Dr. Koop's challenge, resources are available to help you increase your knowledge about treating tobacco use. An invaluable tool is the Clinical Practice Guideline, Treating Tobacco Use and Dependence, which has been published by the U.S. Department of Health and Human Services. A copy of the guideline can be ordered through the National Cancer Institute. This information can also be downloaded from the Surgeon General's web site at www.surgeongeneral.gov/tobacco/default.htm. The information in the Clinical Practice Guideline can be helpful in building an effective counseling program in your patient care area. Every member of your team should have a copy of the summary of the guideline, Quick Reference Guide.

Smokers want to quit

An estimated 70% of Americans using tobacco report an interest in quitting. As many as 40% of these people will make a serious quit attempt in the next year. Dishearteningly, as few as 3% of them will actually remain tobacco-free six months later.5 These statistics are certainly indicative of the severely addictive nature of nicotine. Tobacco users may make several quit attempts before achieving long-term success. As clinicians, we need to help the client understand that relapse is part of the recovery cycle and may actually increase the probability of success on subsequent quit attempts. It is critical that we treat tobacco dependence as a chronic disease, inquiring about a patient's tobacco status at every opportunity and offering evidence-based treatment to every tobacco user wanting to make a quit attempt. Research shows evidence of increased abstinence rates when multidisciplinary teams of clinicians work together to encourage tobacco-free living.[6]

The ideal program includes the following components, which have been shown to improve tobacco abstinence rates: identification of stage of readiness to change behavior, pharmacological treatment, follow-up care, multiple program modalities, physician leadership, multidisciplinary staff and access to a psychiatrist.[7] The availability of multiple program modalities is a key component. Delivery of tobacco cessation interventions by telephone, group and individual counseling methods increases abstinence rates and should be promoted.[8]

Tobacco users with access to a comprehensive program have the greatest potential for long-term success. A comprehensive tobacco cessation program should not only encourage

Continued on page 2

What's Weight Got To Do With It?

A new study from Spanish investigators has found that COPD patients with low body weight exhibit more muscle atrophy and worse exercise capacity than those with a normal body mass index (BMI) - even when suffering from similar degrees of lung function impairment.

According to the researchers, who published their findings in the second August issue of the American Journal of Respiratory and Critical Care Medicine, skeletal muscle cell death and atrophy were increased in seven COPD patients with low BMI when compared to three other groups: eight normal weight COPD patients, eight healthy volunteers and six sedentary volunteers.

The researchers also discovered that exercise capacity in the underweight patients was better correlated with their BMI than with the degree of their airflow restriction. ◆

Want to receive this newsletter electronically?

E-mail: mendoza@aarc.org for more information.

Continuing Care and Rehab Bulletin

published by the
American Association for Respiratory Care
11030 Ables Lane
Dallas, Texas 75229-4593
(972) 243-2272 • (972) 484-2720 FAX
e-mail:info@aarc.org

Chair
Mary Hart, RRT, RCP
Baylor Asthma and Pulmonary Rehab Center
3504 Swiss Ave., Suite 303
Dallas, TX 75204
(214) 820-3500
(214) 841-9799 FAX
maryhar@baylorhealth.edu

Editor
Cara Kraft, RRT, RCP
(214) 820-9791
denkraft@yahoo.com

Continued from page 1

EVIDENCED-BASED TREATMENT OF TOBACCO DEPENDENCY

tobacco users to quit, but also offer them assistance in quitting.[9] Quit attempts that include both counseling to assist movement through the stages of change and pharmocotherapy yield abstinence rates of 20%-25% at one year following initial treatment.[10,11]

A multidisciplinary effort

The Office of Tobacco Education and Research (OTER) has implemented a comprehensive tobacco cessation program on the Baylor Health Care System's Dallas, Texas campus. The OTER staff is comprised of practitioners from respiratory therapy, social work, nursing, public health and physiology. The program includes compulsory education for each staff member in each discipline and tobacco dependence training has also been obtained from a variety of other sources, including the Mayo Clinic's Nicotine Dependence Center in Rochester, MN.

Efforts to systematically identify tobacco users upon hospital admission began in December 2000. Presently, our efforts are focused on the inpatient population at Baylor University Medical Center. The tobacco user is identified by the nursing staff, then this information is communicated to the OTER staff via the Baylor intranet. Our tobacco treatment specialists assess each tobacco user to determine his or her stage of change.[12] Assessing stage of change is crucial to offering stage appropriate counseling to the client. A client in the pre-contemplation or contemplation stage will be given information to decrease his or her ambivalence about quitting. Brief tobacco counseling from all health care professionals, especially the patient's physician, can have an impact and should be offered to every patient who uses tobacco.[13]

A patient in the preparation stage (willing to make a quit attempt in the next 30 days), the action stage (quit within the last 6 months) or the maintenance stage (quit within the last 6-12 months) will be offered the opportunity to enroll in our program. The patient who agrees to participate in the program will complete a questionnaire and meet with OTER's tobacco treatment specialist, usually for 45-60 minutes, to begin developing a plan for a quit attempt or for maintaining a quit status.

The counseling session includes identification of specific behavior modification techniques, discussion of available first-line pharmacological treatments (bupropion SR, nicotine transdermal patches, nicotine gum, nicotine inhaler, nicotine nasal spray), information on maintaining a quit status and what to do if relapse occurs. A workbook is given to the patient to assist in the formulation of a quit plan. We also encourage the patient to review the workbook periodically and to revise the plan in an effort to help prevent relapse.

The session concludes with the tobacco treatment specialist giving the patient written recommendations for one or more pharmacological products. Providing written recommendations may help the patient facilitate an open discussion with his or her physician. Pharmacological recommendations are based on the client's medical history, tobacco use history, previous quit attempts, client preference and financial ability to purchase medications. The client's physician makes the final decision regarding nicotine replacement therapy (NRT) and/or bupropion SR. Most NRT products and bupropion SR require a physician's prescription; however, nicotine patches and gum can be purchased over the counter.

Continuing care

In addition to the initial face-to-face counseling session, the client receives five outbound follow-up calls at predetermined intervals during a 12 month period. The literature suggests a strong dose-response relationship between the intensity and frequency of tobacco dependence counseling and its effectiveness.[14]

An outpatient tobacco treatment program is scheduled to get underway in October. The outpatient program will follow the same model as the inpatient program, including the five outbound telephonic counseling calls to each participant at predetermined intervals. Currently, third party reimbursement for tobacco treatment programs is extremely limited; therefore this service will primarily be funded on a fee-for-service basis.

In addition to the tobacco treatment program, we also offer a monthly group educational program called the You Can Stop Workshop at locations within the Baylor Health Care System. This two-hour workshop offers information on how to quit and stay quit. Topics include the latest recommendations for pharmacological therapies, behavior modification techniques, stress management, maintenance and relapse. The workshop is

currently presented as a community and employee benefit, with no cost to the participants. In the past, we have also offered a group support program facilitated by our social worker. With implementation of our outpatient tobacco treatment program, consideration will be given to reinstituting the support group.

Since most adult tobacco users began using tobacco before the age of 18, preventing kids from ever lighting up in the first place is extremely important. Through a program originally created by Helen Good, RN, and implemented in the Irving Independent School District by staff from Baylor Medical Center at Irving, thousands of adolescents have been impacted by an interactive, hands on tobacco awareness program, Tobacco k**NO**w. Expansion of this program to students in the Dallas Independent School District occurred during the 2000-2001 school year, as Helen joined our team. Plans to continue this program and create additional prevention programs are being explored.

Let's stop it now

The time has come for all health care providers to address tobacco dependency as a chronic disease, offering tobacco users brief counseling at every opportunity and providing effective tobacco dependence treatments to those willing to make a quit attempt.

As the authors of a new textbook on tobacco recently said, "If we do not act decisively, 100 years from now our grandchildren and their children will look back and seriously question how people claiming to be committed to public health and social justice allowed the tobacco epidemic to unfold unchecked."[15] ◆

REFERENCES

1. Fiore MC, Bailey WC, Cohen SJ, Dorfman SF, Goldstein MG, Gritz ER, Heyman RB, Jaen CR, Kottke TE, Lando HA, Mecklenburg RE, Mullen PD, Nett, LM, Robinson L, Stitzer ML, Tommasello AC, Villejo L, Wewers ME. Treating Tobacco Use and Dependence: Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services, Public Health Services, 2000.
2. Fiore MC, et al, op cit.
3. Centers for Disease Control and Prevention. Targeting tobacco use, at a glance. Available at http://www.cdc.gov/tobacco/overview/oshaag.html; Accessed November 8, 2001.
4. McGinnis JM, Foege WH. Actual causes of death in the United States. JAMA 1993; 270:2207-2212.
5. Pan American Health Organization (PAHO), "Nicotine Addiction and Smoking Cessation," Policy Brief, 1999; http://165.158.1.110/english/hpp/wntd_policy.htm.
6. Fiore MC, et al, op cit.
7. Pollex S, Adams J. Baylor Health Care System's Office of Tobacco Education and Research: inception and evolution. Baylor Proceedings, January 2001.
8. Fiore MC, et al, op cit.
9. Fiore MC, et al, op cit.
10. Rohren CL, Croghan IT, Hurt RD, Offord KP, Marusic Z, McClain FL. Predicting smoking outcome in a medical center from stage of readiness: contemplation versus action. Prev. Med 1994; 23:335-344.
11. Kottke TE, Battista RN, DeFriese GH, Brekke ML. Attributes of successful smoking cessation interventions in medical practice. A meta-analysis of 39 controlled trials. JAMA 1988; 259:2883-2889.
12. Prochaska J, DiClemente C. (1982). Transtheoretical therapy toward a more integrative model of change. Psychotherapy: Theory, Research and Practice, 19 (3), 276-287.
13. Fiore MC, et al, op cit.
14. Fiore MC, et al, op cit.
15. Asma S, Yang G, Samet J, Giovino G, Bettcher DW, Lopez A, Yach D. Tobacco. In Oxford Textbook of Public Health, in press.

Continued from page 1

NLHEP GUIDELINES ARE A NATURAL FOR YOU!

If the patient answers "yes" to any one of these questions, he/she should have a simple spirometry test - a test that can and should be performed in the PCP's office. And the only numbers that the doctor needs to interpret are the FEV1, FEV6, and the ratio between the two. As always, good patient effort and reproducibility are the keys to validity.

Given this information, what can you, the RT in continuing care/rehab, do to support the NLHEP guidelines? Here are some ideas:

- Encourage the doctors you work with to become familiar with the NLHEP guidelines. Become a NLHEP "expert" and share the literature with them.
- Help develop and implement a smoking cessation program in your hospital. Talk to school children and large employee groups about smoking and health.
- Set up a "case finding" spirometry program and screen those who fit the criteria. Test fellow employees and the public who come to your facility. You can do testing in the local mall, senior citizens center, and churches and synagogues. How about at the YMCA, local health clubs, and area pharmacies?

Put the following on your "read and share" list:

- The Lung Health Study. JAMA 1994;272:1497-1505.
- Strategies for Preserving Lung Health and Preventing COPD and Associated Diseases. The National Lung Health Education Program. Chest 1998;113(2Suppl): 123S-163S (reprinted in Resp Care, 1998;43[3].
- Petty TL. Simple Office Spirometry. Clinics in Chest Medicine 2001;22(4).
- Chronic Obstructive Pulmonary Disease Surveillance - United States, 1971-2000. Centers for Disease Control. Aug 2002/Vol. 51/No. SS-6.

Those of you who work with COPD patients every day do not need anyone to tell you how this disease devastates patients and their families! How many of you would love to leave your current work setting because there were no more COPD patients to treat? The only way to make that happen for future RTs is to be proactive.

So get out there and talk about the effects of smoking. Set up a smoking cessation program. Work with the PCPs in your area to test those who are most likely to have early disease. Become an expert in the latest treatment options.

There is so much you can do to make a difference! Find out more about NLHEP at www.nlhep.org. Or contact me directly at gl-lungs@swbell.net. ◆

The AARC Needs You!

Did you know it takes more than 500 active volunteers to successfully run the vast and varied programs and services offered by the AARC every year? Who should take on these responsibilities? How about you?

President-elect David Shelledy, PhD, RRT, is currently seeking volunteers to serve on various AARC committees and in numerous other capacities during his presidency in 2003. If you'd like to sign up - or just find out more about how you can become more involved in your professional association - check out the following link on AARC Online: www.aarc.org/headlines/volunteer. ◆

NOVEMBER IS COPD AWARENESS MONTH

American Association for Respiratory Care
11030 Ables Lane
Dallas, Texas 75229-4593

CRCE Online: Click Here, You're There!

Don't forget that you can pick up Continuing Education credits by logging onto CRCE Online at the AARC web site. AARC members receive the highest discounts and have their credits tracked for them through CRCE. Anywhere, anytime, you can access quality continuing education at www.aarc.org. ◆

More AARC Education Courses in 2002 and 2003 All are accredited for CRCE

Polysomnography Registration Preparation Course
Nov. 9-10, 2002 Cleveland, OH

Asthma Education Certification Preparation Course
Dec. 7-8, 2002 Cleveland, Ohio

Patient Assessment Skills Course
April 4-6, 2003, Atlanta, Georgia

Polysomnography Registration Preparation Course
May 3-4, 2003 Dallas, Texas

Summer Forum
July 25-27, 2003 Orlando, Florida

Learn more at www.aarc.org
or by calling 972-243-2272

The High Cost of Prescription Drugs

Many senior citizens are failing to take their medications as prescribed, but it doesn't have anything to do with their ability to remember the correct dosing. According to a new survey from the Kaiser Family Foundation and the Commonwealth Fund, nearly a quarter of all seniors are skipping doses or failing to fill prescriptions because the drugs cost more than they can afford.

The survey found about one in four seniors spends $100 a month or more on prescriptions, and even in states with the highest rates of prescription drug coverage, about one in five lacks prescription drug benefits. Many low income seniors also decline to apply for Medicaid programs that might help, believing Medicaid is only for welfare recipients and could affect their other benefits, or because they can't figure out how to fill out the forms involved.

The survey was conducted among more than 10,000 people age 65 and older in eight states. ◆

Tai Chi Helps Elders Regain Fitness

The low impact Chinese exercise known a tai chi can benefit older adults who are the least physically fit, say investigators who tested the exercise among a group of people age 65 and older, some of whom had limited physical functioning.

The researchers enrolled the participants in twice-weekly tai chi classes, then measured their progress. Those who were originally fit gained little from the exercise, but those who were the least fit reported significant improvements in their self-rated functional limitations in as little as three months. After six months, they were twice as likely a comparison group of wait-listed adults to report not being limited in their ability to perform moderate to vigorous activities.

The study was published in a recent issue of the American Journal of Preventive Medicine.