5720
Ser 16G8/
Nov 24, 2009

From: Commanding Officer, Naval Hospital Bremerton
To: All Ships and Stations, Puget Sound

Subj: HEALTH CARE CONSUMER COUNCIL MEETING MINUTES OF 3 SEPTEMBER 2009

Encl: (1) Attendance roster

The Health Care Consumer Council (HCCC), chaired by Mr. Terry Roberts, Director for Healthcare Business, met at 1000, 3 September 2009, at Naval Hospital Bremerton (NHB) in Ross Auditorium. Captain M. E. Brouker, Commanding Officer, Naval Hospital Bremerton, presided. Enclosure (1) lists attendees.

The CO welcomed everyone and indicated today's agenda included a brief on NHB's Tobacco Cessation (TC) Program, new behavioral health programs and a Health Promotions quarterly update.

Mr. Roberts introduced Mr. Vaughn, Substance Abuse and Rehabilitation Program counselor.

Mr. Vaughan: The addiction of excessive nicotine is chronic, progressive and fatal; basically it's a three-headed dragon because there's a biological, psychological and a social aspect to it. All three aspects need to be treated simultaneously; if not, the individual will relapse. This explains why there is such a high relapse rate. If you look around, people try and try and try. They believe they can take a pill, put on a patch or chew gum and it's a magical program. These are people with an addiction who want instant gratification: They don't want to have to do anything, they just want to put something on or take something and be done with it. But that's not the way it works. Some recent studies show between 60 to 75 percent of people who use tobacco may also have an undiagnosed co-occurring disorder. Usually, it's an undiagnosed mood disorder such as depression, dysthymia or some form an anxiety disorder. When people start smoking, usually at a young age, it's primarily due to peer pressure. Then, after a while they say, "Hey, this actually works for me," and so they continue to smoke (along with the addictive processes of the nicotine and the other 4,000 chemicals involved). So people go through withdrawal symptoms when they're trying to quit, they'll usually make it about three

days, and the third day is usually the worst because by that time the nicotine is out of their system, but you have 4,000 other toxins. You're talking Cyanide, Arsenic, Cadium, Plutonium 210, etc. A person using tobacco products for a long time begins to develop enough of a tolerance for those toxins not to be fatal. Our bodies will adjust to almost anything; but there's a pay back when we stop using it which are withdrawal symptoms. Withdrawal symptoms will last approximately a week to two weeks, and then around four weeks there may be what are called "post acute withdrawal symptoms," which are not physiological but more psychological. There is also a behavior change, and it takes about 21 days for a behavior change to start to take place. So, if we're trying to change a behavior, think about going from being right-handed to left-handed which is similar to what people are doing when trying to quit tobacco products. People are trying to change a behavior that's been going on for a long time. They can almost set their clock by how they smoke: They get up in the morning, they go to the restroom; they grab a cup of coffee; they go outside and have a cigarette, or maybe two, because they're in withdrawal from the night before; and they go back inside, shower and get dressed; go back out and have another cigarette; grab their lunch; get in the car and head to work. Then they stop at the smoking shelter on the way into work or go in and drop off their stuff, grab another cup of coffee and go out to the smoking shelter. Then at ten o'clock they're going to the smoke shelter to take a break. Then noon comes around: smoke, back in; then at 1400 go smoke, back in; then it's another two cigarettes on the ride back home. Then they get home and their pattern/rut/habit continues. Then you have the operative condition where the phone rings and you light up. Because their habit/routine tells them, "Phone rings, got to have a cigarette," so they go outside and light up. And it's all these habits and behaviors that are similar to “How many times do you brush your teeth on the left side, up and down?” Nobody can really answer that question. You've been doing it for so many years, it's an unconscious behavior; it just becomes part of who you are. That's why it's challenging to work with these people because they are ingrained to behave on auto pilot. It's the same as working with any other drug addiction: Cocaine, heroine or alcohol. We're dealing with a biological, psychological and social aspect. Their identification has become: ”I am a smoker, that’s what I do”. When we take that away from them, or they want to quit, its like, "Well, what happens to my routine?" Because we all like our routines in our lives and we have these ruts and we furnish them but we don't like people messing with our

“furniture”. So what we have learned to do is take that rut and refurnish it and teach them new ways to accommodate those behaviors. Like how do they not go to the smoking shelter? That's clearly some of the hardest things to do is to get people to change their behavior. The biological aspect is pretty simple: We can use Nicotine Replacement Therapy (NRT), and there are many types available some with more side effects than others that may impair your ability to operate a car. What we do in our SARP is have counselors that have gone through addiction training. We spend enough time with each patient where we can work with the patient to decide how we're going to treat each one individually, as well as have time to ask questions about alcohol and other kinds of possible issues that may be problematic for them and has the potential to interfere with their ability to quit. The intake takes approximately 60 minutes because one of the biggest things most people share is they relapse from stress -- so one of the questions we ask is, "What kind of internal or external stressors do you have? Are you going through a move; did you just get here? Are you getting ready to retire? Just retired? Do you have financial problems or relationship problems, etcetera? We hear many times people are embarrassed about relapsing and we reassure them that it’s normal due to all things occurring in someone’s life. The reason why people aren't able to quit is they can't control everything externally going on around them, but we can offer them some skills that can help. It's not a bad sign if someone relapses, as long as they are willing to keep trying. For the SARP patients that have an alcohol problem we really stress quitting tobacco use because there is a 25 to 30 percent greater chance of them remaining absent not only from cigarettes, but also from alcohol; the relapse rate drops by 25 to 30 percent if they quit smoking at the same time. We do hear a lot of times people saying, "Well, you shouldn't quit everything all at once." Our response is "So that means if I'm using heroin I shouldn't quit smoking marijuana." We're trying to change their thought process and behaviors on quitting. In a nutshell, we sit down and take the time to find out exactly what's going on with them and then refer them to the appropriate places they need to go if necessary. They may need to see a PCM for medication management; they may have a mental health issue; or we may need to do an alcohol screening. If they have some specific issues that are causing them to use tobacco, such as having marital discord or relationship problems, they may need to be referred to the Fleet and Family Service Center. If you don't take care of those issues then they're not going to be able to quit. We also send them to the nutritionist or to the

gym to talk to one of the personal trainers to get a physical training plan. That's one of the things we want them to do because most smokers have let their physical fitness go. It's estimated that for an active duty member that quits smoking, they will gain one to one and a half minutes off their run. That's pretty significant. One third of individuals who try to quit will make it after a couple of attempts. One third will take multiple attempts to finally quit and then there is one third that is just not capable of quitting. Those are the people that we really can't do anything for. It's not that we don't try to help them, because as long as they keep trying, we'll keep working with them. Our focus is mostly on the new quitters and the patients that have multiple attempts because we know that they will eventually get it. Our approach isn't in and out in 15 minutes, "Here's the patch, here's a drug and see me in two weeks." We offer individual one-on-one counseling or we have group sessions. Last year we had a ten percent difference in the success rate between one-on-one and group counseling. That's fairly significant: ten percent. Our statistics show that for last year, we had approximately 76 percent in group and 68 percent in one-on-one, success rates. For three months follow up we had almost an 85 percent success rate. A lot of people kept coming back.

Mr. Roberts stated there are a number of NHB staff who dip/chew tobacco, does everything you shared apply to these people as well? Mr. Vaughan stated, “absolutely.” It's the nicotine they want not really the tobacco. That's why you see a big push on snuff/chew smokeless tobacco, because people who use these products don't have to spit. By using the pouches in their mouth, they can easily move it around. The tobacco companies are aggressively marketing these products. Mr. Roberts asked if the same warning pertained from the Surgeon General and Mr. Vaughan stated it did. Mr. Roberts asked what NHB could do to promote NHB’s program to the Fleet. Mr. Vaughan stated there were a couple things that can be done, and what they've been doing for the Fleet is that if the Stennis, for example, wants to have their own program onboard their ship, then all they have to do is call me (John Vaughan at (360) 351-3901/02) and I will work with preferably somebody from their medical department and train them to be a tobacco cessation coordinator to run groups on their ship. The biggest issue that most of the commands have is turn over and a lack of funding for NRT while at sea. But while they are in port we will be more than happy to treat them and follow them up. The only caveat to that is they need to be in port at least eight weeks. One of the things we've

discovered, since 1999, is it's easier for people to quit while they're underway. At sea you go do your job, do your duty, go to the movies, sleep, go back to your job and you don't have to worry about all those other stressors inherent to being in port (family duties, bills, home maintenance, etc.). The difficulty with working with the Fleet is the high staff turnover. As far as the ship's OPTAR, I've suggested the ship's store profit from selling tobacco be used to for NRT. CAPT Brouker stated he could not pay for the Fleets NRT, bottom line, but that should not reduce any steps in doing the right thing. Mr. Vaughan agreed and reinforced they need a minimum of eight weeks with an individual so they can be monitored and if they relapse they can be supported. A relapse is not a failure. The only way to fail is to give up and stop coming back.

UNIDENTIFIED SPEAKER: Can people self-refer?

Mr. Vaughan: They can walk-in. We have someone here at NHB on the 7th Floor five days a week. We also have a program at Bangor from 1100-1200 on Thursdays and a group here at NHB on Tuesdays. Doctors may also put in a consult. The patient can call and make an appointment, or walk in and get all the information they need. We try to make it very user friendly.

Mr. Roberts introduced Ms. Susan Scott, TriWest, and stated she would speak about mental health programs.

Ms. Scott indicated she had a DVD handout available, entitled "Help From Home," and asked everyone to take one. She indicated one of the topics covered on the DVD is a crisis line available by calling the 1-888-TRIWEST number. She also covered a TRICARE tri-fold card which lists all the regional TRICARE contractors and overseas contractors, and provides contact information for all other TRICARE services. She then presented a slide show on TriWest Online Care which can be accessed by calling 1-888-874-9378 or on line at www.triwest.com/bh. She stated the access/information is confidential and non-medical counseling is available 24/7 via video conferencing. She indicated no authorization/referral is required and information is provided by licensed counselors. She indicated the Tele-Behavioral Healthcare Network offers clinical services such as counseling, psychotherapy and medication management, which is provided by TRICARE network behavioral healthcare providers.

Subj: HEALTH CARE CONSUMER COUNCIL MEETING MINUTES OF 3 SEPTEMBER 2009

Mr. Roberts introduced Ms. Aimee Aldendorf from Health Promotions.

Ms. Aldendorf shared she is a health educator in Health Promotions. She stated on October 23rd the Health and Wellness Day will take place from 8 AM to 4 PM; they will have interactive displays and literatures on the quarterdeck and seminars in Ross Auditorium where providers will come in and discuss diabetes, depression and women's and men's health.

Mr. Roberts thanked everyone for attending and the meeting was adjourned.

The point of contact for these minutes in the Healthcare Business Directorate is Mr. Hank Rose, Code 16G8, at (360) 475-4365.

/s/ T. D. ROBERTS
By direction