Smoking Cessation Leadership Center

UCSF

University of California San Francisco

Leveraging Quitlines for Tobacco Cessation: Real-World Implementation

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August 24, 2021

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A National Center of Excellence for Tobacco-Free Recovery

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Disclosures

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Anita Browning, Christine Cheng, Brian Clark, Michael C. Fiore, MD, MPH, MBA, Joann Yoon Kang, JD, Jennifer Matekuare, Chad Morris, PhD, Ma Krisanta Pamatmat, MPH, Jessica Safier, MA, Catherine Saucedo, Steven A. Schroeder, MD, and Aria Yow, MA.

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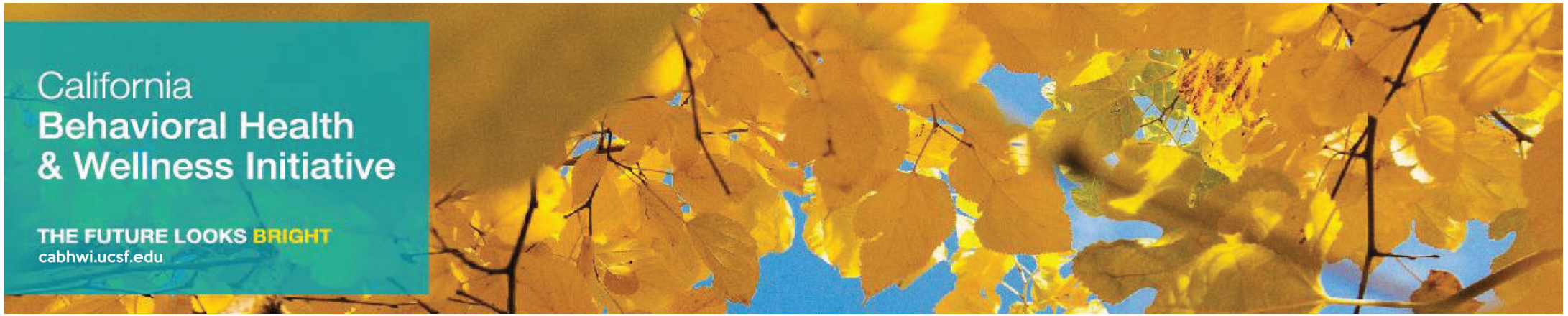
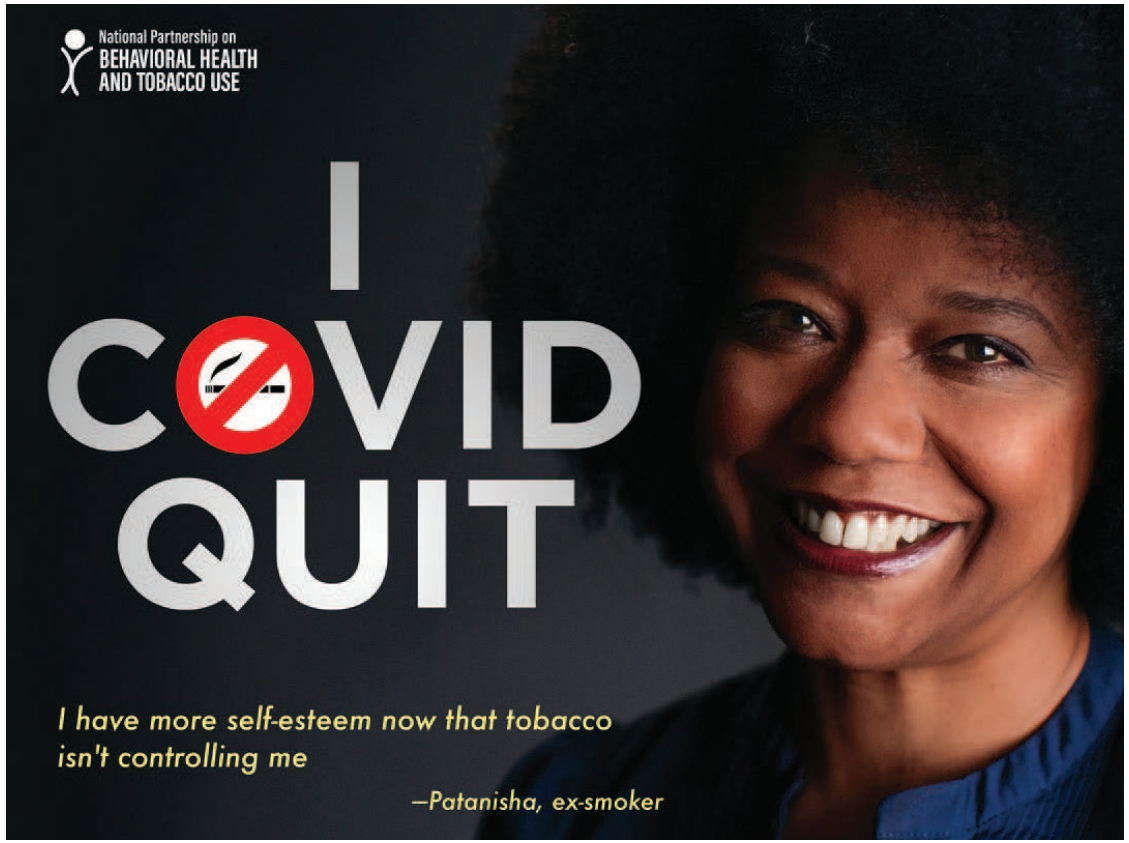


- **Free CME/CEUs** will be available for all eligible California providers, who joined this live activity thanks to the support of the California Tobacco Control Program (CTCP)
- For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.
- For technical assistance please contact (877) 509-3786 or Jessica.Safier@ucsf.edu.
- Visit CABHWI.ucsf.edu for more information

- CDC Tips Campaign 2021 – celebrating 10 years!
- SCLC will partner with the CDC to promote **1 800 QUIT NOW** through new ads as well as some former favorites
- Free NRT available the week of Aug. 30 (next week!) for folks calling the quitline

I COVID QUIT!

- Launched March 31



- SCLC's own campaign funded by Robert Wood Johnson Foundation
- Real people sharing their UNSCRIPTED experiences of improved mental health after quitting smoking—and they did it during the COVID-19 pandemic!
- FREE videos, digital images and toolkit for your use at ICOVIDQUIT.org
- We are also looking for more stories, particularly from those who represent underserved communities! Please email anita.browning@ucsf.edu if you would like to share your story

UCSF

Today's Presenter

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Team Lead, Health Systems and Data Visualization, Policy Unit

Office on Smoking and Health (OSH) at the Centers for Disease Control and Prevention (CDC)

Today's Presenter

Michael C. Fiore, MD, MPH, MBA

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University of Wisconsin School of Medicine and Public Health

Today's Presenter

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Clinical Psychologist and Professor of Psychiatry

University of Colorado - School of Medicine

Director of the Behavioral Health & Wellness Program and Wellness Leadership Institute

THE ROLE OF QUITLINES IN TOBACCO CESSATION

JOANN YOON KANG, JD| POLICY UNIT | OFFICE ON SMOKING AND HEALTH

Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

SCLC Webinar: August 24, 2021

DISCLOSURES

- Presenter is an employee of the U.S. Government.
- Presenter has no conflicts of interest to disclose.

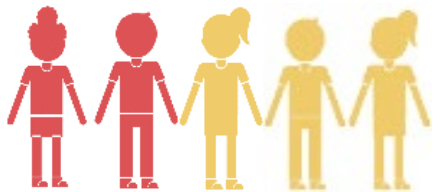
SMOKING IS THE LEADING CAUSE OF PREVENTABLE DISEASE, DISABILITY, AND DEATH IN THE UNITED STATES

34M

An estimated **34.1 million** U.S. adults smoked in 2019.[1]

480,000

Cigarette smoking and secondhand smoke exposure kill about **480,000** people in the U.S. each year.[2]



2 in 5

About **two in every five children** are exposed to secondhand smoke.[3]

1 vs. 30

For every one smoking-related death, **at least 30** people live with a serious smoking-related illness.[2]

$300B

Each year, cigarette smoking costs the United States more than **$300 billion**, including $170 billion in direct medical costs and $156 billion in lost productivity.[2,4]

1. Cornelius ME, et al. Tobacco Product Use and Cessation Indicators Among Adults – United States, 201. MMWR 2020; 69(46);1736–1742.
2. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. (https://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm) Atlanta, 2014.
3. Tsai J, Homa DM, Gentzke AS, et al. Exposure to Secondhand Smoke Among Nonsmokers — U.S., 1988–2014. MMWR Morb Mortal Wkly Rep 2018;67:1342–1346. DOI: http://dx.doi.org/10.15585/mmwr.mm6748a3
4. Xu X, Bishop EE, Kennedy SM, Simpson SA, Pechacek TF. Annual healthcare spending attributable to cigarette smoking: an update. Am J Prev Med 2015; 48(3):326-33.

DISPARITIES PERSIST
Current Cigarette Smoking Among U.S. Adults, 2019

Race/Ethnicity

20.9% American Indians/Alaska Native

15.5% White

Education Level

35.3% GED

4.0% Graduate degree

Annual Household Income

21.4% <$35,000

7.1% ≥$100,000

Health Insurance Coverage

22.5% Uninsured

24.9% Medicaid

10.7% Private

8.6% Medicare

Disability

21.1% Yes

13.3% No

Sexual Orientation

19.2% Lesbian/Gay/Bisexual

13.8% Heterosexual

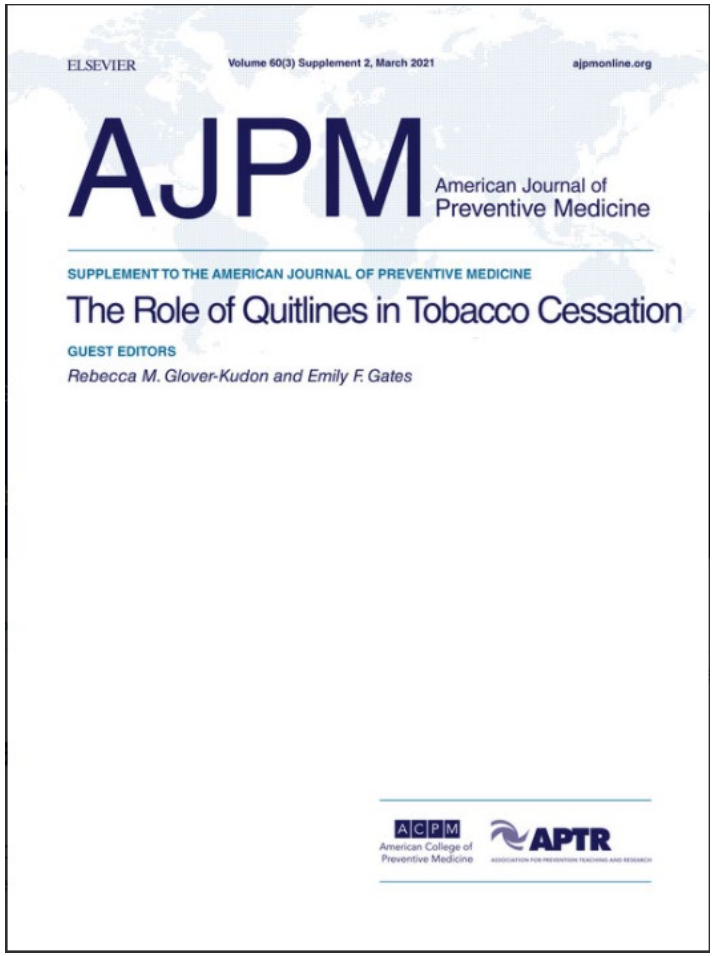
Generalized Anxiety Disorder

34.5% Severe

12.0% None/ Minimal

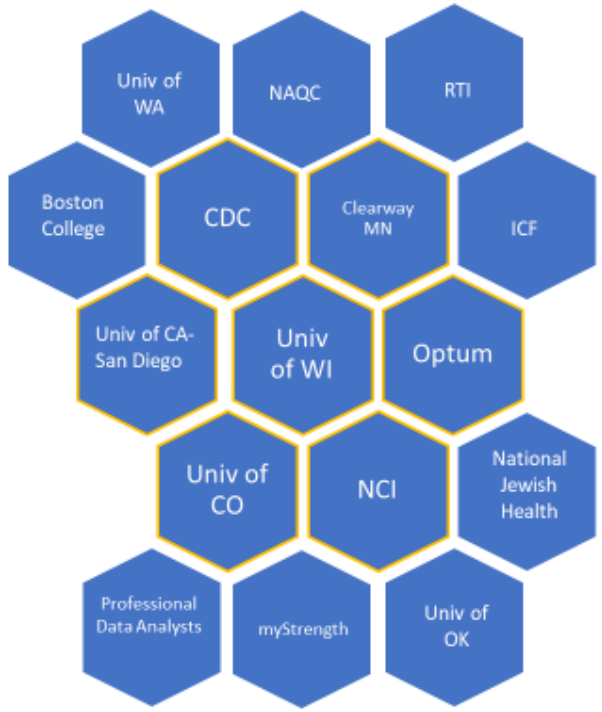
Source: Cornelius ME, et al. Tobacco Product Use and Cessation Indicators Among Adults – United States, 201. MMWR 2020; 69(46);1736–1742.

AJPM SUPPLEMENTAL ISSUE ON QUITLINES

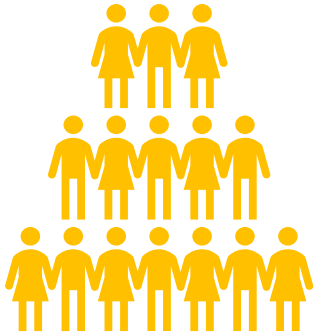


"Better health through better partnerships"

VADM Jerome M. Adams, MD, MPH, U.S. Surgeon General

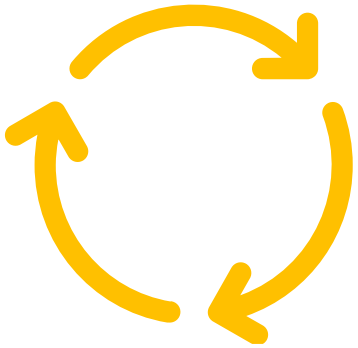


SUPPLEMENT THEMES



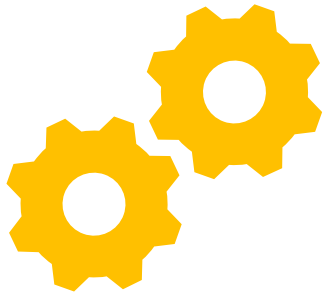
Reach

Ways to improve and assess reach to ensure access to cessation services for individuals seeking help in quitting tobacco



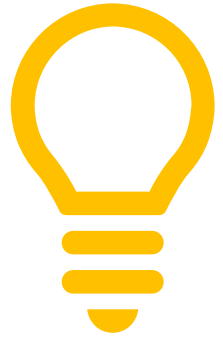
Adapt

Efforts to adapt and expand existing quitline services to incorporate new or modified components



Tailor

Strategies to tailor quitline services to address the needs of populations experiencing higher prevalence of smoking



Innovate & Sustain

Approaches that innovate to extend access to cessation support using digital modes

INTRODUCTION

The Role of Quitlines in Tobacco Cessation: An Introduction

R Glover-Kudon, EF Gates

Ten Million Calls and Counting: Progress and Promise of Tobacco Quitlines in the U.S.

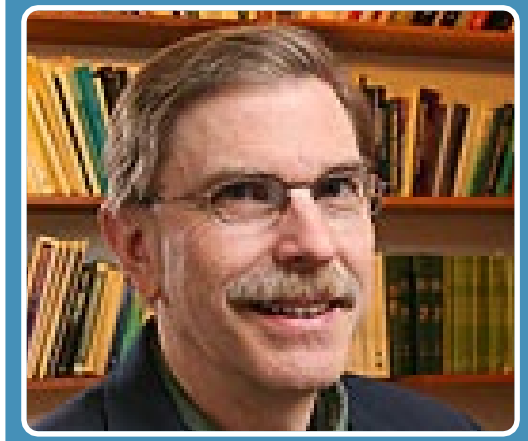
MC Fiore, TB Baker

REACH

Differences in Quitline Registrants' Characteristics During National Radio vs. Television Antismoking Campaigns

L Zhang, R Rodes, N Mann, J Thompson,

T McAfee, R Murphy, R Frank, K Davis, S Babb



Closed-Loop eReferral from Primary Care Clinics to a State Tobacco Cessation Quitline: Effects Using Real World Implementation Training

TB Baker, KM Berg, RT Adsit, AD Skora, MP Swedlund, ME Zehner, DE McCarthy, R Glasgow, MC Fiore

REACH

Utilizing Reach Ratios to Assess Menthol Cigarette Smoker Enrollment in Quitline Services

J D'Silva, RK Lien, R Lachter, PA Keller

Tobacco Smoking Cessation and Quitline Use among Adults Aged 15 Years or Older in 31 Countries: Findings from the Global Adult Tobacco Survey

IB Ahluwalia, AL Tripp, AK Dean, L Mbulo, RA Arrazola, E Twentyman, BA King

ADAPT

Online Versus Telephone Registration: Differences in Quitline Participant Characteristics

PA Keller, RB Lachter, RK Lien, J Klein

Vaping and E-Cigarettes Within the Evolving Tobacco Quitline Landscape

KA Vickerman, K Carpenter, M Raskob, C Nash, R Vargas-Belcher, LA Beebe

TAILOR

Evaluation of the Asian Smokers' Quitline: A Centralized Service for a Dispersed Population

C Chen, CM Anderson, SD Babb, R Frank, S Wong, N Kuiper, S-H Zhu

Quitline Programs Tailored for Mental Health: Initial Outcomes and Feasibility

CD Morris, AV Lukowski, RA Vargas-Belcher, TE Ylioja, CM Nash, LA Bailey

INNOVATE & SUSTAIN

Using Digital Technologies to Reach Tobacco Users Who Want to Quit: Evidence From NCI's Smokefree.gov Initiative

YM Prutzman, KP Wiseman, MA Grady, A Budenz, EG Grenen, LK Vercammen, BP Keefe, MH Bloch

Tobacco Cessation Quitlines: An Evolving Mainstay for an Enduring Cessation Support Infrastructure

KA Hacker, JY Kang

TOBACCO CESSATION QUITLINES:

An Evolving Mainstay for an Enduring Cessation Support Infrastructure

- Tobacco use continues to compromise the health and wellbeing of our nation
- Tobacco cessation remains critical
- Tobacco cessation is possible
- Tobacco cessation quitlines play a key role
- The AJPM Special Issue highlights the ways quitlines contribute to a strong cessation support infrastructure
- Quitlines remain essential as we modernize cessation support

THE IMPORTANCE OF CESSATION IN OUR CURRENT CONTEXT

Vaccine Information for People with Certain Medical Conditions.

This information is intended for a general audience. Healthcare providers should see Underlying Medical Conditions Associated with High Risk for Severe COVID-19 for more detailed information.

Smoking, current or former

Being a current or former cigarette smoker **can make you more likely** to get severely ill from COVID-19. If you currently smoke, quit. If you used to smoke, don't start again. If you've never smoked, don't start.

Get more information:

- Smoking & Tobacco Use | CDC
- How to Quit Smoking | Quit Smoking | Tips From Former Smokers | CDC
- Health Benefits of Quitting Smoking | CDC

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html#smoking

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www.cdc.gov/tobacco

The findings and conclusions in this presentation are those of the presenter and do not necessarily represent the views of the Centers for Disease Control and Prevention.



Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Office on Smoking and Health

Promoting Quitline Use by Primary Care Patients: The Power of eReferral via the Electronic Health Record

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UW Center for
Tobacco Research and Intervention
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SCHOOL OF MEDICINE AND PUBLIC HEALTH

No conflict of interest to declare.

Outline

1. Evolution of Quitlines in the United States
2. Characteristics and reach of Quitlines
3. Quitlines role in primary care treatment
4. Implementation of eReferral in primary care health systems
5. Impact of Quitline eReferral in various subpopulations

Outline

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Evolution of Quitlines in the United States

The Quitline has come a long way

2002: HHS Established Subcommittee on Cessation

- Developed recommendations to increase rates of tobacco cessation
- Proposed National Network of Tobacco Cessation Quitlines (1-800-QUIT NOW)

2004: Launched 1-800-QUIT NOW

- Nationwide portal provides uniform access to Quitlines

2019: 1-800-QUIT NOW Received 10 millionth call

- Millions of smokers have quit tobacco since its inception.

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Characteristics and reach of Quitlines

Core Characteristics of Quitlines

1

SCIENCE BASED

Two decades of research shows Quitlines increase a smoker's likelihood to quit smoking by 60%.

2

DELIVER EVIDENCE-BASED TREATMENT

Trained counselors who coordinate provision of FDA-approved pharmacotherapy.

3

COST EFFECTIVE

Quitlines save money. Repeated economic analysis shows cost savings.

Quitline Reach Enhanced By:

MINIMAL BARRIERS TO TREATMENT

- Free
- No travel needed
- No health insurance required

NATIONAL AND STATE MEDIA CAMPAIGNS

- Tips® markedly increased motivation among smokers to call the Quitline
- Target underserved, high-tobacco using populations
- Close correlation between promotion and calls

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Quitline role in primary care treatment

Quitline Serves as Treatment Extender in Primary Care

- Quitlines reach an estimated half a million tobacco users in the United States each year
- 75% of adult cigarette smokers have at least 1 primary care healthcare visit every year
- Quitlines provide a referral option when clinicians are reluctant or unable to intervene with patients who smoke
- Scope of treatment reflects evolving landscape of tobacco products, including smokeless tobacco, ENDS, and underserved populations

From Fax Referral to eReferral (Adsit et al)

- Enhanced referral from fax-to-quit paper method to electronic health record-based electronic referral (eReferral)
- Prompted smoker identification, assessment of interest in cessation treatment, and referral to Wisconsin Tobacco Quit Line (WTQL)
- WTQL attempted to contact patient and then provided secure feedback into patient's EHR
- Thus, a bidirectional, closed-loop EHR-based treatment option

Referral to Quitline increased from 0.3 to 14%

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Implementation of eReferral in primary care health systems

American Journal of
Preventive Medicine

RESEARCH ARTICLE

Closed-Loop Electronic Referral From Primary Care Clinics to a State Tobacco Cessation Quitline: Effects Using Real-World Implementation Training

Timothy B. Baker, PhD,[1,2] Kristin M. Berg, MD, MS,[1,2,3] Robert T. Adsit, MEd,[1] Amy D. Skora, BS,[1] Matthew P. Swedlund, MD,[3,4] Mark E. Zehner, MS,[1] Danielle E. McCarthy, PhD,[1,2,3] Russell E. Glasgow, PhD,[5] Michael C. Fiore, MD, MPH, MBA[1,2,3]

UW Center for
Tobacco Research and Intervention
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Electronic Health Records (EHRs) can help:

1. Identify Smokers

2. Prompt cessation treatment offers

3. Facilitate treatment referral

BACKGROUND

CHALLENGE

- It is less known how effective eReferral can be implemented in real-world setting vs research context

How Baker et al addressed challenge:

- Implemented in a real-world health system
- The healthcare system, not the research team, managed implementation.
- Intervention collaboratively designed by:
  - UW Health leadership
  - UW-CTRI research and outreach teams
  - Wisconsin Tobacco Quit Line (WTQL)
- Became the sustained new standard of care rather than a time-limited research trial

Timeline

July 2016 – May 2017
Intervention conceptualized, designed, and pilot tested in 1 large clinic.

May 2017
Program launched in all UW Health primary and urgent care clinics

January 2017 – December 2017
Data collection occurred:

- Target population: Adult patients (18+) listed as current tobacco users in EHR
- Assessment of readiness to quit
- Referral to Quitline

October 2018 – June 2019
Post-implementation data captured intervention:

- Reach
- Adoption
- Maintenance

WTQL eReferral Workflow and Feedback

1 Assess current tobacco use

- Roomer updated tobacco use status in EHR
- Documented readiness to quit within the next 30 days
- Offered Quitline eReferral to individuals ready to quit

2 EHR prompts eReferral Invitation

- Roomer opened order
- Documented consent to Quitline services, using text shortcuts and dropdown menus to document
- Pended order for clinician review

3 Clinicians address smoking cessation with patient

- Clinician prompted by order to discuss smoking cessation treatments, including cessation medications
- Clinician signed order for Quitline referral

WTQL eReferral Workflow and Feedback (cont.)

4 eReferral sent via secure message to WTQL

- Quitline attempted to contact patient up to 5 times.
- If successful, Quitline provided:
  - Counseling
  - 2 weeks of NRT
  - Urged patient to set a quit date

5 eReferral outcome sent via secure message to patient's EHR

Quitline electronically sends outcome to EHR within 2 weeks

Staff Training

Pre-Intervention Training – All Online

- UW Health computer-based training (CBT)
  - (CBT is the standard practice for all new clinical practice initiatives at UW Health)
- Complimentary CBT resources:
  - Online video
  - Slides
  - Screenshots detailing step-by-step instructions for:
    - EHR alerts
    - Workflows
    - WTQL information

Post-implementation Training & Feedback

- Included in new employee training after eReferral launch
- Monthly feedback provided to clinic managers regarding each roomer's rates of:
  - Assessment of willingness to quit
  - Quitline referral

MEASURES (USING RE-AIM FRAMEWORK)

REACH

Percentages of patients who smoked and were:

- Asked about making a quit attempt
- Referred to Quitline

EFFECTIVENESS

Percentage of patients who smoked and accepted WTQL treatment

ADOPTION

Percentages of roomers and clinicians who:

- Assessed interest in making a quit attempt
- Identified patients who smoked and were willing to make a quit attempt
- Referred to Quitline

IMPLEMENTATION

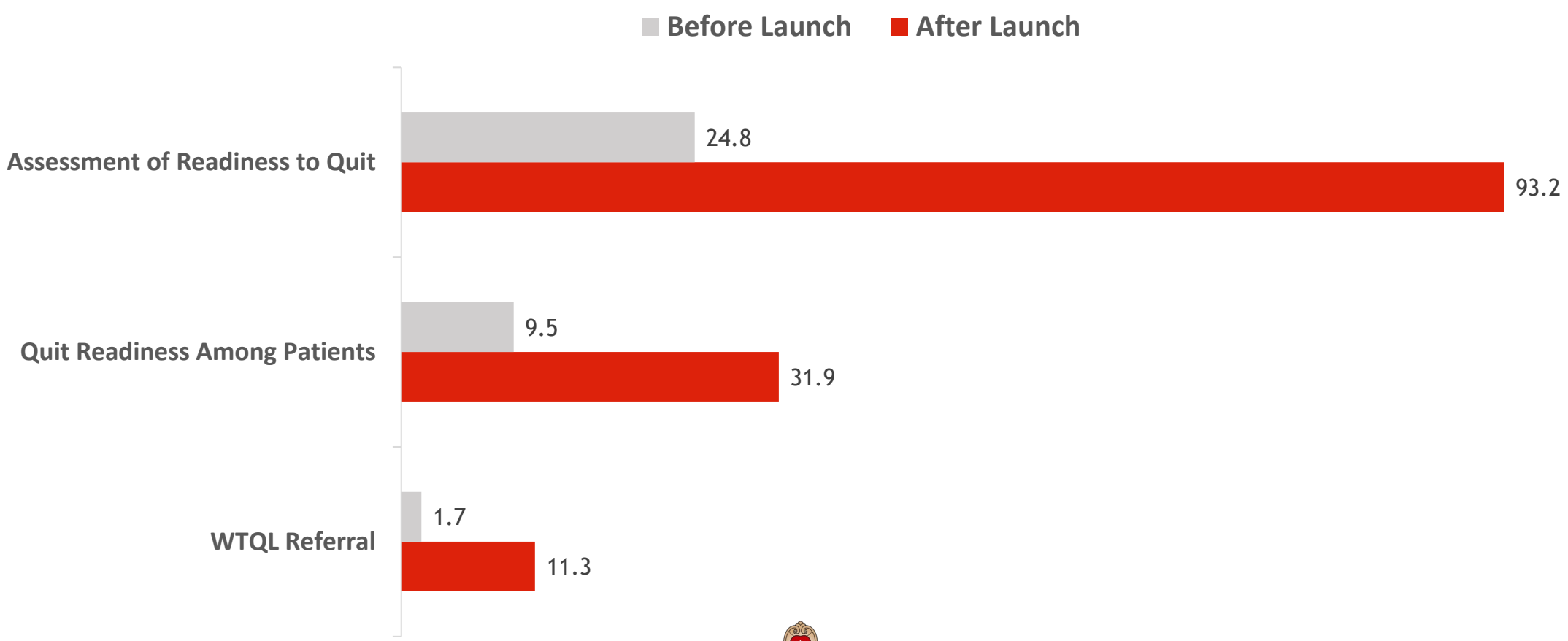
Assessed across 30 primary care clinics in the UW Health System

MAINTENANCE

Examined trends 8 months post-implementation for:

- Reach
- Adoption
- Maintenance

Results of Three Key Deliverables



Results: Staff (Roomer) Outcomes

Assessed 72.8% of patients for readiness to quit and 20.2% of these patients were ready to quit.

52.6% roomed at least 1 patient who smoked referred to the Quitline.

Those who saw very few patients who smoked underperformed across all outcomes.

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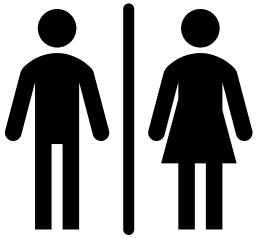
Impact of Quitline eReferral in various subpopulations

Population/Patient Level Variables

AGE

SEX

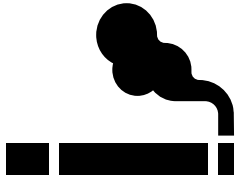


RACE

ETHNICITY

INSURANCE TYPE

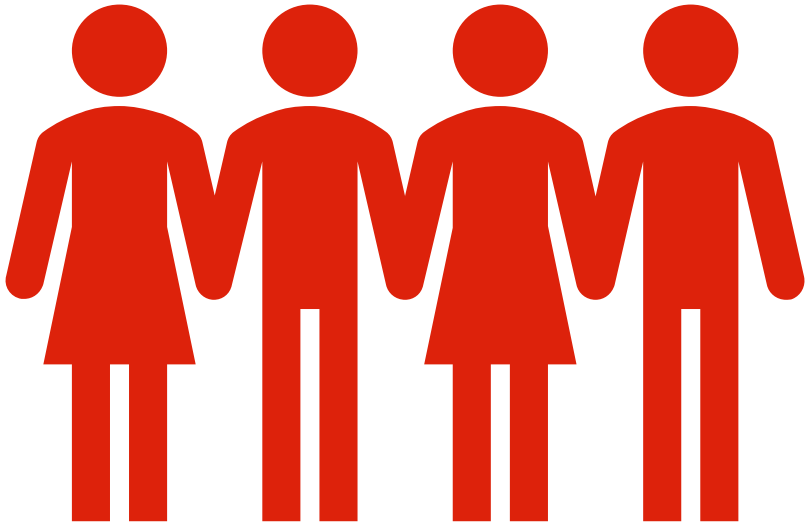
OTHER TOBACCO



Results: Patient-Level Variables

African American patients who smoked were more likely to be eReferred to the Quitline compared to White patients who smoked (15.5% vs 10.7%)

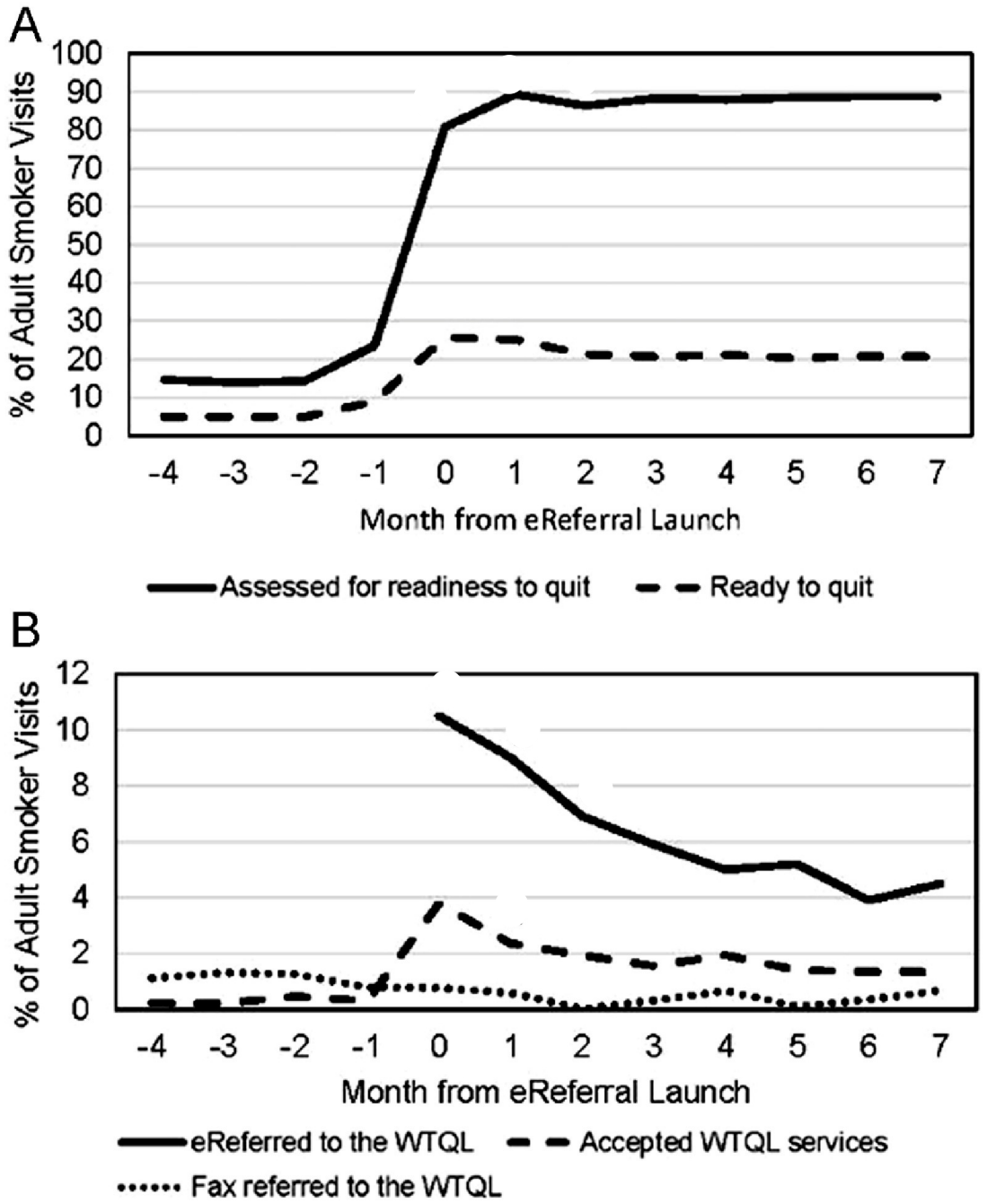
Those using other forms of tobacco in addition to cigarettes were less likely to be eReferred than those who only smoked cigarettes (3.7% vs 11.1%)



Results: Patient-Level Variables

Variable or level	Pre-launch (N=8,569)			Post-launch (N=11,977)			
	M (SD) or *n* (%)	Assessed, M (SD) or *n* (%)	Ready to quit, M (SD) or *n* (%)	M (SD) or *n* (%)	Assessed, M (SD) or *n* (%)	Ready to quit, M (SD) or *n* (%)	eReferred, M (SD) or *n* (%)
Age in years, M (SD)	48.0 (14.8)	48.1 (14.6)	46.8 (13.9)[a]	48.0 (14.9)	48.1 (14.8)[b]	47.6 (13.9)[c]	47.6 (13.6)
Number of clinic visits, M (SD)	1.6 (1.0)	—	—	1.9 (1.5)	1.1 (0.3)[d]	2.3 (1.9)[e]	2.4 (1.8)[f]
Sex, *n* (%)							
Men	3,981 (46.5)	1,007 (25.3)	370 (9.3)	5,620 (46.9)	5,245 (93.3)	1,751 (31.2)	570 (10.1)
Women	4,588 (53.3)	1,119 (24.4)	445 (9.7)	6,357 (53.1)	5,918 (93.1)	2,072 (32.6)	**781 (12.3)**
Race *n* (%)							
White	7,333 (86.7)	1,805 (24.6)	662 (9.0)[g]	10,238 (86.7)	9,576 (93.5)[g]	3,204 (31.3)[g]	1,100 (10.7)[g]
African American	902 (10.7)	234 (25.9)	120 (13.3)[h]	1,255 (10.6)	**1,139 (90.8)[h]**	**461 (36.7)[h]**	**194 (15.5)[h]**
Other minority group	220 (2.6)	56 (25.5)	21 (9.5)[g,h]	318 (2.7)	291 (91.5)[g,h]	93 (29.2)[g]	38 (11.9)[g]
Ethnicity, *n* (%)							
Hispanic	275 (3.2)	60 (21.8)	30 (10.9)	364 (3.1)	326 (89.6)	112 (30.8)	34 (9.3)
Not Hispanic	8,222 (95.9)	2,046 (24.9)	775 (9.4)	11,500 (96.0)	**10,735 (93.3)**	3,667 (31.9)	1,304 (11.3)
Insurance type, *n* (%)							
Commercial (yes versus no)	4,752 (55.5)	1,146 (24.1)	461 (9.7)	6,870 (57.4)	6,387 (93.0)	2,206 (32.1)	754 (11.0)
Medicare (yes versus no)	1,870 (21.8)	470 (25.1)	**152 (8.1)**	2,640 (22.0)	**2,484 (94.1)**	808 (30.6)	293 (11.1)
Medicaid (yes versus no)	1,534 (17.9)	402 (26.2)	**170 (11.1)**	2,088 (17.4)	1,956 (93.7)	**732 (35.1)**	**271 (13.0)**
Uninsured (yes versus no)	789 (9.2)	**235 (29.8)**	84 (10.6)	922 (7.7)	**874 (94.8)**	310 (33.6)	109 (11.8)
Other tobacco, *n* (%)							
Yes	416 (4.9)	75 (18.0)	16 (3.8)	598 (5.0)	531 (88.8)	95 (15.9)	22 (3.7%)
No	8,153 (95.1)	**2,051 (25.2)**	**799 (9.8)**	11,379 (95.0)	**10,632 (93.4)**	**3,728 (32.8)**	**1,329 (11.7)**
Total	—	2,126 (24.8)	815 (9.5)	—	11,163 (93.2)	3,823 (31.9)	1,351 (11.3)

RESULTS: MAINTENANCE



Discussion/Implications

- Real-world implementation increased reach of eReferral
- Reach was equitable across diverse smoker subpopulations
- 1/3 of patients willing to quit accepted Quitline referral
- eReferral increased Quitline connection rate from 0.6% to 3.6%
- Variation in assessment is likely due to roomer rather than patient factors
- Assessment of readiness to quit and smokers ready to quit were stable post-implementation
- eReferral rate dropped by 50% during 5 months post-launch

Limitations

No data on smoking outcomes

Cost and adaptation were not accessed

No evidence that explains staff variability

Conclusion

Real-world implementation of eReferral markedly increased:

- Assessment of readiness to quit
- Quitline referral rates

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1. Fiore MC, Croyle RT, Curry SJ, et al. Preventing 3 million premature deaths and helping 5 million smokers quit: a national action plan for tobacco cessation. *Am J Public Health*. 2004 Feb;94(2):205-210. PMCID:PMC1448229
2. Adsit RT, Fox BM, Tsiolis T, Oglund C, Simerson M, Vind LM, Bell SM, Skora AD, Baker TB, Fiore MC. Using the electronic health record to connect primary care patients to evidence-based telephonic tobacco quitline services: A closed-loop demonstration project. *Transl Behav Med*. 2014; 4:324-332. PMCID:PMC4167898
3. Baker TB, Berg KM, Adsit RT, Skora AD, et al. Closed loop electronic referral from primary care clinics to a state tobacco cessation quitline: Effects using real-world implementation training. *Am J Prev Med*. 2021 March;60(Suppl. 2):S113–22.

QUESTIONS?

Behavioral Health & Wellness Program

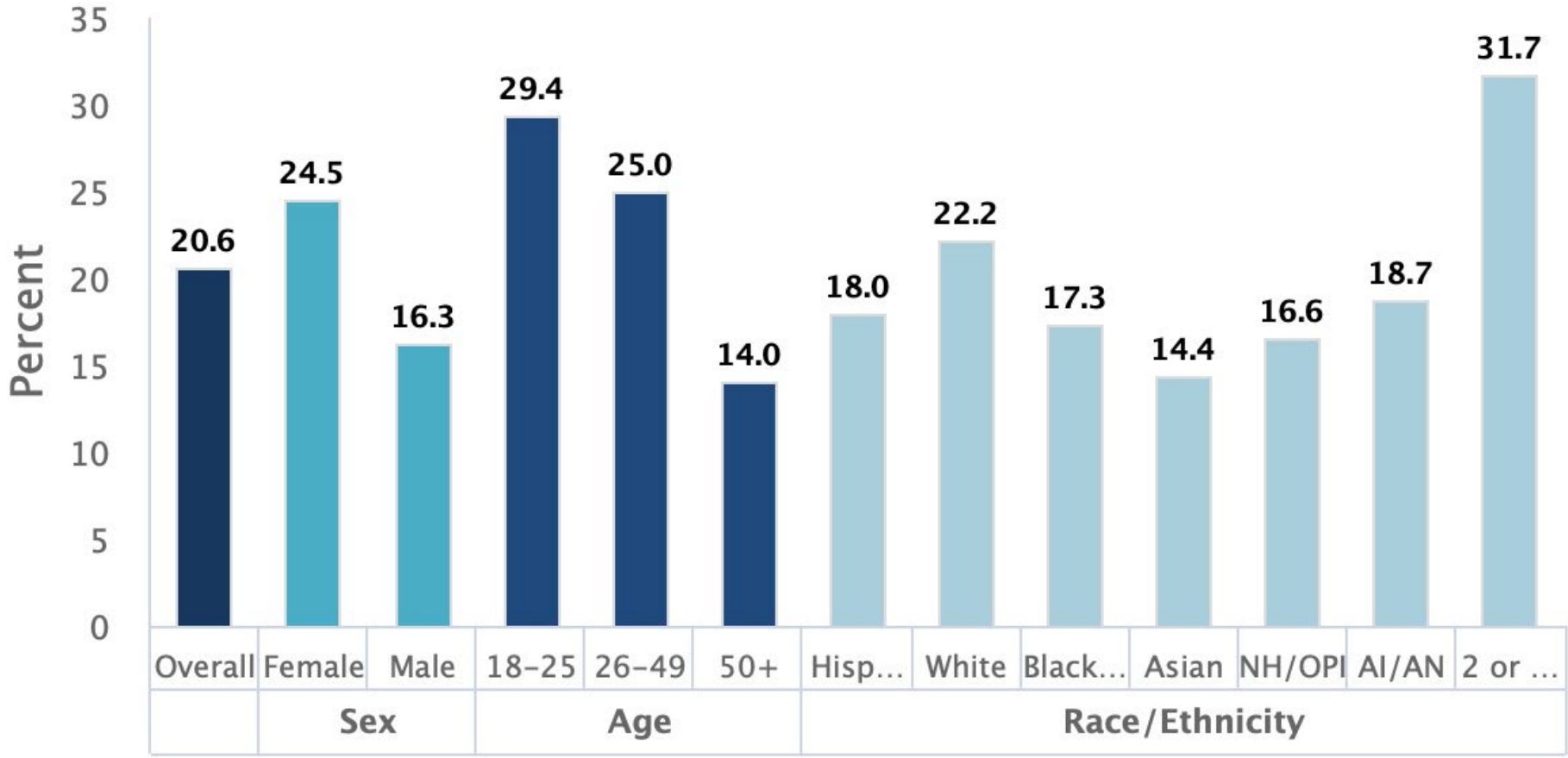
Leveraging Quitlines for Tobacco Cessation: Real-World Implementation

Chad Morris, PhD
24 August 2021

School of Medicine
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

Past Year Prevalence of Any Mental Illness Among U.S. Adults (2019)

Data Courtesy of SAMHSA



https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Treatment Effectiveness for the Behavioral Health Population

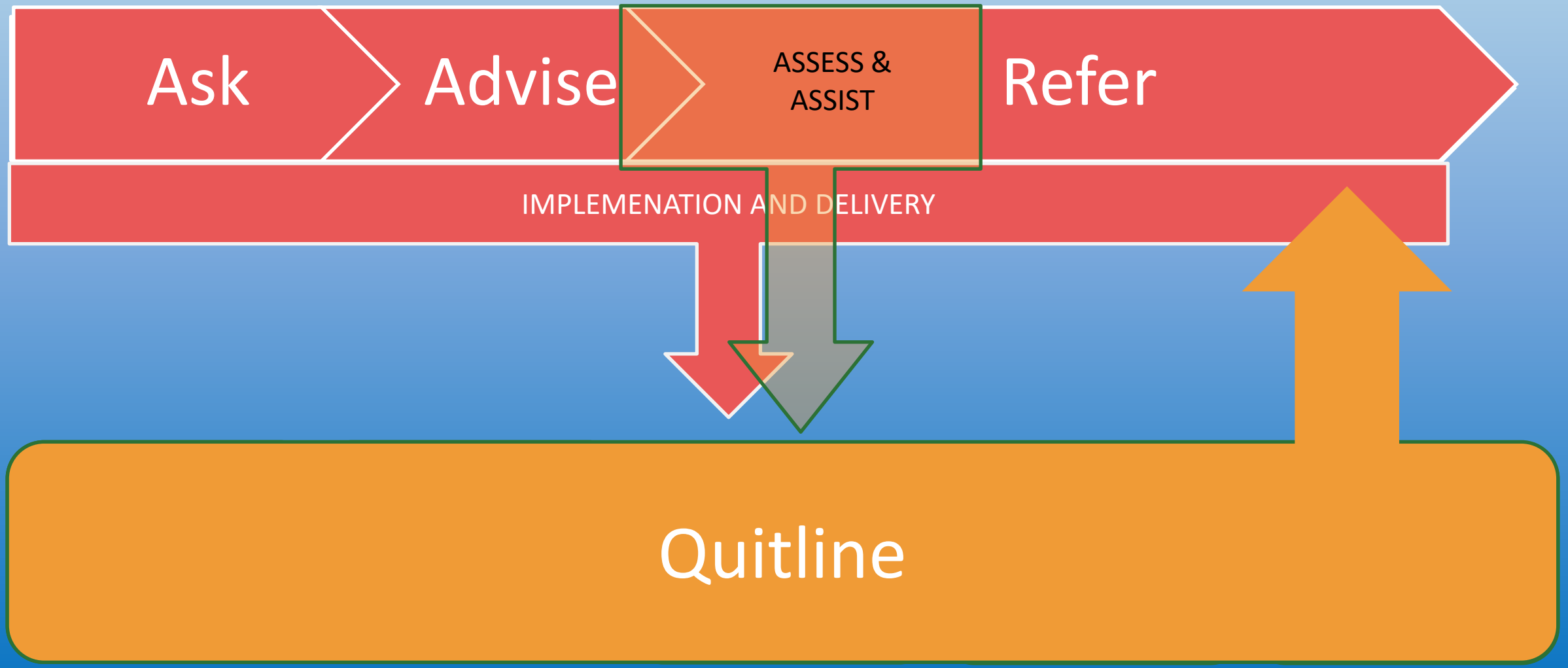
Quitting tobacco is difficult but absolutely feasible for persons with health disparities…

if the right dose of evidence-based assistance is provided

Medication Assisted Treatment

- Combination of behavioral interventions and medications
- Highly effective treatment option for alcohol, opioid, or tobacco dependence
- Reduces drug use and overdose deaths

Health Systems Change Framework



Resources for Health Systems Change

www.bhwellness.org

- 75% of people with a mental health condition desire to quit
- 65% made past year quit attempt
- Cessation treatments are well tolerated and effective
- Approximately 50% of quitline callers self-report a behavioral health condition

Six-State Quitline Study

- History of a mental health condition ranged from 62% in Montana to 89% in Idaho
- Quit rates ↑ for callers without MH issues, but a substantial number of callers reporting MH also sustained quits (43% vs. 33% at 6 months)
- Outcomes appear to be driven by how smokers feel their conditions may influence quit attempts

Lukowski et al., 2015

Quitline Programs Tailored for Mental Health: Initial Outcomes and Feasibility

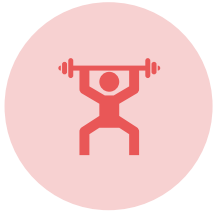
Morris CD, Lukowski AV, Vargas-Belcher RA, Ylioja TE, Nash CM, Bailey LA. Quitline Programs Tailored for Mental Health: Initial Outcomes and Feasibility. Am J Prev Med. 2021 Mar;60(3 Suppl 2):S163-S171. doi: 10.1016/j.amepre.2020.02.025. PMID: 33663704.

Tailored Treatment

Staff Training, Supervision and Fidelity

Screening for Behavioral Health Conditions

Greater Intensity of Services



Patient-Centered, Strength-Based, Care Coordination

Greater Duration of Treatment

CBT, Mood Management, and Motivational Enhancement

National Jewish Health Protocol

(8 states, n=594)

Tailoring

- Specialized training
- Discussion of MHC during calls
- Up to 7 coaching sessions
- Min 8 weeks of combination NRT
- First 3 calls focused on monitoring and managing mood
- Automatic enrollment

Inclusion/Exclusion Criteria

- Self-report anxiety or depression
- No MHC comorbidities
- Not receiving active treatment for MHC
- Moderately to Severely Nicotine Dependent

Optum Protocol

(8 states, n=1,906)

Tailoring

- Specialized training
- Discussion of MHC during calls
- Mandatory stress assessment
- Up to 7 calls
- Up to 12 weeks combination NRT (varied by state)

Inclusion/Exclusion Criteria

- Bipolar and schizophrenia automatic enrollment
- Opt-in for other MHCs thought to interfere with quit attempt

Pilot Outcomes

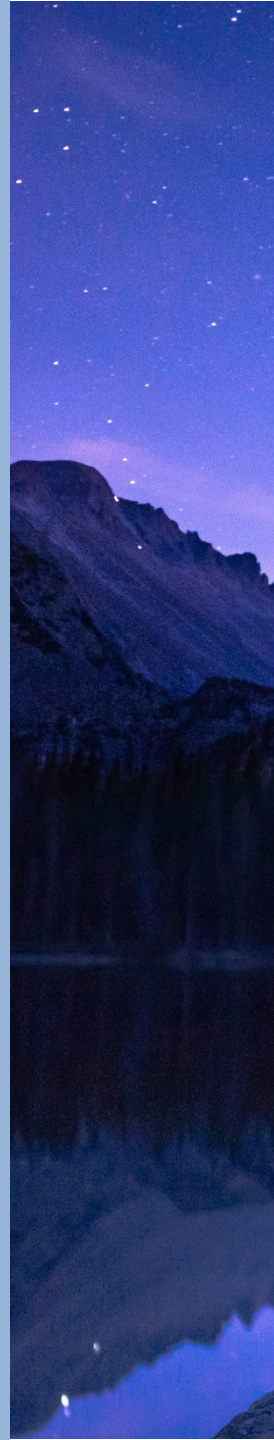
- Successful tailoring
- No significant difference in abstinence rates
- More coaching calls
- Higher dosage & duration NRT

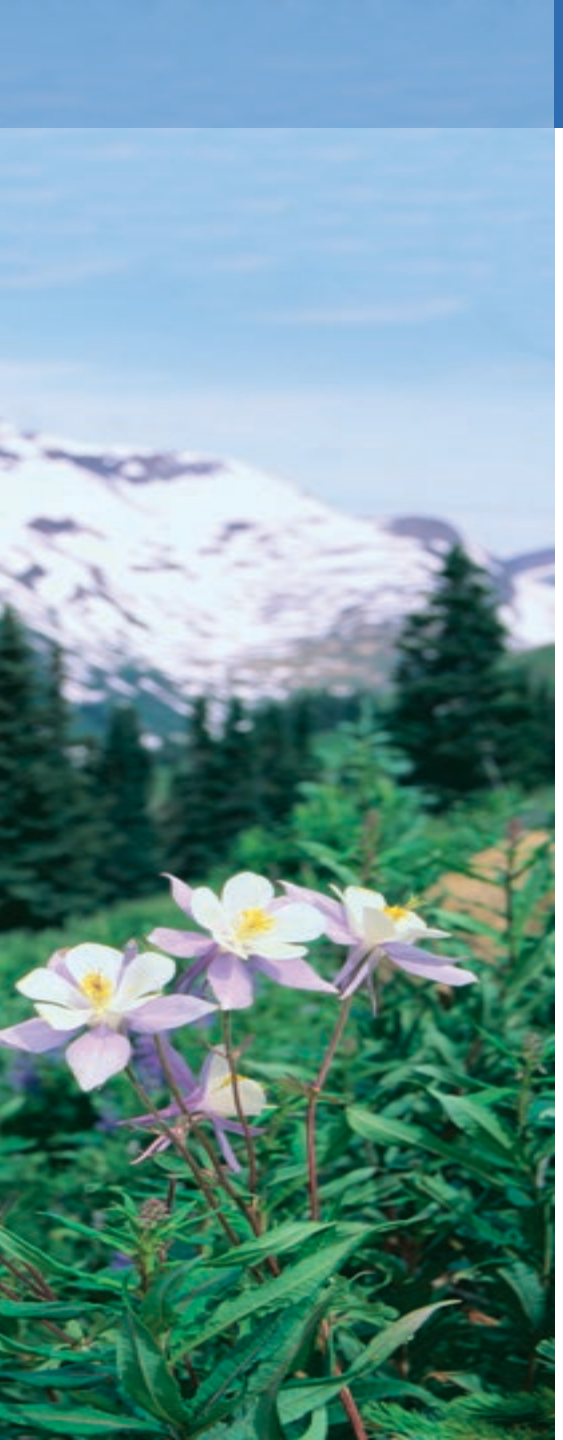
Implications

- Tailored programming increased access and engagement
- Tailored programming might address multiple, intersecting health disparity characteristics
  - Whole health
  - Co-treatment
  - Utilizing CDC sibling networks
- Health neighborhood partnerships might increase reach
- New protocols demand cost-benefit analysis

Quitline Recommendations

- Promote among health care providers
- Increase trust, understanding, and transparency
- Embed in the ‘health neighborhood’
- Integrate into tobacco policy initiatives
- Leverage existing and emerging technologies
- Tailor services to the person





Behavioral Health & Wellness Program

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BHWP_UCD

Q&A

- Submit questions via the **‘Ask a Question’ box**

CME/CEU Statements

Accreditations:
The University of California, San Francisco (UCSF) School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

UCSF designates this live activity for a maximum of *1.25 AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the webinar activity.

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Course meets the qualifications for 1.25 hours of continuing education credit for **LMFTs, LCSWs, LPCCs, and/or LEPs** as required by the California Board of Behavioral Sciences. Provider # 64239.

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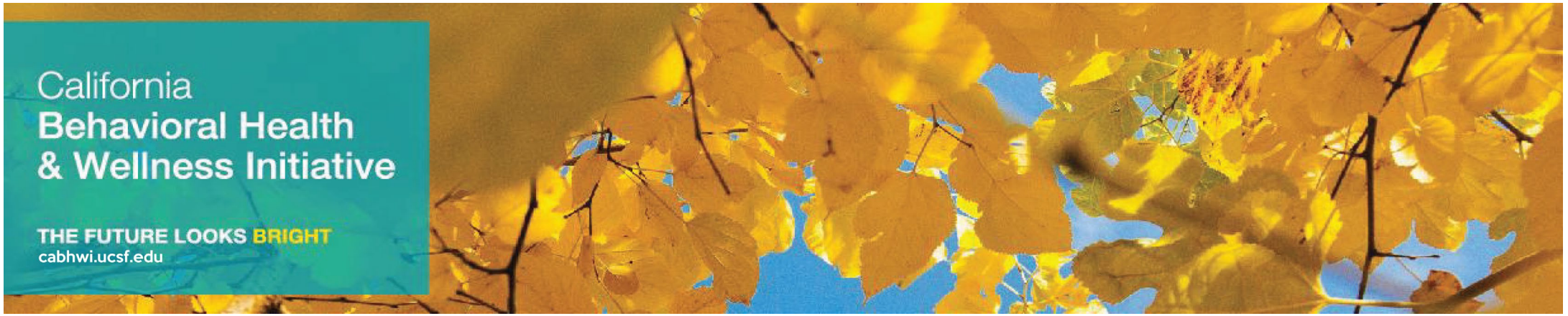
Free 1-800 QUIT NOW cards

✓Refer your clients to cessation services



- **Free CME/CEUs** will be available for all eligible California providers, who joined this live activity thanks to the support of the California Tobacco Control Program (CTCP)
- For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.
- For technical assistance please contact (877) 509-3786 or Jessica.Safier@ucsf.edu.
- Visit CABHWI.ucsf.edu for more information

Back to School Webinar Series with Free CME/CEUs

SCLC is offering FREE CME/CEUs for our recorded webinar collections for a total of ***29.5 units***.

Visit SCLC's website at: https://smokingcessationleadership.ucsf.edu/free-cmeces-webinar-collections

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Post Webinar Information

- You will receive the following in our post webinar email:
  - Webinar recording
  - PDF of the presentation slides
  - Instructions on how to claim FREE CME/CEUs
  - Information on certificates of attendance
  - Other resources as needed

- All of this information will be posted to our website!

Save the Date!

SCLC's next live webinar is, ***What Works: Developing Effective Partnerships to Treat Tobacco Addiction in Behavioral Health Settings***, with Regina Smith, IN, Heath Hayes, OK and Christian Barnes-Young, SC.

- **Thursday, September 23, 2021, 2-3:30 pm EDT**
- Registration will open tomorrow!

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Contact us for technical assistance

- Visit us online at **smokingcessationleadership.ucsf.edu**
- Call us toll-free at **877-509-3786**
- Copy and paste the post webinar survey link: https://ucsf.co1.qualtrics.com/jfe/form/SV_8waEr4cffin8brw into your browser to complete the evaluation

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