Smoking Cessation
Leadership Center

University of California
San Francisco

Veterans and Tobacco: Population, Product Use, and Lessons from the Department of Veterans Affairs, co-hosted by the National Behavioral Health Network for Tobacco & Cancer Control

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Tobacco Product Use Among Military Veterans – United States, 2010-2015

Webinar Presentation
Smoking Cessation Leadership Center of the
University of California at San Francisco
April 18, 2018

Brian Armour, PhD
Michael Tynan, BA
Office on Smoking and Health

Overview & Objective

- Estimated 18.8 million US adults were military veterans in 2015
- Prevalence of tobacco-attributable conditions is high among veterans
- There is paucity of data on tobacco product use among veterans, especially non-cigarette tobacco products

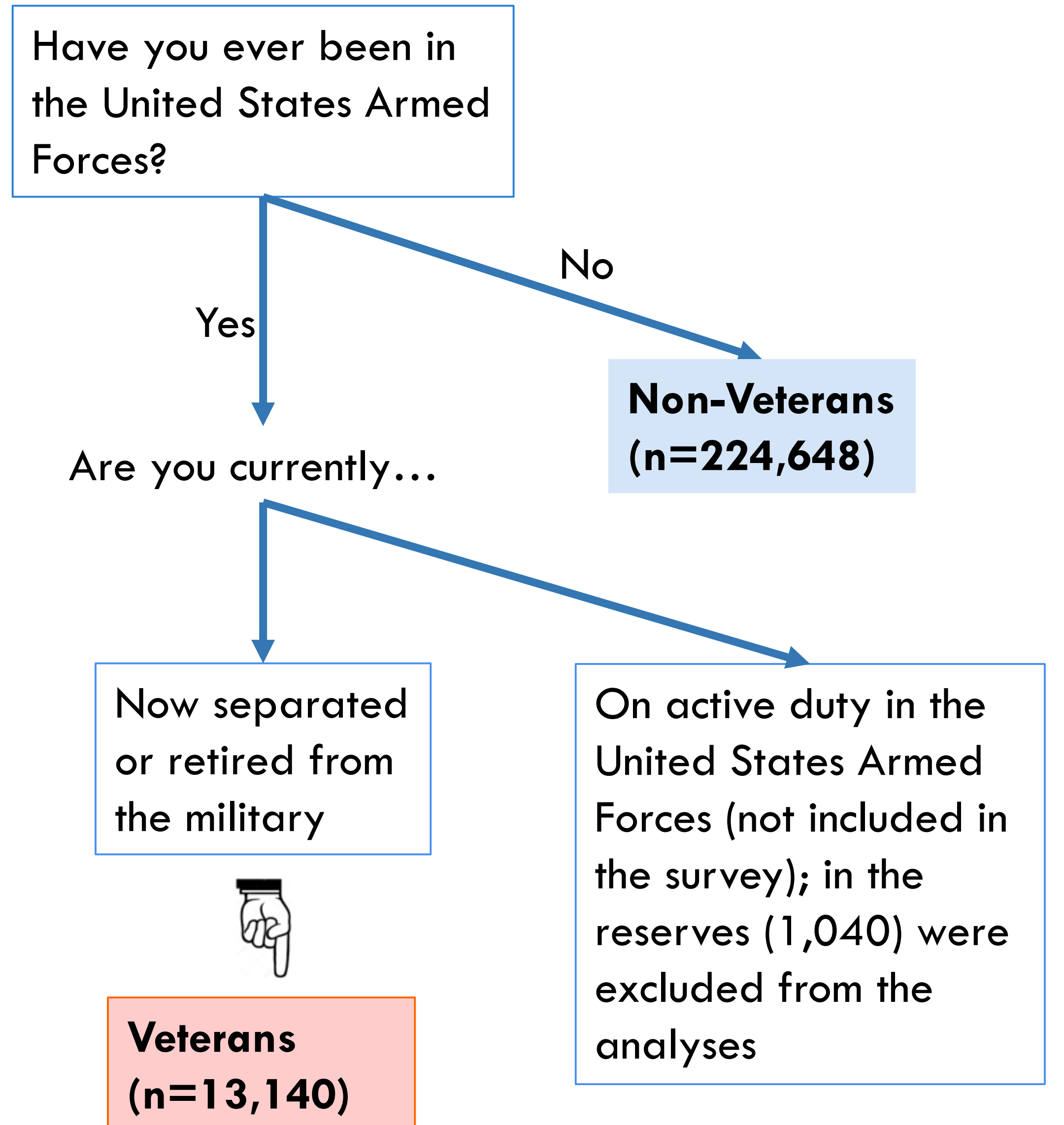
Methods – Data Source

- National Survey on Drug Use and Health (NSDUH)
- Conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Annual, in-person survey of the civilian, noninstitutionalized US population aged ≥12 years conducted at the respondent's residence
  - Analyses were restricted to adults aged ≥18 years
- Data were pooled across recent 6 waves (2010-2015)
- Sample size: 238,917
- Average response rate: 65.4%

Methods – Tobacco Indicators

- Current use of 5 tobacco products
  - Cigarettes
  - Cigars (big cigars/cigarillos/little cigars)
  - Roll-your-own tobacco
  - Pipes
  - Smokeless tobacco (chewing tobacco/snuff/dip/snus)
- 2 aggregated measures
  - Any tobacco (use of ≥1 products)
  - ≥2 tobacco products used

Who are military veterans?



These findings were published as a report in CDC's *Morbidity and Mortality Weekly Report* (*MMWR*) in January, 2018

Morbidity and Mortality Weekly Report

Tobacco Product Use Among Military Veterans — United States, 2010–2015

Satomi Odani, MPH[1]; Israel T. Agaku, DMD, PhD[1]; Corinne M. Graffunder, DRPH[1]; Michael A. Tynan[1]; Brian S. Armour, PhD[1]

In 2015, an estimated 18.8 million U.S. adults were military veterans (*1*). Although the prevalence of tobacco-attributable conditions is high among veterans (*2*), there is a paucity of data on use of tobacco products, other than cigarettes, in this population. To monitor tobacco product use among veterans, CDC analyzed self-reported current (i.e., past 30-day) use of five tobacco product types (cigarettes, cigars [big cigars, cigarillos, or little cigars], roll-your-own tobacco, pipes, and smokeless tobacco [chewing tobacco, snuff, dip, or snus]) from the National Survey on Drug Use and Health (NSDUH). Overall, 29.2% of veterans reported current use of any of the assessed tobacco products. Cigarettes were the most commonly used tobacco product (21.6%), followed by cigars (6.2%), smokeless tobacco (5.2%), roll-your-own tobacco (3.0%), and pipes (1.5%); 7.0% of veterans currently used two or more tobacco products. Within subgroups of veterans, current use of any of the assessed tobacco products was higher among persons aged 18–25 years (56.8%), Hispanics (34.0%), persons with less than a high school diploma (37.9%), those with annual family income <$20,000 (44.3%), living in poverty (53.7%), reporting serious psychological distress (48.2%), and with no health insurance (60.1%). By age and sex subgroups, use of any of the assessed tobacco products was significantly higher among all veteran groups than their nonveteran counterparts, except males aged ≥50 years. Expanding the reach of evidence-based tobacco control interventions among veterans could reduce tobacco use prevalence in this population.

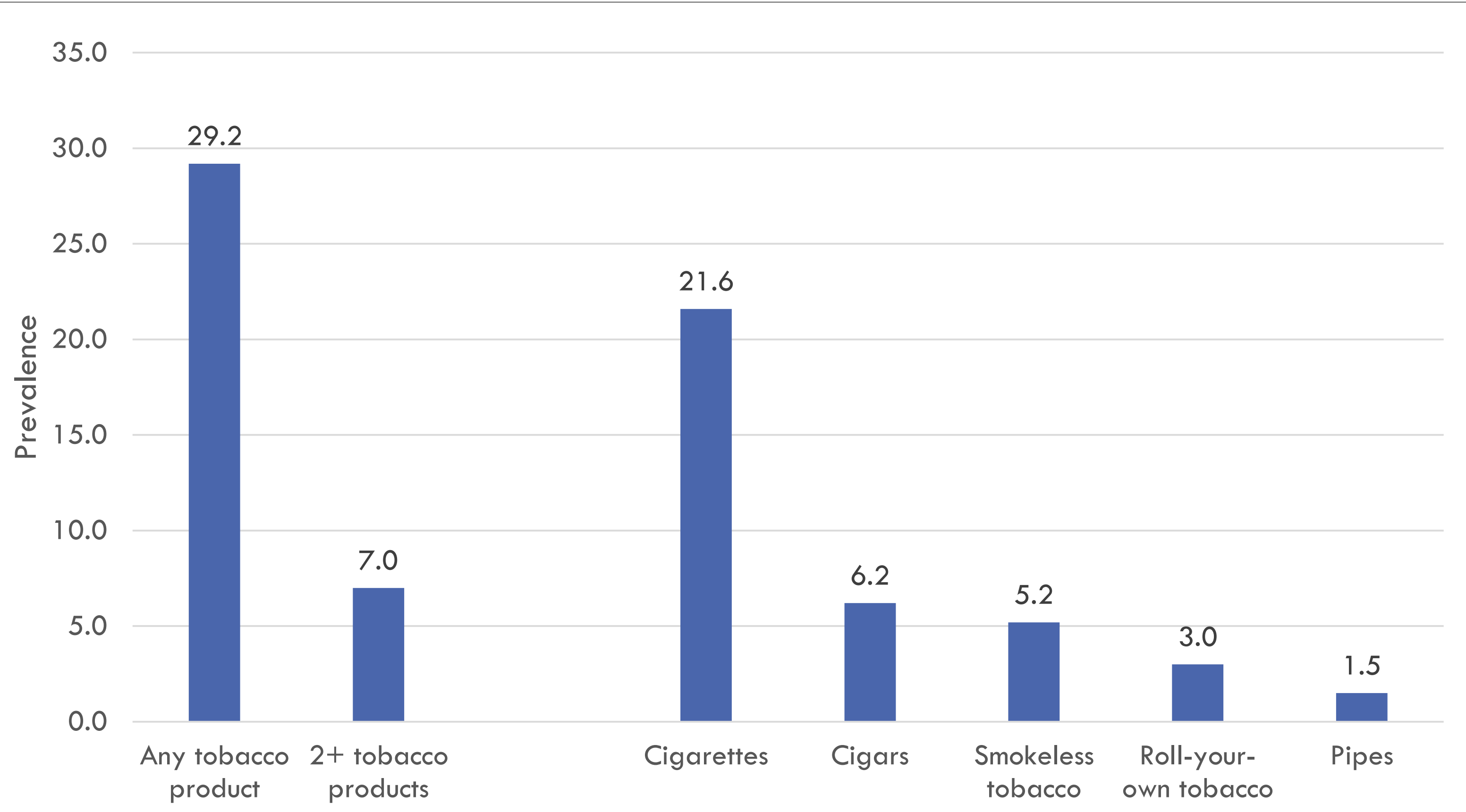
NSDUH is an annual, in-person survey of the civilian, non-institutionalized U.S. population aged ≥12 years conducted at the respondent's residence (*3*). The analyses in this report were restricted to adults aged ≥18 years. Data were pooled for those who had never been in the United States Armed Forces (pooled n = 224,648).[†] Respondents who reported currently being in a reserve component, or did not provide an answer were excluded from the analyses. Current users of cigarettes, cigars, roll-your-own tobacco, pipes, and smokeless tobacco were persons who had used the respective products during the past 30 days. Any tobacco product use was defined as use of any of the five assessed tobacco product types. Respondents who reported use of two or more tobacco product types during the past 30 days were further classified as current users of two or more tobacco product types.[§] Prevalence estimates were calculated overall and by sex, age, race/ethnicity, education, annual family income, poverty status,[¶] marital status, presence of serious psychological distress,[**] and health insurance coverage.[††] Additionally, age- and sex-specific prevalence estimates were calculated among veterans and nonveterans separately to allow direct comparisons of the two groups, given differences between veterans and nonveterans by age and sex.[§§] Cigarette quit ratio was calculated as the proportion of former

[†] To determine military veteran status, respondents were asked two questions. The first question was "Have you ever been in the United States Armed Forces?" Categorical response options were "Yes" or "No." Those who answered "Yes" were then asked "Are you currently on active duty in the United States Armed Forces, are you in a Reserve component, or are you now separated or retired from the military?" Categorical response options were "On active duty in the Armed Forces," "In a reserve component" or "Now separated/retired from reserves/active duty." Persons who reported currently being on active duty were not included in the survey. Respondents who reported currently being in a reserve component (1,040; 0.4% of respondents) and those did not provide an answer (89; 0.04% of respondents) were excluded from the analysis.

[§] For the use of any tobacco product types and two or more tobacco product types, respondents who had at least one missing response to any of the five tobacco product type questions were excluded from the analysis (76; 0.03% of respondents).

[¶] Poverty status was assessed in National Survey on Drug Use and Health since 2003. Poverty status indicates a person's family income relative to Federal

Current tobacco use among military veterans, NSDUH, 2010-2015



Prevalence of current tobacco product use among military veterans, NSDUH, 2010-2015

Characteristic	Cigarettes % (95%CI)	Cigars (% (95%CI)	Roll-your-own tobacco % (95%CI)	Pipe % (95%CI)	Smokeless tobacco % (95%CI)	Any tobacco product % (95%CI)	≥2 tobacco products % (95%CI)
Overall (n = 13,140)	21.6 (20.7–22.6)	6.2 (5.7–6.8)	3.0 (2.7–3.4)	1.5 (1.2–1.7)	5.2 (4.7–5.7)	29.2 (28.1–30.2)	7.0 (6.4–7.5)
Sex							
Male	21.1 (20.1–22.1)†	6.5 (5.9–7.1)†	3.0 (2.6–3.4)	1.6 (1.3–1.9)†	5.6 (5.1–6.1)†	29.1 (28.0–30.2)	7.1 (6.5–7.7)†
Female	28.9 (25.3–32.5)†	2.1 (1.3–2.9)†	3.4 (1.9–5.0)	—§	—§	29.7 (26.1–33.3)	4.8 (3.1–6.5)†
Age group (yrs)							
18–25	47.3 (43.5–51.2)†	13.3 (10.7–16.0)†	5.3 (3.8–6.7)†	2.5 (1.2–3.8)	15.4 (12.7–18)†	56.8 (52.9–60.6)†	21.2 (18.1–24.3)†
26–34	43.7 (40.2–47.2)†	11.2 (9.0–13.4)†	6.0 (4.5–7.4)†	1.6 (0.7–2.4)	12 (9.8–14.2)†	52.7 (49.1–56.2)†	17.6 (15–20.2)†
35–49	31.5 (29.4–33.6)†	8.8 (7.4–10.1)†	3.8 (3.0–4.6)†	1.1 (0.6–1.5)	11.3 (9.8–12.7)†	43.2 (41.0–45.5)†	10.8 (9.4–12.3)†
≥50	17.3 (16.2–18.5)†	5.2 (4.5–5.8)†	2.6 (2.2–3.0)†	1.5 (1.2–1.9)	3.2 (2.7–3.7)†	23.8 (22.5–25.1)†	5.0 (4.4–5.7)†
Race/Ethnicity							
Non-Hispanic white	20.2 (19.2–21.2)†	5.9 (5.3–6.5)†	2.9 (2.5–3.3)	1.5 (1.2–1.9)	5.8 (5.2–6.3)†	28.3 (27.1–29.4)†	6.7 (6.0–7.3)
Non-Hispanic black	26.3 (23.2–29.4)†	9.4 (7.4–11.4)†	3.6 (2.2–4.9)	1.2 (0.5–1.9)	1.9 (1.1–2.8)†	32.1 (28.7–35.4)†	8.3 (6.4–10.1)
Hispanic	29.1 (24.1–34.1)†	6.0 (3.8–8.3)†	—§	—§	4.7 (2.8–6.6)†	34.0 (28.9–39.1)†	7.7 (5.0–10.3)
Non-Hispanic other	29.0 (22.8–35.2)†	—§	5.4 (2.9–7.9)	—§	3.2 (1.8–4.5)†	33.6 (27.1–40.0)†	8.6 (5.7–11.4)
Education							
Less than high school	30.4 (26.6–34.1)	6.6 (4.6–8.7)†	6.1 (4.2–8.0)†	2.8 (1.5–4.1)	6.3 (4.4–8.2)†	37.9 (34.0–41.9)†	10.4 (8–12.7)†
High school	26.3 (24.5–28.1)	5.9 (4.9–6.9)†	4.2 (3.4–4.9)†	1.4 (0.9–1.9)	6.3 (5.4–7.2)†	33.9 (31.9–35.8)†	8.8 (7.7–9.9)†
Some college	25.7 (23.8–27.5)	6.9 (5.9–7.9)†	3.3 (2.6–4.0)†	1.4 (0.9–1.8)	6.1 (5.2–6.9)†	33.6 (31.6–35.5)†	7.9 (6.9–9.0)†
College degree or higher	10.1 (8.7–11.5)	5.8 (4.7–6.8)†	0.7 (0.4–1.1)†	1.3 (0.8–1.8)	2.9 (2.1–3.6)†	17.2 (15.5–18.9)†	3.0 (2.2–3.8)†
Annual family income ($)							
<$20,000	37.7 (34.5–40.9)†	8.2 (6.6–9.9)†	10.3 (8.4–12.3)†	3.0 (1.9–4.0)†	5.2 (3.9–6.6)	44.3 (41.0–47.6)†	15.9 (13.6–18.1)†
$20,000–$49,999	24.8 (23.0–26.5)†	5.6 (4.7–6.5)†	3.5 (2.8–4.2)†	1.6 (1.1–2.1)†	4.9 (4.1–4.9)	31.5 (29.6–33.3)†	7.5 (6.5–7.5)†
$50,000–$74,999	18.7 (16.7–20.8)†	5.6 (4.3–6.8)†	1.5 (0.8–2.1)†	1.6 (0.9–2.3)†	4.6 (3.7–4.6)	25.8 (23.5–28.1)†	4.9 (3.8–4.9)†
>$75,000	15.0 (13.5–16.4)†	6.6 (5.6–7.6)†	1.1 (0.7–1.4)†	0.8 (0.5–1.1)†	5.8 (4.9–6.7)	23.9 (22.1–25.6)†	4.6 (3.8–5.5)†
Poverty status††							
Living in poverty	46.2 (41.9–50.5)†	9.9 (7.5–12.3)†	14.1 (11.1–17.2)†	3.2 (1.8–4.6)†	7.4 (5.2–9.6)†	53.7 (49.4–58.1)†	21.0 (17.5–24.4)†
Up to 2X Federal Poverty Threshold	32.0 (29.3–34.6)†	6.5 (5.2–7.9)†	5.6 (4.4–6.8)†	1.8 (1.0–2.6)†	5.7 (4.6–6.8)†	38.7 (35.9–41.4)†	10.6 (9.0–12.3)†
More than 2X Federal Poverty Threshold	17.5 (16.5–18.6)†	5.9 (5.2–6.5)†	1.6 (1.3–1.9)†	1.3 (1.0–1.6)†	5.0 (4.4–5.5)†	25.2 (24.1–26.4)†	5.1 (4.5–5.6)†
Marital status							
Married	16.6 (15.5–17.7)†	5.6 (4.9–6.3)†	2.1 (1.7–2.5)†	1.1 (0.8–1.3)†	5.1 (4.5–5.7)†	24.3 (23.1–25.6)†	5.2 (4.6–5.9)†
Widowed/Divorced/Separated	30.4 (28.2–32.6)†	6.7 (5.5–7.9)†	4.9 (4.0–5.9)†	2.6 (1.8–3.4)†	4.8 (4.0–5.7)†	37.4 (35.1–39.8)†	9.6 (8.2–10.9)†
Never married	36.1 (33.0–39.3)†	9.9 (8.0–11.8)†	5.2 (4.1–6.3)†	1.5 (0.8–2.1)†	7.4 (5.8–8.9)†	43.4 (40.1–46.8)†	12.9 (11.0–14.8)†
Serious psychological distress§§							
No	21.0 (20.0–22.0)†	6.1 (5.6–6.7)†	2.8 (2.5–3.2)†	1.4 (1.1–1.7)†	5.2 (4.7–5.7)	28.5 (27.4–29.6)†	6.7 (6.1–7.2)†
Yes	40.8 (35.0–46.5)†	9.4 (6.1–12.7)†	9.2 (6.2–12.2)†	4.1 (1.9–6.3)†	6.6 (4.4–8.8)	48.2 (42.2–54.2)†	15.7 (11.9–19.5)†
Health insurance coverage¶¶							
Uninsured	51.4 (46.7–56.1)†	12.0 (9.4–14.5)†	8.8 (6.7–10.8)†	2.6 (1.3–4.0)†	10.5 (7.8–13.2)†	60.1 (55.4–64.8)†	19.4 (16.2–22.6)†
Insured	19.8 (18.9–20.8)†	5.9 (5.3–6.5)†	2.7 (2.3–3.1)†	1.4 (1.1–1.7)†	4.9 (4.4–5.4)†	27.3 (26.2–28.4)†	6.2 (5.6–6.8)†

† Estimates significantly varied within sociodemographic subgroups ($p<0.05$).

§ Estimates not presented because of relative standard error ≥30%.

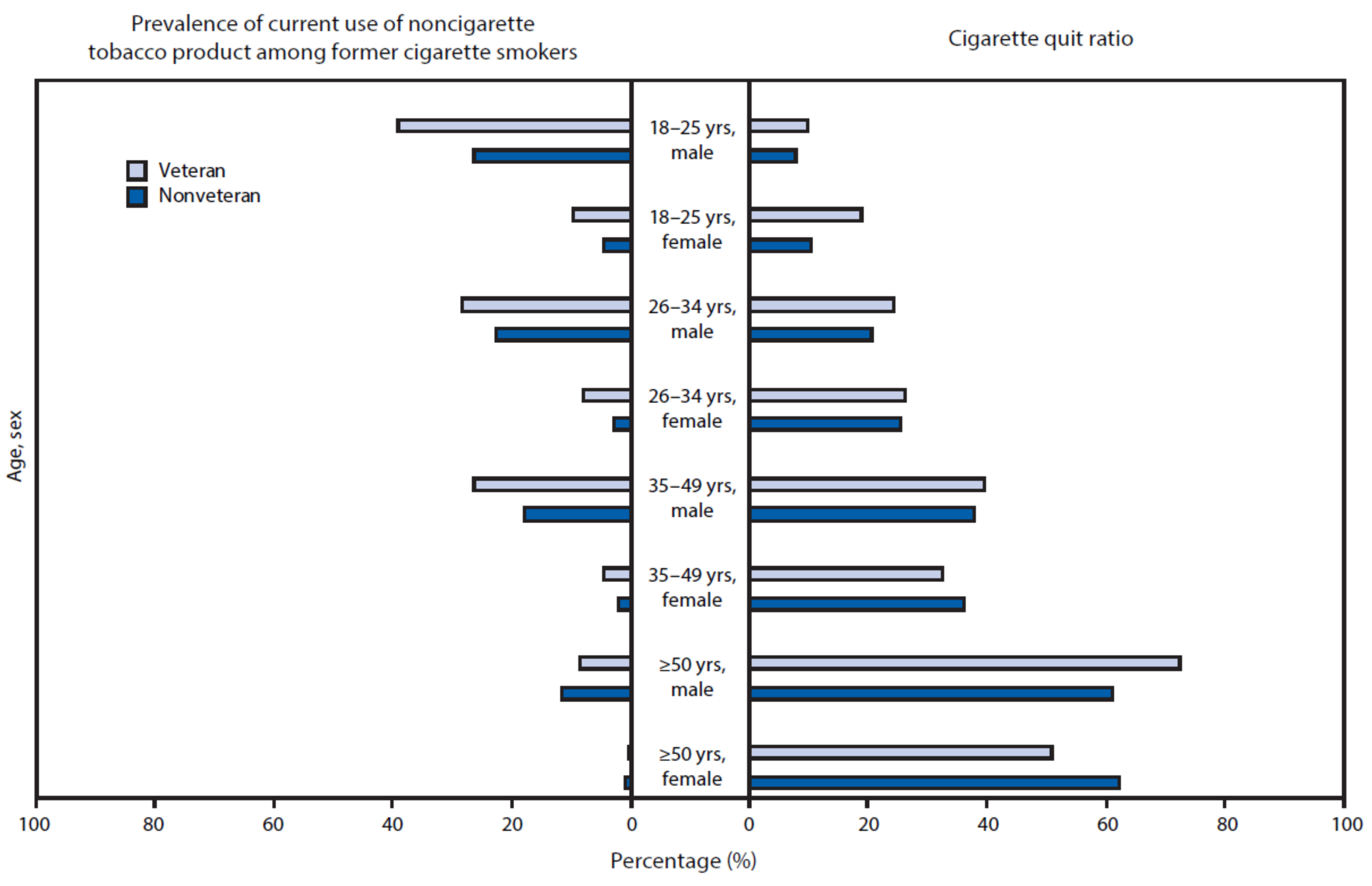
Comparisons of age- and sex-specific prevalence of current use of tobacco products among veterans and non-veterans, NSDUH, 2010-2015

Age group, yrs (sex)	Cigarettes % (95%CI)	Cigars % (95%CI)	Roll-your-own tobacco % (95%CI)	Pipe % (95%CI)	Smokeless tobacco % (95%CI)	Any tobacco product¶ % (95%CI)	≥2 tobacco products** % (95%CI)
Veterans (n = 13,140)							
18–25 (Male)	50.2 (45.8–54.5)†	14.7 (11.6–17.8)	5.6 (3.9–7.4)	3.2 (1.5–4.8)	18.9 (15.7–22.2)†	61.7 (57.4–66.0)†	23.7 (20.1–27.4)†
18–25 (Female)	36.4 (28.8–44.0)†	8.0 (3.4–12.5)	—§	—§	—§	37.9 (30.2–45.5)†	11.4 (6.4–16.4)†
26–34 (Male)	45.5 (41.6–49.5)†	12.7 (10–15.3)	6.2 (4.6–7.9)	1.8 (0.8–2.8)	14.0 (11.4–16.6)†	55.9 (51.9–59.8)†	19.3 (16.3–22.4)†
26–34 (Female)	35.2 (28.2–42.3)†	—§	—§	—§	—§	37.4 (30.3–44.5)†	9.5 (5.3–13.7)†
35–49 (Male)	31.5 (29.2–33.7)†	9.6 (8.2–11.1)†	4.0 (3.1–4.8)	1.2 (0.7–1.8)	12.9 (11.3–14.5)†	44.8 (42.3–47.2)†	11.9 (10.3–13.5)†
35–49 (Female)	31.5 (26.3–36.7)†	—§	—§	—§	—	32.7 (27.5–38.0)†	3.5 (1.7–5.3)
≥50 (Male)	17.0 (15.8–18.1)	5.4 (4.7–6.1)	2.6 (2.1–3.0)†	1.6 (1.2–2.0)	3.3 (2.8–3.9)	23.7 (22.5–25.0)	5.1 (4.4–5.7)
≥50 (Female)	24.8 (18.8–30.8)†	—§	—§	—§	—§	24.9 (10.9–30.9)†	—§
Nonveterans (n = 224,648)							
18–25 (Male)	35.3 (34.7–35.9)†	15.2 (14.7–15.6)	6.7 (6.4–7.0)	2.7 (2.5–2.9)	10.4 (10.1–10.8)†	45.3 (44.7–45.9)†	18.8 (18.3–19.3)†
18–25 (Female)	26.0 (25.5–26.5)†	5.4 (5.1–5.6)	3.5 (3.3–3.7)	1.1 (1.0–1.2)	0.7 (0.6–0.7)	28.8 (28.3–29.3)†	6.5 (6.3–6.8)†
26–34 (Male)	36.3 (35.3–37.3)†	11.5 (10.8–12.2)	5.9 (5.5–6.4)	1.4 (1.2–1.7)	8.4 (7.9–9.0)†	45.2 (44.2–46.3)†	14.8 (14.1–15.5)†
26–34 (Female)	26.7 (25.9–27.5)†	3.1 (2.8–3.4)	3.0 (2.7–3.2)	0.4 (0.3–0.5)	0.5 (0.3–0.6)	28.3 (27.5–29.1)†	4.6 (4.3–5.0)†
35–49 (Male)	26.3 (25.5–27.1)†	7.3 (6.9–7.8)†	4.5 (4.2–4.8)	0.9 (0.8–1.1)	7.8 (7.3–8.2)†	35.6 (34.7–36.4)†	9.3 (8.8–9.8)†
35–49 (Female)	23.0 (22.3–23.6)†	1.8 (1.6–2.0)	2.9 (2.7–3.2)	0.2 (0.1–0.2)	0.3 (0.2–0.4)	23.8 (23.2–24.4)†	3.9 (3.6–4.2)
≥50 (Male)	18.1 (17.2–18.9)	5.7 (5.2–6.2)	3.3 (2.9–3.7)	1.3 (1.1–1.6)	3.7 (3.3–4.1)	25.1 (24.2–26.1)	5.7 (5.2–6.2)
≥50 (Female)	14.8 (14.2–15.3)†	0.6 (0.5–0.7)	2.0 (1.8–2.2)	0.1 (0.1–0.2)	0.4 (0.3–0.6)	15.4 (14.8–16.0)†	2.4 (2.2–2.6)

† Estimates significantly different from corresponding estimate among veteran and nonveteran populations.

§ Estimates not presented because of relative standard error ≥30%.

Cigarette quit ratios and Prevalence of current use of non-cigarette tobacco products among former cigarette smokers, among military veterans and non-veterans, NSDUH, 2010-2015



Key Findings

- Close to 3 in 10 US veterans were current users of any tobacco product
- Prevalence of any tobacco product use was higher among veterans than among non-veterans within all subgroups of age and sex, except males aged ≥50 years
- Despite similar quit ratios among veterans and non-veterans, the prevalence of current cigarette smoking was higher among veterans in most age groups

Implications for Public Health Practice

- Evidence-based strategies can help veterans quit tobacco use
  - Cessation Support (Quitline, text, web)
    - 1-800-Quit-Now
    - https://www.publichealth.va.gov/smoking/smokefreevet.asp
    - https://smokefree.gov/veterans
  - Group/individual counseling
  - Use of FDA approved cessation medications
  - Continued implementation of media campaign (e.g. CDC's *Tips From Former Smokers*® Campaign)
  - Smoke-free and Tobacco-Free Environments
  - Price Increases

Conclusions

- Goal is to make tobacco products and use less acceptable and accessible for both active duty military personnel and veterans

- Recent Progress includes
  - Veterans Health Administration efforts to increase access to tobacco use treatment options
  - U.S. Department of Defense's (DOD) prohibition of tobacco use on DOD medical campuses and medical treatment facilities

- Continued Challenges
  - Continued access to low-cost tobacco products through retailers on DOD property
  - U.S. Department of Veterans Affairs health care facilities are required by Federal law to have designated smoking areas

Questions and comments

MMWR available at:
https://www.cdc.gov/mmwr/volumes/67/wr/mm6701a2.htm

Acknowledgements: MMWR coauthors -- Satomi Odani; Israel T. Agaku; Corinne M. Graffunder

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1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Tobacco Use Treatment in the Department of Veterans Affairs

April 18 Smoking Cessation Leadership Center of the University of California at San Francisco

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Office of Mental Health and Suicide Prevention

AN OVERVIEW

- The Department of Veterans Affairs Health Care System and our population
- Models of Tobacco Use Treatment in VA
- National Initiatives to frame tobacco use treatment in VA
  - Tobacco use as a chronic condition
  - Resources to promote evidence-based care as the standard of care
  - Smoking as a mental health issue
- Models of care outside of the healthcare system
  - National Quitline – 1-855-QUIT-VET
  - Mobile Health initiatives - SmokefreeVET

THE VA HEALTH CARE SYSTEM

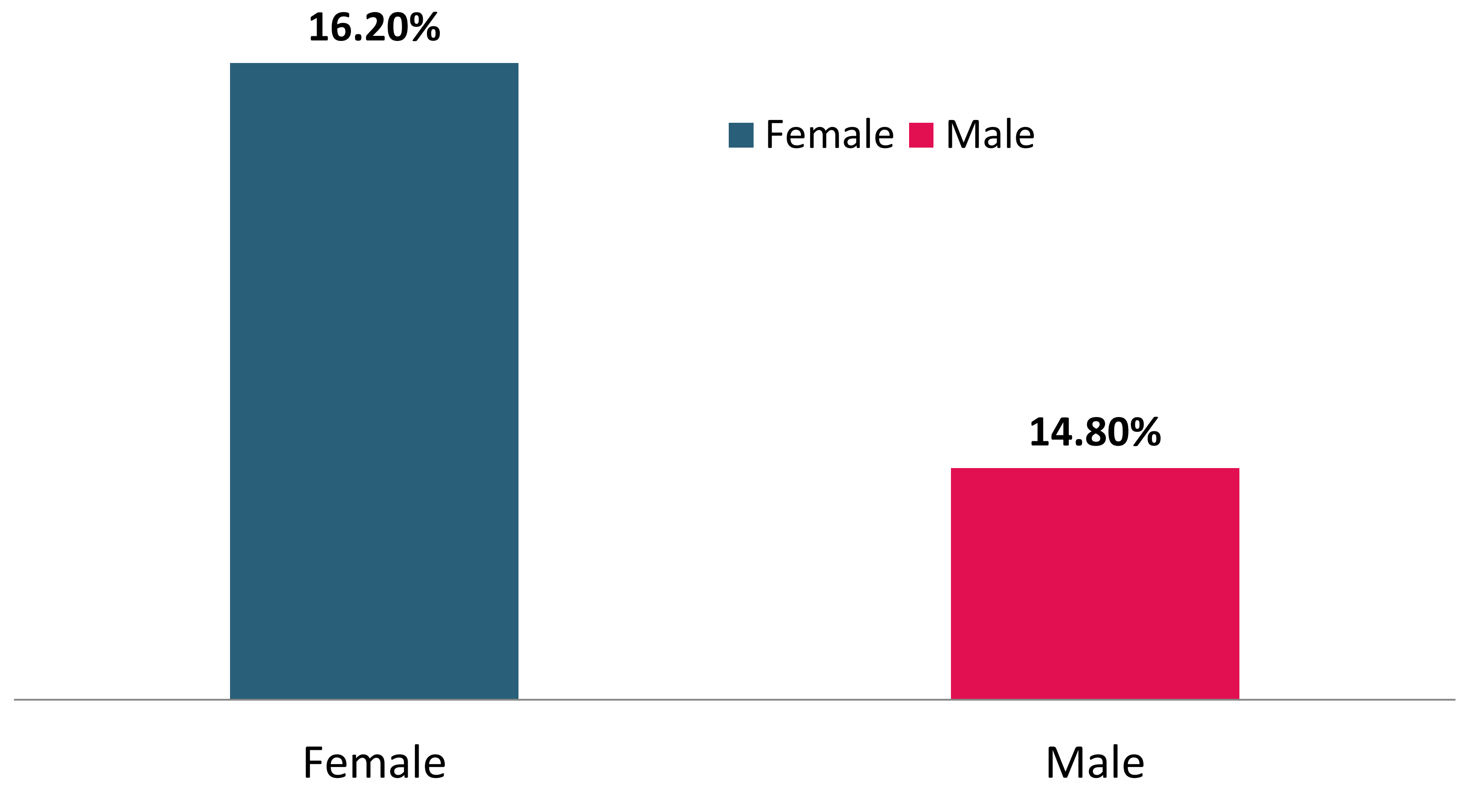
- The Department of Veterans Affairs (VA) Health Care System is the nation's largest integrated health care system.
- VA has over 1200 health care facilities and 9 million of the nation's 22 million Veterans are enrolled for care in our system.
- Individuals who served in under active duty orders and separated from the military under any condition other than dishonorable may qualify for health benefits.
- Veterans with a service-connected disability, recipients of a Purple Heart or Medal of Honor, and with incomes below a certain threshold may have enhanced eligibility for care.
- VA is the nation's largest provider of mental health and addictive disorders care.

VETERANS IN VA HEALTH CARE

- Average VA enrollee is:
  - **61 years old**
  - male
  - white
  - married with dependents
- 39% served during the Vietnam era
- 15% served post-9/11 in Iraq or Afghanistan
- 47% report combat exposure during military service
- 50% have income <$35,000

2016 Survey of Veteran Enrollees' Health and Use of Health Care

PERCENT OF VETERANS ENROLLEES WHO ARE CURRENT SMOKERS



MODELS OF TOBACCO USE TREATMENT IN VA

Care is available to Veterans through:

- Treatment provided through primary care - usually in the form of brief counseling and a prescription for smoking cessation medications
- Referrals to the smoking cessation specialty programs available at all VA health care centers
- Assistance and counseling by a mental health professional, who is part of the primary care team
- Telehealth disease management care with in-home messaging devices and follow-up with telehealth coordinator
- Specialty clinics at some sites that provide care through available in pharmacy clinics, integrated care in mental health care, and other models of care
- 1-855-QUIT-VET, a proactive telephone quitline
- mHealth resources: SmokefreeVET, Stay Quit Coach

APPROACHES TO INCREASE VETERANS' ACCESS TO CARE

Tobacco & Health program

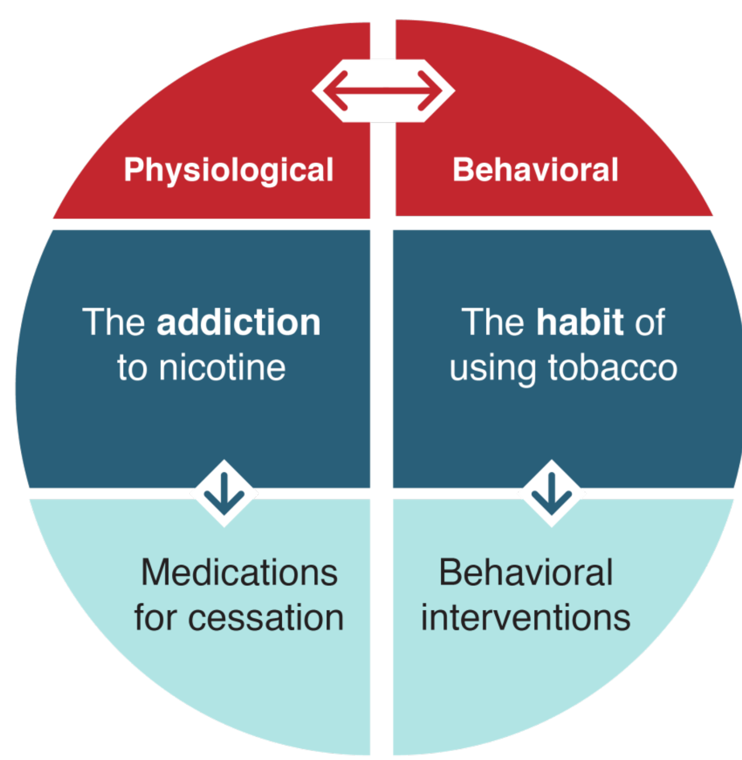
- Train and support VA health care providers
- Identify and target disparate populations
- Provide resources directly to Veterans
  - mHealth
  - Telephone

TRAINING AND RESOURCES TO SUPPORT VA HEALTHCARE PROVIDERS

- Tobacco Cessation Clinical Update Audio Conference Series with continuing education credits (6 times a year)
- Site consultations/trainings
- Clinical resources and print publications available to VHA providers
- Dissemination of materials through facility clinical champions
- Monthly Tobacco & Health newsletter for VA providers with information about clinical resources, upcoming events and trainings, and relevant news items

TOBACCO DEPENDENCE AS A CHRONIC CONDITION

- Tobacco dependence is a chronic disease that often requires **repeated intervention** and **multiple attempts** to quit
- Treatment should address the physiological **and** the behavioral aspects of dependence



PHYSICAL AND MENTAL BENEFITS OF QUITTING

Quitting smoking:

Reduces risk of heart attack, lung disease, and many types of cancers

Improves mood

Reduces stress and anxiety

Makes it easier to stop using alcohol and other drugs

Lowers risk of suicide

SMOKING AS A MENTAL HEALTH ISSUE

- Tobacco users with mental illness have a greater risk of dying from CVD, respiratory illnesses, and cancer, than people without mental illness
- Tobacco-related disease accounts for approximately half of the mortality for individuals with schizophrenia, bipolar disorder, and depression
- Tobacco use disorder predicts future suicidal behavior in Veterans independent of age, gender, psychiatric disorder, service connection, and severity of medical comorbidity
- Patients with schizophrenia who smoke, when compared to those who do not smoke, are likely to have higher rates of hospitalization, higher medication doses, and more severe psychiatric symptoms
- A study of outpatients with schizophrenia estimated the costs of cigarettes to be approximately 27% of their monthly income

SMOKING AS A MENTAL HEALTH ISSUE

- 75% of individuals ages 12+ entering treatment for substance use disorders (SUD) reported tobacco use
- Smokers have poorer long-term substance use outcomes than non-smokers
- Tobacco-related diseases account for 50% of deaths among individuals treated for alcohol dependence
- Health consequences of tobacco and other drug use are synergistic: (50% greater than the sum of each individually)
- The preponderance of evidence suggests smoking cessation does not increase risk for alcohol and other drug relapse

SMOKING AS A MENTAL HEALTH ISSUE

- Integrating tobacco cessation treatment into mental health care is one evidence-based strategy to address this problem

- Through directed implementation efforts, integrated care can be scaled up for delivery in clinical settings treating Veterans with PTSD (and likely in other settings as well).

Effective Treatment

7.2%	16.5%
Patients quit after 6 months	Patients quit after 6 months

Usual Care

Integrated Care

Referral to VA smoking cessation clinic

Smoking cessation treatment delivered as part of primary mental health treatment for PTSD

Integrated care recipients have 2.26 greater odds of prolonged abstinence compared to smoking cessation clinic treatment.

McFall et al., 2010

MODELS OF CARE OUTSIDE OF THE HEALTHCARE SYSTEM

- Importance of access to tobacco use treatment that doesn’t require travel to a health care setting to accommodate the needs of a diverse patient population.

- Thinking outside the model of face-to-face care about modalities to engage a population of tobacco users that may get most of their information from mobile devices such as smartphones

- Solid evidence-base for telephone quitlines as highly effective interventions to increase the reach of tobacco cessation care and the strong emerging evidence base for mobile health initiatives

RESOURCES FOR PATIENTS – VA QUITLINE

- Proactive quitline model with 4 follow-up calls
- Quitline counselors provide callers with:
- - Individualized counseling
  - Help formulating a quit plan
  - Strategies to prevent relapse
  - Up to 4 follow-up calls
  - Counseling in English and in Spanish
- Veterans referred back to health care provider for medications and other health concerns
- For Veteran safety, counselors able to initiate a warm transfer to Veterans Crisis Line
- Available Monday–Friday, 9 AM–9 PM ET
- **1-855-QUIT-VET (1-855-784-8838)**
- A collaboration with the National Cancer Institute

RESOURCES FOR PATIENTS – TEXT MESSAGING PROGRAM

smokefreeVET

- Automated text message tobacco cessation program available in English and Spanish
- Sends 2-5 texts per day beginning 2 weeks before quit date and continuing for 6 weeks afterward
- Provides tips, support, and encouragement for quitting smoking and smokeless tobacco
- Keywords (Urge, Stress, Smoked, Dipped, Crisis) can be used anytime to receive an immediate tip in response
- Connects users with other VA resources: quitline, Veterans Crisis Line, Stay Quit Coach, refers back to VA provider for smoking cessation medications
- smokefree.gov/VET or smokefree.gov/VETespanol
- A collaboration with the National Cancer Institute

SIGN-UP EXPERIENCE

- Same web form/link for sign up or text VET to 47848 for both smoking and smokeless tobacco programs
- Questions tailored on opt-in to type of tobacco use

Which type of tobacco do you use? *

- (●) Cigarettes
- ( ) Dip or Chew

(If you use both, either of these programs will help you quit, please choose one.)

How many cigarettes each day? *

- ( ) 10 or less
- ( ) 11-20
- ( ) 21-30
- ( ) 31 or more

When do you smoke? *

- ( ) Every day
- ( ) Most days
- ( ) Some days
- ( ) Less than that

Which type of tobacco do you use? *

- ( ) Cigarettes
- (●) Dip or Chew

(If you use both, either of these programs will help you quit, please choose one.)

How any cans or pouches per week do you use? *

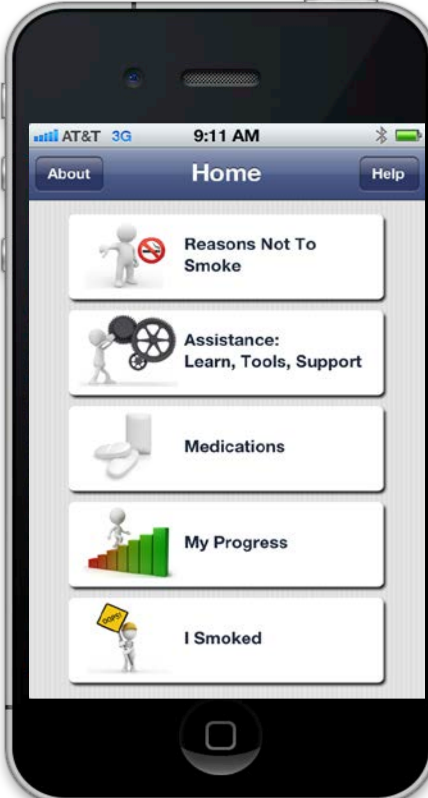
- ( ) 1 or less
- ( ) 2-3
- ( ) 4-6
- ( ) More than 6

When do you use smokeless tobacco? *

- ( ) Every day
- ( ) Most days
- ( ) Some days
- ( ) Less than that

STAY QUIT COACH SMARTPHONE APP

- Designed to assist with smoking cessation as an enhancement to in-person counseling
- Primarily to be used as a relapse prevention tool once a course of treatment is complete. Should be incorporated into sessions with provider
- Can also be used alone, with provider or group counseling, or with quitline interventions
- Development of Stay Quit Coach led by the VA National Center for PTSD



VA TOBACCO & HEALTH PROGRAM RESOURCES

Internet

www.mentalhealth.va.gov/quit-tobacco

smokefree.gov/veterans

VHA Tobacco & Health: Policy and Programs

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Q&A

- Submit questions via the **chat box**

Post Webinar Information

- You will receive the webinar recording, presentation slides, information on certificates of attendance, and other resources, in our follow-up email. All of this information will be posted to our website.
- CME/CEUs of up to 1.5 credit is available to all attendees of this live session. Instructions will be emailed after the webinar.

CME/CEU Statement

Accreditation:

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 *1.5 AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the webinar activity.

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Respiratory Therapists: This program has been approved for a maximum of 1.5 contact hours Continuing Respiratory Care Education (CRCE) credit by the American Association for Respiratory Care, 9425 N. MacArthur Blvd. Suite 100 Irving TX 75063, Course # 150993000.

American Association for Respiratory Care (AARC)

- Free Continuing Respiratory Care Education credit (CRCEs) are available to Respiratory Therapists who attend this live webinar
- Instructions on how to claim credit will be included in our post-webinar email

New Behavioral Health Accreditation

California Association of Marriage and Family Therapists (CAMFT)

This webinar is accredited through the CAMFT for up to 1.5 CEUs for the following eligible California providers:

- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Educational Psychologists (LEPs)

Instructions to claim credit will be included in the post webinar email.

Save the Date

SCLC's next live webinar will be on:

- DATE: Thursday, May 17 at 1pm EDT
- TOPIC: UC Quits project: Every Smoker, Every Encounter
- SPEAKER: Elisa K. Tong, MD, MA, Associate Professor, Department of Internal Medicine, UC Davis

Registration will open soon!

Contact us for technical assistance

- Visit us online at **smokingcessationleadership.ucsf.edu**
- Call us toll-free at **877-509-3786**
- Please complete the post-webinar survey

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