Smoking Cessation Leadership Center

UCSF

University of California San Francisco

The Glass is Half Full: Smoking cessation for smokers with opioid use disorder, co-hosted by ATTUD

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Shadi Nahvi, MD, MS

4/9/19

Moderator

Catherine Saucedo

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University of California, San Francisco

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Disclosures

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Shadi Nahvi, MD, MS –

Pfizer – Grant/Research Support

Thank you to our funders

Robert Wood Johnson Foundation

truth initiative
INSPIRING TOBACCO-FREE LIVES

National Behavioral Health Network
For Tobacco & Cancer Control

SAMHSA
Substance Abuse and Mental Health Services Administration

CME/CEU Statement

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- Please **make sure your speakers are on** and adjust the volume accordingly.
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- **This webinar is being recorded** and will be available on SCLC's website, along with the slides.
- **Use the chat box to send questions** at any time for the presenters.

American Association for Respiratory Care (AARC)

- Free Continuing Respiratory Care Education credits (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 1.0 CEU for the following eligible California providers:

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- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Educational Psychologists (LEPs)

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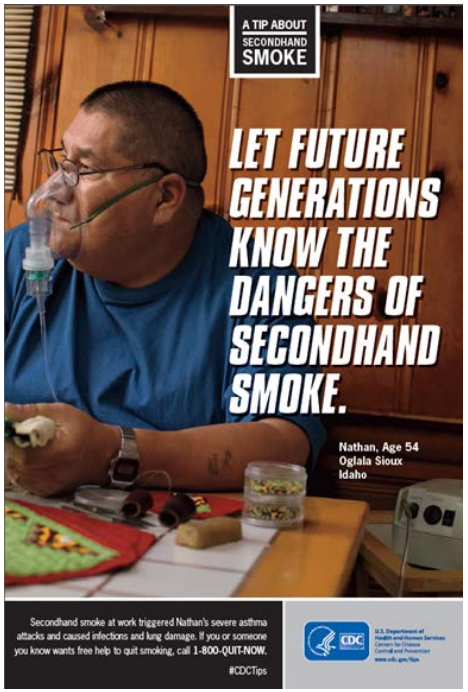
California Behavioral Health & Wellness Initiative

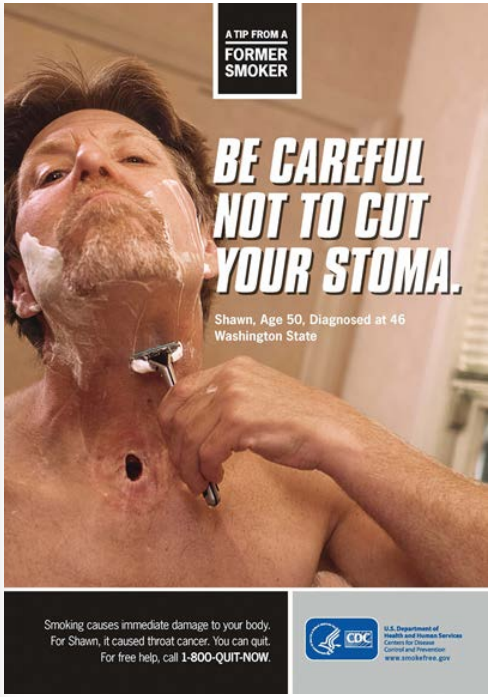
For our CA residents, we are starting a new venture in CA helping behavioral health organizations go tobacco free and integrating cessation services into existing services thanks to the support of the CTCP.

Free CME/CEUs will be available for all eligible California providers, who joined this live activity. You will receive a separate post-webinar email with instructions to claim credit.

Visit CABHWI.ucsf.edu for more information.

Tips® Campaign Overview





1. CDC. Current Cigarette Smoking Among Adults—United States, 2005–2014.. MMWR 2015;64(44):1233–40
2. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: HHS,CDC, NCCDPHP, OSH, 2014

Introduction

Kimber P. Richter, PhD, MPH, NCTTP

Joy McCann Professor of Women in Medicine & Science, Department of Preventive Medicine and Public Health

University of Kansas School of Medicine

Member, ATTUD Behavioral Health Committee

KU SCHOOL OF MEDICINE
The University of Kansas

TRAINING · TREATMENT · RESEARCH
ATTUD
Association for the Treatment of Tobacco Use and Dependence

Presenter

Shadi Nahvi, MD, MS

Associate Professor
Departments of Medicine, and of
Psychiatry & Behavioral Sciences

Albert Einstein College of Medicine /
Montefiore Health System

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The glass is half full: smoking cessation for smokers with opioid use disorder

Shadi Nahvi, MD, MS
Associate Professor
Departments of Medicine and Psychiatry

SCLC / ATTUD Webinar
April 2019

Disclosures

- Smoking Cessation Leadership Committee/ Pfizer Innovative Grants for Learning and Change (through 3/2018)
- Pfizer research support (active and placebo medication)

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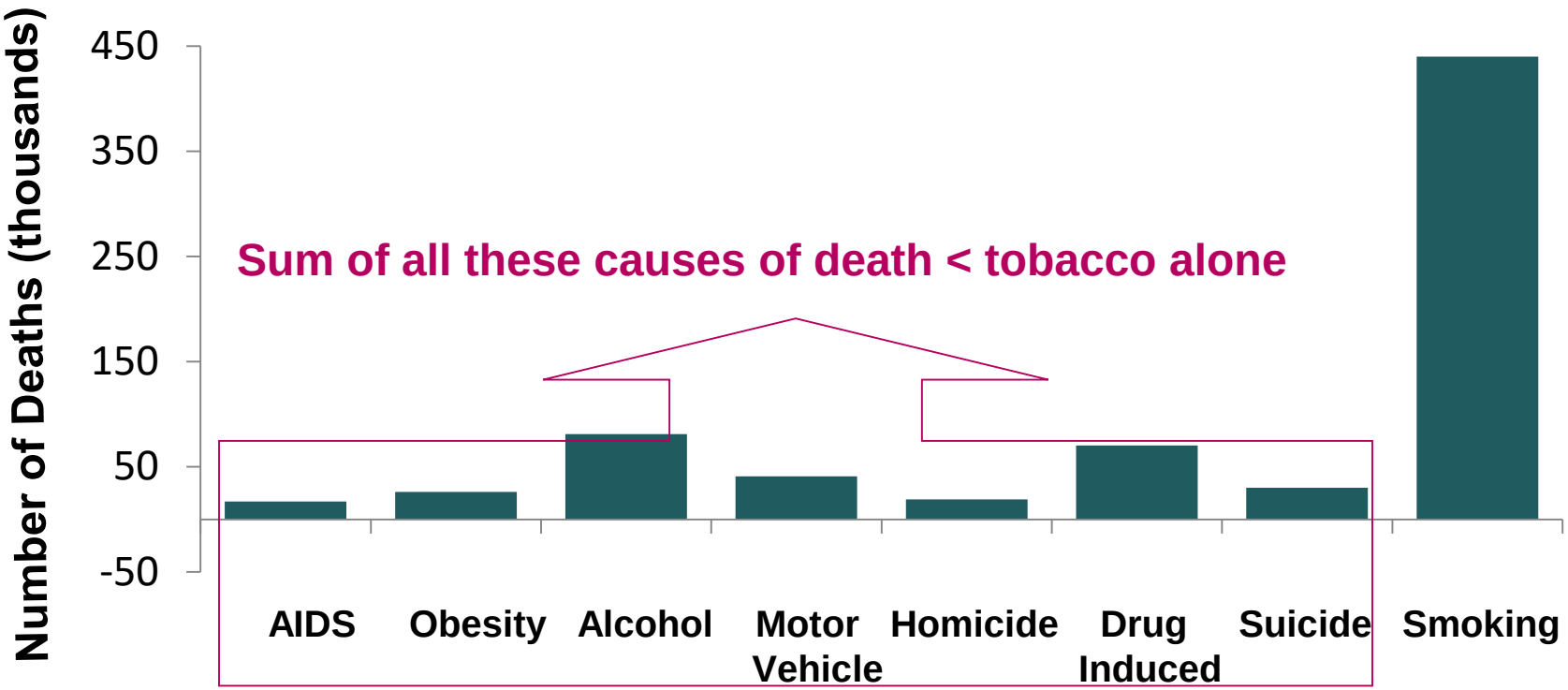
Outline

- Health burden of tobacco use
- Evidence-based cessation treatments
- Optimizing efficacy
- Optimizing implementation

Comparative Causes of Annual Deaths in the U.S.



Source: CDC

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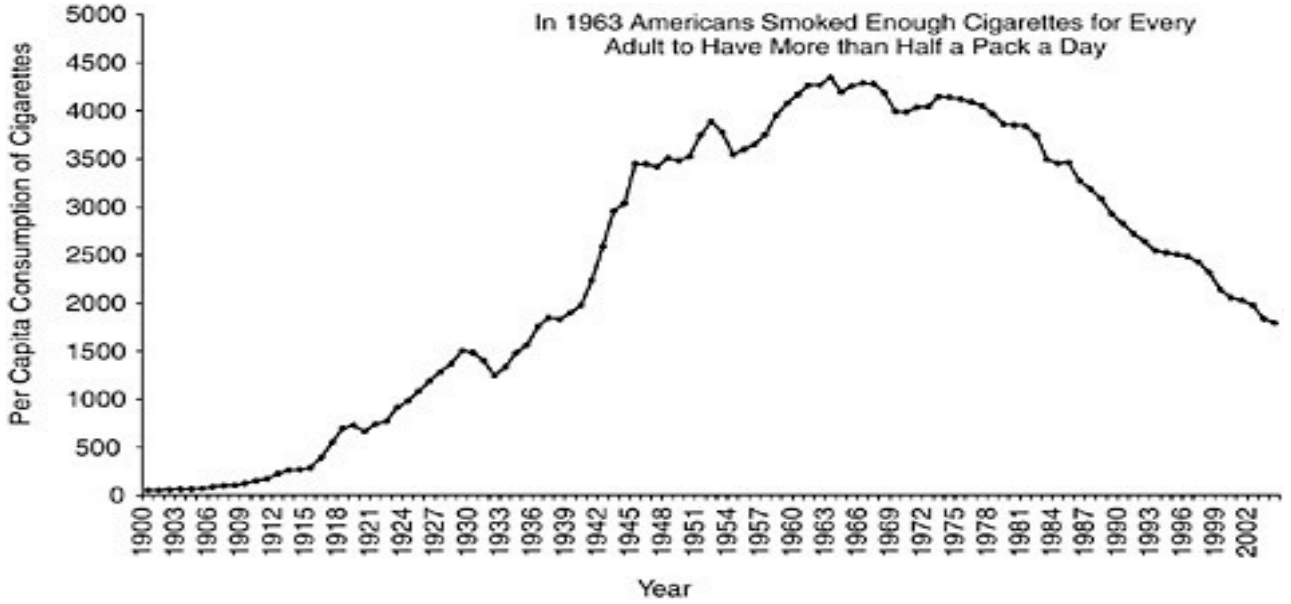
Declining Tobacco Use



IOM, 2007

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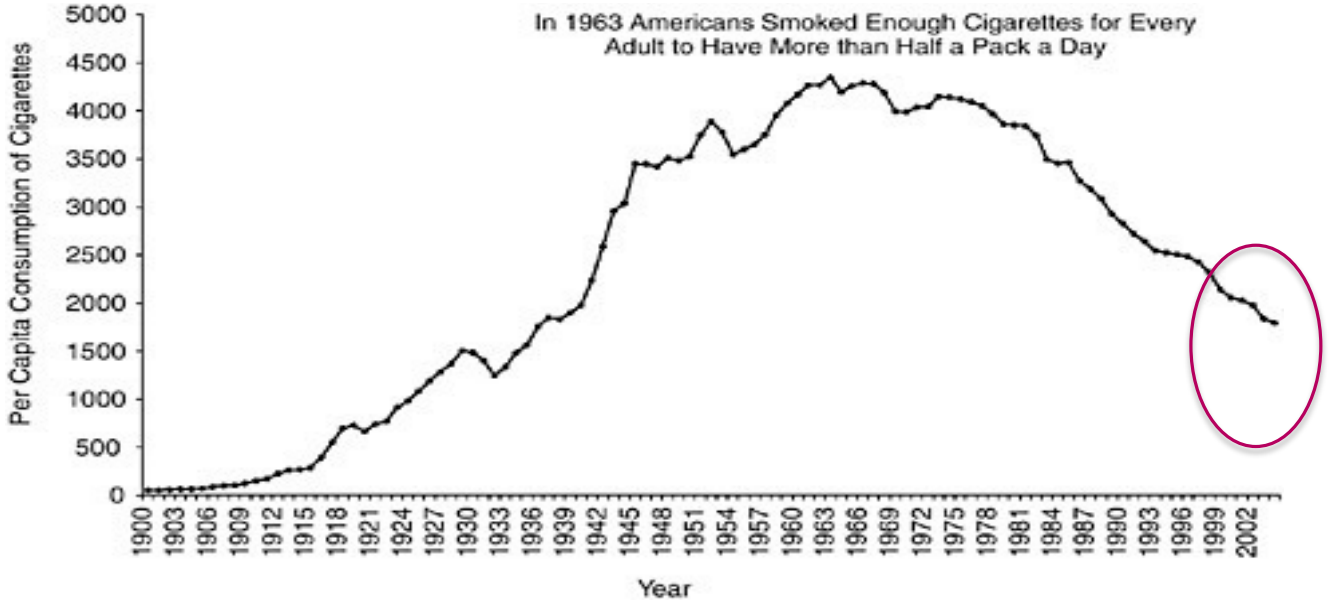
Declining Tobacco Use



IOM, 2007

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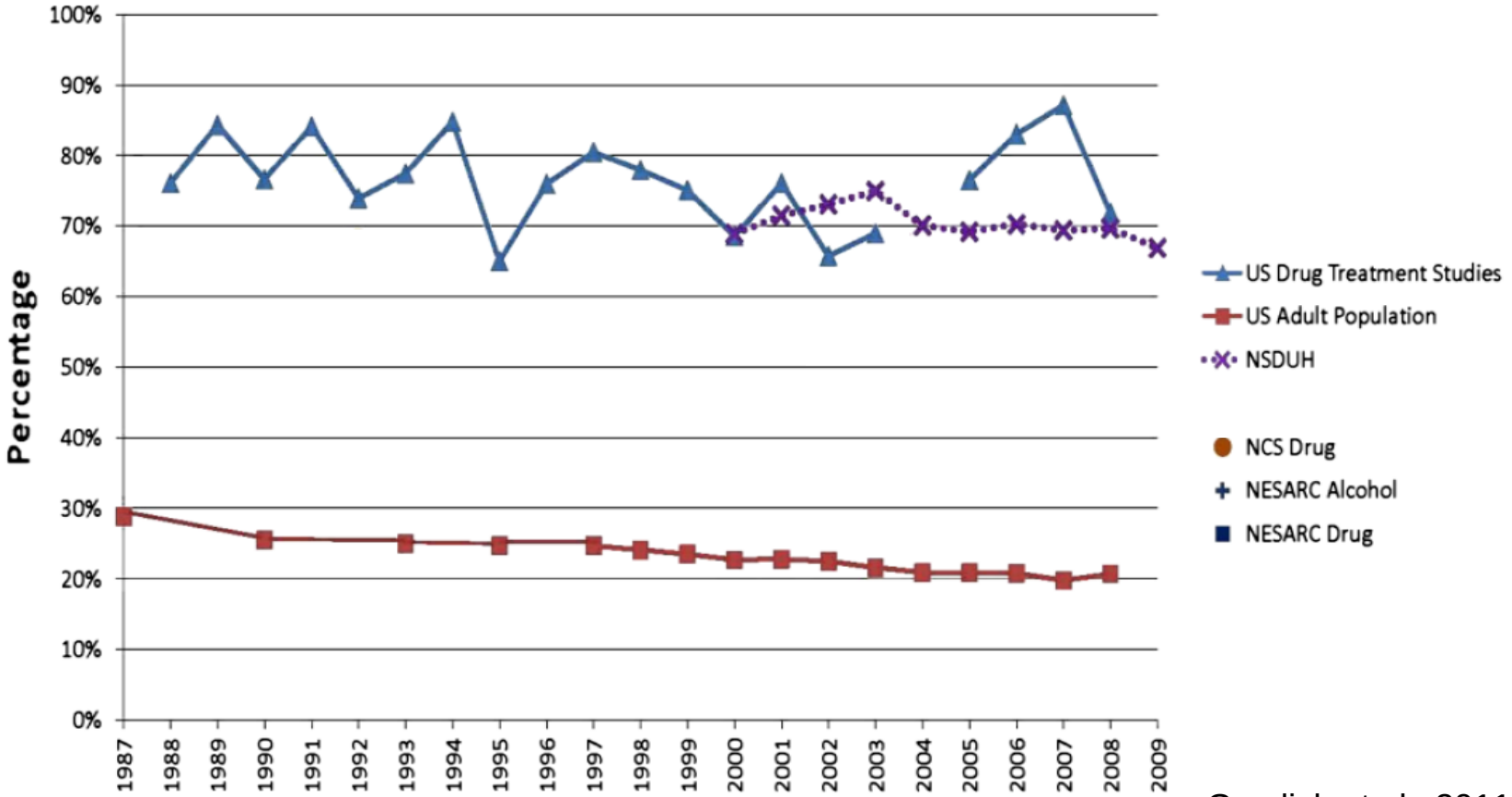
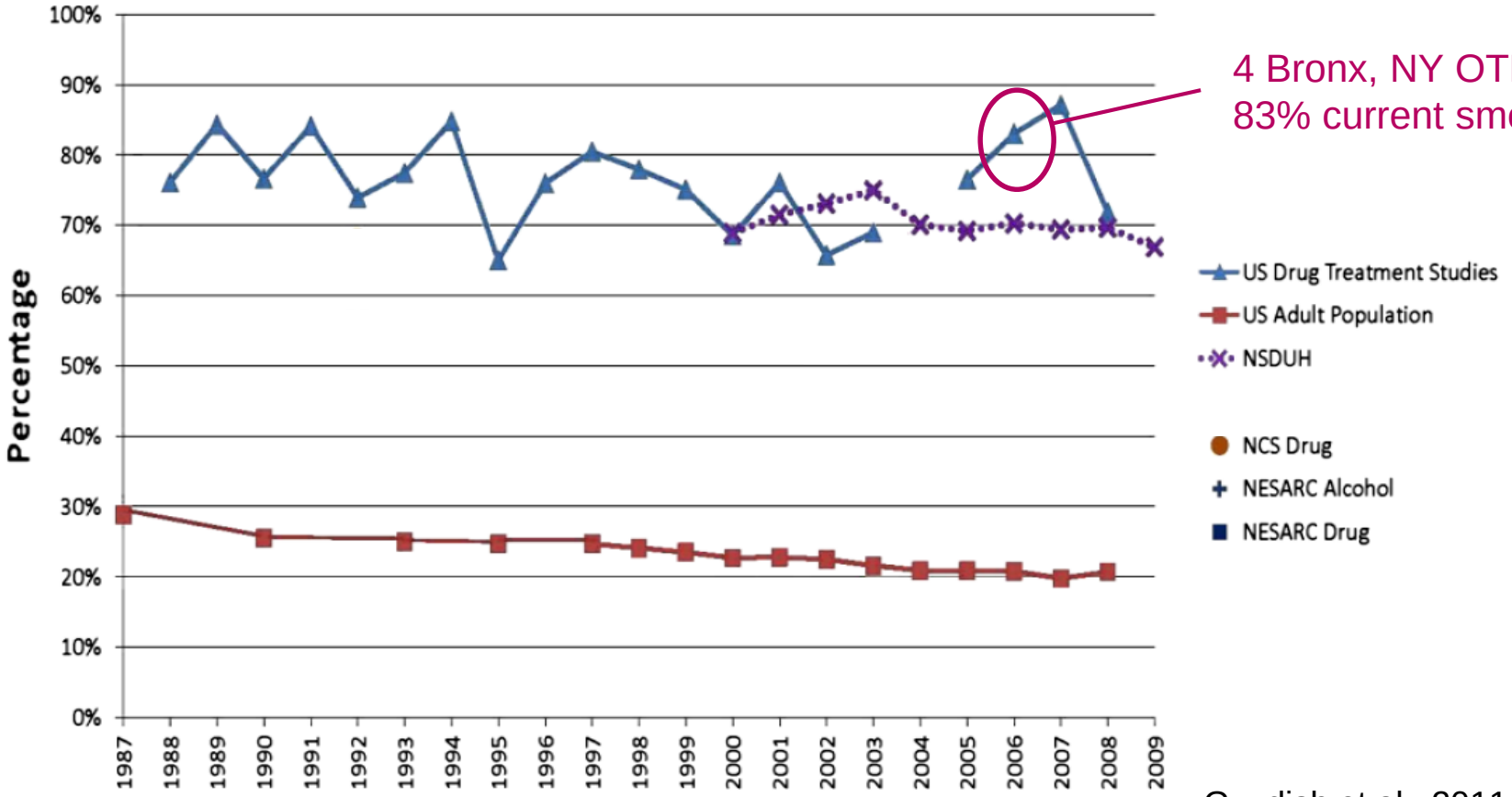
Disproportionate Prevalence



Guydish et al., 2011

Disproportionate Prevalence



Guydish et al., 2011

Smoking threatens recovery; cessation promotes it

Study	Findings
National epidemiologic study (Weinberger et al, 2017)	Tobacco use initiation or continuation increases risk of SUD relapse
Meta analysis of 19 RCTs (Prochaska et al, 2004)	25% increased likelihood of long term abstinence from alcohol and drugs
RCT (Shoptaw et al, 2002)	Smoking cessation correlated with opiate and cocaine abstinence

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Tobacco-related mortality

- Tobacco-related illness is a major cause of death:
  - 51% died of tobacco-related causes
  - Death rate of smokers 4x that of non-smokers

Hurt et al, JAMA, 1996; Hser et al, Preventive Medicine, 1994

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(Better World Advertising : My Greatest Enemy Campaign, 2009)

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Outline

- Health burden of tobacco use
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How can we help smokers with opioid use disorder to quit?

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Provide evidence-based treatment

What is the evidence base?

- In opioid agonist treatment:
  - Methadone > buprenorphine
- Smokers interested in quitting
- Behavioral and pharmacological interventions

Brief Counseling Intervention: The 5As

Ask about tobacco use

Advise to quit

Assess willingness to quit

Assist in quit attempt

Arrange follow up

(Fiore et al., 2008)

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How well are SUD treatment programs doing?

- Multiple surveys of SUD treatment programs
  - 18 - 45% of programs provide smoking cessation counseling
  - 12 - 33% of programs provide cessation pharmacotherapy
  - Number of treated patients is low
  - Declines in treatment provision over time

Richter et al., Psych Serv, 2004; Friedmann et al., JSAT, 2008; Hunt et al., JSAT, 2012; Eby et al., JSAT, 2015

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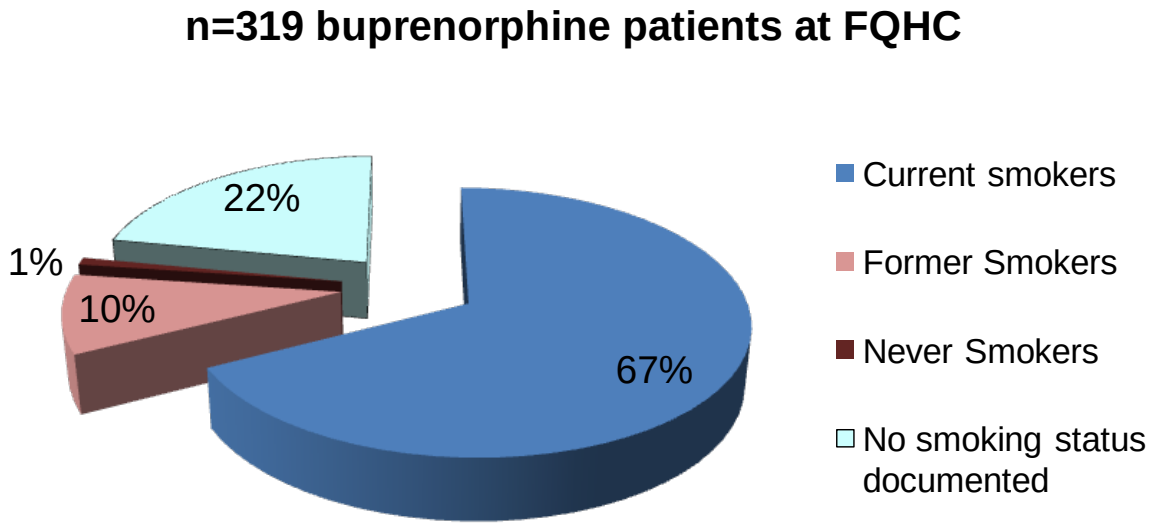
Smoking status



Nahvi et al., JSAT 2014

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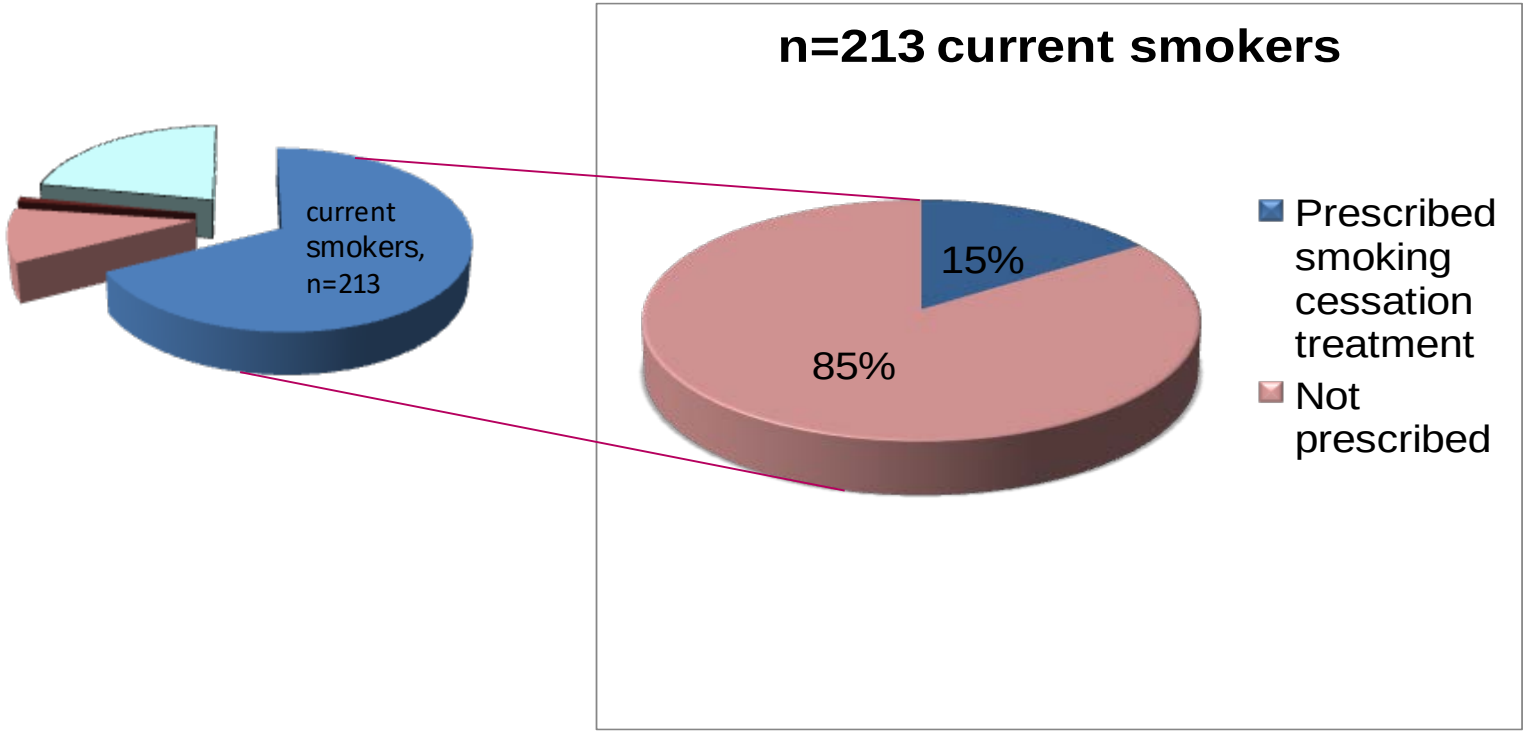
Smoking cessation treatment



Nahvi et al., JSAT 2014

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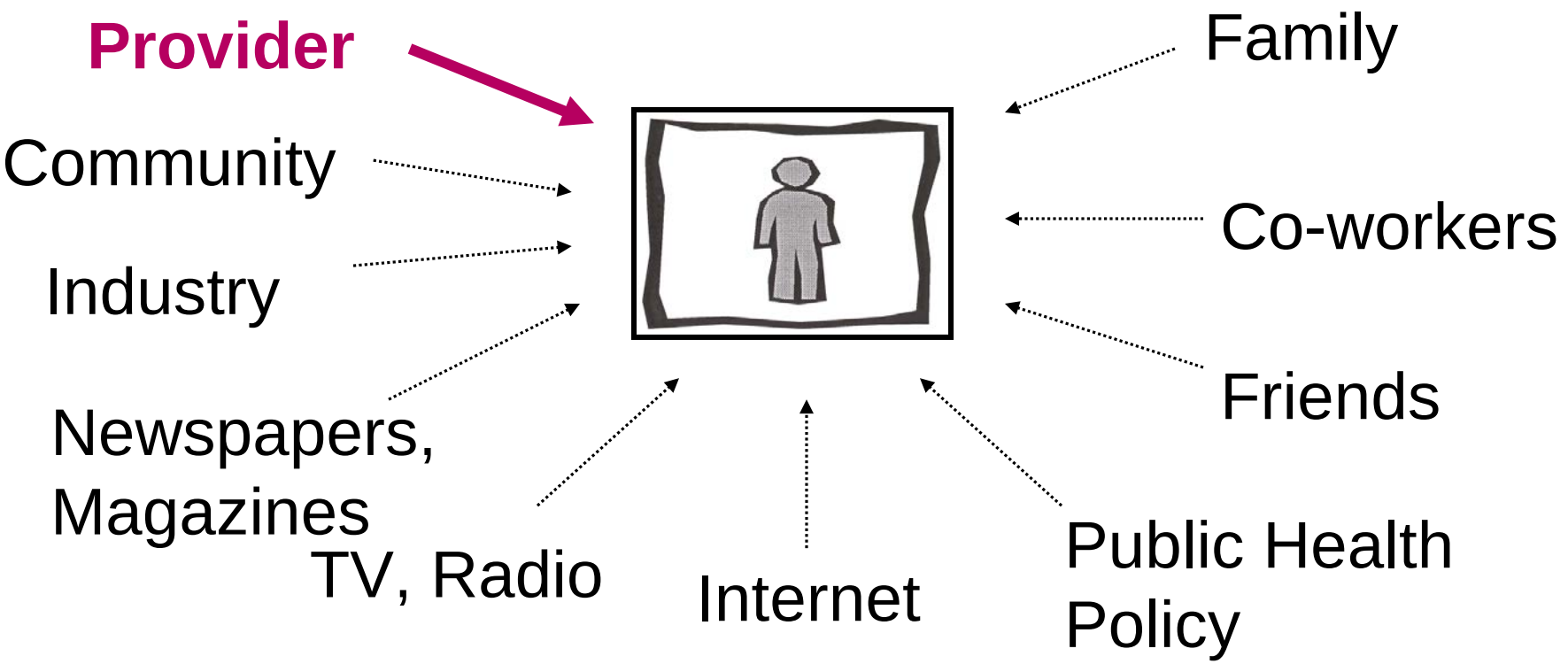
If not us, who provides cessation information?



Misperceptions about smoking cessation treatment

Limited perceived efficacy

- Don’t know that meds alleviate withdrawal symptoms and craving
- 16% agree: “helps people quit smoking”

Overestimate the risks

- Believe that medication effects are worse than the effects of smoking

Etter 2001; Fu 2007; Mooney 2006

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Provide evidence-based cessation treatment

1. Provide behavioral treatment
2. Provide pharmacotherapy

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Maria is a 56 year old woman with HIV (CD4 400s on HAART) who was recently hospitalized for pneumonia. She has never tried to quit smoking and doesn't want to stop.

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Brief Counseling Intervention: The 5As

Ask about tobacco use

Advise to quit

Assess willingness to quit

Assist in quit attempt

Arrange follow up

(Fiore et al., 2008)

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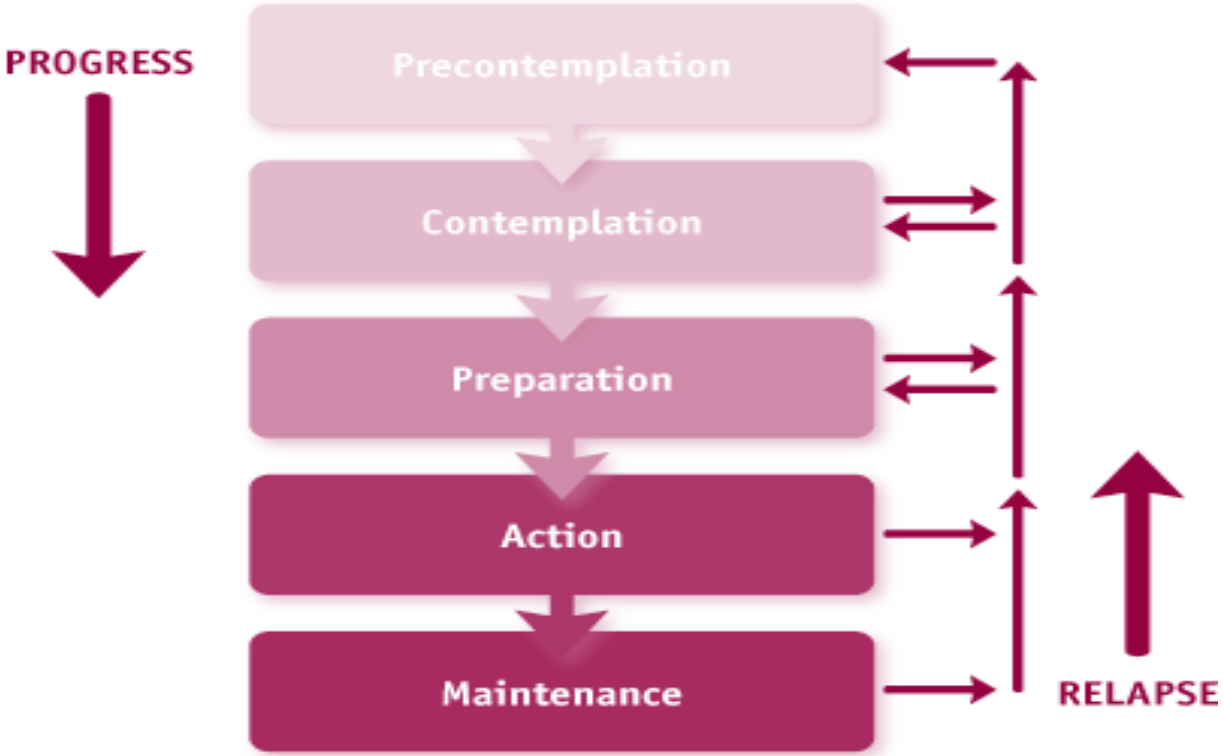
Stages of Change



Motivational 5Rs for smokers not ready to quit

Relevance to quitting smoking
Risks associated with cont'd smoking
Rewards to being tobacco-free
Roadblocks to successfully quitting
Repetition of assessment

(Fiore et al., 2008)

Evidence base is limited

Pilot Study of a Tailored Smoking Cessation Intervention for Individuals in Treatment for Opioid Dependence

Nina A. Cooperman PsyD[1], Shou-En Lu PhD[2], Kimber P Richter PhD[3]
Steven L. Bernstein MD[4], Jill M. Wi

A smoking cessation intervention for the methadone-maintained

Michael D. Stein, Marjorie C. Weinstock, Debra S. Herman, Bradley J. Anderson,
Jennifer L. Anthony & Raymond Niaura[1]

wn University Medical School, Providence, RI, USA

Cigarette Smoking Cessation Intervention for Buprenorphine Treatment Patients

Sharon M. Hall PhD[1], Gary L. Humfleet PhD[1], James J. Gasper Pharm D[2], Kevin L. Delucchi PhD[1], David F. Hersh MD[3], Joseph R. Guydish PhD[4]

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Smoking reduction

- Enhance cessation
  - ≥ 50% reduction: predictor of cessation
- Improve health
  - Decreased cardiovascular risk
  - Decreased respiratory symptoms
  - Decreased lung cancer risk
- Engage smokers not yet ready to quit

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Remaining questions

- Best strategies to reduce tobacco use?
- Can reductions be sustained?
- Compensatory smoking?
- Can we reduce toxicant exposure and harm?

Maria has been hospitalized multiple times for pneumonia. She comes in with a productive cough x 3 days. She is sick of smoking and wants to stop.

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Provide evidence-based cessation treatment

1. Provide behavioral treatment
2. Provide pharmacotherapy

Brief Counseling Intervention: The 5As

Ask about tobacco use

Advise to quit

Assess willingness to quit

Assist in quit attempt

Arrange follow up

Brief (3 minute) counseling increases cessation success by 30%

(Fiore et al., 2008)

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Brief Counseling Intervention: The 5As

Ask about tobacco use

Advise to quit

Assess willingness to quit

Assist in quit attempt

Arrange follow up

Dose response between number of clinician types offering counseling and cessation success (Fiore et al., 2008)

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Counselors

- Frequent patient contact
- Skills to address substance use disorders

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Patient Referral Services: Telephone Counseling

- Quitline efficacy (Stead et al., Cochrane Library, 2007)
  - Multiple calls: OR 1.41 (1.27-1.57) increase in successful quit attempts
  - Efficacy for long term cessation
  - Effective at reaching racial/ethnic minority smokers
- Services:
  - Free telephone counseling in English, Spanish & other languages
  - Free Nicotine Replacement Therapy (NRT)
  - Referrals to local counseling & cessation programs
  - Free educational materials

1-800-QUIT-NOW

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No cessation with low intensity counseling

Pilot Study of a Tailored Smoking Cessation Intervention for Individuals in Treatment for Opioid Dependence

Nina A. Cooperman PsyD[1], Shou
Steven L. Bernstein MD[4], Jill M.

Varenicline efficacy and safety among methadone maintained smokers: a randomized placebo-controlled trial

Shadi Nahvi[1,2], Yuming Ning[1], Kate S. Segal[1], Kimber P. Richter[3] & Julia H. Arnsten[1,2,4]

Cigarette Smoking Cessation Intervention for Buprenorphine Treatment Patients

Sharon M. Hall PhD[1], Gary L. Humfleet PhD[1], James J. Gasper Pharm D[2], Kevin L. Delucchi PhD[1], David F. Hersh MD[3], Joseph R. Guydish PhD[4]

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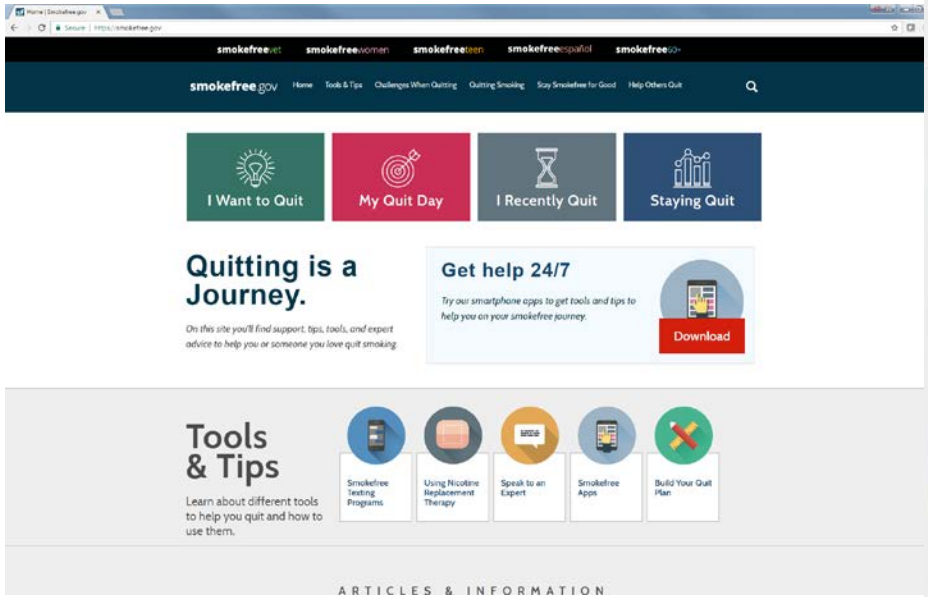
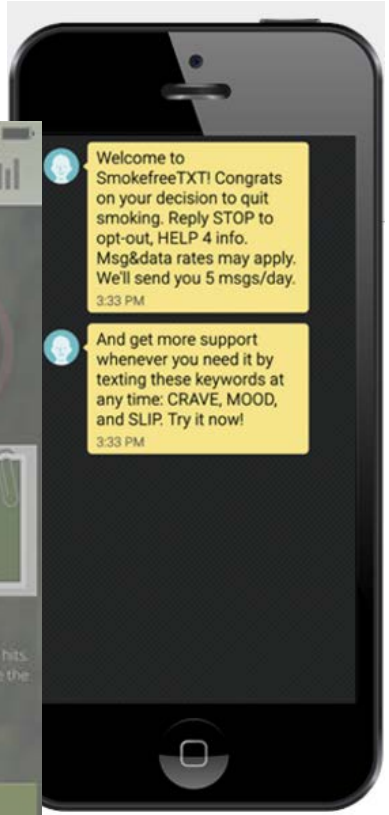
mHEALTH?





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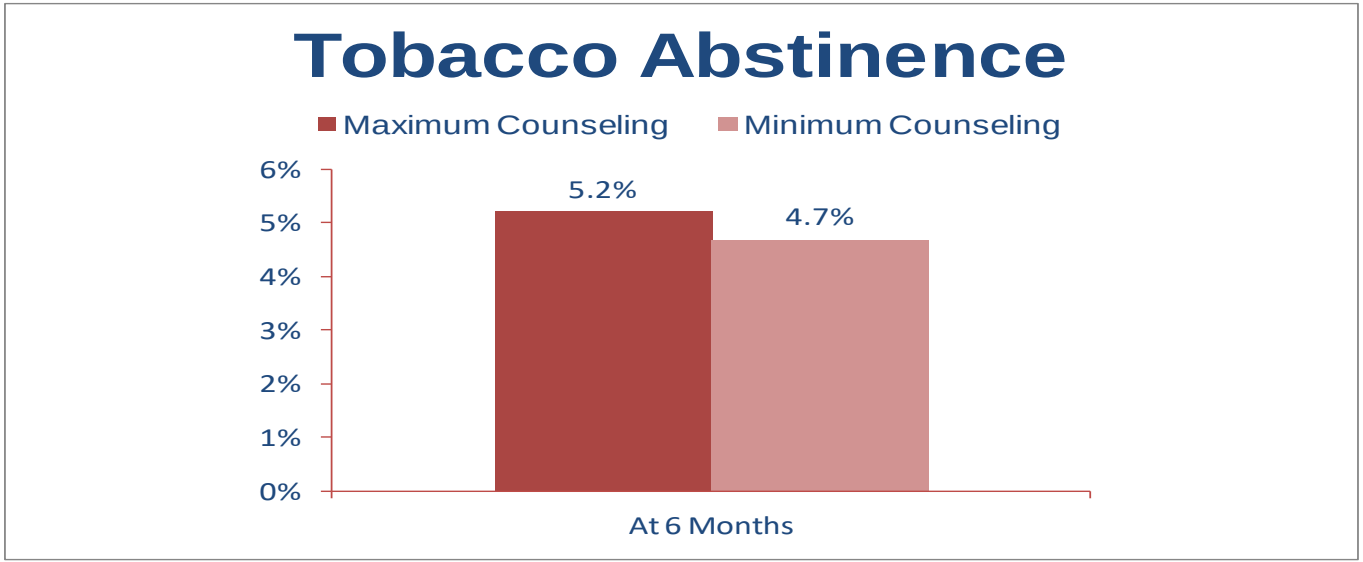
Modest effects of motivational counseling

n=383 methadone maintenance patients



Stein, Addiction, 2006

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Modest effects of motivational counseling

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Contingency management

Smoking cessation in methadone maintenance

Steve Shoptaw[1,2], Erin Rotheram-Fuller[1], Xiaowei Yang[4], Dominick Frosch[1,3], Debbie Nahom[1], Murray E. Jarvik[1,2], Richard A. Rawson[1,2] & Walter Ling[1,2]

Financial incentives to promote extended smoking abstinence in opioid-maintained patients: a randomized trial

Stacey C. Sigmon[1,2,3], Mollie E. Miller[1,3], Andrew C. Meyer[1,2], Kathryn Saulsgiver[5], Gary J. Badger[4], Sarah H. Heil[1,2,3] & Stephen T. Higgins[1,2,3]

- Potent short-term effects
- Effects not maintained

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Remaining questions

- Potency
- Adherence
- Scaling

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Provide evidence-based cessation treatment

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Tobacco Cessation Medications: first line

Nicotine Replacement

- Patch*
- Gum*
- Lozenge*
- Nasal Spray
- Inhaler

Oral agents

- Bupropion SR (Zyban)
- Varenicline (Chantix)

* Available OTC

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“I don’t want to try medications.
I know I can do this on my own.”

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Cold Turkey

- 72% of quit attempts are without treatment
- 3-5% of self quitters achieve prolonged abstinence
- Most relapse within 8 days

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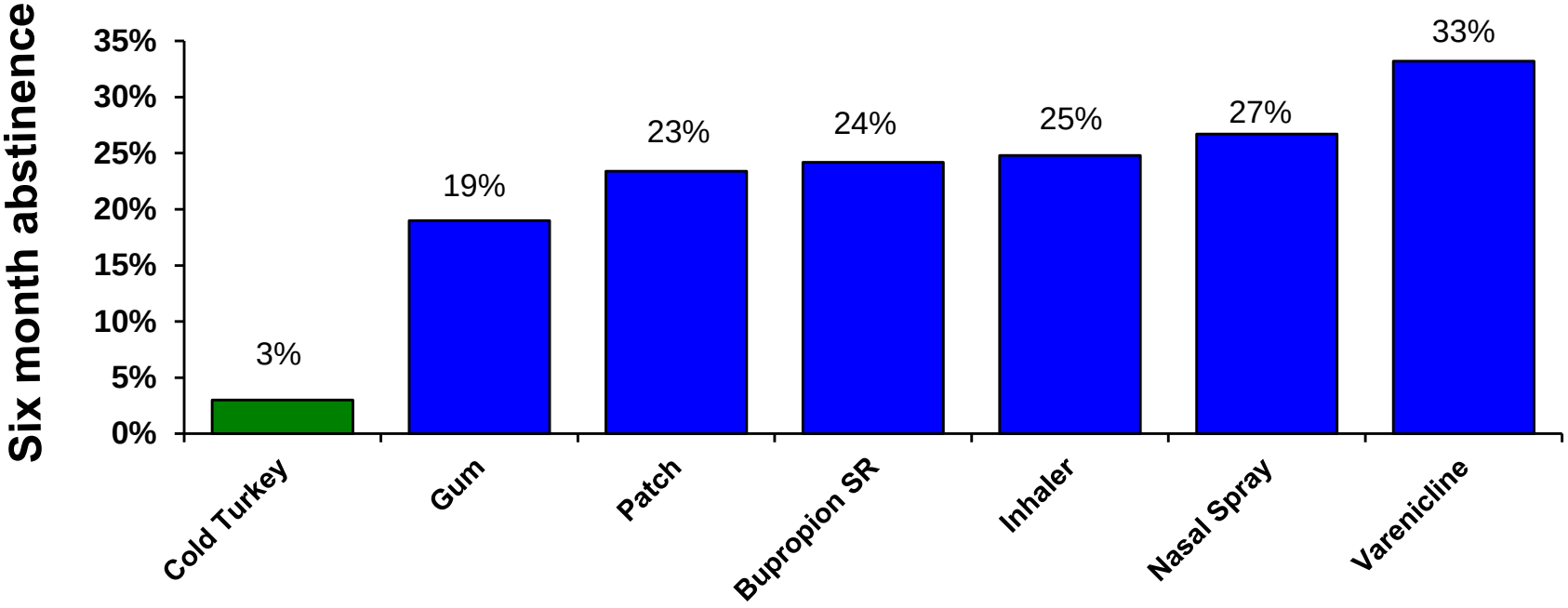
Hughes, Addiction 2004

Tobacco Abstinence Rates



Hughes 2004; Fiore 2008

Cigarettes are the most addictive drugs of abuse

“The experience of smoking for me, when I’m jonesing and I take in that first hit, it’s like scratching an itch. It’s like taking a drink on a really thirsty day. It’s like taking a breath of air when you’ve had your head under water and you pop back up.”

Richter et al, 2002

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Withdrawal Symptoms

- Headaches
- Drowsiness
- Depression
- Hunger
- Anxiety
- Irritability
- Poor concentration
- Restlessness
- Craving

“I’ve tried patches and nicotine gum before. They didn’t work for me.”

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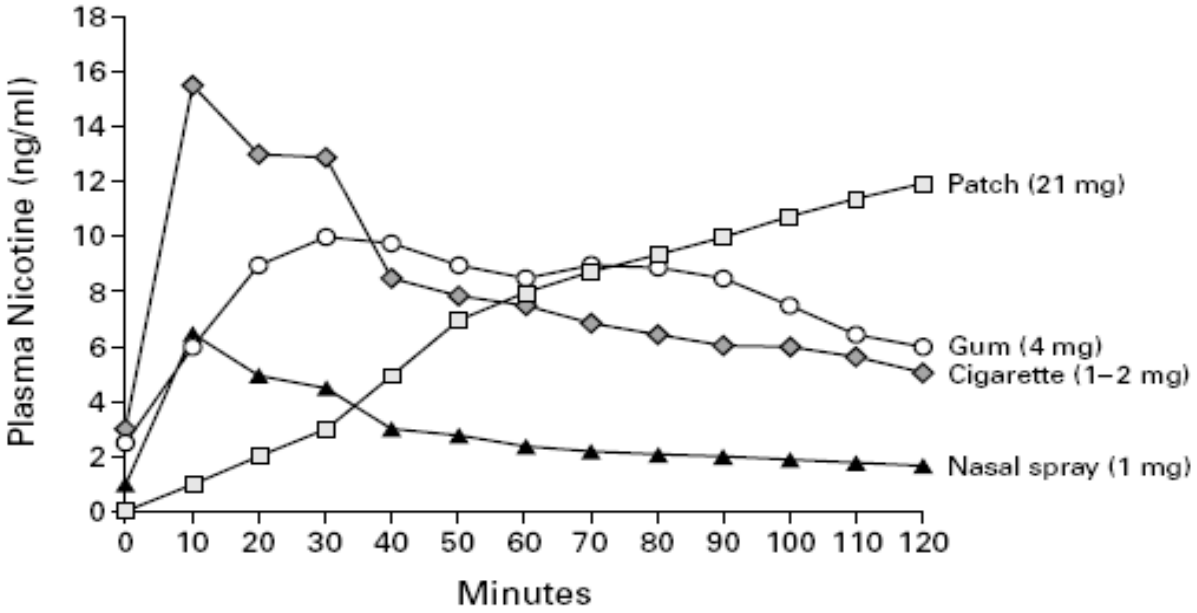
Plasma Nicotine Levels



Rigotti, NEJM, 2002

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Nicotine Replacement Therapy

	Dosage	Duration	Coverage
Patch 	21 mg / 24 hours 14 mg / 24 hours 7 mg / 24 hours	4 weeks 2 weeks 2 weeks	OTC Medicaid Medicare
Gum 	≥25 cigs/d: 4 mg 1-24 cigs/d: 2 mg *1-2 pieces/hr (max 24/d)*	Up to 12 weeks	OTC Medicaid
Lozenge 	1st daily cig < 30 min: 4 mg 1st daily cig > 30 min: 2 mg *1-2 pieces/hr (max 20/d)*	Up to 12 weeks	OTC
Oral inhaler 	10 mg (delivers 4 mg) *6-16 cartridges/d*	Up to 6 months	Medicaid Medicare
Nasal spray 	0.5 mg/spray *8-40 doses/d*	3-6 months	Medicaid Medicare

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Comparison of Nicotine Replacement Therapies

No differences in

- withdrawal discomfort
- urges to smoke
- abstinence

Adherence:

- High: patch
- Low: gum
- Very low: nasal spray, inhaler

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Hajek et al, 1999; Fiore et al, 2008

Combination NRT

	OR cessation	95% confidence interval
High vs. standard patch dose	1.21	1.03 - 1.42
Combination NRT (patch ± other agents)	1.42	1.14 - 1.76

Clinically modest but statistically significant benefit over standard dose NRT alone

Silagy et al., Cochrane Library, 2006

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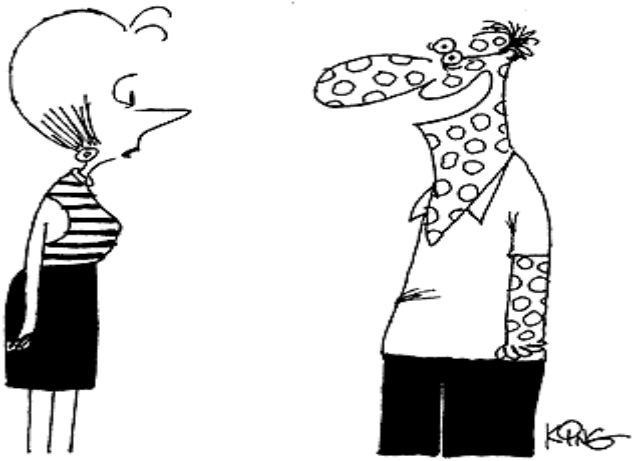

"It took 279 nicotine patches, but I no longer have the urge to smoke."

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Bupropion	Multiple potential mechanisms of action	Reduction of withdrawal symptoms, craving
Varenicline	Partial agonist of alpha-4 beta-2 nicotinic receptors	Partial agonism→ decreased craving and withdrawal sx's Blocks nicotine binding → prevents reinforcing effects

	Dosage	Duration	Coverage
Bupropion SR	1-2 weeks prior to quit date: 150 mg qAM x 3d, then 150 mg BID	7-12 weeks, up to 6 months	Medicaid Medicare
Varenicline	1 week prior to quit date: 0.5 mg daily x 3 d, then 0.5 mg BID x 4 d, then 1 mg BID	3-6 months	Medicaid Medicare

Drug and Alcohol Dependence 169 (2016) 180–189

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

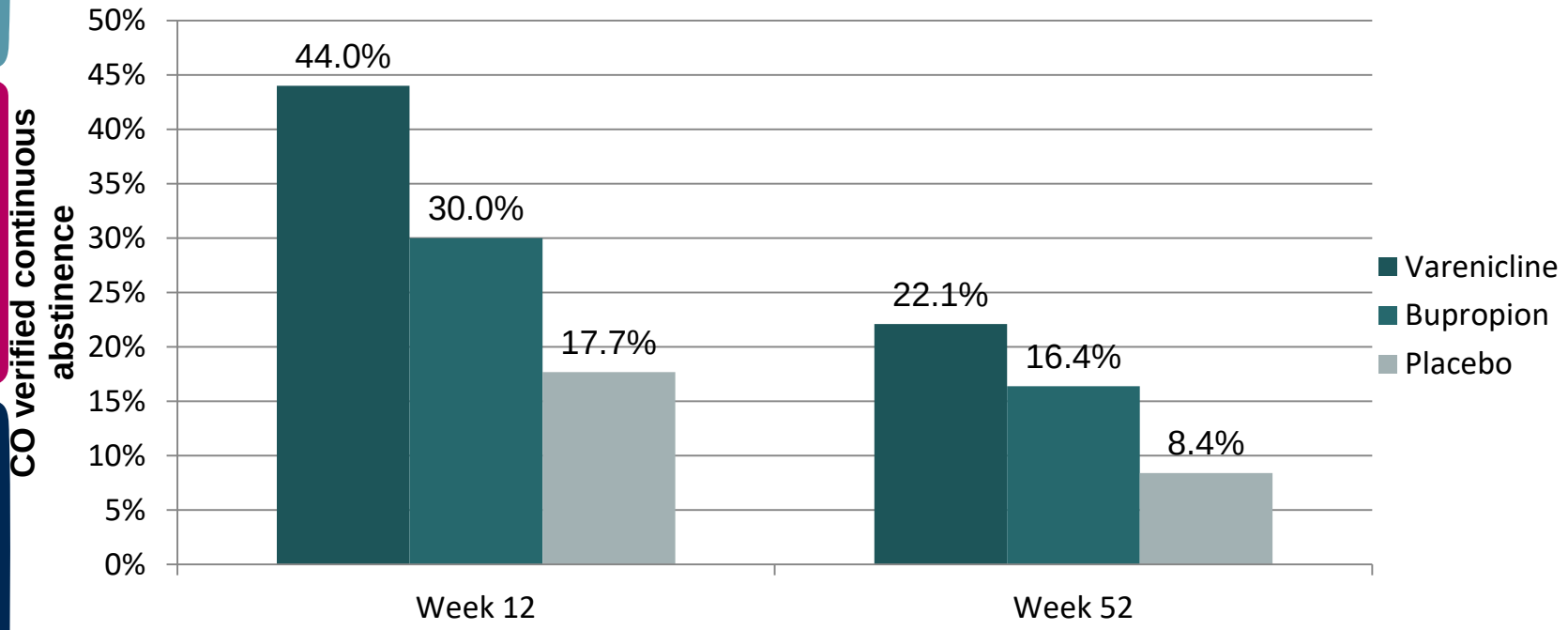
Review

Selection criteria limit generalizability of smoking pharmacotherapy studies differentially across clinical trials and laboratory studies: A systematic review on varenicline

Courtney A. Motschman[a], Julie C. Gass[a], Jennifer M. Wray[a,b], Lisa J. Germeroth[a], Nicolas J. Schlienz[a,c], Diana A. Munoz[a], Faith E. Moore[a,d], Jessica D. Rhodes[a,e], Larry W. Hawk[a], Stephen T. Tiffany[a,*]

Common eligibility criteria eliminate ~50% of daily smokers

Efficacy of Varenicline v. Bupropion v. Placebo



(Jorenby et al, 2006; Gonzalez et al, 2006)

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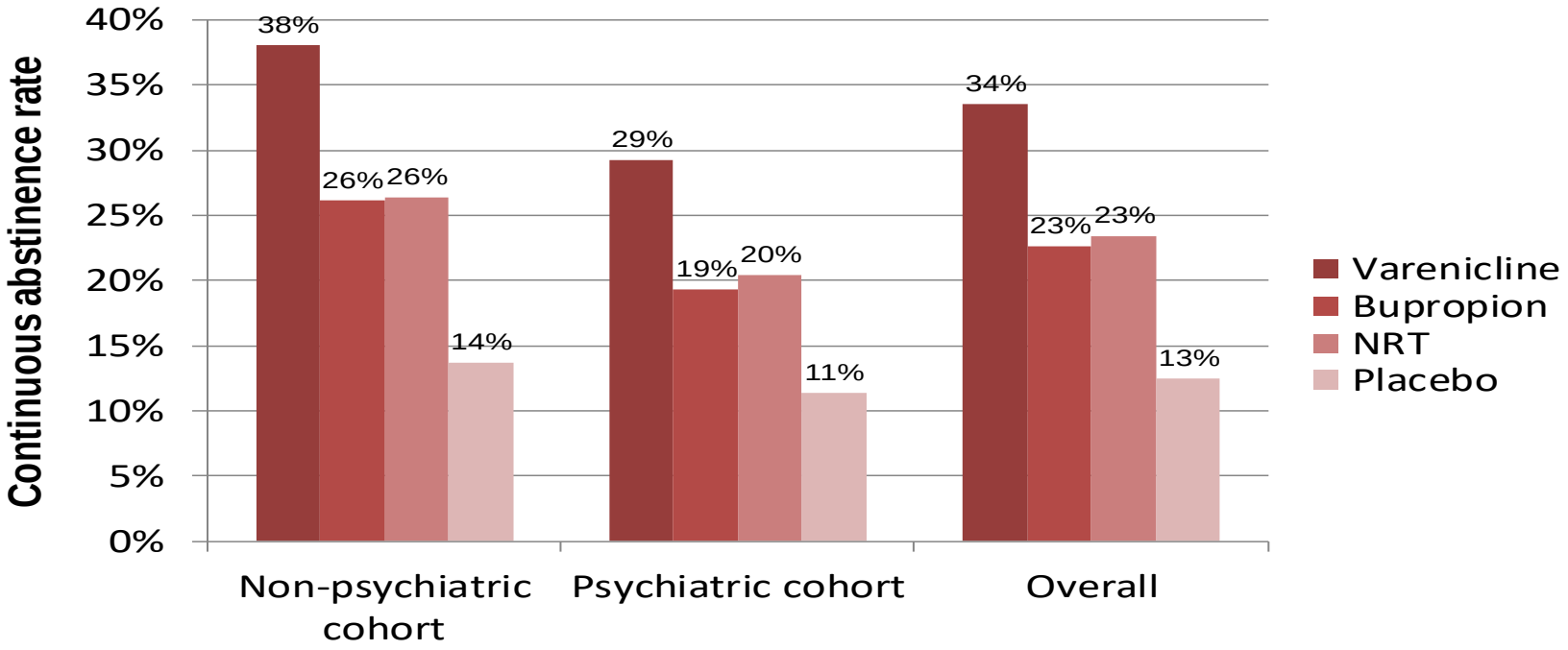
Pharmacotherapy efficacy, EAGLES trial



Anthenelli et al., Lancet, 2016

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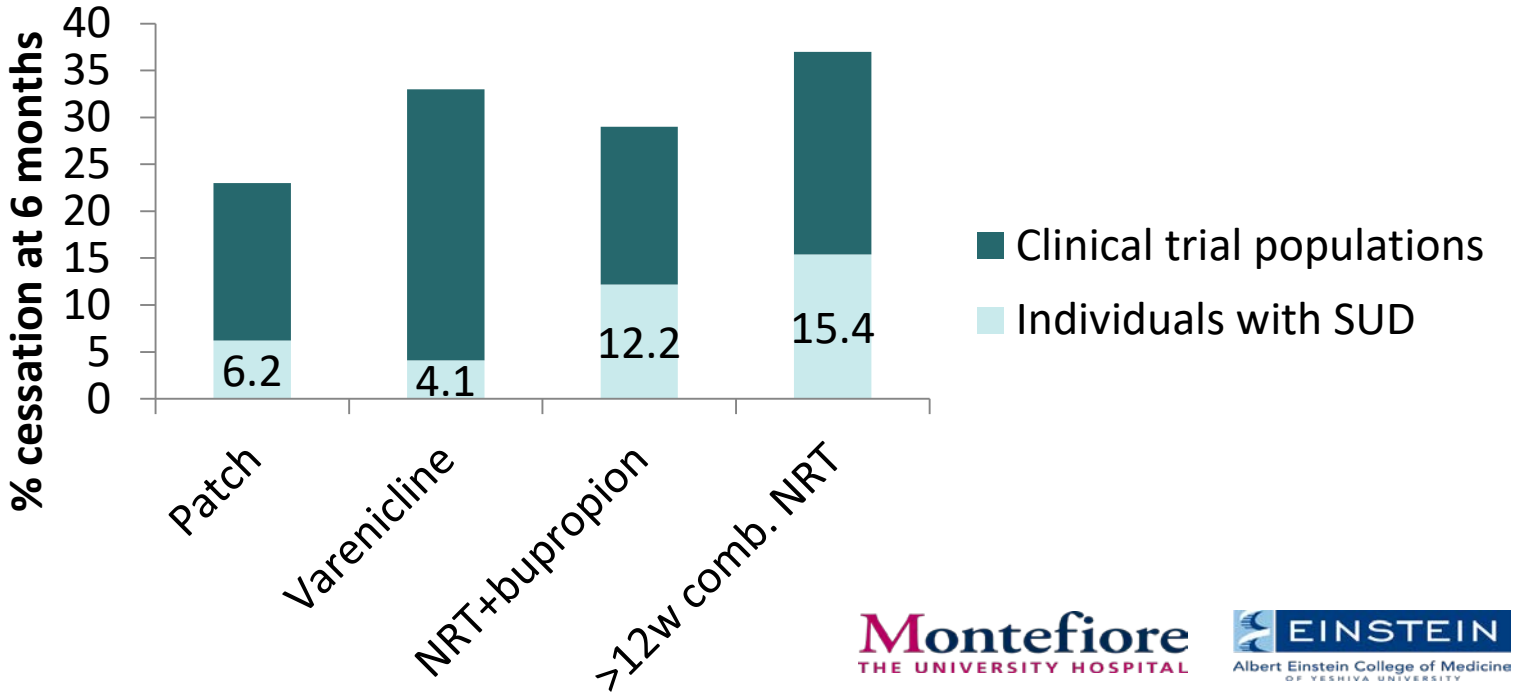
Tobacco abstinence rates



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Nicotine & Tobacco Research, 2015, 955–
doi:10.1093/ntr/nt
Commen

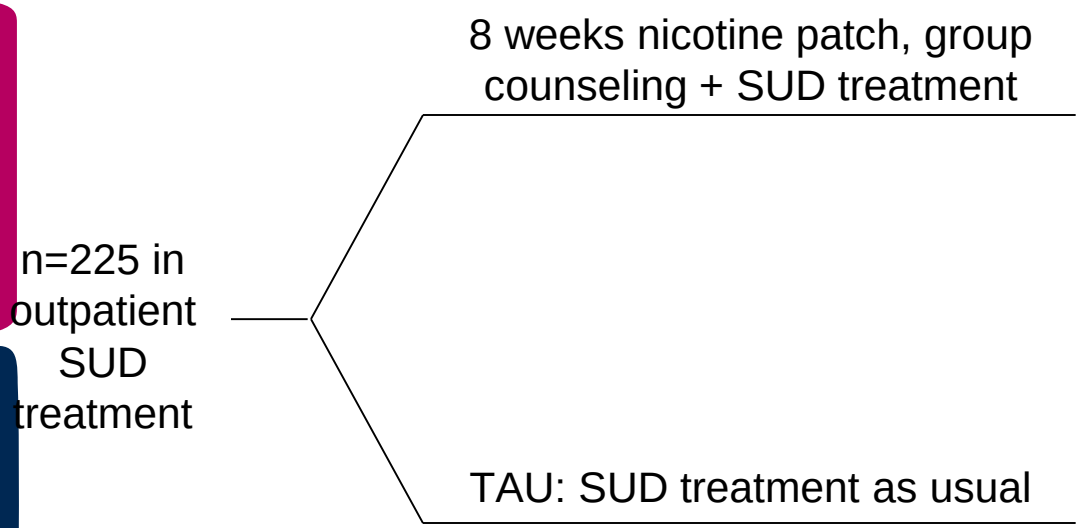
Commentary

Are Pharmacotherapies Ineffective in Opioid-Dependent Smokers? Reflections on the Scientific Literature and Future Directions

Mollie E. Miller PhD,[1] Stacey C. Sigmon PhD[2,3,4]

Treatments help

No cessation without treatment



Abstinence

End of Treatment

10%

0%

Reid, JSAT, 2008

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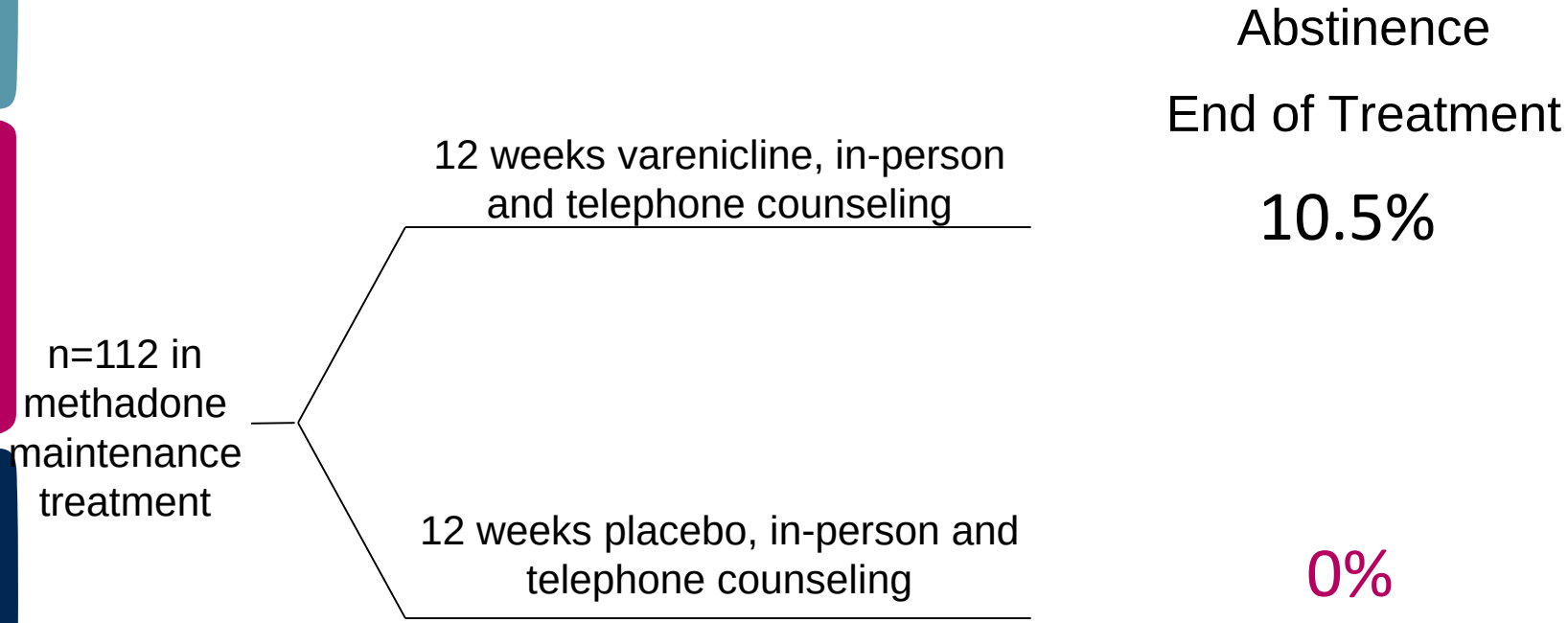
No cessation without treatment



Nahvi et al, Addiction, 2014

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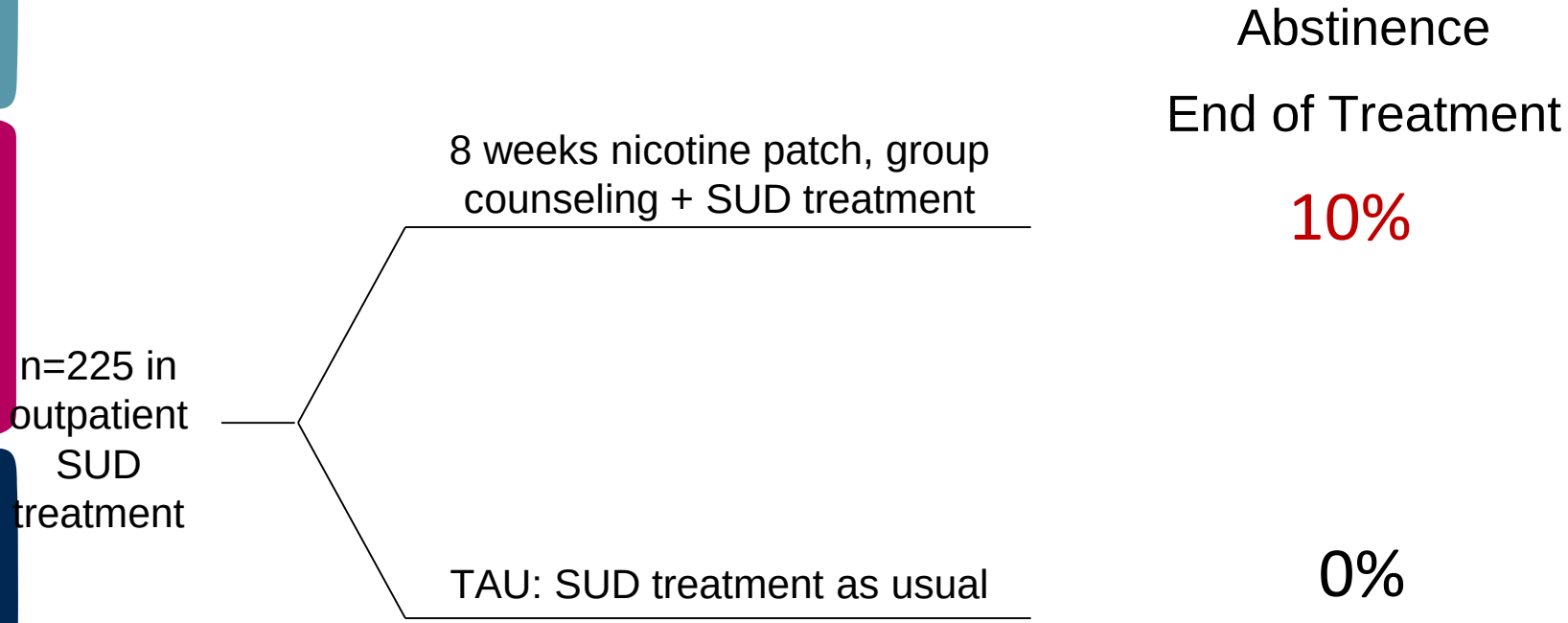
Treatments help,
but effects are modest

Cessation effects are modest



Reid, JSAT, 2008

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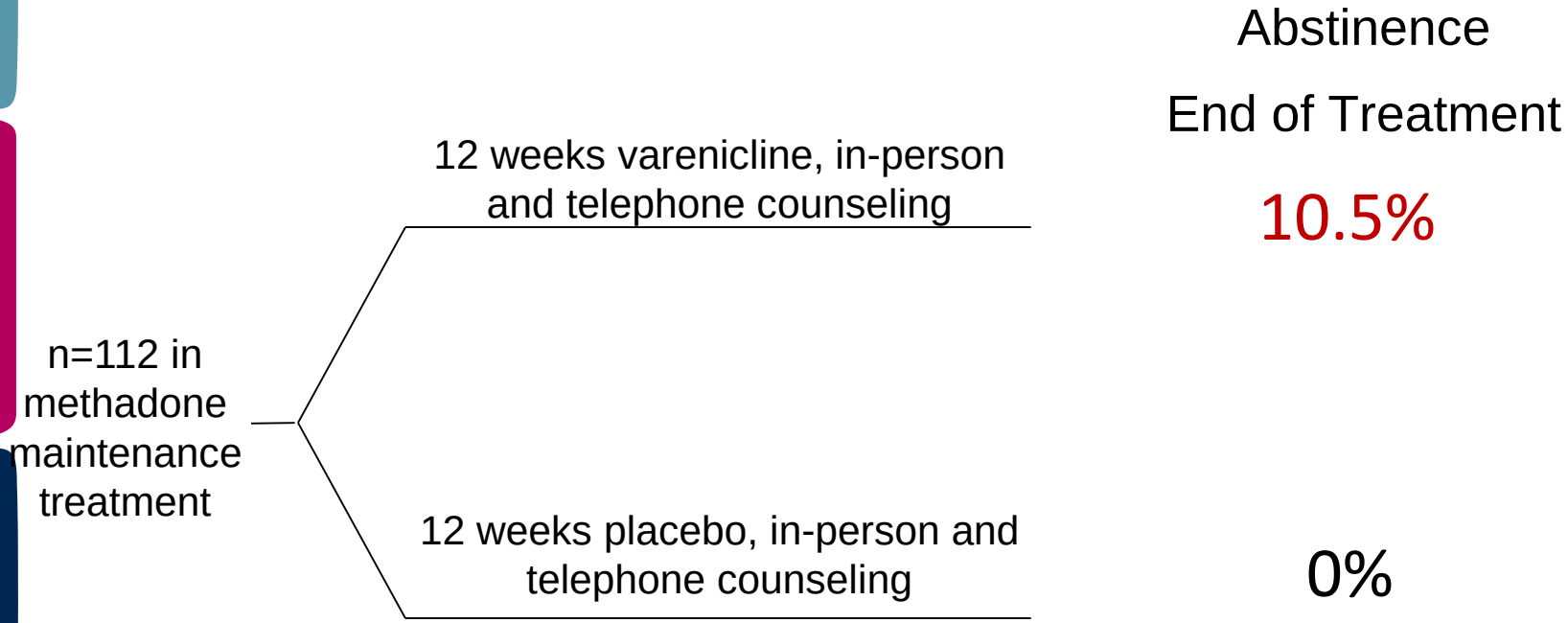
Cessation effects are modest



Nahvi et al, Addiction, 2014

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Treatment emergent adverse effects, n (%)

	Varenicline n = 57	Placebo n = 55	p value*
Change in taste	18 (32)	14 (25)	
Dry mouth	27 (47)	23 (45)	
Change in appetite	29 (51)	18 (35)	
Nausea	29 (51)	14 (27)	.01
Vomiting	11 (19)	8 (16)	
Gas	19 (33)	15 (29)	
Constipation	23 (40)	9 (18)	.01
Headache	11 (19)	18 (35)	
Insomnia	15 (26)	13 (24)	
Vivid/frequent dreams	18 (32)	22 (43)	

* $p \geq .05$ except as indicated

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Psychiatric outcomes, n (%)*

	Varenicline n = 57	Placebo n = 55
Incident major depressive episode	2 (4)	1 (2)
Incident manic episode	0	0
Incident psychotic disorder	1 (2)	3 (6)
Suicidal ideation	3 (5)	4 (8)

* $p \geq .05$ for comparison between groups

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EAGLES trial neuropsychiatric outcomes

RCT, n=8144 (4116 psychiatric cohort, 4028 non-psychiatric cohort)

Moderate - severe neuropsychiatric adverse events (psychiatric cohort)

- Varenicline 6.5%
- Bupropion 6.7%
- Nicotine patch 5.2%
- Placebo 4.9%

Varenicline – placebo risk difference 1.59 (95% CI -0.42 to 3.59)

Varenicline – nicotine patch risk difference 1.22 (95% CI -0.81 to 3.25)

Anthenelli et al, Lancet, 2016

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Outline

- Health burden of tobacco use
- Evidence-based cessation treatments
- Optimizing efficacy
- Optimizing implementation

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Why are cessation rates so low?

Why are cessation rates so low?

Limited treatment provision

Limited social support

Short-term treatment

Poor adherence

Opioid nicotine interactions

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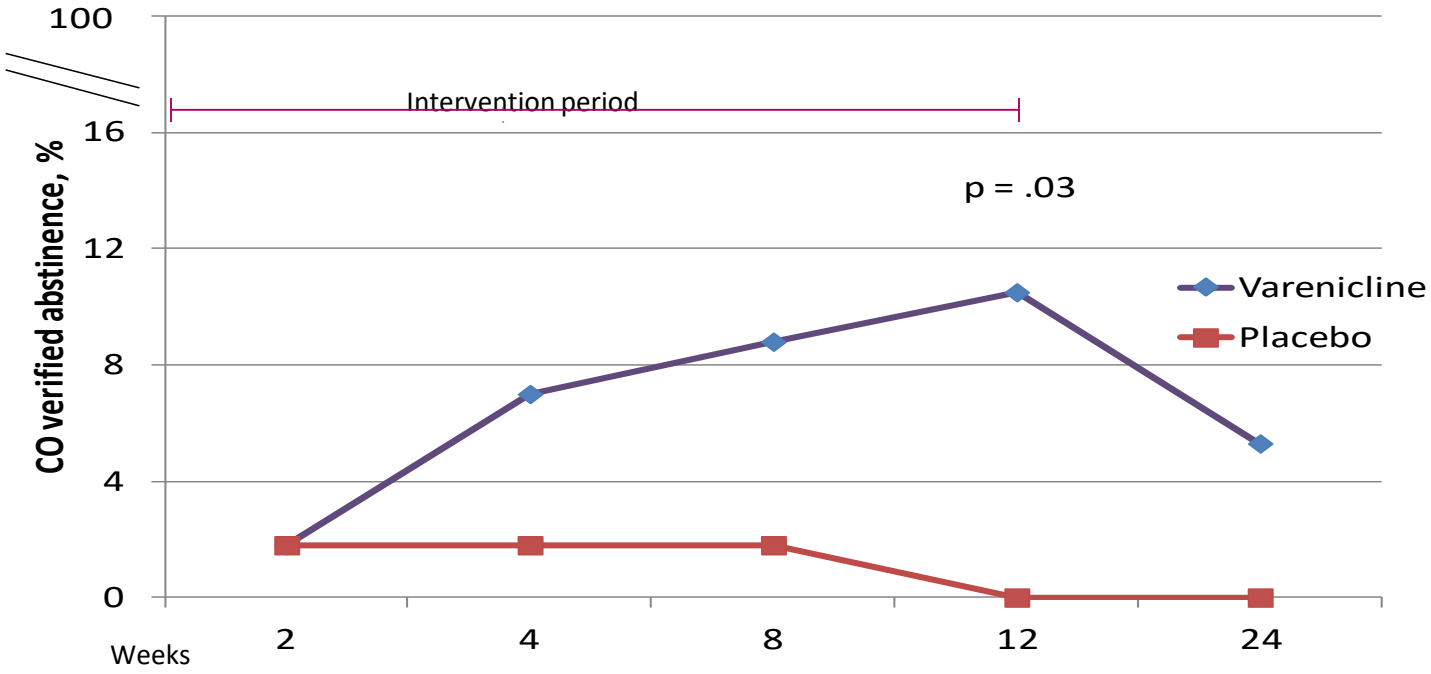
Short-term treatments may be inadequate

Limited initial abstinence

- Establishing initial abstinence is a critical prerequisite of long-term cessation
- 35% made initial quit attempt

de Dios et al., NTR, 2014

Limited initial abstinence



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Pre-cessation patch treatment

- Meta-analysis of 4 studies comparing patch prior to target quit date v patch on quit date
- Pre-cessation patch doubled odds of quitting:

	OR	95% CI
6 weeks	1.96	1.31–2.93
6 months	2.17	1.46–3.22

Shiffman and Ferguson, 2008

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Varenicline “preloading”

- RCT, n=101 smokers, randomized to:
  - Varenicline x 4 weeks pre quit date
  - Placebo x 3 wks, Varenicline x 1 wk pre quit date
  - Varenicline x 3 mo (after quit date, both groups)
- Varenicline preloading
  - Reduced prequit smoking enjoyment
  - Increased 12 wk abstinence rates
    - 47.2% varenicline v 20.8% placebo, p=.005

Hajek et al, Arch Int Med 2011

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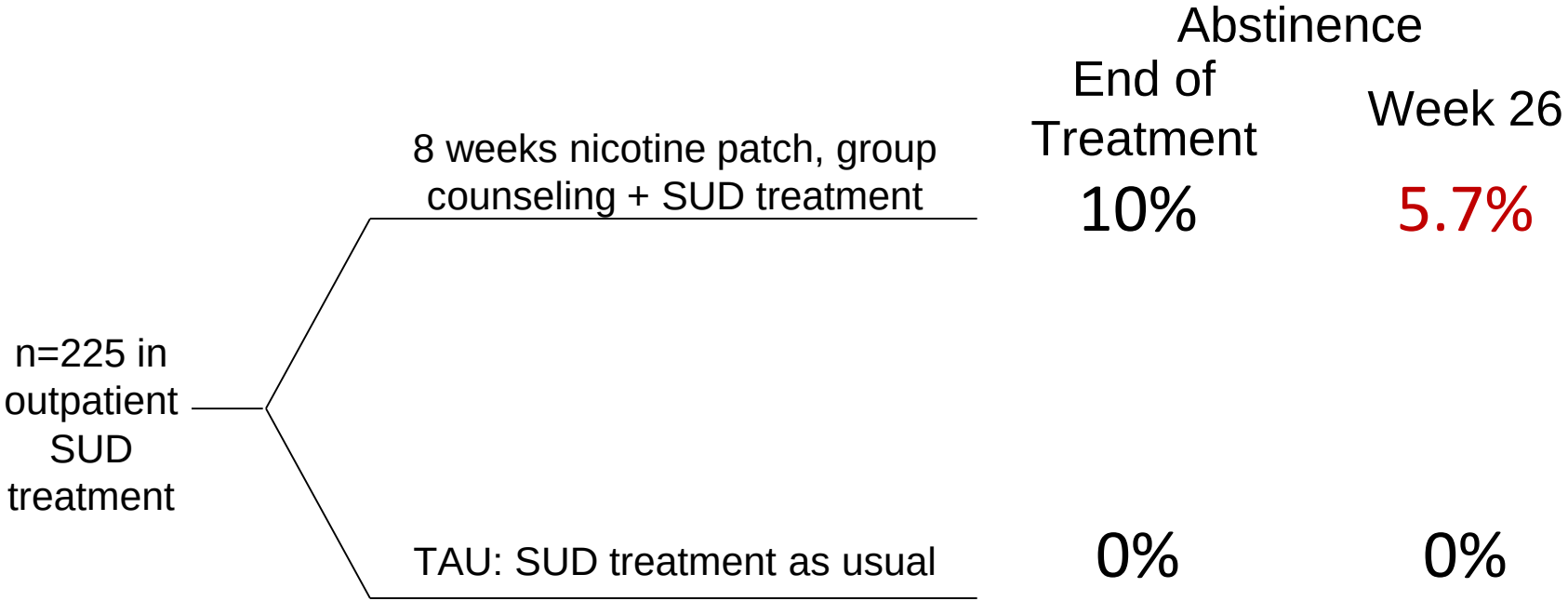
“But you know, even when I’ve quit before, I’ve gone back to smoking a month later.”

Effects are not sustained



Reid, JSAT, 2008

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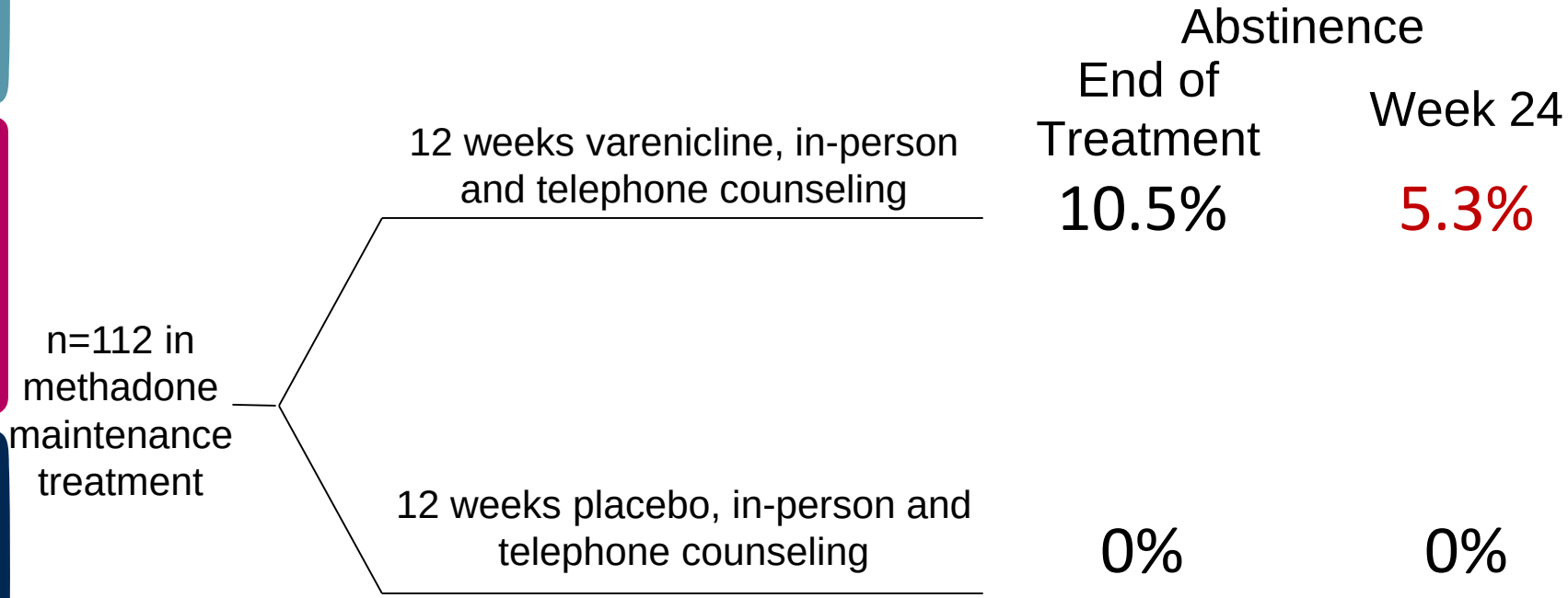
Effects are not sustained



Nahvi et al, Addiction, 2014

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Extended treatment

Study	n	Intervention	Findings
Schnoll et al, 2010	568	Nicotine patch 2 v 6 months	Extended treatment significantly •Increases abstinence •Increases time to relapse
Hays et al, 2001	784	Bupropion 7 v 52 wks	
Tonstad et al, 2006	1210	Varenicline 3 v 6 months	
Schnoll et al, 2015	525	Nicotine patch 2 v 6 v 12 months	

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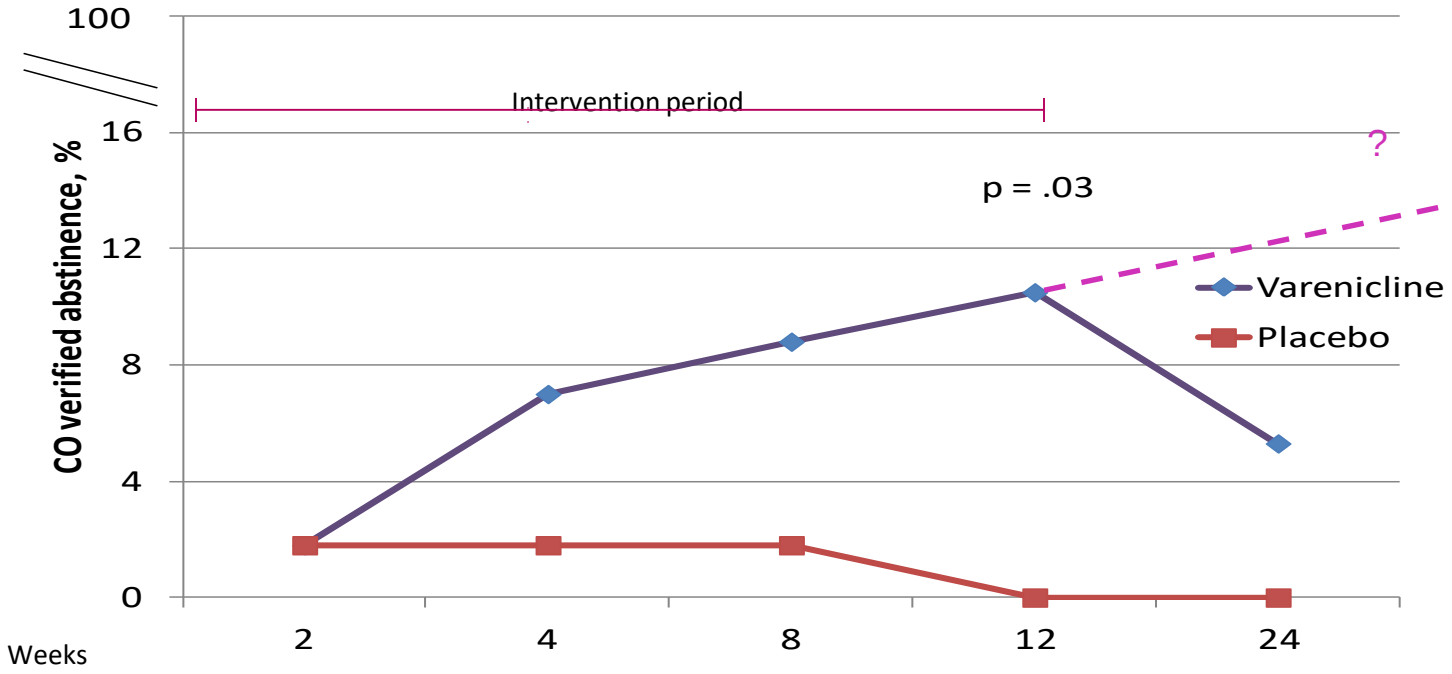
Extended treatment



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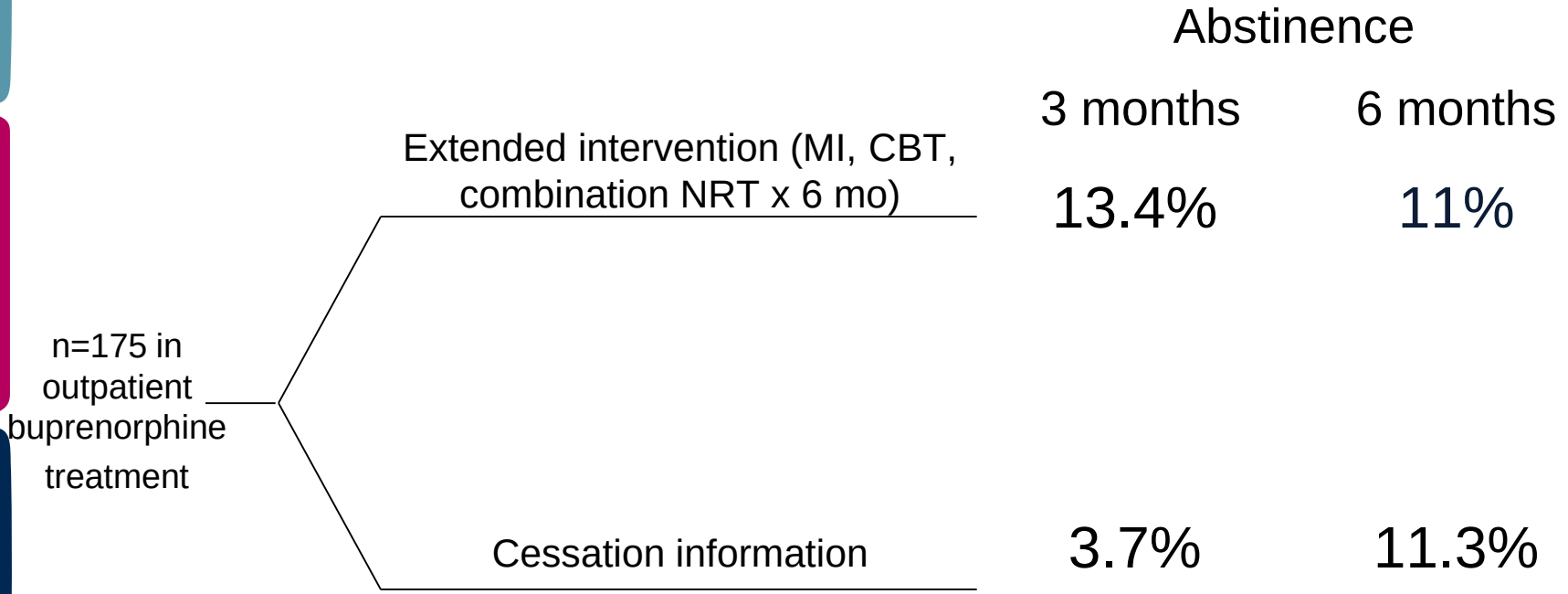
Extended treatment



Hall et al., NTR, 2018

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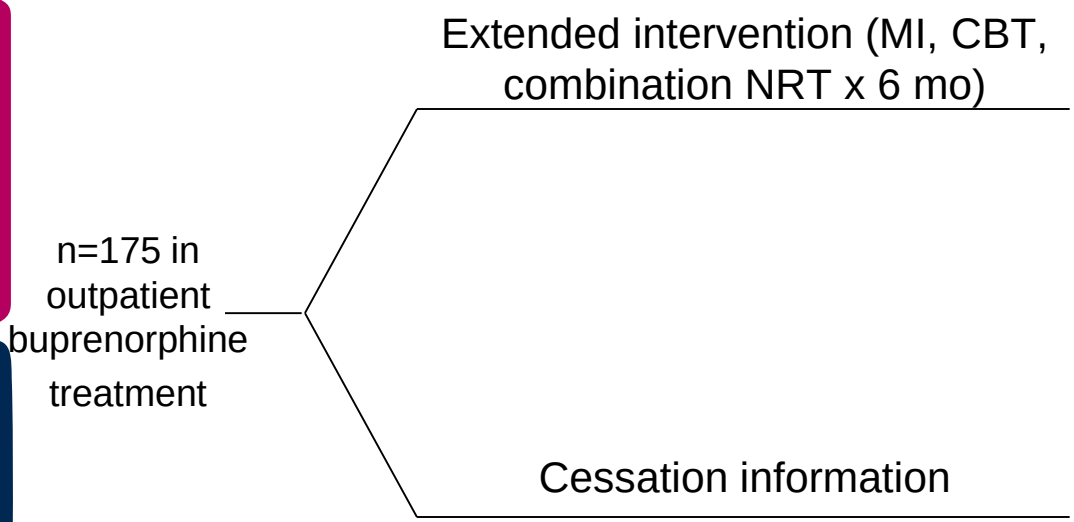
Extended treatment



Increased motivation:

- Quit attempts
- Goal of complete abstinence
- Advanced stage of change

Hall et al., NTR, 2018

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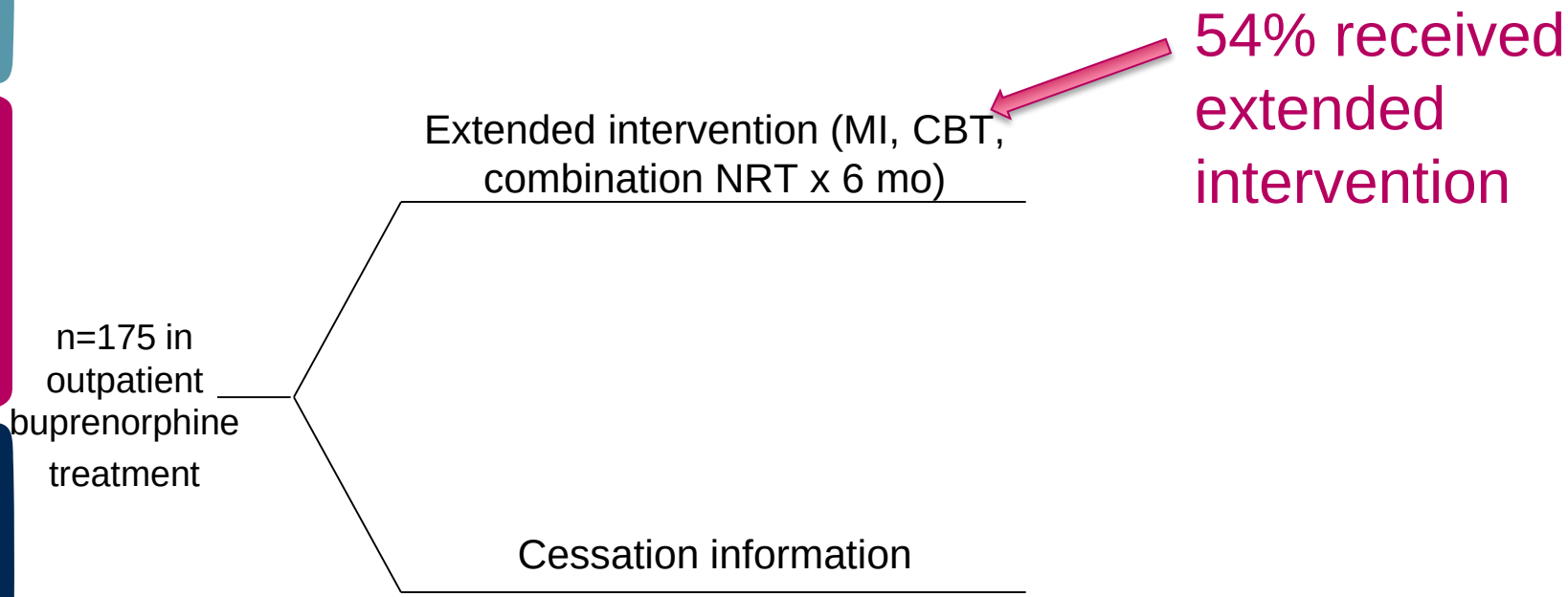
Extended treatment



Hall et al., NTR, 2018

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Why are cessation rates so low?

Limited treatment provision

Limited social support

Short-term treatment

Poor adherence

Opioid nicotine interactions

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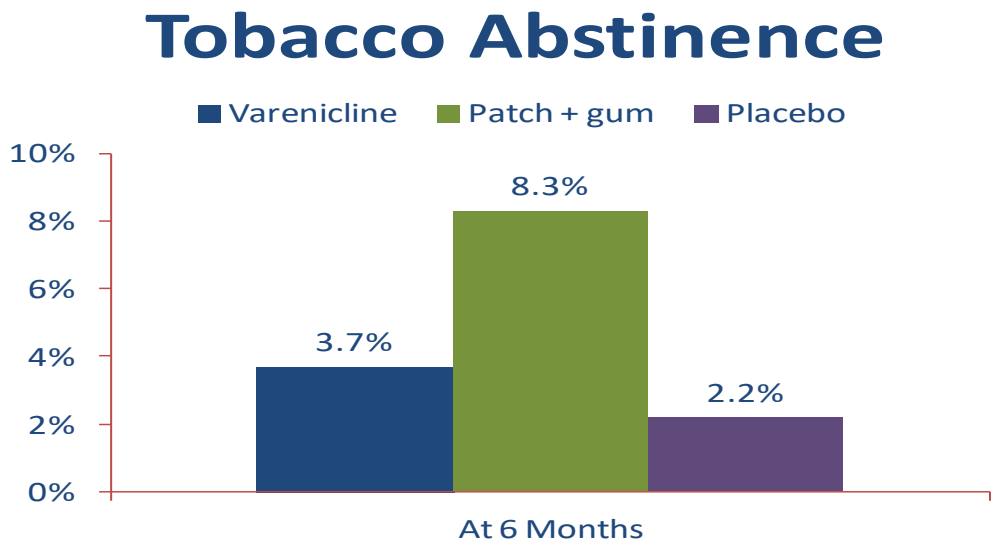
Low adherence, low cessation



Adherence at 6 months: 34.2 % 48.8 % 34.4 %

Stein, Drug Alc Dep, 2013

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Adherence improves outcomes

Adherence improves outcomes

Participants	Findings
n= 225 smokers with SUD	# weeks abstinent correlated with: Counseling adherence (r=.31, p<.001) Nicotine patch adherence (r=.15, p<.05)
n= 383 smokers with OUD	44.1% nicotine patches used On days nicotine patches were used: 7.1x higher smoking abstinence (p<.001) Fewer cigs/d (15 v 5, p<.001)

1. Reid et al, JSAT, 2008; 2. Stein et al, JGIM, 2006

Adherence matters

- Few studies have evaluated adherence interventions
- Directly observed therapy (DOT) improves adherence and clinical outcomes

Objectives

- To evaluate, in a randomized trial, whether methadone clinic-based varenicline directly observed therapy is efficacious at improving adherence and smoking cessation among MM smokers

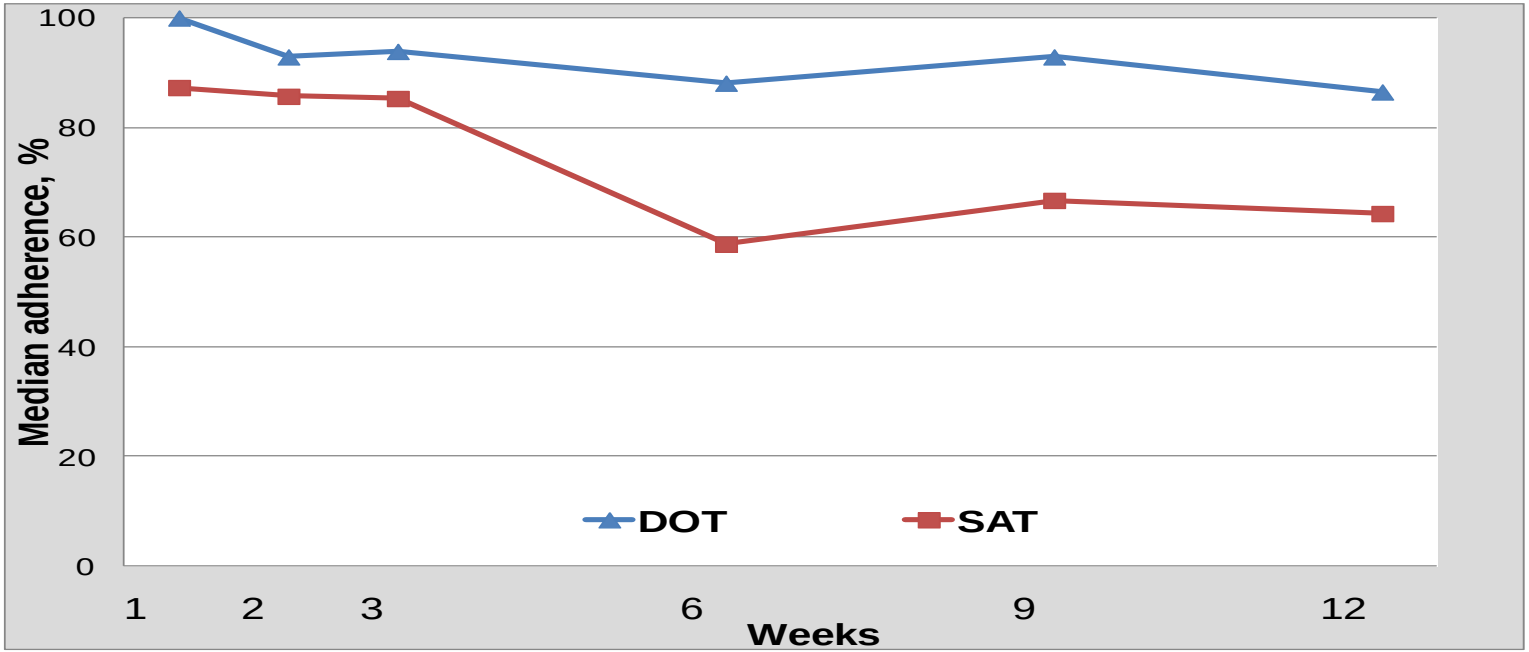
Setting

Interventions

Methadone maintained smokers

- Directly observed (DOT) varenicline x 12 w
- Self-administered (SAT) varenicline x 12 w

Varenicline adherence



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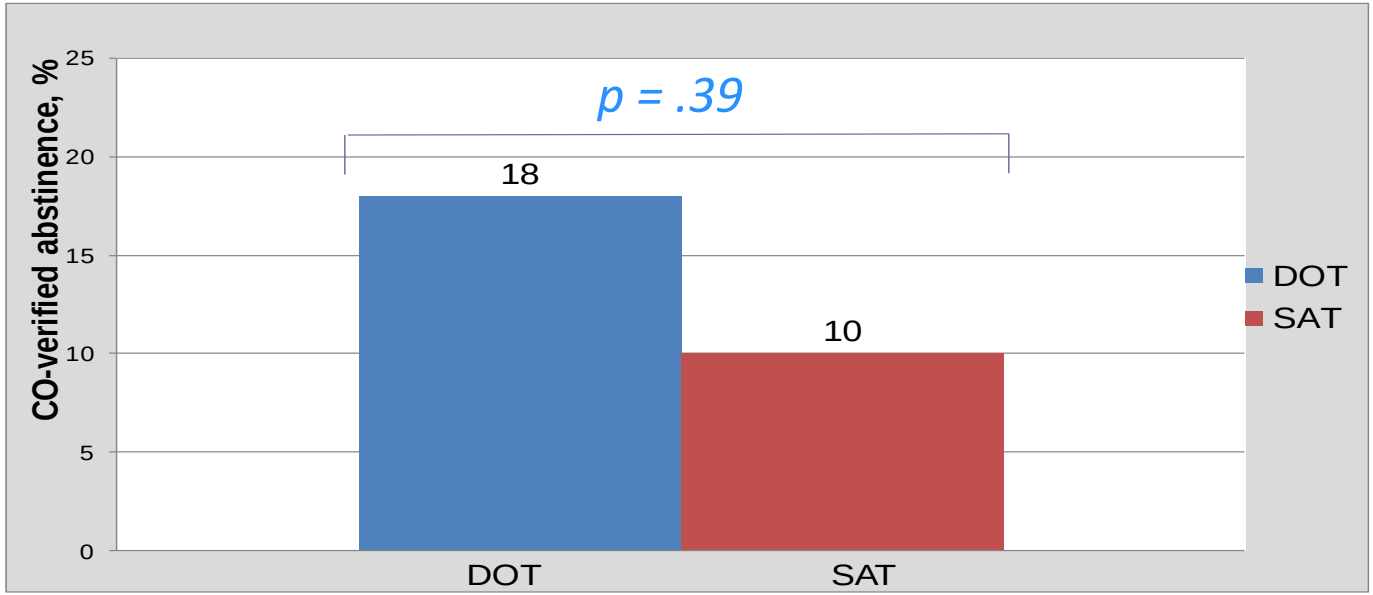
Abstinence at 12 weeks



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DOT is promising

- DOT varenicline was associated with significantly higher overall adherence than self-administered treatment
- Cessation rates with DOT were nearly double that of SAT, and higher than that seen in prior trials among methadone maintained smokers

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DOT implementation

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Intervention effects

- Unassisted cessation rates 0%
- Tobacco cessation rates are modest (5-14%)
- Short-term treatments are insufficient
- Adherence improves outcomes

Next Steps

		Directly observed therapy +	Directly observed therapy -
Long-term varenicline	-	DOT/LT	SAT/LT
	+	DOT/ST	SAT/ST

NIDA R01 DA042813

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Outline

- Health burden of tobacco use
- Evidence-based cessation treatments
- Optimizing efficacy
- Optimizing implementation

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Telephone quitline referral

- n=112 methadone maintained smokers enrolled in a clinical trial
- All offered telephone quitline referral
- 22% utilized telephone quitline counseling
  - Comparable to quitline referral in primary care
  - Much higher than population-based utilization

Griffin et al., Nic & Tob Rsch, 2016

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Telephone quitline barriers

n=112 methadone maintained smokers enrolled in a clinical trial

Baseline telephone access	n (%)
Does not own a cellphone	15 (14%)
Cellphone service lapse	31 (32%)
Problems charging cellphone	15 (15%)
Running out of cellphone service minutes	28 (27%)
Does not have a landline	57 (51%)

Griffin et al., NTR, 2016

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Telephone quitline barriers

- Competing life demands:

  “I’m hardly home. I’m in the meth program…”

  “Shelter is too hectic.”

- Skeptical of quitline efficacy:

  “I just don’t believe in it. I want to do it on my own.”

  “I really don’t need any encouragement to quit.”

Griffin et al., NTR, 2016

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Counselors

- Frequent patient contact
- Skills to address substance use disorders

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Interventions

Category: Biomedical Conditions

Problem: **Da**

Patient reports current conditions of asthma, diabetes, and high chole

Diagnosis: Tobacco use disorder, moderate

Long Term Goal: "I know I should quit smoking but I'm not ready".

Short Term Goal: "I want to cut down on my smoking".

Progress Since Last Plan:

LTG: "I know I

STG: "I want to

Patient Form Screen

Report Name Heavy Smoking Index

Form Type Medical

Enter Report Body Text

1: How many cigarettes does the patient smoke each day?
N/A 31 plus (1.5 pack plus) = 3 Points
[X] 21-30 plus (1 - 1.5 packs) = 2 Points
N/A 11-20 plus (1/2 - 1 pack) = 1 Point
N/A 1-10 plus (1/2 pack or less) = 0 Point

2 How soon after waking does the patient smoke the first cigarette?
N/A Within 5 minutes = 3 points
N/A From 6 -30 minutes = 2 points
[X] From 30 minutes ? 1 hour = 1 point
N/A More than one (1) hour = 0 point

Heavy Smoking Index Score (add points 1 & 2 above):
N/A 0 - 1 = Light Smoker
[X] 2 - 3 = Moderate Smoker
N/A 4 - 6 = Heavy Smoker

Heavy Smoking Index Score =3.0

Finish Later | Save Complete | Redo | Print

Delete | Patient Inquiry | Close

- Electronic health record forms
- Counselor supervision

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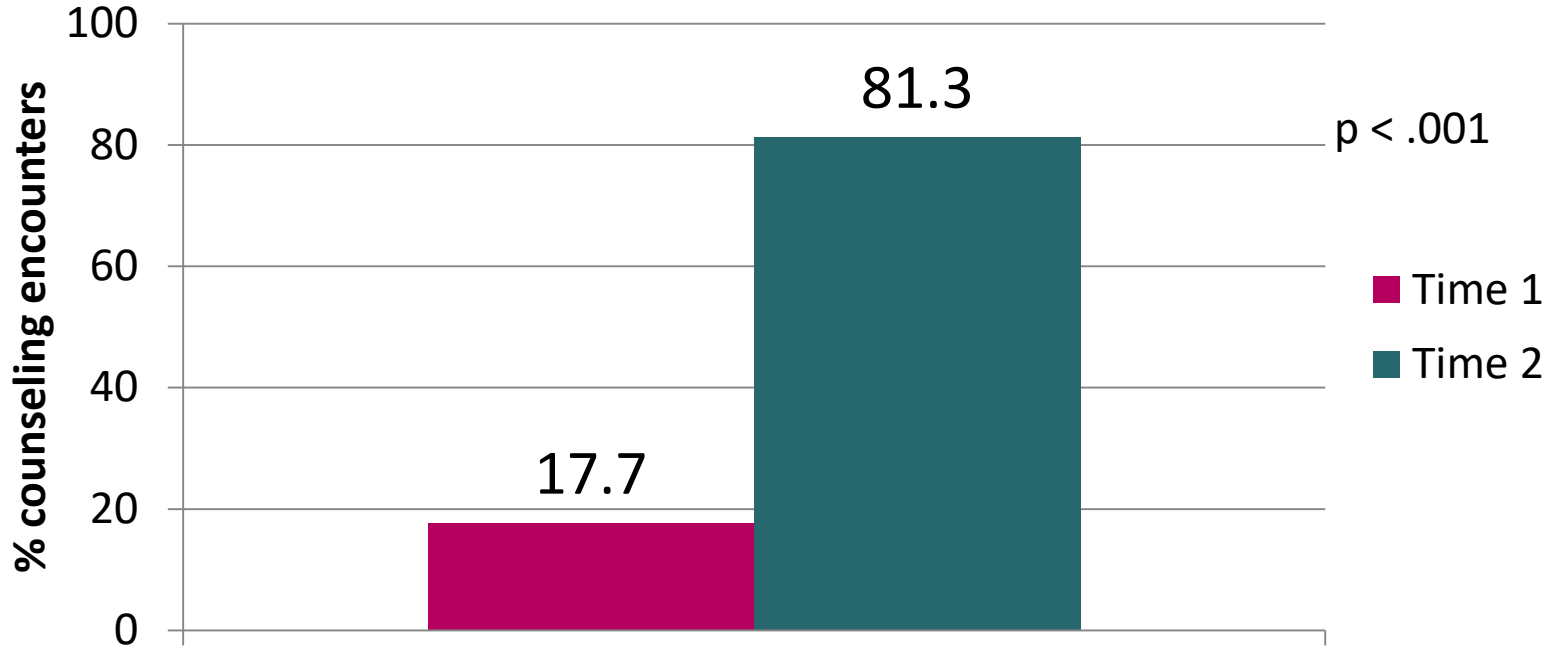
Identification of tobacco use



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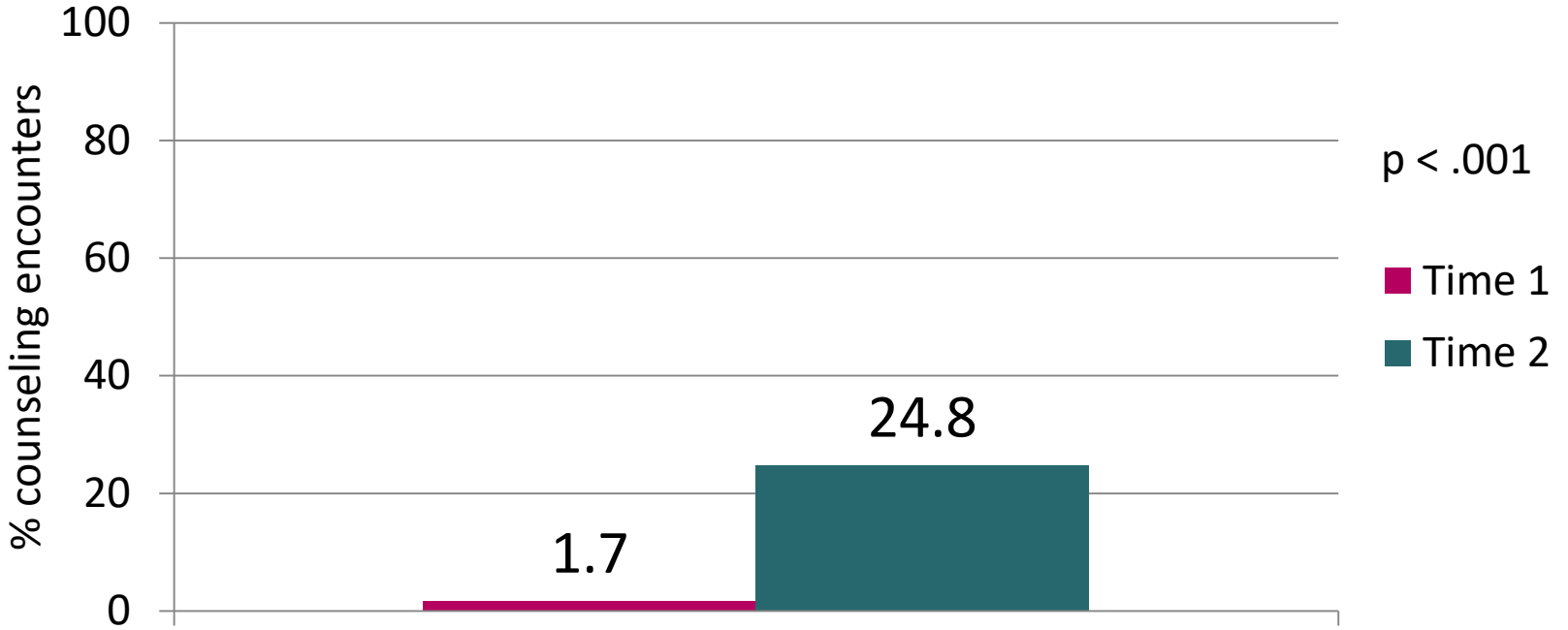
Tobacco counseling



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Conclusions

- Low intensity health system level intervention, including electronic health record forms and provider training
  - Increased documentation of tobacco use
  - Increased counseling for tobacco use

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Organizational change intervention

- Staff training, policy development, leadership support, access to NRT
  - More favorable staff beliefs
  - More NRT provision
  - More tobacco-related services

Guydish et al., DAD, 2012

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Multiple intervention targets

Limited treatment provision

Limited social support

Short-term treatment

Poor adherence

Nicotine opioid interactions

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Conclusions

- Significant burden of tobacco use
- Identify tobacco use
- Provide evidence-based treatment
- Optimize interventions to enhance efficacy
- Scale interventions to reach this high risk population of smokers

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QUESTIONS?

snahvi@montefiore.org

Electronic Cigarettes

- http://nationalacademies.org/hmd/Reports/2018/public-health-consequences-of-e-cigarettes.aspx
- Fewer, lower level of toxicants
- Variable nicotine exposure
- May result in dependence (but less than combustibles)
- May cause youth to transition to combustibles
- May increase adult cessation

National Academies Science Engineering Medicine, 2018

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Electronic Cigarettes

- n=657 RCT x 13 weeks
- 6 mo abstinence
  - 16 mg e cig: 7·3% (21 of 289)
  - placebo e cig: 4·1% (three of 73)
  - 21 mg patch: 5·8% (17 of 295) with patches
  - Nicotine e-cigs *v* patches 1.51 [95% CI −2.49 to 5.51]
  - Nicotine e-cigs *v* placebo e-cigs 3.16 [95% CI −2.29 to 8.61])

Bullen et al, Lancet 2013

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Q&A

- Submit questions via the **chat box**

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California Marriage & Family Therapists: University of California, San Francisco School of Medicine (UCSF) is approved by the California Association of Marriage and Family Therapists to sponsor continuing education for behavioral health providers. UCSF maintains responsibility for this program/course and its content.

Course meets the qualifications for 1.0 hour of continuing education credit for **LMFTs, LCSWs, LPCCs, and/or LEPs** as required by the California Board of Behavioral Sciences.

Respiratory Therapists: This program has been approved for a maximum of 1.0 contact hour Continuing Respiratory Care Education (CRCE) credit by the American Association for Respiratory Care, 9425 N. MacArthur Blvd. Suite 100 Irving TX 75063, Course # 181054000.

California Behavioral Health & Wellness Initiative

For our CA residents, we are starting a new venture in CA helping behavioral health organizations go tobacco free and integrating cessation services into existing services thanks to the support of the CTCP.

Free CME/CEUs will be available for all eligible California providers, who joined this live activity. You will receive a separate post-webinar email with instructions to claim credit.

Visit CABHWI.ucsf.edu for more information.

American Association for Respiratory Care (AARC)

- Free Continuing Respiratory Care Education credits (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 1.0 CEU 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 for these CEU opportunities will be included in the post-webinar email and posted to our website.

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.
- FREE CME/CEUs of up to 1.0 credit are available to all attendees who participate in this live session. Instructions will be emailed after the webinar.

Save the Date

- SCLC's next live webinar, co-hosted with NBHN
- May 23, 2019 at 2:00 pm EDT
- Older Adults and Smoking
- Registration coming soon!

SCLC Recorded Webinar Promotion

SCLC is offering CME/CEUs for our 2016 and 2017 recorded webinar collections for FREE. Each collection includes up to 14 CEUs and up to 10 webinars!

Visit SCLC's website at: https://smokingcessationleadership.ucsf.edu/celebrating-15-years for more information.

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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