# THE INTERSECTION OF TOBACCO AND OPIOID USE DISORDER: A GUIDE FOR HEALTH CENTER PROVIDERS

## BACKGROUND

Nicotine and tobacco use disorder (TUD) is a dangerous, but treatable addiction. TUD commonly co-occurs with other addictions, including opioid use disorder (OUD) [1,2]. People with behavioral health and substance use disorders smoke and use tobacco at higher rates than the population as a whole [3]. At the same time, people with OUD and behavioral health disorders report similar levels of motivation to quit smoking as people without these issues [4]. While outcomes are far from perfect, tobacco dependence treatment (TDT) and tobacco recovery programs work. Evidence-based programs, including cognitive-behavioral and pharmacologic components, are effective for individuals with and without mental health and substance use disorders (Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons. US Preventive Services Task Force Recommendation Statement).

> "People with OUD want to and can quit smoking."

Combining treatment for TUD and OUD is becoming increasingly common. Supporting patients to make multiple positive health behavior changes in tandem is becoming the norm. Providing treatment of TUD alongside OUD increases the likelihood of long-term recovery by up to 25% [4]. Research indicates that people with serious mental and psychiatric illness who are able to quit smoking experience reduced anxiety, depression, risk of developing another substance use disorder, and improved quality of life [5]. While opioids and nicotine create addiction through different neurochemical mechanisms and different medications may be needed to help manage the physical withdrawal, there is substantial overlap in the cognitive and behavioral strategies that help someone recover.

However, integrating TUD recovery with recovery from other substances has been complicated by a long history of smoking being part of the daily routine at addictions treatment and behavioral health care sites. Tobacco and smoking have traditionally been, and still to this day are often used as a "break" or as a reward for good behavior in behavioral health care facilities. Moreover, addiction treatment staff (many of whom are in recovery themselves) use tobacco at higher rates than the general population [6]. Unlike the past, when psychiatric and addictions recovery sites used tobacco and smoking as a reward, as a part of the daily routine, increasingly addictions recovery treatment sites are becoming tobacco and nicotine-free, integrating TUD recovery, treating patients and staff with TUD, and making their campuses and properties smoke and vape-free.

However, a lack of financially viable business models, minimal insurance reimbursement, lack of staff trained on nicotine replacement and smoking cessation treatments, as well as some philosophical differences about whether patients in recovery should be asked to refrain from tobacco use while they are undergoing withdrawal from opioids, has to lead to a potential gap in staff desire to implement TUD alongside OUD services. Various advocacy and training groups, as well as state and county-level health departments are working to facilitate the systems change and culture change to make tobacco recovery part of recovery in general.

### KEY POINTS

In July 2018, the U.S. Department of Housing and Urban Development (HUD) released a final rule requiring local public housing agencies (PHAs) to adopt smoke-free policies for federally-owned housing. Smoke-free housing aligns with HUD's mission to provide safe, decent, and sanitary housing for the most vulnerable populations across the country. To support this mission, Public Housing Primary Care Centers (PHPCs) can address smoking cessation in the primary care setting. The median number of patients seen at PHPCs are 50% more likely to have a tobacco use disorder than the median number of patients seen at all other health centers. And people with substance use disorders and other mental illnesses, do not quit smoking at the same rate as those in the general population.[1] As health centers continue to increase their capacity to address mental health and substance use concerns, adding smoking cessation counseling and medication assisted treatment will support improved health of residents of public housing and help patients to achieve sobriety and prolonged wellness.

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While addiction treatment sites are embracing tobacco recovery, a new, additional, opportunity has emerged to integrate the treatment of OUD and TUD: primary care sites such as community health centers. Health centers are becoming increasingly responsible for the delivery of OUD treatment. As of 2019, over 60% of health centers provided Medication Assisted Treatment (MAT) [7]. Health centers treat vulnerable and under-served populations, for example residents of public and low-income housing, pregnant individuals, people with substance use disorders. In addition to the cross over in target populations, in the "mission" to provide the best care possible, there is overlap in the infrastructure needed to provide smoking and nicotine treatment services.

Prescribing, health education, and referral systems: primary care sites already have the systems needed to promote tobacco and nicotine dependence treatment. This report will describe the philosophical and logistical overlap in the treatment of OUD and TUD and serve as a roadmap for community health centers and primary care sites to integrate tobacco dependence treatment and recovery into the treatment of other addictions and OUD. The goal is to provide best practices for aligning the treatment of the separate but connected substance use disorders.

## INTEGRATING NICOTINE AND OPIOID ADDICTION TREATMENTS IN PRIMARY CARE

In addition to being safe and essential for individual and public health, treatment of TUD is cost-effective for the healthcare system. TDT prevents hospitalizations and emergency room visits and reduces the severity of chronic diseases [8]. All health care outlets should have some form of a tobacco treatment program as part of daily routines and clinical workflows. This is especially true in health centers that serve under-resourced communities more likely to use tobacco (i.e. low income, those uninsured or covered by Medicaid and Medicare).

Nicotine replacement products, such as the patch and the gum, and medications (i.e. "Chantix" varenicline, "Wellbutrin", "Zyban" bupropion) have been repeatedly established as safe and effective in a wide variety of settings, across the world as well as in populations with serious mental illness, heart and cardiovascular disease, people experiencing incarceration [9,10]. The FDA-approved medications for TDT/TUD and NRTs do not interfere with OUD treatments, further reducing the barriers to access and use, since the implementation of the Affordable Care Act. Therefore, these products should and could be more regularly prescribed. Many NRT products are also available over the counter.

Further unlocking the potential of NRT, medications, counseling, and the power of combining tobacco recovery with OUD recovery, requires a clearly defined, fully embedded, and practical set of protocols for treating TUD. Preparing and maintaining responsive and reliable TUD and OUD treatment requires a team-based approach, including mechanisms to help let the patient drive their treatment plan. The following sections will describe the primary care setting-specific opportunities to create a sustainable effort to help patients change their tobacco use behavior while they undergo treatment for OUD.

### ADDITIONAL RESOURCES

Health Promotion Council: hpcpa.org

NNCC: nurseledcare.phmc.org

Public Health Management Corporation: phmc.org

CDC Tips from Former Smokers: cdc.gov/tobacco/campaign/tips/index.html

FDA: fda.gov/tobacco-products

American Heart Association: heart.org

American Lung Association: lung.org

National Cancer Institute - Free PDF Booklet: "Clearing The Air: Quit Smoking Today": cancer.gov/publications/patient-education/clearing-the-air

### CONTACT

NNCC's website: nurseledcare.phmc.org/

Twitter: @NurseLedCare

IG: @NurseLedCare

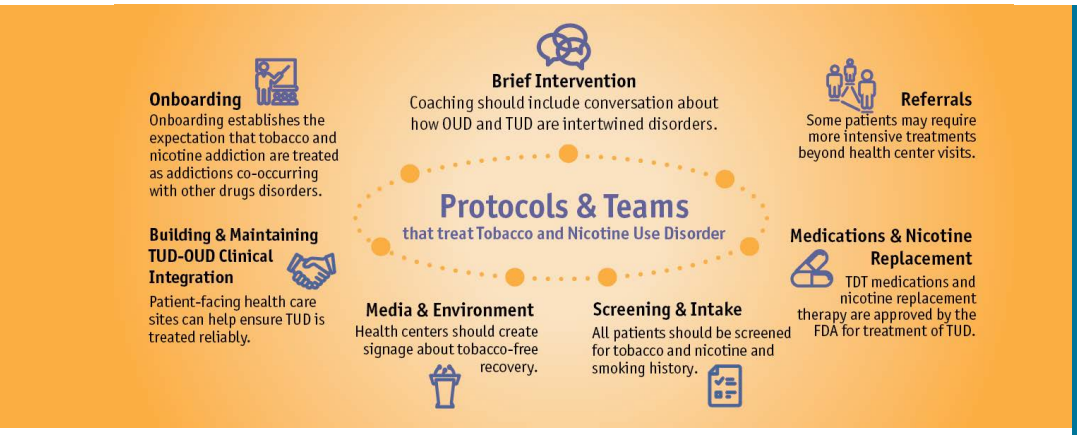
FB: facebook.com/nursingclinics

HPC's website: www.hpcpa.org/

Twitter: @HPCPhilly

IG: @HPCPhilly

FB: www.facebook.com/healthpromotioncouncil/




## *Onboarding and Staff Training*

The goal for those reading this report is to feel they have tools to effectively establish a culture of treating tobacco use within their normal workflow. Building this moment and creating this change starts, often with onboarding and staff training, with the caveat that this sort of treatment is often a joint, ongoing effort between counselors, peer recovery specialists, nurses, doctors, etc., and the patient. Regardless of the exact roles of those serving the patient population, all staff, during hiring, likely undergo an "on-boarding" and new employee orientation.

Onboarding and orientation present the first, and potentially most important opportunity to establish that tobacco and nicotine addiction are treated as addictions co-occurring with opioid use and other drugs disorders and that in order to provide the best, most comprehensive treatment, every effort is made to treat all the addictions at once. Along with meeting all the other primary care needs, OUD included, TUD receives the same due diligence: i.e., in partnership with the patient, establishing a treatment plan, helping the patient receive and engage with multiple treatment options, providing education about proper medication usage and adherence, and build patient motivation.

In addition to establishing clear TUD and OUD recovery integration expectations, depending on their role, staff may require additional training, resources, and support in order to best educate and prescribe their patients about tobacco-free recovery. One example is for health center agencies to create tobacco and nicotine and vaping, and TUD-OUD integration training available on internal training portals. Completing these training could be mandatory, or optional, depending on the role of the staff, and the current level of "compliance" and commitment to treating TUD.

External, professional development training opportunities for tobacco recovery treatment providers are becoming increasingly available. A wide variety of licensed health professionals (ie. Respiratory Therapists, SW, Counselors, Peer Recovery Specialists, etc. list more) require continuing education. From tobacco, vape, and smoke-free policies, to evidence-based strategies and motivational interviewing for effective TUD recovery counseling, to NRT and medications, to billing and coding, to referrals, to tobacco use as a social justice issue, to the neurobiological impacts of nicotine, there are plenty of areas for continuing education for health care professionals and teams.

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## *Building and Maintaining TUD-OUD Clinical Integration*

A flawless TUD-OUD treatment program does not exist. However, patient-facing health care sites, health centers included, can help ensure TUD is treated as naturally, systematically, and reliably as possible, while accounting for potential challenges such as limited time with each patient, competing health care needs, staffing, or need for resources (i.e. patient education materials). For the most part, these challenges are present when treating OUD in primary care, as well, highlighting the need to pair these treatment efforts.

## *Screening and Intake*

All patients, those with or without substance use disorders, should be screened for tobacco and nicotine and smoking history. Many health care providers use online and tablet-based forms to expedite patient intake. These forms (which can include questions about tobacco, vaping, nicotine use) can often be completed before arriving at the health center, upon arrival at check-in, and during the pre-exam or pre-visit with a medical assistant. Ideally, the tobacco use screening questions, if not completed during intake, are embedded in electronic medical records (EMRs) and are tied to "no skip logic", meaning the user must answer the question in order to continue with the visit.

Language and terms used in screening questions are another important consideration. Simply asking someone if they smoke cigarettes may be missing a rather large proportion of tobacco and nicotine users. E-cigarettes, vaping devices, e-hookahs, "pens", regular hookah, mini-cigar, blunt cigars are more regularly the tobacco and nicotine intake delivery device of choice among young people [13]. Even irregular or non-daily use of these products may still lead to nicotine dependence and impact treatment of OUD. Screenings that only trigger treatment for infrequent or non-regular tobacco or nicotine users are likely missing opportunities to treat nicotine dependence. Similarly, asking about motivation to quit can be helpful in identifying patients are ready to develop a plan, but motivation level should not dictate whether or not a tobacco user is offered resources and treatment. One of the cardinal signs of nicotine dependence is ambivalence around quitting. Patients can both want to quit and not want to quit. Part of the work of clinicians is to help move patients progress along the "stages of change."

Another way to leverage the strengths of EMRs is to guide treatment planning. Depending on the number of additional questions a health center is willing to add to their intake and screenings, it can be useful to ask more specific questions in the EMR:

- "How motivated are you to change your tobacco and nicotine use?"
- "Have you tried to cut down or quit in the past?"
- "Did you use any nicotine replacement, medications, or coaching resources to help you quit?"
- "What types of nicotine replacement would you be interested in receiving?" (Patch, Gum, Lozenge)

Once a selection is made, the EMR could potentially trigger 1) a note for the doctor or prescriber attending to the patient that they want a prescription for NRT, and that the prescriber should then be presented with guidance about dosage, and 2) the automatic addition of instructions about how to use the nicotine replacement and medications, as well as information about referrals for more intensive local Certified Tobacco Treatment programs, and 1-800 QUIT NOW. For more information about prescribing NRT, dosage, and how to instruct patients about proper use please use the Treating Tobacco Use and Dependence: Clinical Practice Guideline [14].

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## *Brief Intervention*

Once a patient has screened positive for tobacco use, it is incumbent on the treatment team to provide intervention. In addition to prescribing NRT products and or medications, someone must be assigned the role of conducting brief interventions, abbreviated coaching sessions focused on proper use of medication, and building a quit plan. Hopefully, the EMR system can be programmed to automatically suggest that the care provider provide a brief counseling session, and it might even suggest some potential topics depending on where the patient is in their quit journey.

Brief interventions are evidenced-based, and lightweight in terms of what they add to a provider's daily workload. Ideally, this coaching will include some conversation about how OUD and TUD are intertwined disorders and that addressing both at the same time can increase their chances of long-term success. Further, patients should be shown that many cognitive-behavioral strategies (combined with MAT) can help with their OUD, so help with their recovery from tobacco. Like OUD, medications complement the broader goal of helping patients develop a comprehensive set of cognitive-behavioral and emotional coping strategies to use in the face of urges to use substances.

## *Medications and Nicotine Replacement*

TDT medications (ie. varenicline, bupropion), and nicotine replacement therapy (NRT) products have been well-studied, are safe, and approved by the FDA for treatment of TUD [15]. While these products can improve a patient's likelihood of achieving long-term abstinence from nicotine, the efficacy is fully realized when paired with coaching or counseling to promote healthy coping strategies, secure social support, and prevent relapse [14, 16].

> "For best-practices and how to educate patients about TDT products, please visit the CDC's Best Practices Cessation User Guide or the American Cancer Society [16, 17]."

Many TUD treatments are covered by public and private health insurance plans. When patients learn their health insurance coverage can completely or almost completely cover the cost of NRT, they are more likely to try it, at least trying something, and trying at least one form of treatment is a key step. Even though side effects are usually mild and few and far between, some patients will find certain products are not for them. For example, a small percentage of people experience a rash from the adhesive on the nicotine patch. In that case, a different brand could be tried, and or a different form of NRT could be tried (i.e. gum, lozenge, nasal spray, inhaler).

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## *Referrals*

Even with a fully integrated TUD and OUD program in a health center, primary care providers usually have extremely limited time with each patient. Having a dedicated professional to provide TDT is ideal. While the entire care team should view treating tobacco dependence part of their job, some patients may require or request more intensive treatments beyond what can be provided during the health center visits for OUD treatment. In those cases, every attempt should be made to provide at least some counseling and to provide prescriptions for TDT for OUD patients, and then refer patients to additional services.

Depending on one's geographic location, and in which state they reside, there are often local, no cost treatment programs that are funded by Master Settlement Agreement funds or by State and County-level Public Health Departments.

All States have a no-cost quitline. However, depending on the state, a variety of services are offered (e.g. some states offer nicotine replacement, and some just offer coaching). Also depending on the State, the quitline vendor, and the electronic health record system being used at the health center, there is sometimes the possibility of connecting, through HIPAA compliant integration, the patient's medical record with the quitline. Providers can then view how many calls and when their patient engaged with the quitline, their quit attempt status, and if they used any form of nicotine replacement in their quit attempt. This information can be helpful for primary care and OUD treatment providers to help troubleshoot,
motivate the patient, and make their care more comprehensive. For more information about connecting the quitline and EMRs, contact your State health department or call 1-800 QUIT NOW.

## *Media and Environment*

In addition to the clinical workflow, staff training, automated EMR screening, resources and information in take-home paperwork, and "warm-hand offs" and referrals, there are also environmental and passive strategies for promoting treatment of TUD along with OUD. Most waiting rooms have television screens or monitors that display patient information, chronic disease management programs, health center events, etc. Health centers should include messages about tobacco-free recovery and the resources available can be put into the regular rotation of content on those displays.

Print materials can also be helpful. Whether it be posters, flyers, brochures, rack cards, or business cards, health centers should post images and messages promoting recovery from tobacco in waiting rooms, exam rooms, and on outdoor signage (ie. "This is a smoke and vape-free environment"). Print materials can also be added to take-home materials, such as patient encounter summaries. Many states offer printed materials (i.e. CDC Tips from Former Smokers campaign materials) at no cost. Health centers should contact their county or state-level health departments with these inquiries. Calling 1-800 QUIT NOW and asking for referrals to local in-person tobacco dependence treatment providers may also present an opportunity to garner additional resources depending on the program's offerings. For example, in Pennsylvania, the Department of Health contracts with "regional primary contractors" who make print materials available at the county and local levels. Local treatment providers can also be an excellent source of guidance and technical assistance when integrating TDT with treatment of OUD.

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## *Discussion*

With tobacco use remaining the leading cause of preventable death and disease, and the extremely high rates of comorbid TUD and OUD, there is a pressing need for all aspects of the healthcare system to tackle these issues. Treating patients for OUD and TUD at the same time is safe and increases the efficacy of both treatments over the long-term. Furthermore, many, if not most of the counseling and cognitive behavioral strategies for overcoming OUD are also relevant to helping patients develop the skills to manage urges to use tobacco or nicotine. Similarly, the alterations to clinical workflow required to embed OUD and TUD in community health centers look very similar. In other words, the logistics and the treatment best-practices suggest that OUD and TUD can and should be treated together.

Training is often available, as are additional tobacco-free recovery resources, some of which are listed below. For questions or requests about additional resources, please contact Health Promotion Council at www.hpcpa.org.

*This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.*