Navigating the Intersection of Tobacco and Opioid Use Disorder

Shadi Nahvi, MD, MS, Professor, Departments of Medicine, and of Psychiatry & Behavioral Sciences, Albert Einstein College of Medicine / Montefiore Health System
Moderator

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Executive Director

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University of California, San Francisco

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Disclosures

This UCSF CME activity was planned and developed to uphold academic standards to ensure balance, independence, objectivity, and scientific rigor; adhere to requirements to protect health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and include a mechanism to inform learners when unapproved or unlabeled uses of therapeutic products or agents are discussed or referenced.

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Catherine Bonniot, Anita Browning, Christine Cheng, Brian Clark, Jennifer Matekuare, Shadi Nahvi, MD, MS, Ma Krisanta Pamatmat, MPH, CHES, Jessica Safier, MA, and Maya Vijayaraghavan, MD, MAS.
Thank you to our funders
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- Use the ‘Q & A’ box to send questions at any time to the presenters.
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In support of improving patient care, the University of California, San Francisco is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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- 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.
- New CDC Tips Campaign 2024

- Tips From Former Smokers Motivational Cards:

- Find resources at: https://www.cdc.gov/tobacco/campaign/tips/index.html
The African American Tobacco Control Leadership Council (AATCLC) and the Smoking Cessation Leadership Center (SCLC) of the University of California, San Francisco have joined forces to promote Spiral Up Lite (©2024 EBT, Inc.).

Click here for more information: https://online.fliphtml5.com/negtk/osvt/#p=1
Today’s Presenter

Shadi Nahvi, MD, MS,
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Albert Einstein College of Medicine / Montefiore Health System
Navigating the intersection of tobacco and opioid use disorder

Shadi Nahvi, MD, MS
DISPROPORTIONATE PREVALENCE

Guydish et al., 2011
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
Smoking threatens recovery; cessation promotes it

<table>
<thead>
<tr>
<th>Study</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>National epidemiologic study</td>
<td>Tobacco use initiation or continuation increases risk of SUD relapse</td>
</tr>
<tr>
<td>(Weinberger et al, 2017)</td>
<td></td>
</tr>
<tr>
<td>Meta analysis of 19 RCTs</td>
<td>25% increased likelihood of long term abstinence from alcohol and drugs</td>
</tr>
<tr>
<td>(Prochaska et al, 2004)</td>
<td></td>
</tr>
<tr>
<td>RCT</td>
<td>Smoking cessation correlated with opiate and cocaine abstinence</td>
</tr>
<tr>
<td>(Shoptaw et al, 2002)</td>
<td></td>
</tr>
</tbody>
</table>
How can we help smokers with opioid use disorder to quit?
OVERARCHING RESEARCH QUESTIONS

IDENTIFY AND TREAT TOBACCO USE

EFFICACIOUS TREATMENTS

OPTIMIZE TREATMENT EFFECTS
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
IDENTIFICATION OF TOBACCO USE

N=319 BUPRENORPHINE PATIENTS AT FQHC

Smoking status
not identified

Current smokers

67%

22%

Never smokers

1%

Former smokers

10%
## Telephone quitline barriers

*n* = 112 methadone maintained smokers enrolled in a clinical trial

<table>
<thead>
<tr>
<th>Baseline telephone access</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not own a cellphone</td>
<td>15 (14%)</td>
</tr>
<tr>
<td>Cellphone service lapse</td>
<td>31 (32%)</td>
</tr>
<tr>
<td>Problems charging cellphone</td>
<td>15 (15%)</td>
</tr>
<tr>
<td>Running out of cellphone service minutes</td>
<td>28 (27%)</td>
</tr>
<tr>
<td>Does not have a landline</td>
<td>57 (51%)</td>
</tr>
</tbody>
</table>

Griffin et al., NTR, 2016
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
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., NTR, 2016
DOSE RESPONSE BETWEEN NUMBER OF CLINICIAN TYPES OFFERING COUNSELING AND CESSATION SUCCESS
Counselors

- Frequent patient contact
- Skills to address substance use disorders
INTERVENTIONS

- Electronic health record forms
- Counselor training and supervision
Identification of tobacco use

% counseling encounters

- Time 1: 17.7%
- Time 2: 81.3%

p < .001
Tobacco counseling

% counseling encounters

Time 1
Time 2

p < .001

1.7
24.8
LOW INTENSITY HEALTH-SYSTEM LEVEL INTERVENTION

- Increased documentation of tobacco use
- Increased counseling for tobacco use
If not us, who provides cessation information?

- Provider
- Community
- Industry
- Newspapers, Magazines
- TV, Radio
- Internet
- Family
- Co-workers
- Friends
- Public Health Policy
How can we help smokers with opioid use disorder to quit?
OVERARCHING RESEARCH QUESTIONS

IDENTIFY AND TREAT TOBACCO USE

EFFICACIOUS TREATMENTS

OPTIMIZE TREATMENT EFFECTS
Common eligibility criteria eliminate ~50% of daily smokers
Maria is a 56 year old woman living with HIV. She 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.
SMOKING CESSATION MEDICATIONS

Hughes 2004; Fiore 2008
Commentary

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

Mollie E. Miller PhD,1 Stacey C. Sigmon PhD2,3,4
Treatments help
NO CESSATION WITHOUT TREATMENT

Reid, JSAT, 2008

8 weeks nicotine patch, group counseling + SUD treatment

n=225 in outpatient SUD treatment

TAU: SUD treatment as usual

End of Treatment

Abstinence

10%

0%
NO CESSION WITHOUT TREATMENT

12 weeks varenicline, in-person and telephone counseling

- n=112 in methadone treatment

12 weeks placebo, in-person and telephone counseling

End of Treatment
0%

Abstinence
10.5%

Nahvi et al, Addiction, 2014
Treatments help, but effects are modest
CESSATION EFFECTS ARE MODEST

8 weeks nicotine patch, group counseling + SUD treatment

n=225 in outpatient SUD treatment

TAU: SUD treatment as usual

Abstinence

End of Treatment

10%

0%

Reid, JSAT, 2008
CESSATION EFFECTS ARE MODEST

12 weeks varenicline, in-person and telephone counseling

12 weeks placebo, in-person and telephone counseling

n=112 in methadone treatment

Abstinence
End of Treatment
10.5%
0%

Nahvi et al, Addiction, 2014
Contingency management increases cessation
CONTINGENCY MANAGEMENT

Extended CM x 10 wks

Extended non-CM x 10 wks

Abstinence

% neg samples

46.7% 3.31 wks

23.5% 1.68 wks

n=88 people on MOUD

Sigmon, Addiction, 2016
Why are cessation rates so low?
OVERARCHING RESEARCH QUESTIONS

IDENTIFY AND TREAT TOBACCO USE

EFFICACIOUS TREATMENTS

OPTIMIZE TREATMENT EFFECTS
Why are cessation rates so low?

- Limited treatment provision
- Limited social support
- Short-term treatment
- Adherence challenges
- Opioid nicotine interactions
Why are cessation rates so low?

- Limited treatment provision
- Limited social support
- Short-term treatment
- Adherence challenges
- Opioid nicotine interactions
Short-term treatments may be inadequate
Limited initial abstinence

CO verified abstinence, %

Weeks

Intervention period

p = .03

Varenicline

Placebo
“But you know, even when I’ve quit before, I’ve gone back to smoking a month later.”
Effects are not sustained

8 weeks nicotine patch, group counseling + SUD treatment

TAU: SUD treatment as usual

n=225 in outpatient SUD treatment

Abstinence
End of Treatment
Week 26

10% 5.7%

0% 0%

Reid, JSAT, 2008
Effects are not sustained

12 weeks varenicline, in-person and telephone counseling

12 weeks placebo, in-person and telephone counseling

n=112 in methadone maintenance treatment

Abstinence

End of Treatment

Week 24

10.5% 5.3%

0% 0%

Nahvi et al, Addiction, 2014
## EXTENDED TREATMENT

<table>
<thead>
<tr>
<th>Trial</th>
<th>n</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schnoll et al, 2010</td>
<td>568</td>
<td>Nicotine patch 2 v 6 months</td>
<td>Extended treatment significantly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increases abstinence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increases time to relapse</td>
</tr>
<tr>
<td>Hays et al, 2001</td>
<td>784</td>
<td>Bupropion 7 v 52 wks</td>
<td></td>
</tr>
<tr>
<td>Tonstad et al, 2006</td>
<td>1210</td>
<td>Varenicline 3 v 6 months</td>
<td></td>
</tr>
<tr>
<td>Evins et al, 2014</td>
<td>203</td>
<td>Varenicline 3 v 6 months</td>
<td></td>
</tr>
<tr>
<td>Schnoll et al, 2015</td>
<td>525</td>
<td>Nicotine patch 2 v 6 v 12 months</td>
<td></td>
</tr>
</tbody>
</table>
EXTENDED TREATMENT

Extended intervention (MI, CBT, combination NRT x 6 mo)

n=175 in outpatient buprenorphine treatment

Cessation information

Hall et al., NTR, 2018
EXTENDED TREATMENT

Extended intervention (MI, CBT, combination NRT x 6 mo)

n=175 in outpatient buprenorphine treatment

Cessation information

54% received extended intervention

Hall et al., NTR, 2018
EXTENDED TREATMENT

Extended intervention (MI, CBT, combination NRT x 6 mo)

Abstinence
6 months
11%

n=175 in outpatient buprenorphine treatment

Cessation information
11.3%

Hall et al., NTR, 2018
WHY ARE CESSATION RATES SO LOW?

Limited treatment provision
Limited social support
Short-term treatment
Adherence challenges
Opioid nicotine interactions
LOW ADHERENCE, LOW CESSATION

Tobacco Abstinence

- Varenicline
- Patch + gum
- Placebo

At 6 Months

Adherence at 6 months: 34.2% 48.8% 34.4%

Stein, Drug Alc Dep, 2013
Adherence improves outcomes
## ADHERENCE IMPROVES OUTCOMES

<table>
<thead>
<tr>
<th>Participants</th>
<th>Findings</th>
</tr>
</thead>
</table>
| 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, $p<.001$) |

ADHERENCE MATTERS

FEW ADHERENCE INTERVENTIONS TESTED

DIRECTLY OBSERVED THERAPY 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 smokers in OUD treatment
INTERVENTIONS

Directly observed (DOT)
varenicline x 12 w

Self-administered (SAT)
varenicline x 12 w

N=100 methadone maintained smokers

Nahvi et al, Addiction, 2021
SIGNIFICANTLY HIGHER ADHERENCE

CESSATION RATES NEARLY DOUBLE

DOT IS PROMISING

Nahvi et al, Addiction, 2021
INTERVENTION EFFECTS

UNASSISTED CESSATION RATES 0%

CESSATION RATES WITH TREATMENT ARE MODEST

SHORT-TERM TREATMENTS ARE INSUFFICIENT

ADHERENCE MAY IMPROVE OUTCOMES
### CURRENT RESEARCH

#### Directly observed therapy

<table>
<thead>
<tr>
<th></th>
<th>Long-term varenicline</th>
<th>DOT/LT</th>
<th>SAT/LT</th>
<th>DOT/ST</th>
<th>SAT/ST</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
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<tr>
<td>-</td>
<td></td>
<td></td>
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</tbody>
</table>
How can we reduce tobacco-related harms?
SMOKING REDUCTION

• Enhance cessation
  – ≥ 50% reduction: predictor of cessation
• Improve health
  – Decreased cardiovascular risk
  – Decreased respiratory symptoms
  – Decreased lung cancer risk
• Engage people not yet ready to quit smoking
REMAINING QUESTIONS

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

n=302 people with OUD who smoke

Outcomes

- Switching
- Reduction in smoking
- Reduction in toxicant exposure

Standard Research E Cigarette, motivational counseling

Combination NRT, motivational counseling

El Shahawy, R01DA055675
Multiple intervention targets

Systems

Limited treatment provision
Limited social support
Short-term treatment
Adherence challenges
Nicotine opioid interactions

Patients
WHAT DO WE KNOW?

- Significant Burden of Tobacco Use
- Identify Tobacco Use
- Provide Evidence-Based Treatment
- Optimize Treatment
- Expand Access
QUESTIONS?

shadi.nahvi@einsteinmed.edu
## Treatment emergent adverse effects, n (%)

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

* p ≥ .05 except as indicated
Psychiatric outcomes, n (%)*

<table>
<thead>
<tr>
<th></th>
<th>Varenicline (n = 57)</th>
<th>Placebo (n = 55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident major depressive episode</td>
<td>2 (4)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Incident manic episode</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Incident psychotic disorder</td>
<td>1 (2)</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>3 (5)</td>
<td>4 (8)</td>
</tr>
</tbody>
</table>

* p ≥ .05 for comparison between groups
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
SMOKING CESSATION MEDICATIONS

Clinical trial populations
Individuals with SUD
Submit questions via the ‘Q & A’ box
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Free 1-800 QUIT NOW cards

Take Control
1-800-QUIT-NOW
Call. It's free. It works.
1-800-784-8669
For details on your state services, go to: http://map.naquitline.org

✓ Refer your clients to cessation services
Post Webinar Information

- You will receive the following in our post webinar email:
  - Webinar recording
  - 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 at https://SmokingCessationLeadership.ucsf.edu
SCLC next live webinar is “Empowering Change: Using Brief Motivational Interviewing for Tobacco Cessation in Oral Cancer Prevention, co-hosted by the American Dental Hygienists’ Association”

- Wednesday, April 17, 2024
- 1:00 pm – 2:00 pm EDT
- Registration opens today
Contact us for free technical assistance

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• **Call** us toll-free at **877-509-3786**
• **Provide Feedback** - complete the evaluation, which you will see at the end of this webinar

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