TVC - National Assoc. of Chronic Disease Directors (NACDD) Webinar
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>> Welcome, everyone. Thank you for joining us for SCLC's webinar, service to support, Addressing Tobacco Use in Veterans, co-hosted by the National Behavioral Health Network for Tobacco and Cancer Control.

Cohosted by our partners for tobacco and cancer control.

I am Catherine Bonniot, the SCLC director, executive director and I will be your moderator today.

In the interest of our topic and broad array of participants I am a white female in mid-50s, brown hair, with a dark green V-neck sweater.

A special thank you to our speakers, we have Paul Caseley, Dana Christofferson, and Alex Hurst.

Whom you will hear more about later in the presentation.

We also welcome our ASL interpreters for this webinar, Kelly Greer and Tricia Vasquez.

We would like to thank them for their effort. For those unfamiliar with SCLC, we are based at UCSF, reducing tobacco use, disparities, promoting cessation through partnership, policy and education and since 2003 we have worked to eliminate commercial tobacco as a leading cause of death with support from the Robert Wood Johnson foundation, and others.

For housekeeping we have some tips for you today.

Your lines are muted, the cameras are off, audio streams through the computer speakers, the webinar is being recorded and we are going to make it available on the SCLC website along with all the slides and transcript.

Q&A will follow the presentation, you can submit questions at any time using the Q&A box.

Since we have multiple speakers indicate who your question is being directed to.

CART captioning will be available for the presentation.

By Michelle Schneider and you can access this through zoom captioning and the CART stream link, the link is sent through the chat box.

Please provide feedback by completing our evaluation at the end of the webinar, you can earn 75 minutes of credit, free credit for attending this live session today. That is February 26th, 2025.

And free credits are available, the American psychological Association, the Association of social work boards, California addiction professionals can claim 10 hours of non-accredited continuing education, just for anyone who is not listed here, check with your state board if you are outside California and the certificate can be used.

Instructions for claiming credit will be sent via email after the webinar so anything you need to know.

You can see that tips from former smokers promotes health equity by expanding the reach, representation and accessibility of smoking cessation methods, please explore the resources and learn about the spokesperson, the campaign is running currently.

Now I have the pleasure of introducing our speakers, first we have Paul Caseley, a program manager at the veteran commercial tobacco and -- tobacco cessation program, spearheads innovative efforts to expand access to evidence-based standard of care treatment for the states 500,000+ veterans.

With funding from the community disparity grant Paul is working with the Washington state health department, Department of Health to address the needs of health disparities, facing Washington's diverse population.

By removing barriers to assessment and treatment, conducting targeted outreach and building a robust network of veterans facing tobacco treatment specialists.

Participating in our Washington state leadership Academy for tobacco free recovery.

And second, we have Dana Christofferson, she is the Deputy Director of the tobacco use national program office for the VA healthcare system.

Responsible for developing policy, managing national initiatives including the VA quick line, text message programs, overseeing program evaluation efforts in the VA healthcare system to provide veterans with high quality evidence-based tobacco use treatment.

And our third speaker, Alex Hurst, currently serves as the director of practice improvement, consulting for the national behavioral health network and tobacco cancer control as part of the parent organization of the national Council for mental well-being.

Based in Houston, Texas, leading a multifaceted array of initiatives focused on eliminating tobacco and cancer related disparities in the mental health population.

His purview spans a facilitation of numerous immunity of practices, the strategic development of resources and webinars in the provision of comprehensive training and technical assistance to local state and national partners.

And with that, please join me in welcoming our speakers.

>> Awesome, thank you for that.

Good afternoon to all of those of you joining us from the East and Central time zones. Good morning to everyone else.

As Catherine shared my name is Alex Hurst, a black male who is bald with brown eyes.

With a mustache and goatee and today I am wearing a red button-down shirt with a Black jacket.

As Catherine shared, I serve as the director for the national behavioral health network and with the national Council for mental well-being and it is a pleasure to be here with you to join this distinguished panel of speakers.

During our time together today I am going to set the stage for the discussion by sharing some key data points and insights that highlight the intersection of tobacco use, cancer and behavioral health.

My goal will be to provide a foundation that is not only framed around the challenges we see day to day and the settings in which we work.

But also explore solutions through the presentation.

We know people with disabilities and individuals with the substance use challenges face a unique set of barriers that contribute to significant health disparities.

Particularly when it comes to commercial tobacco use and understanding disparities is critical to advancing policies that we are working on, practice, and answering practices and creating interventions that promote health access and improve outcomes for those communities.

On the next slide I would like to start the presentation and I would be remiss if I did not by providing a quick overview of who we are with the national behavioral health network for tobacco and cancer control. As you know us as NBHN, one of nine national networks committed to limiting disparities.

And advancing health access for all.

Through our work we provide training, technical assistance opportunities including webinars, and many other valuable resources focusing on tobacco and cancer disparities for individuals experiencing mental health and substance use challenges.

If you'd like to learn more about the program, please visit our website.

For more information about the toolkits, guides, resources, and the webinars we are offering.

On the next slide I will jump into the content of my presentation for today.

We will jog in history with you and as you are aware, tobacco has been deeply rooted in advertising to military personnel and adding it to military culture through aggressive marketing strategies and the strategies date back to over a century.

They have had a lasting impact and consequences on the health of our service members. During World War I and two, tobacco companies provided free cigarettes to troops.

While framed as a morale booster, this normalized smoking within military and bolstered lifelong addiction. Research continues to show these early interventions contributed to higher smoking rates amongst veterans long after their service.

Beyond providing free cigarettes, the industry engaged in military personnel sponsorships.

Between 1980 and 2000 tobacco companies sponsored 1500 events that were catered to servicemen and women. The efforts helped cultivate a military environment where tobacco use was seen as part of the lifestyle.

Further reinforcing long-term use.

Cigarettes are not only accessible but also sold at reduced pricing in commissaries and exchanges.

This happens still to this day.

And the discount lowers the financial barrier for those military personals to continue smoking making it easier to purchase and consume tobacco.

They tailor advertising as you can see, and in these ad themes featuring soldiers and action, reinforcing the idea that it is part of service life. Like the ones found at the bottom, from the jewel campaign, these are recent ads and they are still targeting and focusing on military personnel.

And lastly, the tobacco industry and the marketing tactics to military personnel, it is not accidental, it is strategic and deliberate. The consequences of these are still seen today.

With higher smoking rates among the veteran population compared to civilian. And understanding the history is crucial as we start to talk about holistic approaches to addressing programmatic and healthcare outcomes.

And with that, we are going to move onto the next slide where I would like to start focusing on healthcare outcomes.

This slide in particular illustrates the key determinants of health.

And the contributions to overall health, if you participate on one of our webinars you have heard us table a lot of the discussion around healthcare outcomes.

As you are familiar, while it's important to focus on health behaviors in the way we do our traditional addiction, discourse and programming, it is as important to focus on the other buckets.

We also can contribute to.

As I mentioned, 30% of the health outcomes are focused on traditional programming.

Like diet, exercise, supporting those who want to quit smoking.

So while this approach is overarching and significant, social and economic factors such as income, education and community connections are the largest bucket for health outcomes.

Sorry, if we can go back.

These factors, social and economic factors are crucial.

They shape the resources, trust levels and overall well-being as we think about vulnerable populations like veterans.

And the other three include clinical care, the quality of healthcare that is being provided to military veterans. Access to care, while often we think access to care as making sure the VA will cover a certain medication or strategy or practice, if we need to think about holistic things like transportation, availability of competent providers, as well as scheduling flexibility.

Limited access affects certain communities including veterans and individuals with substance use disorder and last bucket, physical environment.

Living conditions, housing stability, air quality and the neighborhood in which the veterans work and live.

That certainly plays an extremely important role in overall health outcomes.

While health behaviors are incredibly important, they are only one piece to a larger generalized puzzle in addressing social and economic and environmental factors.

They will be essential in achieving meaningful and equitable health outcomes.

And on the next slide I will continue that conversation and share with you we want to focus more specifically on a couple of populations and that includes those individuals with disabilities as well as people experiencing mental health and substance use disorders.

In the US nearly 60 million adults live with a disability.

That is a huge portion of the population.

When we talk about this we are not just referring to mobility challenges. We are talking about cognitive limitations, hearing, vision, as well as other mental health challenges. At the same time we also know we have to think about mental health and substance use disorders.

As you see an estimated one out of four people in the US make up the population.

25% of the U.S. population has some shape or form of a mental health or substance use challenge.

This will be incredibly important because it means it is deeply intertwined with the overall health outcomes.

One of the most concerning disparities amongst the populations is tobacco use and people with disabilities and nearly twice the rate of those without, that is not just some coincidence. There are multiple contributing factors from stress levels to systemic barriers to care, targeted marketing of the tobacco industry and those higher smoking rates lead to greater health issues including higher rates of certain cancer, among people with disabilities.

We need to be intentional about addressing these, we must ensure any prevention and treatment strategies we talk about our accessible and the healthcare providers are supporting people with disabilities and we are integrating mental health into substance use care into the broader public health strategies.

When we center around these needs and think about policies and programs, we are not just improving healthcare outcomes.

We ensure that no one is left behind.

On the next slide we will talk more about the data and statistics, I mentioned in the slide that 18.5% of adults with disabilities smoke cigarettes compared to just 10% of those adults without.

And that is a staggering rate in this disparity. It is deeply rooted in some of those social determinants of health including barriers, barriers to healthcare access and financial instability and targeted marketing by the tobacco industry and higher stress levels.

Similarly individuals living with mental health and substance use disorders are affected by commercial tobacco industries. Despite making up the smaller portion of 25% of the population, this group consumes 40% of all cigarettes smoked in the US.

This highlights how urgent the need is.

For integrated behavioral health injuring those struggling with mental health or substance use challenges have the support they need to successfully quit.

The impact of the disparities is severe and research shows people with disabilities and mental health and substance use challenges will experience or experience a prevalence of cancer directly linked to tobacco use.

We can have this conversation without addressing the experiences of U.S. veterans who have higher prevalence of tobacco use compared to nonveterans.

And those disparities are greater among those facing additional challenges, tobacco use amongst veterans experiencing psychological distress is nearly 50%.

It's over 50% for those living in poverty and jumps to 60% for those without health insurance.

These numbers show a clear story and tobacco use is not just in the individual choice. It is a systemic issue tied to access to appropriate mental health and economic stability.

As we talk about the solutions in the coming sides, take that into consideration and think about holistic approaches and the means in which we address underlying areas to drive reduction in tobacco use ensuring programs are

integrated with mental health and disability services and we are pushing forward policies that create access for all to healthcare.

I will give you another framing for this particular case.

This represents a layered framework through this local, ecological model, influencing veterans mental health and substance use.

Organize from individuals and societal circles.

Starting at the smallest and working our way out to the outer layer. First and foremost as we think about the individual we have to think about things like stigma and motivational change.

We now veterans may face stigma related mental health and substance use issues, cultural norms might be perceived as we, may cause not to leverage needed services and motivation for change is a critical element and could vary from one to the next but we know substance use like tobacco is seen as a coping mechanism and some veterans may turn to tobacco as a means to manage stress, trauma or emotional pain.

Further complicating mental health needs.

As we move further to the relational considerations, family support is critical. Support for family includes the social circles playing a role in the journey. Veterans who lack the support system may face barriers to seeking care, maintaining long-term help.

And as we think about community, where does community play a role, deployment experiences, during deployment such veterans experience things such as trauma, combat and loss. All of these things can significantly shape a veteran’s mental health.

Also think about access to care, limited access to care in certain areas like rural or underserved areas, it may be a significant challenge for many veterans so these things should be taken into consideration and societal factors. Things like cultural norms.

We know cultural norms such as negative societal perceptions around mental health are addressing mental health can discourage veterans from seeking help.

We think about policies like housing stability or access to support systems have a profound impact on mental health outcomes and areas to centralized care can lead to fragmented support for veterans.

So some key takeaways from this is we want to be assured that mental health and substance abuse, we understand they are a multifaceted issue and will require a holistic approach when addressing them. And addressing these factors across all levels will lead to more effective support systems and better outcomes for veterans.

On the next slide I have a quick chart I want to share with you.

In this data from the 2023 national survey on drug use and health.

Demonstrating that tobacco products are the second most commonly used substance among veterans ages 18 and older.

25% of veterans equivalent to 4.9 million individuals reported using tobacco within the past 30 days.

Alcohol use remains the most prevalent reported by 10.5 million veterans.

Tobacco use surpasses the other substances listed below and mind those other two substances listed below tobacco.

Which are nicotine, vaping and marijuana.

We know tobacco use among veterans is not just a standalone issue but contributes to a higher risk of chronic illness.

Cancer and heart disease.

On the final slide I want to talk through a couple of overarching strategies.

We are going to recommend and you will hear more about from my fellow presenters.

What can you do?

There is a need to increase availability and awareness of VA sponsored treatment programs. We need to ensure all veterans have access to comprehensive support.

Programs should include counseling, replacement therapy and prescription medications to provide a range of options for veterans depending on their stage of readiness to quit. Awareness efforts should be ramped up to ensure veterans are aware of the resources.

Especially in communities that have limited access to healthcare.

Tobacco use, often reoccurs with other substances and mental health, providing treatment to substance use recovery continuum and mental health treatment programs, we can then address both dependencies simultaneously and educate veterans about the impact of tobacco use on the recovery process.

That is essential to providing a holistic approach to care.

Veteran led groups like mentorship programs can be powerful tools and encourage a tobacco free lifestyle and utilize peer support within the groups to help provide reinforcement for quitting tobacco and making a more relatable and motivating them to stick to their plan.

Creating supportive environments for veterans to try to quit is essential to strengthen -- will require programs like strengthening tobacco free policies in VA hospitals, regional clinics, as well as housing programs.

Policies help ensure veterans are not exposed to any triggers that can undermine efforts to quit and promote healthier overall lifestyles and raising awareness of the veterans specific to treatment resources.

You hear about them from my colleagues, but programs like the quit line, provide convenient services, quitting services for veterans who are seeking it and

resources are designed to connect veterans with the support they need providing counseling tips, motivation as well as the nicotine replacement therapy.

And on the left side I want to give a quick plug as I transition and hand the microphone over to our next presenter.

These QR codes listed here, they will provide you direct links to our website.

You can use your phone and the camera on the phone to hover over those codes and click the link. If you would like please join our list for up-to-date information and access to our newsletter and other opportunities to continue the conversation.

And to the right I would be remiss if I did not promote our amazing national network, the disabilities network who is doing amazing work and disability advocacy.

Please hover over that QR code to the right and visit the website, join the list to receive the newsletters and ask for their support and technical assistance opportunities. Without I will turn it back over to our next presenter.

Thank you.

>> Thanks, Alex.

Dana, you are up next.

>> Thank you so much for having me today.

I am Dana Christofferson, the deputy director of the VA National program office for tobacco use treatment. I am a white female with curly brown hair.

Wearing a green shirt with a Black sweater.

I am going to be speaking today about the veterans’ health administration, the healthcare side of the Department of Veterans Affairs in the United States.

Offering to veterans for tobacco use treatment. To start I want to start with a brief overview of the healthcare system for those of you that may not be aware.

The a is the nation's largest integrated healthcare system, we have 1380 healthcare facilities across the United States.

On the side I have included a map which shows the administrative regions of our system, that piece is less important but it does represent all of the places in the United States and territories where a veteran can provide care, you will see we have locations or where a veteran can receive care so you will see we have locations across all 50 states.

And U.S. territories including Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, we have a clinic in Manila, in the Philippines for U.S. veterans located there.

As an integrated healthcare system the VA provides outpatient care, preventive services, inpatient hospital services, urgent and emergency care, pharmacy

services and dispensing, mental health care, assisted living, home healthcare, other healthcare services for veterans.

They have special programs for veterans' caregivers, programs for housing homeless veterans, programs for rural veterans and other target and priority populations.

There are 9.1 million veterans in the United States, enrolled in VA healthcare.

I will note this is about half the total veteran population in the U.S. I think this bears repeating, VA does not provide care for all military veterans in the United States.

There are specific eligibility requirements for VA care, that are set by Congress.

Eligibility is based on a veteran's military service history, discharge status.

Once a veteran is determined to be eligible for care and has enrolled for care, veterans in the VA are assigned to our priority group.

This priority group determines the amount of copayments, if any, they may be charged for healthcare.

One distinction I would like to note here is VA is a direct care provider, we are not a health insurer.

As such veterans are not charged premiums for VA healthcare.

Healthcare is provided generally free of charge with copayments as determined.

A veterans priority group assignment is determined by criteria including any service-connected disability they may have and the level of disability.

Military exposures, these may include things such as agent orange for Vietnam era veterans, burn pits, other toxic exposures for veterans of the more recent conflicts.

Income is also considered as well as other factors including medals and awards for military service.

I have included links on the side, VA.gov/health, VA.gov/health-care.

You can learn about benefits, specifics of the eligibility requirements, and priority group assignments.

A little bit about who is enrolled for healthcare in VA.

In part the patient population reflects the population of the military.

The vast majority of our patient population is male, 90% men, 10% of our patient population is female.

Our population skews older, half of our patient population is age 65 or older.

Another 30% are between the ages of 45 and 64.

21% of our patient population is younger than 45 years old.

Over 1/3 of our population served during the Vietnam era.

Increasingly our population is represented by veterans who have served post 9/11.

They now make up just about another third of our patient population.

The remainder of during other conflicts, in the US. 50% of our patients report combat exposure.

Combat exposure does vary by the period of active duty service, I will know veterans that served post 9/11 have a higher reported rate of combat exposure then veterans that served during earlier conflicts.

I have included in the slide a graph that shows the VA enrolled population by assigned priority group.

Priority group one listed here is the largest of all of our priority groups, 38% of the enrolled population.

Priority group run represents veterans with service-connected disabilities that are considered to be 50% or more disabling.

Veterans that are determined to be unemployable due to service-connected conditions, veterans awarded the medal of honor.

Veterans and priority group 1 are most likely to use VA for all or most of their healthcare needs.

Over half, 57% use VA for all or most of their needs. Collectively the other priority groups in VA have somewhat lower rates of use of VA care.

Veterans and priority group one are more likely to be younger, a higher proportion are women, are more likely to have served post 9/11 and to have served in a combat zone.

Some of the side I have included information about tobacco use among veterans enrolled in the system.

Enrolled annually, asks about cigarette smoking, smokeless tobacco use, e-cigarette use.

So looking first at the top green line of the graph, this represents every day or someday cigarette smoking.

Between 2019 and 2023.

We have seen it with a year-over-year decline in our patient population and in 2023, 11.4% all veterans enrolled reported current smoking.

The blue line represents smokeless tobacco use, including chewing tobacco, dip, snuff and snus, you will note this rate does not change much over these years, maybe a slight decrease in recent years, 4.5% of all veterans involved in VA care reported some use of smokeless tobacco in 2023.

I will note the rate is higher than the U.S. adult population the 2021 national health interview survey reported 2.1% of all U.S. adults use smokeless tobacco products.

And e-cigarette use is reflected in the orange line on the graph. We have seen increases each year in the proportion of veterans reporting use of e-cigarettes.

From 2020 onward. And in 2023 most 5% of veterans in our system reported either every day or someday use of e-cigarette products.

These are overall prevalence of use in our system.

The rates vary quite a bit by veteran's demographics, race and ethnicity and comorbidities.

One piece I will note is among veterans under the age of 45 we see much higher rates of smokeless tobacco and e-cigarette use.

Then depicted on this graph.

One piece I have included here, in the text on the right, what rates look like among veterans and priority group one which as you recall is the group with higher levels of service-connected disabilities.

Priority group one veterans had lower rates of current smoking in 2023.

Then the overall population, 10.2%.

Reported current smoking.

Priority group one veterans were showing higher rates of e-cigarette use and smokeless tobacco use than the general VA enrollee population.

One of the priority groups for VA is treating veterans with mental health and substance use disorders, VA is a major provider of mental health care for veterans.

In the general U.S. population adults with these have smoking rates that are 2-3 fold higher and among veteran enrollees in VA we see similar trends, veterans with mental health and substance use disorder diagnosis have smoking rates that are several fold higher than veterans without those conditions.

We see some of the highest smoking rates among veterans with substance use disorder, depicted on the bottom bar of the graph and veterans with serious mental illness, including schizophrenia and bipolar disorder. These are consistent with findings from the national Institute on drug use and health, consistent with what Alex shared, half of U.S. veterans in the United States overall.

Serious psychological distress using tobacco products.

So the way the VA approaches tobacco use treatment is with a broad public health approach.

We have a strong national program that supports the delivery of evidence-based care in our system.

We promote the delivery of evidence-based treatment with patient targeted materials.

Provider targeted guidance and information.

As well as a multidisciplinary clinical training program for staff.

We also have population-based programs that aim to increase the reach of treatment directly to veterans so not requiring a healthcare visit, not requiring someone to step inside VA at all in order to receive treatment.

We have a proactive quit line, text messaging program and we have a smart phone app and I will speak more about the resources.

The treatment program is guided by the U.S. Public health service, clinical guidelines, the 2008 update as well as the U.S. preventative services task force recommendation published in 2021.

They are screened for tobacco use and we have a national outpatient clinical reminder.

That helps to affect this screening.

And at this time veterans are offered annually both behavioral counseling and medication treatment.

Coupled with this we have performance measures that track the screening of veterans and the delivery of care in our system on inpatient and outpatient measures.

So I am going to describe in the coming sides in a high level that veterans have access to and I will note that per VA policy every Medical Center is required to have a tobacco treatment program and provide care and per policy all veterans are required to be screened and offered treatment and provided treatment if they are interested.

One piece I want to mention that I don't have time to cover is innovation is core to the VA mission and we worked to pilot and adopt innovative models of treatment and treatment delivery, based on the needs of our population and the evidence based, we have initiatives to implement contingency management for smoking accidents and integrate tobacco use treatment into lung cancer screenings.

In terms of the behavioral interventions available at VA, behavioral interventions can be delivered through multiple modalities. Including In person treatment, telephone treatment and video telehealth.

Each VA facility has the ability to determine what modalities make the most sense for their patient.

We have a number of rural facilities in VA and they may choose to predominantly deliver to that treatment over the phone and video telehealth in order to increase the accessibility for veterans who may live many hours from a VA clinic or medical Center.

In addition many of our facilities provided treatment in individual and group formats.

Groups in particular are really common, they may consist of counseling only or a shared medical appointment with a mental health provider and a prescriber where a veteran can receive both counseling and medication treatment and management.

In VA we find the group treatment models are effective to provide more intensive treatment and balance clinical capacity and we have a number of sites that provide chronic care groups which are essentially an ongoing, open-ended group that are well-suited to address the needs of complex patients such as those with mental health conditions and are suitable for providing support for patients at various stages of change and relapse prevention.

The VA has worked to involve many types of healthcare providers and deliver tobacco use treatment in line with the scope of practice.

And care is delivered by physicians, nurses, psychologists, psychiatrists, clinical pharmacists, social workers, addiction counselors and dentists.

I do want to specifically call out the role of clinical pharmacy specialists in the VA.

The federal system, this profession is able to directly prescribe and manage medications for patients.

And can Council patients and these clinical pharmacy specialists play and the important role in treating tobacco use and we have a number of sites where the tobacco program is led by a clinical pharmacist.

In addition we have the VA tobacco quit line, this program is a collaboration that we have had for the last 12 years.

With the National Cancer Institute.

So the quit vet coaches provide individual multisession proactive counseling in English and Spanish.

Free to any veteran enrolled for care in VA.

Veterans can directly call the number to initiate counseling themselves.

And providers have the option to conduct referrals or a warm hand off.

In order to directly engage eligible patients for the quit line.

Another piece of our collaboration with the National Cancer Institute is the smoke-free Vet program, for those familiar, it was developed from that program.

It is another automated text message program that offers 6-8 weeks of tailored support, tips and encouragement available in English and Spanish.

The program is tailored based on a veteran’s reported type of tobacco use.

Provides specific guidance on medication or over-the-counter nicotine replacement therapy that the veteran indicates using as well as specific tips and coping strategies for common triggers that a veteran may have.

Veterans can directly enroll in this program through SMS or logging in online and signing up.

And we have a strong outreach campaign as well that is focused on increasing the visibility of the program directly for veterans.

The other component of VA care is of course pharmacotherapy and medication utilization.

A little bit of history on this side, since the early 2000 the VA has been working to expand the access of tobacco use treatment for veterans.

In 2003 they may policy changes that require medication to be made available to all interested veterans regardless of enrollment in a counseling program.

Recognizing the evidence at medication use alone is effective at increasing abstinence.

So the graph here is from a publication that analyzes medication utilization within the system between 2004 and 2013.

I would direct your attention to the top solid line that represents all forms of pharmacotherapy including nicotine replacement therapy, so you can see between 2004 and 2008 as a result of VA policy changes and implementation of national performance measures we saw a rise in the proportion of current tobacco users that initiated medication treatment.

And in 2013, the last year included here, one quarter of all VA patients who used tobacco used pharmacotherapy.

I will note this study represents medications dispensed from VA only and does not capture veterans who could have used medications from other sources including other healthcare providers or over-the-counter purchases.

Related analysis conducted at the same time and published found use of cessation medications by veterans in VA care increased the odds of quitting and it was a cost-effective intervention.

Demonstrating the real-world efficacy of the program.

The analysis also found differences within the VA patient population about who is most likely to use medication.

Interestingly and veterans with mostly psychiatric disorders, COPD, vascular disorders and younger veterans were more likely to initiate medications.

Some groups of veterans including men, Hispanic veterans, less likely to initiate medication.

Today according to survey data one third of all who smoke are using medications to quit each year.

We still have some room for improvement.

But we have worked to make all FDA approved and available cessation medications the first line on the formulary, any veteran can access it. Without restriction.

No prior authorization or previous trials of medication required.

We strongly encourage the use of domination nicotine replacement therapy as a first-line agent.

I would like to share a few resources at the end of my talk for you all.

I know many of you here today are healthcare providers or counselors so I put together a few links and information on courses and guidance you may find helpful.

The first is a military cultural competency course.

This was jointly developed by the VA and DoD.

It describes military organizations and roles on military specific stressors and treatment tools for best practices in military patients.

The VA has found military cultural competency can improve the therapeutic alliance between patients and providers and remotes understanding of military culture for any clinician providing treatment with military and veteran patients.

We also have an ongoing national webinar series within VA that we make available externally on the training.org website.

These are one-hour webinars on topics including medications for tobacco use treatment, group counseling, behavioral counseling and special topics such as tobacco treatment and lung cancer screening populations.

The trainings can be accessed live or in the recorded enduring content.

A training.org.

We have a podcast series titled tobacco unfiltered, conversations with clinicians . This is available on all major podcast platforms and the host is a clinical psychologist who invites guests to discuss various topics and tobacco use treatment so there are podcasts on topics such as initiating tobacco use treatment in patients who are not ready to quit, using motivational interviewing to encourage change and others that may be interesting for you.

We also have publicly available patient workbooks and provider handbooks at the mental health.VA.gov link on the screen. We have looks targeted to primary care populations, women veterans, veterans who use smokeless tobacco and a number of patient information sheets and guides on her website.

The site describes some of the publicly available resources we have for veterans, I have discussed the 1-855 telephone quit line and the smoke-free that program, those are intended for VA enrollees but they can access them.

More broadly for veterans we have a number of resources on mentalhealth.VA.gov, and information on smoke-free.gov, there is a separate subsite for veterans that includes some really cool interactive tools like building a quit plan or helping to choose a nicotine replacement therapy and we also have a coach app available for Apple and android phones that can be available for those trying to reduce or quit use of multiple types of tobacco products.

So just to summarize and reflect on what Alex shared at the start.

Clinical care is one aspect that impacts health so what I have described today is what VA as a healthcare system can offer veterans in terms of treatment.

And in some cases, we are limited as a healthcare system.

To providing care for the veterans that are or who enroll for care in VA and choose to utilize VA care.

We are also limited to providing care to the veterans themselves.

In many cases we are not able to take care of veteran's family members.

I want to recognize the work VA does to improve the health of veterans is really supported by the communities, the other organizations that work with veterans.

I strongly believe we would not have seen the progress we have made in VA this far in terms of reducing cigarette smoking among veterans in our system without the tobacco control policies, that states and localities have implemented and the federal government as well as the community support, encouragement and prevention that has been conducted in the communities.

So last slide.

I will leave you with a few takeaways and things you can do first and foremost.

Encourage veterans to enroll in VA care if they are eligible.

We have a website which is choose.VA.gov/health.

It offers a number of options and ways of entering can enroll for a healthcare and that is by in large the best way to get veterans access to all of the resources that VA has available for tobacco use treatment.

Mental health care, substance use disorder care and others.

I would encourage you to share some publicly available websites and resources like smoke-free.gov, our VA .gov page, stay quit coach app and I will draw your attention to a partner toolkit we have available on smoke-free.gov which includes printouts and posters and flyers that can be shared with that. And a reminder if you are a healthcare provider, take a look at some of the training and resources that VA has available.

Thank you for your time and I will turn it over to the next speaker.

>> Thanks, Dana. Welcome, Paul.

>> Thank you, everybody. Good morning and good afternoon on the East Coast.

Paul Caseley, the program manager for our veteran commercial tobacco cessation program.

We are a partnership between the Washington Department of Health the youth and cannabis prevention program.

My program as part of the counseling and wellness department and I want to acknowledge all the support and collaboration between Catherine at the SCLC and our partners at Fort liberty and the folks from North Carolina Department of Health and DHHS, Sally Herndon and thank you, I stand on their shoulders and this is an honor to be here today. Thank you.

I mentioned on part of the counseling wellness department for Washington state departments of veteran affairs it's important to mention at the onset that we are always recommending the federal VA services first for tobacco cessation.

And Washington State Department of veteran affairs comes in where many of our programs to fill those gaps, remove barriers, and that is what we have been able to do with this program so far and I first became associated with the program.

In and around the fall of 2022 before we called it a program. We are recipients of CDC grant funds for the community disparities grant and we are priority population and we are a subcontract with the Washington State Department of Health.

Our mission for the program, we exist to connect Washington veterans to resources that help decrease tobacco and nicotine dependence and cessation efforts to remove barriers and increase access to treatment.

This supports our agency's mission of serving those who served and explicitly contribute to the agency's goals of providing quality healthcare services and responsive veteran programs.

The mission of counseling and wellness is to transform the lives of veterans and families through growth and resiliency related experiences.

I would like to point out a few of our numbers here in Washington state for context.

We have approximately 562,000 veterans, 65,000 active duty, 17 1/2 thousand guard and reserve, the percent of our adult population that are veterans is about 8.9%.

And the number of veterans age 65 and over is 244,000.

Which is about 43%.

The number of veterans receiving disability compensation with VA is 150,000.

And the number of enrollees in VA healthcare system is 230,000, less than half of our veteran population.

I'm going to be talking to you today about three different areas where we have been able to essentially make veterans a priority population around tobacco in our state.

Education and outreach, training and collaboration, assessment and treatment.

I am going to delve into these separately to show you how we have been able to connect with veterans in our state and make them aware of resources and also In some cases do some actual direct care and provide assessment and treatment.

The first area is education and outreach.

We have been able to connect with veterans and I find it is best to actually get face-to-face with veterans where they gather.

Where they live and some of these areas will reflect that. Veteran resource events, community resource events that have resources with veterans.

Veteran specific events, we call some of those stand downs where in a large event arena all the resources in the community will come together for veterans

and set up tables, resource tables and veterans will come to those tables and you get to be face-to-face with those veterans.

Anywhere from free haircuts to clothing, signing people up for benefits, we found that to be very successful and getting people to quite right on the spot.

So the next would be the veterans service organization.

Which Dr. Christofferson mentioned, many service organizations are partners, providing services and I will speak to that more later when we talk about training.

We have had a lot of success with military bases in the area, particularly at the Naval Hospital in Bremerton.

Joint base Lewis McCord and the National Guard, Camry facility, on the east side of the state with the air guard out there.

In Spokane.

Transitional housing programs, our state VA operates for veterans' homes in our state and two are transitional housing programs.

One in Port Orchard and the other in the old soldiers' home and making frequent visits there, once a month.

Speaking to the weekly house meeting.

And currently we have 5-6 at each location in an active quit journey.

We have our that core program, our recipients of the AmeriCorps grants stipend, part of the America service mission and these volunteers essentially serve on college campuses, also in some veteran service organizations and they help veterans get connected to the benefits.

And also, we have been able to provide training to some of those that core folks at the annual training and also with tobacco treatment specialist training which I will talk more about in a little bit.

It's important to collaborate with our other programs so we have recently launched some traumatic brain injury peer support groups.

And MOU was signed with the Elks Lodge here in Bremerton, Washington.

I was featured as a guest speaker in that group a couple weeks ago.

We have been able to connect there with some other programs and also offer the services available to anybody in that region.

Those people could take that information and pass it on.

Last week I was out in the Spokane area speaking to the Spokane veterans forum which provides resources to the veterans and spoke to about 50 veterans for about an hour.

And they are in there for mainly substance use infractions, a diversion for about one year.

And some of the pictures you see, the first picture at the top of the screen with a gentleman and a computer, we were actually at that moment distributing digital navigator program computers and cell phones.

A free program with T-Mobile.

And a gentleman was receiving a chrome book and a two-year contract with T-Mobile.

During that conversation we had a discussion about nicotine and tobacco also. So sometimes you are there talking about other programs and representing the agency for outreach and the tobacco and nicotine resources will come up.

Other outreach opportunities here, in the bottom right corner we have the Washington State fair, where veterans gather sometimes.

We have our LGBTQ plus liaison, the vet corps representative there, it is an integrated approach to outreach.

Next slide please.

The next area I would like to talk about is the training and collaboration.

As I mentioned we have our vet corps members, recently we were able to give them some training through Duke University.

And we also have our veteran certified peer counselors.

Our agency collaborated with the healthcare authority here in Washington.

To create a veteran specific certified peer counselor certification.

We have two cohorts go through with that right now.

Probably 60 people have been trained.

I had about an hour to give them the tobacco cessation piece there.

The most recent development is that we were able to use our CDC funding to provide a scholarship for TTS training with the Duke and University of North Carolina program.

That occurred in the fall for the fall TTS.

And we trained 33 people there.

17 of those folks have now agreed to take the certification exam through the American Heart Association, which we are also covering the cost for.

Currently we have four people going through the Duke training as we speak, they are on day two for the spring 25 training.

Another area of training collaboration has been conference presentations and attendance.

Resource tables. We have our annual serving those who serve conference.

Put on by our agency.

I was able to get several people to agree to enter a quit journey, the last conference was seven people, some are actually state employees that attended a conference.

We tabled the Washington state public health conference, the CDC and OSH office of smoking and health award meeting in Atlanta, we have a joint presentation with North Carolina.

And efforts on Fort Liberty. And also we have presented the Washington State Department of Health quarterly meetings.

Coalition involvement has been integral to our work here particularly when this began for us in the fall of 2022, we did not know much about the space and again the coalition involvement with Margaret Shields from Washington breathes has been integral in our work and learning all about the space.

The cancer action plan of Washington, we are a member of that and you can't speak on behalf of veterans unless you are at the table.

So trying to make sure we are represented in the various groups doing work for our state and around the country.

Recently we became a member of the Washington State behavioral health workgroup attached to the UCSF SCLC and it looks like we are going to be members of a new Academy leadership Academy for that, I forget the acronym but that is coming to fruition right now.

And we are providing training for providers with credit through our veterans training support Center, collaboration with the University of Washington, King County Department of Health, Pierce County Department of Health.

Once a month I go to the Naval Hospital with a mental health behavioral health next steps group there.

Usually there is about 6-10 folks and around a conference table receiving transition services.

We have been very active in that collaboration.

I alluded to that we have been able to train folks with the Duke fall TTS training and the spring TTS training. We have 12 counties represented and those are on the map here.

We have the I-5 corridor represented in the West.

Goes down the middle of that group being there.

A large concentration around the Naval Hospital, we also have a large concentration around Spokane, the Spokane area, two veteran service offices out of Spokane County veterans service office that were trained and also I met with them last week and in Spokane we were talking about what it might look like out of that office.

And how we can develop and use that as a pilot and spread that across the state.

These are some of the roles of those people participating in that program.

With the scholarship program.

Some veteran service officers, mental health counselors, substance use counselors, certified peer counselors, some of our Vet Corps members, to name a few.

In assessment and treatment, we have been able to serve over 60 folks with direct care and most of those in the last year as a direct result of outreach we have an assessment, make recommendations and so far we have been able to give out as much as 406 weeks worth of free nicotine replacement therapy, reducing barriers to the cost.

We have follow-up counseling available without.

And also 406 weeks of NRT is about seven and half years worth of NRT.

Our next steps for the program would be to develop a community of practice for our newly trained tobacco treatment specialists.

Build the coalition capacity with Washington State behavioral health and the Washington breathes coalition and our own veteran commercial tobacco cessation coalition. We will collaborate with the suicide prevention program, TBI program, looking to collaboration with the healthcare authority around some treatment hubs, healthcare hubs they are establishing.

Continue to work with partners at the Department of Health and target and get upstream with our Junior ROTC programs and high schools.

We are recipients of Department of Commerce grant reducing violence in the home.

And received an additional $50,000 from our Department of Commerce.

And recently we were able to negotiate with tomorrow health and it's an app technology similar to the app the federal VA has with generated texting and we were able to negotiate up to 15 veterans to have eight weeks free NRT, an alternative source for veterans.

We look forward to continued collaboration with DOH funding to perhaps increase that.

Over the next coming two years. We anticipate funding for the next year from CDC coming in April.

And expansion further would include substance use disorder research to expand to other substances and have some listening sessions around that, client feedback on needed support and program improvement and adjustments.

Again, I would just like to say this has been mighty work, there is folks that have been doing this longer than I have and I am honored to be here today.

I have learned a lot over the last two years and we will keep doing this work.

And to fill the gap and here are some resources for you as far as how to get a hold of us. The QR code will go directly to our webpage and phone numbers and email.

Thank you very much. Have a great day, everyone.

>> Thank you, this has been, we got someone who said this has been a great webinar.

We are going to see if we can get one question in.

When you have multiple speakers sometimes we have some timing issues.

I am going to give it a go and if our presenters could answer as quick as you can.

Thank you for all of your questions, we will get them answered most webinar.

First question I have is for Dana, around coverage.

Two fold, why does TRICARE not cover [Indiscernible] for patients over the age of 65.

And the second question related to that is are there any out-of-pocket costs for NRT and medications for veterans?

>> Very briefly, TRICARE is a Department of Defense program, VA is a different government agency.

I can't speak to DoD policies.

I don't actually know the details.

I apologize.

For VA, copayments are determined by the priority group.

So some veterans, I believe priority group one has no copayments assessed for any medication treatment.

Veterans and other groups may have a copayment assessed for medication.

A copayment is I believe $8 for a 30-day supply right now.

For any of the drugs in VA.

>> Thank you. This question is for Alex.

As briefly as you can to answer.

How do military culture and stressors contribute to the normalization of tobacco use?

>> Absolutely, I honed in on this during my presentation.

As many of us know, tobacco use is historically ingrained in military culture.

Through whether it is targeted promotional advertisement, discounted cigarettes, so that commissaries and exchanges, all these ways in which military has inundated itself into the military culture so we have to continue finding ways to counteract that.

Address those myths that tobacco use is not used as a social means through military personnel.

And as it relates to stressors in particular, we know tobacco is used as a coping mechanism for those stressors. Culturally we need to address those myths.

>> Thank you.

And our final question for Paul.

I think this is a great one. Thank you.

Do you have any advice for working with local VA providers on tobacco initiatives, I have tried to reach out before and hit a brick wall.

It almost feels like if you are not part of the VA world you have little chance of reaching anyone.

Thoughts, give it to the audience.

>> I would suggest contacting Dana Christofferson. She can give you all her folks in the facilities and local area.

In Washington state we have Dr. Tiffany Finnell, she has been a great source for me in this effort.

>> Excellent. Thank you.

Thank you to all of our speakers, that concludes our Q&A session.

We are definitely going to take our speakers up on the fact that they will love to answer questions posed webinar.

We will save all those answers on the website. Thank you again to our speakers, really interesting getting great feedback, before we close, I want to invite Alex for a quick special announcement.

>> Thanks for giving me a quick moment to share with you, after hearing a presentation like the one today we are excited to take the opportunity to share publicly that our team will be launching a community of practice opportunity and this in particular will provide a space for those organizations that want to do more, collaborate, strategize and take action towards addressing this critical challenge. The opportunity to do so over the next six months so if you can, please do go to our website, use the QR code on the screen to join our network to stay tuned for the information and we will send it here in the coming weeks regarding the opportunity. Look forward to having you all share your interest and participate.

>> Super, I want to say, save the date, our next -- you can see the CME but save the date, our next live event is a billion lives, annual symposium on April 11th, 2025 from 8:00 to 5:30, Pacific time.

Is an in person event but there will be a virtual option for those who can't attend in person. Please, we encourage you to visit the website to register.

Other than that you will get all the information you need about claiming credit, there are cards available if you want to use those and order those.

And we invite you to contact if you need technical assistance. We are here for you, email or call toll-free, the number on this screen, thanks to everybody we hope you have a great rest of the day. And also thank you to our speakers and CART Captioner is.