

# Smoking Cessation and Tobacco Use Prevention: Evidence-Based Smoking Cessation and Motivational Interviewing

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Jessie A Junker, MD, MBA

- Spouse employed at Akorn
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The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated:

- Nicotine vaccine is a novel experimental approach to treating tobacco dependence but have not generated adequate antibody responses or demonstrated efficacy versus placebo.

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## Mary Krebs, MD, FAAFP

*Family physician/Medical leader, HealthSource of Ohio, Lebanon; Faculty, Family Medicine Residency at Soin Medical Center, Beavercreek, Ohio*

Dr. Krebs earned her medical degree from the Ohio State University College of Medicine in Columbus and completed a family medicine residency at Miami Valley Hospital in Dayton, Ohio. She is a solo family physician at a rural federally qualified health center (FQHC) and teaches residents at a new family medicine residency program. She is developing a practice management curriculum and is focused on the patient-centered medical home (PCMH) and quality improvement. Her completed projects include efforts to improve diabetes care, improve preventive health, decrease emergency department and hospital utilization, improve care coordination, address population health, measure physician quality, and deliver medical neighborhood care within the context of the PCMH model. Dr. Krebs has experience writing and evaluating quality measures and served on the American Medical Association (AMA) Prediabetes Quality Measures Technical Expert Panel. She is frequently consulted on matters relating to quality measures, population health, lifestyle modification, value-based payment, and diabetes. In addition, she is a frequent contributor to *The Ohio Family Physician* and has written on a variety of public health issues.

Previously, Dr. Krebs co-ran Family Practice Associates, an independent practice where she led transformation to the PCMH model of care and was involved in the Center for Medicare & Medicaid Innovation's Comprehensive Primary Care (CPC) initiative. She also implemented clinical staff and electronic health record (EHR) training, numerous quality improvement and population health projects, and other efforts to improve patient and practice team satisfaction. Dr. Krebs currently serves on the AAFP's Commission on Quality and Practice and is the chair of the AAFP Working Group on Rural Health, as well as serving on the Ohio Academy of Family Physicians Board of Directors. In the past, she has served on the National Conference of Constituency Leaders (formerly the National Conference of Special Constituencies), the Congress of Delegates, and the Reference Committee on Organization and Finance. She served on the quality committee for Premier Health—a physician-led insurance plan—to help make decisions regarding measurement of physician performance, population health, development of quality measures, compensation for quality, and privileging.

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# Learning Objectives

1. Screen all adult patients and pregnant women for tobacco use.
2. Educate patients, utilizing motivational interviewing, about the health risks of tobacco use.
3. Create an individualized smoking cessation plan for patients.
4. Know how to prescribe tobacco cessation pharmacotherapy and evidence base behind various therapies.

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## 5 A's

- Ask
- Advise
- Assess
- Assist
- Arrange

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# ASK

Ask about tobacco use at every visit.

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# ADVISE

Advise the patient to quit smoking.

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## Tell Patient to Quit

Assuming an unassisted quit rate of 2-3%, brief advice intervention can increase quit rates by an additional 1-3%.

Small additional benefit of more intensive intervention compared to brief intervention.

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## Tell the patient to quit

Although quitting smoking at any age is beneficial, smokers who quit by the time they are 35 to 44 years of age avoid most of the risk of dying from a smoking-related disease.

Strong and personalized.

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# Remind Smokers of Risks

Emphysema/COPD  
Heart disease and heart attack  
Stroke  
Cancer  
Gum disease  
Bad breath  
Tooth loss  
Decreased circulation to the hands and feet  
Hip fractures  
Cataracts  
Wrinkles  
Cost

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# ASSESS

Is the patient willing to quit at this time?

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# ASSESS

How severe is the patient's nicotine addiction?

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## Stages of Change

Pre-contemplation (not ready to quit)

Contemplation (considering a quit attempt)

Preparation (actively planning a quit attempt)

Action (actively involved in a quit attempt)

Maintenance (achieved smoking cessation)

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## If Not Ready to Quit

Physician's role is to understand the patient's perspective of the risks and benefits of continuing to smoke in order to help the smoker contemplate quitting. Most smokers want to stop smoking, but may not be ready to take specific actions to quit.

Ask what he or she likes and does not like about smoking.

Personalized message about a smoking-related health problem the patient is experiencing may motivate the patient to act.

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## 5 Rs to Motivate Patients to Quit

Relevance

Rewards

Risks

Roadblocks

Repetition

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# Heavy Smoking Index

a. How many cigarettes, on average, do you smoke per day?

1-10 (score 0)

11-20 (score 1)

21-30 (score 2)

31+ (score 3)

b. How soon after waking do you smoke your first cigarette?

Within 5 minutes (score 3)

6-30 minutes (score 2)

31-60 minutes (score 1)

61+ minutes (score 0)

An HSI score  $\geq 4$  indicates a high level of nicotine dependence

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# Fagerstrom Test For Nicotine Dependence

Standard instrument for assessing the intensity of physical addiction to nicotine.

Contains six items that evaluate the quantity of cigarette consumption, the compulsion to use, and dependence.

Yes/no items are scored from 0 to 1 and multiple-choice items are scored from 0 to 3. The items are summed to yield a total score of 0-10.

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# Fagerstrom Test for Nicotine Dependence

1. How soon after you wake up do you smoke your first cigarette?  
Within 5 minutes (3 points)  
5 to 30 minutes (2 points)  
31 to 60 minutes (1 point)  
After 60 minutes (0 points)
2. Do you find it difficult not to smoke in places where you shouldn't, such as in church or school, in a movie, at the library, on a bus, in court or in a hospital?  
Yes (1 point)  
No (0 points)
3. Which cigarette would you most hate to give up; which cigarette do you treasure the most?  
The first one in the morning (1 point)  
Any other one (0 points)
4. How many cigarettes do you smoke each day?  
10 or fewer (0 points)  
11 to 20 (1 point)  
21 to 30 (2 points)  
31 or more (3 points)
5. Do you smoke more during the first few hours after waking up than during the rest of the day?  
Yes (1 point)  
No (0 points)
6. Do you still smoke if you are so sick that you are in bed most of the day, or if you have a cold or the flu and have trouble breathing?  
Yes (1 point)  
No (0 points)

**Scoring:** 7 to 10 points = highly dependent; 4 to 6 points = moderately dependent; less than 4 points = minimally dependent.

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# ASSIST

- Counseling
- Pharmacotherapy

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## Individual Counseling

Individually-delivered smoking cessation counselling can assist smokers to quit. (high-quality evidence)

Smaller relative benefit when counselling is used in addition to pharmacotherapy, and of more intensive counselling compared to a brief counselling intervention. (moderate-quality evidence)

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## Success Rates at One Year

3-5% when the patient simply tries to stop

7-16% if the smoker undergoes behavioral intervention

Up to 24% when receiving pharmacological treatment and behavioral support

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## Evidence for Motivational Interviewing

Motivational interviewing appears to help more people to quit smoking than brief advice or usual care when provided by general practitioners and by trained counsellors.

Motivational interviewing carried out by general practitioners appeared to be more successful than when carried out by nurses or counsellors.

Shorter motivational interviewing sessions (less than 20 minutes per session) were more effective than longer ones.

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## Evidence for Motivational Interviewing

A single session of treatment appeared to be marginally more successful than multiple sessions, but both delivered successful outcomes.

The evidence for the value of follow-up telephone support was unclear, and face-to-face counseling did not help more people to quit than telephone counseling.

Both approaches were more successful than brief advice or usual care.

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# Motivational Interviewing

Generally quiet and eliciting.

Motivation to change is elicited from within the patient, and not imposed from without.

It is the patient's task to articulate and resolve ambivalence.

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# Motivational Imaging: OARS

Open-ended Questions

Affirmations

Reflective Listening

Summaries

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## Motivational Interviewing Techniques

Open-ended questions: “What are some of the reasons you would like to quit smoking?”

Develop discrepancy: “It sounds like you are very devoted to your family. How do you think smoking is affecting your children?”

Reflective listening: “It sounds like trying to quit smoking has been frustrating for you.”

Support self-efficacy: “So you were fairly successful last time you tried to quit.”

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## Assisting with Smoking Cessation

Help the patient with a quit plan

Provide practical counseling

Provide support

Recommend the use of approved pharmacotherapy except in special circumstances

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## Printed Self-Help Information

Standard, print-based self-help materials increase quit rates compared to no intervention, but the effect is small.

No evidence of additional benefit when used alongside other interventions such as advice from a healthcare professional, or nicotine replacement therapy.

Evidence shows materials that are tailored for individual smokers are more effective than non-tailored materials, although size of effect is still small.

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## Nicotine Replacement Therapy

Side effects include gastrointestinal symptoms (nausea, vomiting, abdominal pain, diarrhea), headache, and local irritation depending on the delivery method.

Nicotine dependence from NRT rarely occurs, especially with the long-acting patch. Nicotine does not cause cancer.

Safe to use in patients with known stable cardiovascular disease (CVD).

Limited information regarding its use after acute coronary syndrome (ACS), it is generally used to reduce nicotine withdrawal symptoms in the hospital when needed.

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## NRT Efficacy

Individual NRT products were found to be superior to placebo, increasing quit rates up to twofold.

One randomized trial among the NRT patch, gum, inhaler, and nasal spray found no difference in efficacy.

Single-agent NRT is less effective than combining the long-acting patch with a short-acting form such as gum, lozenge, or inhaler.

In some but not all trials, NRT benefits men more than women.

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## Combining NRT Products

NRT products can be used in combination because each agent produces a lower blood nicotine level than does smoking one pack of cigarettes daily.

Smokers can titrate their nicotine intake to avoid nicotine withdrawal and nicotine overdose.

The initial dosing of most NRT products is based on the number of cigarettes smoked daily, then gradually tapered.

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## Combining NRT Products

NRT use is recommended for two to three months after smoking cessation, though NRT use for as long as a smoker is at high risk for relapse is acceptable because NRT is much safer than continuing to smoke.

NRT products can also be used while the smoker is still smoking.

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## Nicotine Patch

Long-acting, slow-onset pattern of nicotine delivery, which produces relatively constant relief from withdrawal over 24 hours but requires several hours to reach peak levels.

Compliance is high.

Cannot adjust the dose of nicotine being released to respond to nicotine cravings and withdrawal symptoms.

Available over the counter and by prescription.

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## Nicotine Patch: How to Use

>10 cigarettes per day and weight >45 kg – Start with the highest dose nicotine patch (21 mg/day) for six weeks, followed by 14 mg/day for two weeks, and finish with 7 mg/day for two weeks.

≤10 cigarettes per day or weight < 45 kg – Start with the medium dose nicotine patch (14 mg/day) for six weeks, followed by 7 mg/day for two weeks.

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## Nicotine Patch: How to Use

Apply one patch each morning to any non-hairy skin site. Rotate the site daily to avoid skin irritation (most common side effect). Hydrocortisone cream may be used to relieve skin irritation if it occurs.

Remove and replace the patch with a new one at bedtime. If leaving the patch on overnight is causing the frequently reported side effects of insomnia and vivid dreams, replace the patch the next morning. Smoking cessation rates are similar whether the patch is left on for 24 hours or taken off at night.

When the patch is removed at night, substantial plasma levels of nicotine are reached 30-180 minutes after a new patch is applied in the morning. If the patch is removed at night and morning nicotine cravings occur, use a short-acting NRT (eg, gum, lozenge) while waiting for the nicotine patch to take effect.

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## AES Question #1

Mrs. Jones is using the nicotine patch and has not smoked in three days. She complains of occasional cravings and vivid dreams. What would you do?

- A. Continue current treatment.
- B. Change to varenicline.
- C. Advise her to take off the patch at night and add nicotine gum.
- D. Stop the patch all together.

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## Short-acting NRT

Options: lozenge, gum, inhaler, or nasal spray.

Can be used as a single agent or added to daily nicotine patch therapy.

Require repeated use throughout the day, lead to more variable nicotine levels than the patch, and require more instructions for correct use.

Smokers may be instructed to use the product when they have a craving, but this generally leads them to underuse the products. Another option is to have the smoker use the short-acting NRT product at least once every hour while awake and more often as needed.

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## Nicotine Gum

Chewing the gum releases nicotine to be absorbed through the oral mucosa.

Peak blood nicotine levels 20 minutes after starting to chew.

Available in several flavors.

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## Nicotine Gum

Dosing is determined by the number of cigarettes smoked daily.

- $\geq 25$  cigarettes per day – 4 mg dose of gum is recommended
- $< 25$  cigarettes per day – 2 mg dose of gum is recommended

Chew at least one piece of gum every one to two hours while awake and also whenever there is an urge to smoke.

Use up to 24 pieces of gum per day for six weeks.

Gradually reduce use over a second six weeks, for a total duration of three months.

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## Nicotine Gum

Gastric and esophageal irritation can occur if the gum is chewed too rapidly, because nicotine is released faster than it can be absorbed by the buccal mucosa and the nicotine is thus swallowed. Nicotine absorbed from the gastrointestinal tract is largely metabolized by the liver and relatively ineffective for smoking cessation.

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## Nicotine Gum

"Chew and park" is recommended: chew the gum until the nicotine taste appears, then "park" the gum in the buccal mucosa until the taste disappears, then chew a few more times to release more nicotine. Repeat this for 30 minutes, then discard the gum (because all nicotine in the gum has been released).

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# Nicotine Gum

Acidic beverages (eg, coffee, carbonated drinks) lower oral pH, which reduces nicotine absorption.

Side effects are mostly a consequence of excess nicotine release with overly vigorous chewing and consist of nausea, vomiting, abdominal pain, constipation, hiccups, headache, excess salivation, a sore jaw, and mouth irritation or ulcers.

Chewing gum may exacerbate TMJ disease and the gum can damage or adhere to dental appliances. Smokers with TMJ disease, with poor dentition, or who use dental appliances may do better with the lozenge or inhaler.

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# Nicotine Lozenges

Pharmacokinetics similar to nicotine gum.

Lozenges are easier to use correctly than nicotine gum and are available in different flavors.

A smaller mini-lozenge that resembles a "Tic Tac" is also on the United States market. It dissolves more rapidly and delivers nicotine more rapidly than the original lozenge.

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## Nicotine Lozenges

Can be used in smokers with TMJ disease, poor dentition, or dentures.

Side effects include mouth irritation or ulcers, in addition to nicotine-related side effects of abdominal pain, nausea, vomiting, diarrhea, headache, and palpitations.

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## Nicotine Lozenges

Dosing is determined by how soon the first cigarette is typically smoked upon awakening:

- Smokers who smoke within 30 minutes of awakening: 4 mg dose recommended
- Smokers who wait more than 30 minutes after awakening to smoke: 2 mg dose recommended

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## Nicotine Lozenges

Use up to one lozenge every one to two hours for six weeks. The maximum dose is five lozenges every six hours or 20 lozenges per day.

Gradually reduce number of lozenges used per day over a second six weeks.

Place lozenge in the mouth and allow it to dissolve for 30 minutes. The lozenge does not need to be chewed.

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## Nicotine Inhalers

Consist of a mouthpiece and a plastic, nicotine-containing cartridge.

The inhaler addresses not only physical dependence but also the behavioral and sensory aspects of smoking.

When the smoker inhales through the device, nicotine vapor (not smoke) is released, deposited primarily in the oropharynx, and absorbed through the oral mucosa. Nicotine vapor does not reach the lungs to an appreciable extent.

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## Nicotine Inhalers

Side effects include localized irritation of the mouth or throat, particularly during the early stages of use. Inhaled nicotine may cause bronchospasm, so may be less ideal for smokers with a history of severe airway reactivity.

Requires prescription.

The ad lib use of the nicotine inhaler produces plasma nicotine levels that are roughly one-third of those that occur with cigarette smoking. The pharmacokinetics of the inhaler resemble those of nicotine gum.

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## Nicotine Inhaler

Dosing, duration and instructions for use:

- Use 6 to 16 cartridges per day for the first 6 to 12 weeks
- Gradually reduce dose over the next 6 to 12 weeks

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## Nicotine Nasal Spray

The nicotine nasal spray delivers an aqueous solution of nicotine to the nasal mucosa.

Absorption via nasal mucosa results in peak nicotine levels 10 minutes after nasal spray use (more rapid rise in plasma nicotine concentration than gum, inhaler, or lozenge). Nasal spray more closely mimics changes in nicotine concentration that occur while smoking, although the nasal spray does not increase nicotine levels nearly as fast as smoking a cigarette.

Requires prescription.

**FMX**

## Nicotine Nasal Spray

Dosing, duration, and instructions for use:

- Dose is one or two sprays per hour
- Use for about three months
- The maximum dose is 10 sprays per hour, not to exceed 80 total sprays per day

Side effects include nasal and throat irritation, rhinitis, sneezing, and tearing. Nasal irritation is extremely common, occurring in 94 percent of patients during the first two days of use and continuing in 81 percent of patients after three weeks of therapy.

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## Varenicline Efficacy

Multiple studies have shown the efficacy.

More effective for smoking cessation than placebo, bupropion, and nicotine patch.

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## Varenicline

A four-week preload of varenicline produced higher abstinence rates at 12 weeks, compared to three weeks of placebo followed by one week of varenicline (47 versus 21 percent).

Evidence does not suggest that varenicline causes more neuropsychiatric symptoms than other FDA-approved smoking cessation aids, but the FDA still recommends that any patient started on varenicline who develops neuropsychiatric symptoms including changes in behavior, hostility, agitation, depressed mood, suicidal ideation, and suicide attempts should stop the medication, contact their physician, and seek medical attention, right away.

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## Varenicline Safety

Common side effects reported are nausea, insomnia, and abnormal dreams.

Early concerns about neuropsychiatric and cardiovascular side effects, but subsequent studies have not supported these.

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## Varenicline Mechanism

Reduces the symptoms of nicotine withdrawal by blocking nicotine from binding to the receptor that mediates the reinforcing effects of nicotine that lead to nicotine dependence. This reduces the rewarding aspects of cigarette smoking. It does this by binding with high affinity and producing partial stimulation of the alpha-4 beta-2 nicotinic receptor.

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## How to Use Varenicline

Start varenicline one week prior to quit date, by which time stable blood levels are achieved. However, a longer preloading period of up to four weeks prior to the quit date is also effective for achieving abstinence.

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## How to Use Varenicline

The recommended dose of varenicline is 0.5 mg daily for three days, then 0.5 mg twice daily for four days, and then 1 mg twice daily for the remainder of a 12-week course. The up-titration of varenicline dose is done to minimize gastrointestinal side effects, especially nausea.

Dose reduction is required for those with at least moderate renal insufficiency because varenicline is excreted almost entirely by the kidney.

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## Varenicline Troubleshooting

Nausea is reduced if the dose of varenicline is titrated upward, taking varenicline with food and a full glass of water, or reducing dose to 0.5 mg twice daily.

Dreams can be reduced by taking the evening dose of varenicline earlier in the day or by skipping the evening dose.

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## Varenicline Troubleshooting

Patients who have successfully quit at 12 weeks may benefit from continuing on varenicline for an additional 12 weeks to prevent relapse. Smokers treated with varenicline for an additional 12 weeks had higher rates of continuous abstinence (weeks 13 through 24: 71 versus 50 percent; weeks 13 through 52: 44 versus 37 percent).

Increasing the dose of varenicline has not been shown to improve smoking cessation rates.

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# Bupropion

Believed to act by enhancing central nervous system noradrenergic and dopaminergic release.

Contraindicated in patients with a seizure disorder or eating disorders. The risk of seizure is dose-dependent.

Common side effects are insomnia, agitation, dry mouth, and headache. Randomized trials have demonstrated the efficacy of bupropion in smoking cessation. Higher quit rates with varenicline than bupropion, while nicotine patch produced comparable cessation rates to bupropion.

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# Bupropion

Start Bupropion SR one week before a smoker's target quit date (takes five to seven days to reach steady-state blood levels).

The recommended dose of bupropion is 150 mg/day for three days, then 150 mg twice a day thereafter for at least 12 weeks.

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## Bupropion

Bupropion 150 mg/day (rather than 300 mg/day) is an option for smokers who do not tolerate the full dose due to side effects.

Two randomized trials found that the 150 mg/day dose was as effective as the 300 mg/day dose and associated with fewer side effects.

Longer duration of treatment can be considered in individual cases, based on the patient's previous quit attempts and patient preference.

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## Nortriptyline

Second-line therapy that has shown moderate efficacy in aiding smoking cessation for individuals who cannot use a first-line agent or who need an adjunct to first-line therapy.

Side effects include dry mouth and sedation.

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## Minimal or Unproven Effect

Clonidine is now generally regarded as having limited efficacy for smoking cessation.

SSRIs, MAOIs and anxiolytic drugs generally have not been shown to be effective for smoking cessation.

Nicotine vaccine is a novel experimental approach to treating tobacco dependence but have not generated adequate antibody responses or demonstrated efficacy versus placebo.

Electronic cigarettes (e-cigarettes) are nicotine delivery devices that use a battery to aerosolize nicotine.

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## Alternative Therapies

Pooled estimates suggest possible short-term effects but there is no consistent, bias-free evidence that acupuncture, acupressure, or laser therapy have a sustained benefit on smoking cessation for six months or more. Lack of evidence and methodological problems mean that no firm conclusions can be drawn.

Well-designed research into acupuncture, acupressure and laser stimulation is justified since these are popular interventions and safe when correctly applied, though these interventions alone are likely to be less effective than evidence-based interventions.

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## AES Question #2

Which intervention has the highest success rates for smoking cessation?

- A. Acupuncture
- B. Varenicline
- C. Nicotine patch
- D. Bupropion

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## ARRANGE

Arrange for follow up.

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## Follow Up

All patients who initiate pharmacotherapy should have initial follow-up (office visit or telephone call) within one to two weeks to assess for side effects, optimize treatment, and to provide reinforcement for smoking cessation if needed.

Further follow-up should be scheduled at three months and one year, and more frequently if necessary.

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## Persistent Smoking

Incorrect use of medication(s)

Intolerance of side effects

Failure of the drug to reduce nicotine withdrawal symptoms, despite correct use of the medication

If the patient is already medication correctly and maximally without sufficient effect at four weeks, the options are to continue the therapy, switch to a different first-line therapy or nortriptyline (a second-line therapy), or consider combining medications by adding another first-line agent. If there has been no response to the initial agent, switching to a different medication is recommended.

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## AES Question #3

You prescribed Mr. Smith varenicline, but he is still smoking. Which action should you perform?

- A. Assess compliance
- B. Ask about side effects
- C. Ask about nicotine cravings
- D. All of the above

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## Combination Therapy

Nicotine patch and varenicline— in a randomized trial, treatment with varenicline and nicotine patch for 12 weeks resulted in a higher rate of continuous abstinence compared with varenicline and placebo patch (49 versus 33 percent) six months after the treatment end. Nicotine or placebo patches were started two weeks before the quit day and varenicline was started one week before the quit day.

Bupropion and varenicline— in a randomized trial, 12 weeks of combination therapy with bupropion and varenicline resulted in higher rates of prolonged abstinence at 12 and 26 weeks than varenicline alone. At 52 weeks, abstinence rates also appeared to be higher with combination therapy, although the difference was not significant. The combination was well-tolerated.

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## Combination Therapy

Bupropion and NRT – in a meta-analysis of 12 randomized trials, there was a nonsignificant trend toward higher rates of abstinence with the combination of NRT and sustained-release bupropion than with NRT alone.

Nortriptyline and NRT – in a meta-analysis, adding nortriptyline to NRT showed a trend toward higher rates of abstinence compared with NRT alone. This result is similar to what was found by adding bupropion to NRT.

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## Coding: Commercial Insurance

99406 Counseling on smoking cessation 3-10 minutes (intermediate)

99407 Counseling on smoking cessation >10 minutes (intensive)

May be bundled. Check with each insurance.

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## Coding: Medicare

Same codes as commercial

Two attempts per year, up to four sessions (intermediate or intensive) per attempt

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## Coding: Medicaid

Many states offer some payment for individual tobacco cessation and treatment counseling for Medicaid patients. For example, the ACA requires states to expand Medicaid coverage of cessation services for pregnant women. You are encouraged to contact your state Medicaid office for coverage information in your specific state.

The Centers for Medicare and Medicaid Services encourage state partners to support smoking cessation by ensuring coverage of all FDA-approved smoking cessation medication (prescription and over-the-counter [OTC]) without a copayment requirement or other financial barrier.

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## Helping Patients Afford Help

Resources for patients who do not have insurance coverage or who have limited coverage by their insurance carrier include the following:

- Quit line: 1-800-QUIT-NOW (1-800-784-8669)
- Flexible spending accounts may be used for smoking cessation
- Employee assistance programs (EAP), in some cases
- Community resources and support groups
- Out-of-pocket spending
- Online resources

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## Practice Recommendations

- Work with your team to screen all patients for tobacco use
- Advise patients to quit every visit
- Assess readiness to change

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## Practice Recommendations

- Offer pharmacologic therapy to all patients who want to quit
- Plan your counseling strategies for pharmacologic therapy (may use staff or handouts)
- Review troubleshooting for patients still smoking

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## Questions



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## Contact Information

- Mary Krebs
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## Resources

Agency for Healthcare Research and Quality. Five Major Steps to Intervention (The "5 A's").

Anthenelli RM, Benowitz NL, West R, et al. Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): a double-blind, randomised, placebo-controlled clinical trial. *Lancet* 2016; 387:2507.

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# Resources

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