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MDQuit NEWSLETTER

SUMMER/FALL 2015 EDITION

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Special Population: Older Adults

As early Baby Boomers enter older adulthood (65+ years), the time has come for health care providers to consider how best to address the smoking cessation needs of this population. While prevalence of smoking among older adults in the U.S. is lower than that of younger generations, older adults are more likely to be heavy smokers and are at heightened risk for chronic diseases such as cardiovascular disease, respiratory conditions, and cancer.^{1,2} Older adults who smoke are also more likely to report mental health problems, such as depression.³ Additional risks include an accelerated rate of cognitive decline and greater likelihood of developing Alzheimer's disease.¹ **In general, adults lose approximately 10 years of life due to smoking-related diseases.**⁴



As adults age and visits to doctors increase, health care providers have more opportunities to encourage older patients to quit smoking. However, this doesn't always happen — patients in one study who were older and in poorer health were less likely to receive smoking cessation advice.⁵ In a recent survey of primary care doctors, 90% reported inquiring about older patients' smoking status, but just over half reported providing older patients with smoking cessation support.⁴

There is always hope for adults who smoke, and it is never too late to quit. Research has shown that adults with 10 years of abstinence can reduce their risk of lung cancer by about 50%.⁶ As for coronary heart disease, former smokers can significantly lower their mortality risk in as little as two years, and by 15 years, risk is lowered to the same level as never-smokers.⁷ And, the majority of older adults **do** want to quit smoking, have made previous attempts, and are most likely to be successful with the right combination of medical and psychosocial interventions.^{8,9}

Considering the immediate and long-lasting benefits of smoking cessation at any age, health care providers have a golden opportunity to engage with their patients and motivate all age groups to embark upon — or continue — their quit journey.

¹Cawkwell, P. B., Blaum, C., & Sherman, S. E. (2015). Pharmacological smoking cessation therapies in older adults: A review of the evidence. *Drugs & Aging*, 1-9. ²Zbikowski, S. M., et al. (2012). A review of smoking cessation interventions for smokers aged 50 and older. *Maturitas*, 71(2), 131-141. ³Almeida, O. P., & Pfaff, J. J. (2005). Depression and smoking amongst older general practice patients. *J. of Affective Disorders*, 86(2/3), 317-321. ⁴Huddleston, L., et al. (2015). Treating tobacco dependence in older adults: A survey of primary care clinicians' knowledge, attitudes, and practice. *BMC Family Practice*, 16(1), 97. ⁵Chen, D., & Wu, L. T. (2015). Smoking cessation interventions for adults aged 50 or older: A systematic review and meta-analysis. *Drug & Alcohol Dependence*, 154, 14-24. ⁶Doolan, D., & Froelicher, E. (2008). Smoking cessation interventions and older adults. *Progress In Cardiovascular Nursing*, 23(3), 119-127. ⁷Dresler, C., & Leon, M. (2007). Tobacco Control: Reversal of Risk After Quitting Smoking. *IARC Handbooks of Cancer Prevention* No. 11. World Health Organization. ⁸CDC (2011). Quitting smoking among adults—U.S., 2001-2010. *MMWR*, 60(44), 1513. ⁹Brown, D. W., et al. (2004). Inpatient smoking-cessation counseling and all-cause mortality among the elderly. *American Journal of Preventive Medicine*, 26(2), 112-118.

**COMING
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**MDQUIT'S
10TH ANNUAL
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CONFERENCE**

**WATCH YOUR
INBOX FOR FUTURE
ANNOUNCEMENTS!**



BH2 Training Update

MDQuit continues state-wide dissemination of its **FREE** training program: “*Breaking the Habit in Behavioral Health (BH2): New Hope for Clients Who Smoke.*” This initiative—to incorporate smoking cessation into behavioral health treatment settings throughout Maryland—involves dissemination and training of flexible and tailored group treatment protocols, and ongoing consultation for implementation of smoking cessation programming into behavioral health agencies. To date, over 600 providers from over 100 behavioral health agencies have received training in smoking cessation for their clients.

In addition to the onsite BH2 trainings provided at Maryland behavioral health agencies, MDQuit offers trainings on a regular basis at UMBC’s South Campus facility (bwtech@UMBC South). Space is still available for the following training:

Friday, December 11th—Multiple Session training (8:30am-4:00pm)

Please notify us of your interest in attending this session by sending an email to trainings@mdquit.org

The training schedule for 2016 will be announced early next year.

Development and dissemination of these trainings have been made possible through initial funding received from Pfizer, Inc., along with subsequent additional funding from the Behavioral Health Administration (BHA - formerly ADA and MHA).



MDQuit Director Carlo DiClemente and Center Specialist Alicia Wiprovnick recently trained an enthusiastic group of counselors from the New Vision House of Hope in Baltimore

“Selling Tobacco to Kids – It’s Not a Minor Thing!”



In connection with their **Responsible Tobacco Retailer Initiative**, the Center for Tobacco Prevention and Control at DHMH announces a new online training module for tobacco retailers at:

www.NoTobaccoSalesToMinors.com

Campaign materials are also available on the website for **free** download. If you have questions about the campaign or would like to order materials, contact:

dhmh.notobaccosalestominors@maryland.gov

FDA Updates Chantix[®] Warning

The FDA’s updated black box [warning](#) on Chantix[®] (Varenicline) includes new information about possible adverse reactions when taking the smoking cessation medication along with alcohol (e.g., decreased tolerance resulting in increased drunkenness, and unusual and aggressive behavior). The warning also highlights an increased risk of seizures and behavior changes when using the drug.¹ Side effects previously reported include hostility, depressed mood, and suicidal behavior.² Such behavioral changes are a common response to nicotine withdrawal following stopping smoking; thus, it is not always clear whether Chantix[®] is responsible.³

Patients who experienced seizures within the first month of taking Chantix[®] either had no history of seizures or their seizure disorder had been under control, suggesting their seizures were likely attributable to the drug.¹ Although Pfizer had proposed removal of the black box warning from its product, the FDA opted to retain its strongest warning on Chantix[®], particularly in light of the new findings.⁴ These warnings warrant serious consideration before initiating smoking cessation treatment with Chantix[®], and all patients using this drug or other pharmacological smoking cessation aids should be monitored by a physician.

¹Food & Drug Administration (2015, March 9). FDA Drug Safety Communication: FDA updates label for stop smoking drug Chantix(varenicline) to include potential alcohol interaction, rare risk of seizures, and studies of side effects on mood, behavior, or thinking. Retrieved from <http://www.fda.gov/Drugs/DrugSafety/ucm436494.htm>.²Medline Plus (2015, March 15). Varenicline. Retrieved from <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a606024.html>.³Stanton, T. (2015, March 10). FDA keeps black box on Pfizer's Chantix, adds new warning about alcohol. FiercePharma. Retrieved from <http://www.fiercepharma.com/story/fda-keeps-black-box-pfizers-chantix-adds-new-warning-about-alcohol/2015-03-10>.⁴CBS News (2015, March 10). New FDA warning for anti-smoking drug Chantix. Retrieved from <http://www.cbsnews.com/news/new-fda-warning-for-anti-smoking-drug-chantix/>



MDQuit was invited by Rebecca Dineen, Assistant Commissioner of Maternal and Child Health at the Baltimore City Health Department, to attend a press conference on July 22 announcing the steady decline in sleep-related infant deaths in Baltimore. MDQuit partners with B'More for Healthy Babies in their efforts to raise awareness of the effects of secondhand smoke on infants and children.

Center Specialist Shayla Thrash (far left) represented MDQuit at the event, joining Mayor Stephanie Rawlings-Blake, Health Commissioner Dr. Leana Wen, and other stakeholders.



Widespread Support for a Raised Minimum Age For Tobacco Purchases

During the 1990's, the Minimum Legal Sale Age (MLSA) for tobacco products in the U.S. became 18 years old.¹ Since then, the federal government has had limited ability to further regulate the MLSA, leaving additional policy decisions up to individual states and municipalities. Over the last several decades, higher tobacco taxes and smoke-free laws at federal and state levels have been used to combat underage tobacco initiation in lieu of raising the MLSA.² However, in the last few years, the MLSA has once again become a topic of discussion. In 2013, New York City became the first locality to raise the MLSA to 21 years old, followed by over 80 other cities and towns across the country.² This year, Hawaii became the first state to mandate a MLSA of 21.

A higher MLSA is expected to have widespread lifesaving potential. A report by the Institute of Medicine predicted that raising the MLSA to 21 will:

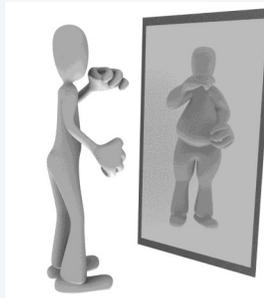
- reduce smoking rates by 12%,
- prevent over 249,000 premature smoking-related deaths, and
- reduce the number of adolescents and young adults who start smoking.³

The report indicates that over half of current smokers began before age 18; thus, an increase in the MLSA will likely prevent — or at the very least, delay — adolescent tobacco use. And the notion of raising the MLSA is gaining popularity among smokers and non-smokers alike: a recent CDC report stated that 75% of adults support a MLSA of 21, including 7 out of 10 smokers.² These findings, along with the broad public health impacts, are prompting states across the U.S. to consider the idea.

¹Tobacco Control Legal Consortium (2015, March). Raising the minimum legal sale age for tobacco and related products. Retrieved from <http://publichealthlawcenter.org/sites/default/files/resources/tclc-guide-minimumlegal-saleage-2015.pdf>; ²Campaign for Tobacco-Free Kids (2015, July 15). Increasing the minimum legal sale age for tobacco products to 21. Retrieved from <https://www.tobaccofreekids.org/research/factsheets/pdf/0376.pdf>; ³Institute of Medicine (2015). Public health implications of raising the minimum age of legal access to tobacco products. National Academies Press: Washington, DC. Retrieved from <http://www.iom.edu/Reports/2015/TobaccoMinimumAgeReport.aspx>

If I Quit Smoking, I Will Gain Weight: Fact or Fiction?

What is it that many people who smoke fear in anticipation of kicking their habit? *The dreaded weight gain.* The belief that weight gain is a consequence of quitting smoking can deter some people from making a quit attempt. While some weight gain post-quit may be rather common, recent literature suggests that this phenomenon is not that simple.



One study in particular¹ indicates that the relation between smoking and weight may be more complex than the basic assumption: *If I quit smoking, I will gain weight.* Recently, a poster at the Endocrine Society's annual meeting in San Diego presented results from an investigation of the effects of quitting on metabolic rates and fat distribution.¹ Participants were physically healthy individuals who smoked between 1/2 - 2 packs-per-day. These individuals were enrolled in an 8-week smoking cessation program — receiving behavioral counseling and medication — and were then followed for 16 weeks. Among those who maintained abstinence from smoking, there was initially a slightly higher concentration of fat in the abdomen — however, this effect was reversed over subsequent months.

Though the fear of weight gain may be a deterrent to quitting smoking for some individuals, in the long term, quitting can result in healthier weight distribution.

¹Lohr, A. (March, 2015). Quitting smoking has favorable metabolic effects. The Endocrine Society. Retrieved from http://www.eurekalert.org/pub_releases/2015-03/tes-qsh030515.php

MDQuit's NEW Online Trainings

Our Fax to Assist training has been revamped and moved from our website to the more interactive LITMOS training platform. To become certified in Fax to Assist and refer clients to the Quitline, use the following link and training code:

<https://mdquittraining.litmos.com/self-signup/>

Training code:

F2A

We have also developed a training to help providers connect clients — especially Medicaid enrollees — to effective tobacco cessation resources, including the Quitline. Trainees are also certified in F2A.

<https://mdquittraining.litmos.com/self-signup/>

Training code:

medicaid



**NEW RESOURCE
ON MDQUIT.ORG:**

[Tobacco 101:](#)

Fact Sheets for a Foundational Knowledge in Tobacco and Cessation



Managing Asthma in Childcare Settings: Reducing Exposure to Environmental Tobacco Smoke

Childcare centers represent a critical point of intervention with regard to reducing exposure to environmental tobacco smoke (ETS) among young children with asthma. According to most recent national estimates, 4.2% of children aged 0-4 years currently have asthma, and nearly 25% of children under the age of 5 in the U.S. regularly spend time in organized childcare facilities.^{1,2} Research suggests that exposure to both secondhand and thirdhand ETS increases risk for developing pediatric asthma, and ETS exposure represents one of the most common asthma attack triggers among children with current asthma.^{3,4,5,6}

Although secondhand smoke has received the most attention as a pediatric asthma trigger, thirdhand smoke exposure has also been shown to impair lung functioning in children.^{5,6} Due to known risks associated with ETS exposure, the National Asthma Education and Prevention Program (NAEPP) recommends keeping childcare centers smoke-free, thereby eliminating exposure to secondhand smoke.⁷ However, the NAEPP does not appear to make any specific recommendations with regard to limiting child exposure to thirdhand smoke.⁷ **Given the hazards associated with thirdhand smoke, it is important to incorporate this additional form of exposure into childcare center policy—and to take steps to reduce exposure to all forms of environmental tobacco smoke.**

¹CDC (2015). Most recent asthma data: National current asthma prevalence, 2013. Accessed at http://www.cdc.gov/asthma/most_recent_data.htm. ²U.S. Census Bureau (2011). Who's minding the kids? Child care arrangements: Spring 2011. Accessed at <http://www.census.gov/prod/2013pubs/p70-135.pdf>. ³CDC (2015). Asthma and secondhand smoke. Accessed at <http://www.cdc.gov/tobacco/campaign/tips/diseases/secondhand-smoke-asthma.html>. ⁴Al-Ghamedi, et al. (2015). Association between asthma prevalence and environmental tobacco smoke (ETS) exposure in schoolchildren from the Pittsburgh region. *J. of Allergy & Clinical Immunology*, 135, S2, AB70. ⁵De La Riva-Velasco, E., Krishnan, S., & Dozor, A.J. (2012). Relationship between exhaled nitric oxide and exposure to low-level environmental tobacco smoke in children with asthma on inhaled corticosteroids. *J. of Asthma*, 49, 673-678. ⁶Ferrante, G., et al. (2013). Third-hand smoke exposure and health hazards in children. *Monaldi Arch Chest Dis*, 79(1), 38-43. ⁷Young, C.A., et al. (2015). Development of a tool to evaluate asthma preparedness and management in child-care centers. *Pediatric Allergy, Immunology, & Pulmonology*, 28, 121-128.

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MDQuit.org

TRUTH INITIATIVE

is the new name for the *American Legacy Foundation*, the non-profit organization known for tobacco control and community activism and engagement, particularly among youth.

<http://truthinitiative.org/>



NOVEMBER 19th:

American Cancer
Society's
*Great American
Smokeout*

and

Tobacco-Free College
Campus Initiative's
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