

VA/DOD Clinical Practice Guidelines



TOBACCO USE TREATMENT



VA/DoD Evidence-Based Practice

Provider Summary

Version 1.0 | 2026



VA/DOD CLINICAL PRACTICE GUIDELINE FOR TOBACCO USE TREATMENT

Department of Veterans Affairs

Department of Defense

Provider Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) guidelines are based on the best information available at the time of publication. The guidelines are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This clinical practice guideline (CPG) is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when providers consider the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Therefore, every health care professional using these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation with a patient-centered approach.

These guidelines are not intended to represent VA or DOD policies. Further, inclusion of recommendations for specific testing, therapeutic interventions, or both within these guidelines does not guarantee coverage of civilian sector care.

Version 1.0 – 2026

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I. Introduction

The Department of Veterans Affairs (VA) and Department of Defense (DOD) Evidence-Based Practice Work Group (EBPWG) was established and first chartered in 2004, with a mission to advise the “...Health Executive Council on the use of clinical and epidemiological evidence to improve the health of the population across the Veterans Health Administration and Military Health System,” by facilitating the development of clinical practice guidelines (CPGs) for the VA and DOD populations.⁽¹⁾ Development and update of VA/DOD CPGs is funded by VA Evidence Based Practice, Office of Quality and Patient Safety. The system-wide goal of evidence-based CPGs is to improve patient health and wellbeing. This CPG’s use of Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach reflects a more rigorous application of the methodology than previous iterations.⁽²⁾

The VA/DOD EBPWG initiated the creation of the VA/DOD Tobacco Cessation CPG in 2024. This CPG provides an evidence-based framework for evaluating and managing adult patients, 18 years or older, who are eligible for care in the VA and/or DOD healthcare systems and may benefit from tobacco cessation. Successful implementation of this CPG will:

- Emphasize the use of patient-centered care using risk factors and event history;
- Minimize preventable complications and morbidity;
- Optimize each patient’s health outcomes and improve quality of life; and
- Assess the patient’s condition and in collaboration with the patient, family, and caregivers, determine optimal treatment.

The full VA/DOD Tobacco Cessation CPG, as well as additional toolkit materials including a pocket card and patient summary, can be found at: [VA/DOD Clinical Practice Guidelines Home](#).

II. Recommendations

The evidence-based clinical practice recommendations listed in the table below were developed using a systematic approach considering four domains as per the GRADE approach (see Summary of Guideline Development Methodology in the full text version of the Tobacco Cessation CPG). These domains include confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient values and preferences, and other implications (e.g., resource use, equity, acceptability).

Table 1. Evidence-based Clinical Practice Recommendations with Strength and Category^{a,b}

Topic	#	Recommendation	Strength ^a	Category ^b
Treatment Engagement	1.	We suggest using motivational interviewing to increase engagement in treatment for tobacco and nicotine use.	Weak for	Reviewed, New-added
Pharmacotherapy Interventions	2.	We recommend the use of FDA-approved pharmacotherapies (e.g., bupropion sustained release, nicotine replacement therapy [NRT], and varenicline) for increasing abstinence from combustible tobacco.	Strong for	Reviewed, New-added
	3.	For patients using nicotine replacement therapy (NRT), we recommend combination therapy (e.g., patch and short-acting NRT) over single NRT products for increasing abstinence from combustible tobacco.	Strong for	Reviewed, New-added
	4.	For patients receiving a single medication, we recommend varenicline over other monotherapies (e.g., bupropion sustained release; single-agent nicotine replacement therapy [NRT]) for increasing abstinence from combustible tobacco.	Strong for	Reviewed, New-added
	5.	In patients using bupropion sustained release, we suggest extending use beyond 12 weeks to maintain abstinence from combustible tobacco.	Weak for	Reviewed, New-added
	6.	There is insufficient evidence to recommend for or against the extended use of varenicline or nicotine replacement therapy beyond standard duration of therapy (12 weeks) to achieve abstinence from combustible tobacco.	Neither for nor against	Reviewed, New-added

Topic	#	Recommendation	Strength ^a	Category ^b
Pharmacotherapy Interventions	7.	We suggest using varenicline or nicotine replacement therapy (NRT) for increasing abstinence from electronic nicotine delivery systems (ENDS).	Weak for	Reviewed, New-added
	8.	We suggest using nicotine replacement therapy (NRT) for increasing abstinence from smokeless tobacco.	Weak for	Reviewed, New-added
	9.	We recommend using varenicline for increasing abstinence from smokeless tobacco.	Strong for	Reviewed, New-added
	10.	We suggest varenicline be started prior to surgery to assist patients in quitting tobacco use.	Weak for	Reviewed, New-added
	11.	There is insufficient evidence to recommend for or against the use of nicotine replacement therapy (NRT) or bupropion for tobacco cessation in the perioperative period.	Neither for nor against	Reviewed, New-added
Alternate Tobacco Products	12.	We suggest against electronic nicotine delivery systems (ENDS) products for improving abstinence from tobacco and nicotine products. (ENDS is classified as a tobacco product and is not FDA approved for any use)	Weak against	Reviewed, New-added
Behavioral Counseling Interventions	13.	We recommend more intensive behavioral counseling (at least four encounters) as compared to less intensive counseling to increase abstinence from tobacco and nicotine products.	Strong for	Reviewed, New-added
	14.	We suggest using text messaging (SMS) programs to increase abstinence from tobacco and nicotine products.	Weak for	Reviewed, New-added
	15.	There is insufficient evidence to recommend any specific behavioral counseling intervention over standard cognitive behavior therapy for tobacco cessation.	Neither for nor against	Reviewed, New-added
	16.	There is insufficient evidence to recommend for or against adding lifestyle interventions (e.g., diet, exercise) to behavioral counseling for tobacco cessation.	Neither for nor against	Reviewed, New-added
	17.	There is insufficient evidence to recommend either for or against smartphone apps for increasing abstinence from tobacco and nicotine products.	Neither for nor against	Reviewed, New-added

Topic	#	Recommendation	Strength ^a	Category ^b
Relapse	18.	If patients return to tobacco use, we suggest immediate repeat treatment with pharmacotherapy and counseling.	Weak for	Reviewed, New-added
Not Ready to Quit Population	19.	In patients not ready to quit (e.g., in the next 30 days), we suggest nicotine replacement therapy (NRT) to increase quit attempts.	Weak for	Reviewed, New-added
	20.	In patients not ready to quit (e.g., in the next 30 days), we suggest varenicline to increase quit attempts and abstinence from tobacco and nicotine products.	Weak for	Reviewed, New-added
	21.	There is insufficient evidence to recommend either for or against medication sampling* for increasing treatment engagement.	Neither for nor against	Reviewed, New-added
Treatment Recommendations for Selected Subpopulations	22.	In patients with stable mental health conditions, we suggest treating tobacco use with pharmacotherapy.	Weak for	Reviewed, New-added
	23.	In patients with stable mental health conditions, we recommend varenicline over single agent nicotine replacement therapy (NRT) or bupropion sustained release to improve continuous abstinence.	Strong for	Reviewed, New-added
	24.	We suggest counseling be adapted to address both tobacco use and co-occurring serious mental illness (e.g., bipolar disorder, schizophrenia, other psychotic disorders).	Weak for	Reviewed, New-added
	25.	In patients being treated for alcohol use disorder/substance use disorder, we suggest concurrently treating tobacco use with behavioral counseling and pharmacotherapy.	Weak for	Reviewed, New-added
	26.	There is insufficient evidence to recommend for or against counseling that combines treatment for tobacco use and depression or post-traumatic stress disorder compared to standard tobacco cessation counseling.	Neither for nor against	Reviewed, New-added
	27.	There is insufficient evidence to recommend for or against the effectiveness of bupropion or nicotine replacement therapy for tobacco cessation during pregnancy.	Neither for nor against	Reviewed, New-added

Topic	#	Recommendation	Strength ^a	Category ^b
Complementary and Integrative Health Interventions	28.	As a standalone therapy, we suggest against acupuncture, mindfulness, or hypnotherapy for abstinence from tobacco and nicotine products.	Weak against	Reviewed, New-added
Neurostimulation Interventions	29.	There is insufficient evidence to recommend either for or against repetitive transcranial magnetic stimulation, transcranial direct current stimulation, and intermittent theta burst stimulation for abstinence from tobacco and nicotine products, reduced use, or cravings.	Neither for nor against	Reviewed, New-added
Interventions Implemented at System-level	30.	We recommend using proactive outreach to increase engagement in treatment for tobacco and nicotine use.	Strong for	Reviewed, New-added
	31.	We suggest the use of contingency management or incentives in combination with behavioral counseling and pharmacotherapy for treating tobacco and nicotine use.	Weak for	Reviewed, New-added
	32.	There is insufficient evidence to recommend either for or against the use of an opt-out approach to increase engagement in treatment for tobacco and nicotine use.	Neither for nor against	Reviewed, New-added

^a For additional information, see Determining Recommendation Strength and Direction in the full text version of the Tobacco Cessation CPG.

^b For additional information, see Recommendation Categorization in the full text version of the Tobacco Cessation CPG.



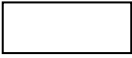

* Medication sampling for smoking cessation medications refers to the practice of providing individuals with a short term supply of medications used to help quit smoking so they can try the medication before committing to a full course of treatment.

III. Algorithm

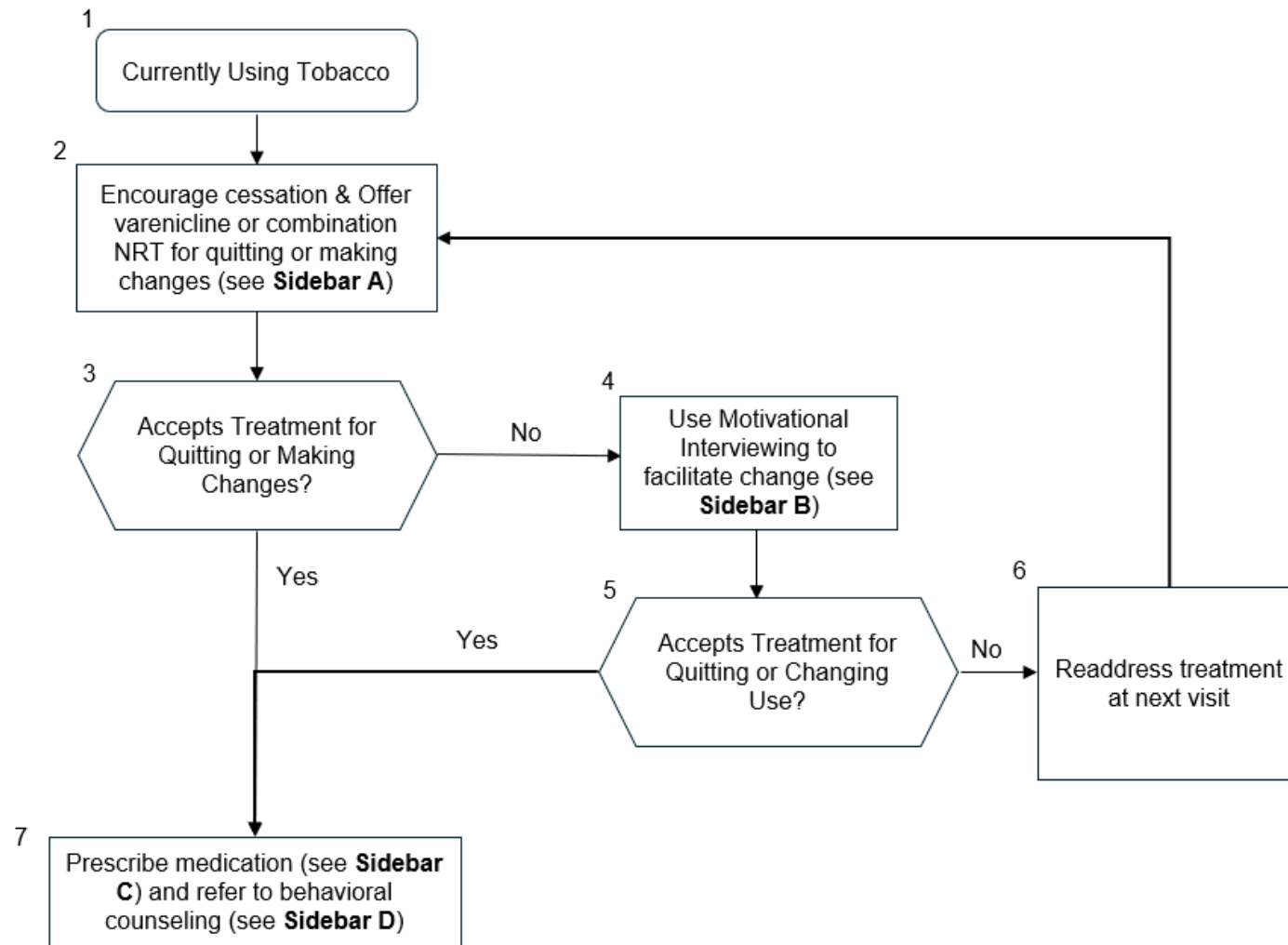
This CPG’s algorithm is designed to facilitate understanding of the clinical pathway and decision-making process used in the management of tobacco cessation. It includes:

- An ordered sequence of steps of care,
- Recommended observations and examinations,
- Decisions to be considered, and
- Actions to be taken

The algorithm is a step-by-step decision tree. Standardized symbols display each step, and arrows connect the numbered boxes indicating the order in which the steps should be followed. (3) Sidebars provide more detailed information to assist in defining and interpreting elements in the boxes.

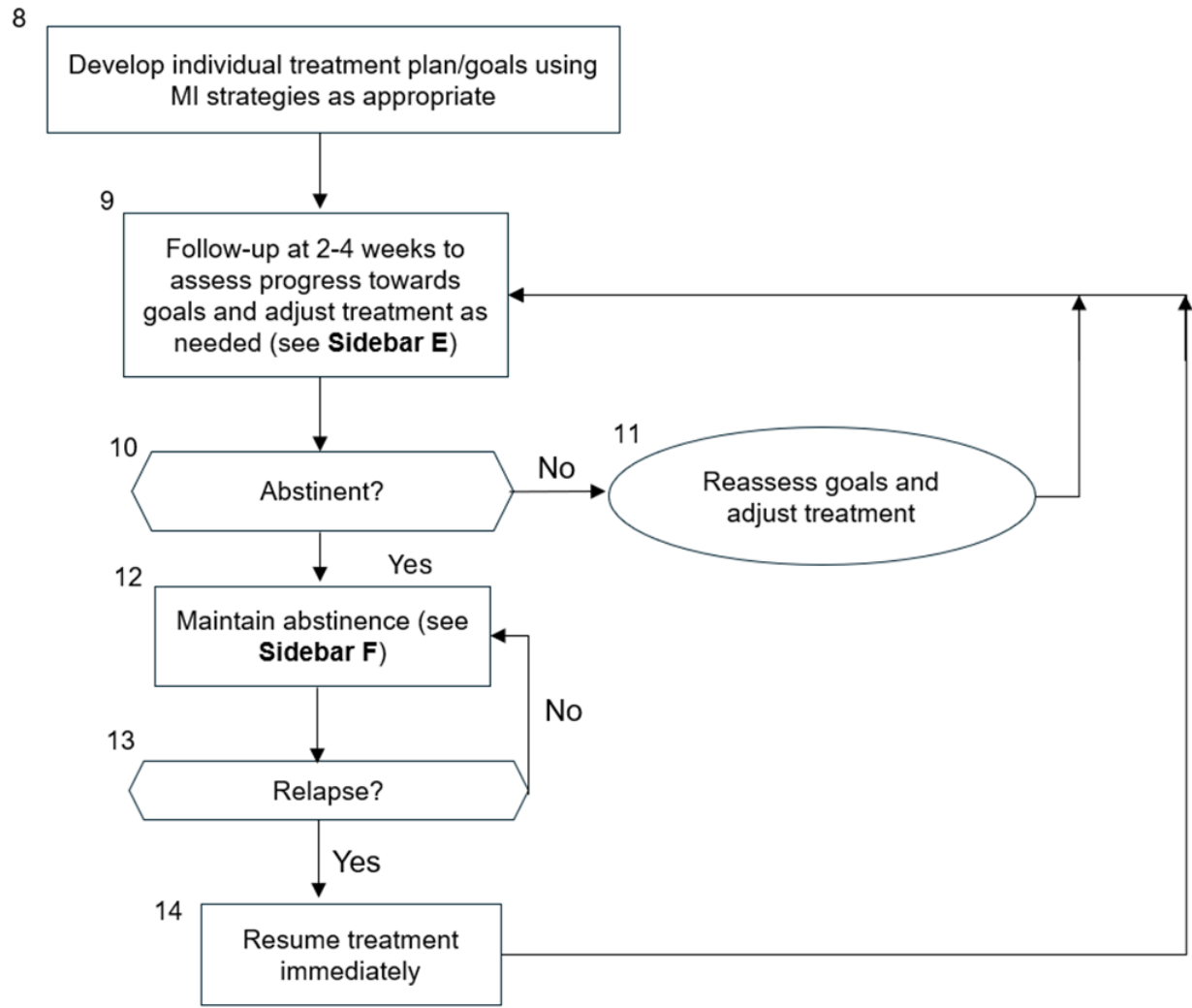
Shape	Description
	Rounded rectangles represent a clinical state or condition.
	Hexagons represent a decision point in the guideline, formulated as a question that can be answered “Yes” or “No”.
	Rectangles represent an action in the process of care.
	Ovals represent a link to another section within the algorithm

Module A: Initial Treatment



Abbreviations: NRT: nicotine replacement therapy

Module B: Treatment Follow-up and Ongoing Care



Abbreviations: MI: Motivational Interviewing

Sidebar A: Treatment Offer Example Script

- *“Quitting tobacco use is the most important thing you can do for your health.”*
(How has using tobacco negatively affected your health or your life?)
- *“Nicotine replacement therapy or varenicline are medications that can help you quit tobacco use and can be used even if you are not ready to set a quit date.”*
- *“You can use medication to help you make some changes like cutting back on your tobacco use. It is safe to use these medications while smoking.”*
- *“What changes would you like to make to your tobacco use at this time?”*
 - Engage in shared decision making to decide on medication and behavioral support plan.
 - Use MI Strategies to enhance motivation for change: asking permission, open-ended questions, reflections, affirmations.

Abbreviations: MI: Motivational Interviewing

Sidebar B: Enhancing Motivation***If ambivalent or not ready for change:***

- Enhance motivation:
 - Assess importance of making changes: *“How important is it for you to stop using tobacco (1=not important, 10= very important)”*
 - Elicit change talk:
 - If important (≥ 8) *“what makes it so important?”*
 - If less important (< 8): e.g., *“why is it a 6 and not a 3?”*. This helps patient to articulate their reasons for considering cessation.
 - Reflect concerns/change talk (state and wait for response): *“X makes it important for you to stop using tobacco”*
 - With permission, discuss your concerns about their use: *“Can I share with you some concerns I have about your tobacco use?”*
Link use to concerns relevant to reasons for visit or patient’s health issues e.g., physical health and disease, mental health, substance use recovery
- Ask what changes patient is considering making
 - Provide menu of change options: *“How do you feel about making changes to your tobacco use? Changing can include cutting down, changing use patterns, using medications before stopping, or stopping entirely. What, if any, of these changes would you like to make?”*
 - Reflect selected goal: and affirm willingness to make a change, e.g., *“Right now you’re ready to cut down. You’ve taken an important step by setting this goal. That shows a lot of commitment.”*
 - If patient still declines to set a goal, reflect and ask permission to revisit in future: *“I understand that right now you don’t want to make any changes to your tobacco use. Is it ok if we discuss this again at our next appointment?”*
- If change goal selected, restate and confirm identified goal: e.g., *“right now you want to work on cutting down”*

If declined treatment OR has set new change goal:

- Offer medication and counseling assistance for meeting selected goal(s)
 - Discuss value of medications and counseling: *“We know that using medications and counseling significantly increases your likelihood of success”*
 - *“What are your thoughts about using medications or counseling?”*
 - *“When you are ready, I can provide you with medications and/or connect you with behavioral support to help you reach your goals”*

* MI Strategies to employ: asking permission, open-ended questions, reflections, affirmations

Abbreviations: MI: Motivational Interviewing

Sidebar C: Pharmacotherapy

■ **Varenicline:**

- Start at 0.5 mg daily for 3 days, then increase to 0.5 mg twice daily, then increase to target dose of 1 mg twice daily

■ **Nicotine Replacement Therapy:** A combination of long acting (patches) and short acting (gum or lozenges) is preferred

- Nicotine patches: 21 mg, 14 mg, and 7 mg
 - Moderate to high nicotine dependence or >10 cigarettes/day; start with 21 mg/day then taper
 - Low nicotine dependence or < 10 cigarettes/day; start with 14 mg/day then taper

PLUS 1 of the following:

- Nicotine gum: 2 mg and 4 mg
 - Bite 1 piece (bite intermittently and park between cheek and gums)
 - May use up to 10 – 12 pieces of gum per day as needed
- Nicotine lozenges: 2 mg and 4 mg
 - Dissolve 1 lozenge orally between cheek and gums
 - May use up to 10 – 12 lozenges per day as needed
- Nicotine nasal spray: 0.5 mg per actuation
 - For one dose use with 1 spray in each nostril
 - May use up to 10-12 doses per day as needed
 - Max dosing is 5 doses per hour

■ **Bupropion (sustained release):**

- 150 mg daily for 3 days; then increase to 150 mg twice daily

* See Appendix H for a more detailed discussion of pharmacotherapy.

Abbreviations: mg: milligrams

Sidebar D: Behavioral Support

- Behavioral support can be delivered individually, in groups, over the phone, or digitally.
- Effective behavioral support includes the following components:
 - Enhance motivation for change
 - Help develop a plan for making a quit attempt or making changes
 - Discuss strategies for coping with craving and triggers (e.g., alcohol, other people who use tobacco at home, stress).
 - Encourage use of additional resources for support (e.g., 1-855-QUIT-VET or SmokefreeVET text)
- Referral Resources:
 - Quit Lines (1-800-QUIT-NOW; 1-855-QUIT-VET (for VHA enrollees)
 - Digital Interventions (Veterans.Smokefree.gov; ycq2.org)

Sidebar E: Assessing Treatment Plan Progress

- Ask open-ended questions about making changes or quitting
 - E.g., *“How have you been doing since we last talked?”*
- Ask about experience with taking cessation medications
 - *“Are you noticing any side effects?”*
 - *“How are the medication(s) helping with withdrawal or resisting the urge to smoke?”*
- Ask about needing medication refills
- Ask about use of behavioral strategies
 - *“What coping strategies are working for you?”*
- Ask patients who were working on making changes to their smoking if they are now ready to make a quit attempt
 - If yes, connect patient to cessation-focused treatment
 - If no, encourage continued medication use for making changes and provide motivational counseling

Sidebar F: Maintaining Tobacco-Free Lifestyle

- Congratulate patient on achieving abstinence and discuss immediate improvements to their health
- Discuss and reinforce positive changes:
 - Ask about any improved symptoms, since early “wins” help promote cessation.
 - Improved health and feeling better physically
 - Financial savings and benefits
 - Improved appearance including reduced wrinkling/aging of skin and whiter teeth
- Discuss triggers and how to manage or avoid them, such as:
 - Withdrawal symptoms
 - Fear of failure or guilt after slips
 - Weight gain
 - Enjoyment of tobacco
 - Being around other people who use tobacco
- Discuss improved health benefits
 - Improved taste and sense of smell
 - Heart rate and blood pressure will decrease
 - Circulation improves and lung function increases
 - Coughing and shortness of breath decrease
 - Risk of coronary heart disease and stroke decreases
 - Risk of mouth, throat, bladder, esophagus, cervical, pancreatic and lung cancer decreases
- Focus on new health activities that can be enjoyed
 - Walking, biking, hiking, swimming, dancing, gardening or yoga

IV. Highlighted Features of this Guideline

This is a new VA/DOD Evidence-Based CPG. The major strengths of this CPG are the use of GRADE methodology and the coordination and collaboration among the members of the multidisciplinary CPG Development Work Group, ensuring a broad representation of providers engaged in the care of patients using tobacco and nicotine. The following paragraphs summarize selected important clinical recommendations and findings for providers who use this CPG. The Work Group also developed an [Algorithm](#) to support clinical workflow that aligns with the evidence-based recommendations and insights. This CPG also includes [Research Priorities](#), which list areas the Work Group identified as needing additional research. To accompany this CPG, the Work Group also developed toolkit materials for providers and patients, including a provider summary, a patient summary, and a quick reference guide, which can be found at <https://www.healthquality.va.gov/index.asp>.

The Work Group developed 32 new evidence-based recommendations; including 7 “Strong for” recommendations, 13 “Weak for” recommendations, 10 “Insufficient evidence to recommend for or against” recommendations, and 2 “Weak against” recommendations. Most of the recommendations in this guideline are directed toward healthcare providers; however, three recommendations are about interventions directed to healthcare organizations for system-wide implementation.

After a systematic review of the evidence on tobacco and nicotine cessation interventions, the Work Group found the following:

1. Use of motivational interviewing increases engagement in treatment for tobacco and nicotine cessation. (*Weak for*)
2. Pharmacotherapy:
 - a. Food and Drug Administration (FDA)-approved pharmacotherapies are recommended for attaining abstinence from combustible tobacco. (*Strong for*)
 - b. For patients using nicotine replacement therapy (NRT), combination treatment with patch and short-acting NRT is more effective than using a single form of NRT for increasing abstinence. (*Strong for*)
 - c. As a single agent, varenicline is recommended above other medications for attaining abstinence from all tobacco and nicotine products. (*Strong for*)
 - d. There is insufficient evidence for using varenicline or NRT beyond the standard duration (12 weeks). (*Neither for nor against*)
 - e. In patients using bupropion sustained release, we suggest extending use beyond 12 weeks to maintain abstinence from combustible tobacco. (*Weak for*)
 - f. To achieve abstinence from smokeless tobacco or ENDS, both varenicline (*Strong for*) or NRT (*Weak for*) are effective.
 - g. For patients undergoing surgery, starting varenicline pre-operatively assists with tobacco cessation. (*Weak for*)
 - h. For tobacco cessation, the Work group suggests against using ENDS, which is not approved by the FDA for treatment of any medical condition. (*Weak against*)
3. Intensive behavioral counseling increases abstinence (4 or more sessions). (*Strong for*)
4. Text messaging programs increase abstinence. (*Weak for*)
5. For patients who attain abstinence but then resume using tobacco or nicotine products, immediate repeat treatment is suggested. (*Weak for*)
6. For patients not yet ready to quit tobacco or nicotine products, NRT or varenicline may be offered to

increase quit attempts and improve abstinence. (*Weak for*)

7. For individuals who use tobacco and nicotine and have a stable co-occurring mental health condition or alcohol/substance use disorder, concurrent treatment with pharmacotherapy and behavioral counseling for tobacco or nicotine use is suggested. (*Weak for*)
8. Complementary and Integrated Health interventions (e.g., acupuncture, mindfulness, and hypnotherapy) alone are not effective treatments for attaining abstinence from tobacco and nicotine products. (*Weak against*)
9. Healthcare organizations can implement system-level interventions such as proactive outreach (*Strong for*) and contingency management (*Weak for*) to those who use tobacco and nicotine to increase engagement with treatment.

V. Scope of the CPG

This CPG is based on published clinical evidence and related information available through December 10, 2024. It is intended to provide general guidance on best evidence-based practices (see Appendix A in the full text of the Tobacco Cessation CPG for additional information on the evidence review methodology). Although the CPG is intended to improve the quality of care and clinical outcomes (see [Introduction](#)), it is not intended to define a standard of care (i.e., mandated or strictly required care).

This CPG is intended for use by VA and DOD primary care providers (PCP) and others involved in the health care team who provide health care to tobacco or nicotine users (e.g., physicians, nurses, nurse practitioners, physician assistants, dentists, respiratory therapists, psychologists, social workers and counselors, pharmacists, and others).

This CPG is intended for adults (18 years or older) with use of a tobacco or nicotine product of any variety (including smoking, electronic nicotine delivery system, smokeless tobacco, dissolvable nicotine pouches, etc.) who are users of the VA and DOD healthcare systems. This includes Veterans and Service members as well as their eligible adult dependents.

VI. Methods

The Work Group used the GRADE approach to craft each recommendation and determine its strength. Per the GRADE approach, recommendations must be evidence based and cannot be made based on expert opinion alone. The GRADE approach uses the following four domains to inform the strength of each recommendation (see Determining Recommendation Strength and Direction).⁽⁴⁾

1. Balance of desirable and undesirable outcomes
2. Confidence in the quality of the evidence
3. Patient or provider values and preferences
4. Other implications, as appropriate (e.g., resource use, equity, acceptability, feasibility, subgroup considerations)

Using these four domains, the Work Group determined the relative strength of each recommendation (*Strong or Weak*). The strength of a recommendation is defined as the extent to which one can be confident that the desirable effects of an intervention outweigh its

undesirable effects and is based on the framework above, which incorporates the four domains. (4) A Strong recommendation generally indicates High or Moderate confidence in the quality of the available evidence, a clear difference in magnitude between the benefits and harms of an intervention, similar patient values and preferences, and understood influence of other implications (e.g., resource use, feasibility).

In some instances, insufficient evidence exists on which to base a recommendation for or against a particular therapy, preventive measure, or other intervention. For example, the systematic evidence review might have found little or no relevant evidence, inconclusive evidence, or conflicting evidence for the intervention. The way this finding is expressed in the CPG might vary. In such instances, the Work Group might include among its set of recommendations a statement of insufficient evidence for an intervention that might be in common practice although it is unsupported by clinical evidence and particularly if other risks of continuing its use might exist (e.g., high opportunity cost, misallocation of resources). In other cases, the Work Group might decide to exclude this type of statement about an intervention. For example, the Work Group might remain silent where an absence of evidence occurs for a rarely used intervention. In other cases, an intervention might have a favorable balance of benefits and harms but might be a standard of care for which no recent evidence has been generated.

Using these elements, the Work Group determines the strength and direction of each recommendation and formulates the recommendation with the general corresponding text as shown in [Table 2](#).

Table 2. Strength and Direction of Recommendations and General Corresponding Text

Recommendation Strength and Direction	General Corresponding Text
Strong for	We recommend . . .
Weak for	We suggest ...
Neither for nor against	There is insufficient evidence to recommend for or against . . .
Weak against	We suggest against . . .
Strong against	We recommend against . . .

VII. Guideline Development Team

Table 3. Guideline Work Group and Guideline Development Team

Organization	Names*
Department of Veteran Affairs	Dana Christofferson, PhD (Champion)
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	Patrick Calhoun, PhD
	Scott Sherman, MD, MPH
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	Sophie Roberts, BS
	Dan Sztubinski, BS
	Emilio Berdiel, MPH
	Aggee Loblack, MPH
	Rebecca Rishar, MLIS
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	Nancy Sullivan, BA
Duty First Consulting	Kate Johnson, BS
	Anita Ramanathan

* Additional contributor contact information is available in Appendix C in the full text version of the Tobacco CPG.

VIII. Patient-Centered Care

VA and DOD encourage providers to be sensitive to demographic, cultural, and other differences that affect patients' values, needs, and preferences. Patient-centered care is aimed at treating the condition while also optimizing the individual's overall health and well-being. Regardless of the care setting, all patients should have access to individualized evidence-based care. Patient-centered care can decrease patient anxiety, increase trust in providers, and improve treatment adherence. (5.6) A holistic health approach (<https://www.va.gov/wholehealth/>) empowers and equips individuals to meet their personal health and well-being goals. Good communication is essential and should be supported by evidence-based information tailored to each patient's needs. Guideline recommendations should be applied in a holistic approach to care that is patient-centered, culturally appropriate, and available to people with limited literacy skills and physical, sensory, or learning disabilities.

IX. Patients with Co-occurring conditions

Co-occurring conditions can modify the degree of risk, impact diagnosis, influence patient and provider treatment priorities and clinical decisions, and affect the overall approach to tobacco cessation management. Many Veterans, active-duty Service members, and their families have one or more co-occurring conditions. Because tobacco cessation is often accompanied by co-occurring conditions, collaborative management with other care providers is often best. Some co-occurring conditions may require early specialist consultation to determine necessary changes in treatment or establish a common understanding of how care should be coordinated.

X. Shared Decision Making

Throughout this VA/DOD CPG, the authors encourage providers to focus on shared decision making (SDM). The SDM model was introduced in *Crossing the Quality Chasm*, an Institute of Medicine (IOM) (now called the National Academy of Medicine [NAM]) report, in 2001.(7) It is readily apparent that patients, together with their providers, make decisions regarding their plan of care and management options. Providers must be adept at presenting information to their patients regarding individual treatments, expected outcomes, and levels and/or locations of care. Providers are encouraged to use SDM to individualize treatment goals and plans based on patient capabilities, needs, goals, and preferences.

XI. Additional Information on Tobacco Use and Treatment

A. Assessment of Current Tobacco Use

It is essential that providers and healthcare delivery systems consistently identify and document tobacco use status and treat every patient seen in a healthcare setting who uses tobacco. All patients should be asked about their tobacco use at every clinical encounter. This should include assessing both the types of tobacco used (e.g., cigarettes, ENDS, pipe, cigarillos) as well as the frequency of use. All patients should be informed that quitting tobacco is the best thing they can do for their health, and all patients should be provided with evidence-based treatment for their tobacco use, regardless of their readiness to make a quit attempt.

A.1. Tobacco Treatment Models. Two different tobacco use assessment models guide current routine care: the 5A's of Treatment Tobacco and Ask, Advise, Act.

5A's of Treating Tobacco

A sk about tobacco use
<i>Do you use any nicotine or tobacco products such as cigarettes or ENDS? What type do you use? How frequently do you use it each day or week (if not daily)?</i>
A dvice the patient to quit using the nicotine or tobacco product using a clear, personalized message
<i>Stopping your use of cigarettes (or other nicotine or tobacco products) is the most important thing you can do for your health (personalize to the patient's specific health conditions).</i>
A ssess readiness to quit
<i>I can help connect you with treatment that can help you quit. Are you interested in making a quit attempt?</i>
A ssist with treatment for patients who are ready to quit and not ready to quit
<i>If ready to try quitting, provide cessation treatment (section B). If not ready to quit in the near future, provide treatment for those not ready to quit (section C).</i>
A rrange follow-up and support
<i>All patients who initiate tobacco treatment should receive follow-up and be referred for additional support (see referral sources in section E).</i>

Ask, Advise, Act

A sk about tobacco use
<i>Do you use any nicotine or tobacco products such as cigarettes or ENDS? What type do you use? How frequently do you use it each day or week (if not daily)?</i>
A dvice patient to quit using the nicotine or tobacco product using a clear, personalized message
<i>Stopping your use of cigarettes (or other nicotine or tobacco products) is the most important thing you can do for your health (personalize to the patient's specific health conditions).</i>

Act

Provide medication and counseling support. Refer and connect with additional support (section E). Check on progress and adjust support.

B. Interventions For Adults Ready to Set a Quit Date in the Next 30 Days*Treatment Overview*

Tobacco dependence treatments are effective across a broad range of populations. Both behavioral interventions and pharmacotherapy alone can increase the likelihood of achieving abstinence, but the combination of counseling with medication is most effective relative to either alone for smoking cessation.(8) Providers should encourage every patient willing to make a quit attempt to use a combination of recommended pharmacotherapy and behavioral support.

Pharmacotherapy

There are effective medications for treating smoking. Providers should encourage the use of medication by all patients who use tobacco except when medically contraindicated. There are seven FDA-approved medications that have been shown to increase long-term smoking abstinence (varenicline, bupropion sustained release, nicotine patch, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray; see Pharmacotherapy [Appendix H](#) for use instructions). Medications can be combined to increase their effectiveness, especially long-acting NRT (patch) with a short-acting formulation (nicotine gum or lozenge).(8,9) Follow-up is recommended within about 2-4 weeks of starting medication to assess for side effects, provide support, and encourage medication adherence. If the patient relapses, pharmacotherapy should be continued to help reinstate abstinence.(8)

Behavioral Treatment

It is recommended that patients making a quit attempt should receive behavioral treatment in addition to medication. Evidence suggests that there is a dose dependent relationship between the intensity of counseling and treatment success.(8) Effective behavioral treatment can be provided in person (individually or group) or over the phone.(10) Therefore, it is important to connect patients with additional sources of behavioral support to increase their likelihood of success (see referral resources in [Section E](#)). A variety of behavioral approaches have been found to be effective for smoking cessation (see Psychotherapy [Appendix I](#)). Several counseling elements have been identified as effective components of behavioral support. Behavioral treatments should enhance motivation, help develop a quit plan, review and learn from past quit attempts, discuss strategies for coping with craving and environmental triggers (e.g., alcohol, living with people who smoke, social situations), and encourage the use of additional sources of social support.(8) Counseling should also address misconceptions of medication (e.g., NRT is addictive) to increase medication adherence.(8)

C. Interventions For Adults Who are Not Ready to Quit

All adults who use tobacco should be provided with tobacco treatment regardless of their readiness to quit. Evidence supports the effectiveness of NRT and varenicline to support intermediate goals such as smoking reduction to encourage quit attempts and promote abstinence.(11,12) Adults not ready to quit should be offered NRT (nicotine patch, gum, mini-lozenge) or varenicline to help them make changes to their smoking. Providers should help

patients identify a smoking change goal that feels right for them (e.g., reducing smoking heaviness, increasing time between cigarettes, delaying smoking, or eliminating smoking in specific situations). Counseling support, if provided, should emphasize feelings of competence and self-efficacy resulting from the practice of smoking reduction or pattern changing skills. Patients who become ready to make a quit attempt should be provided with cessation focused counseling and pharmacotherapy (i.e., if already using nicotine-mini lozenge, include nicotine patch to support quitting).[\(13\)](#)

D. Interventions For Pregnant Adults

It is recommended that pregnant adults receive behavioral counseling. Message tailoring for pregnant adults and increased counseling intensity has been shown to increase the overall effectiveness of counseling.[\(9\)](#)

E. Referral Resources

Evidence supports the effectiveness of telephone quit lines.[\(14,15\)](#) Providers should refer patients to quit lines (1-800-QUITNOW; 1-855-QUIT-VET) for additional counseling and support. Digital smoking treatment Interventions (e.g., Smokefree.gov, Veterans.Smokefree.gov) can also recommended to patients as a strategy for increasing support.[\(16\)](#)

XII. References

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Access to the full guideline and additional resources is available at:
<https://www.healthquality.va.gov/>.

