

Office of Behavioral and Social Sciences Research (OBSSR),
Office of the Director, NIH
Dr. David B. Abrams

Project Update

<http://obssr.od.nih.gov/>

The OBSSR mission is to stimulate behavioral and social sciences research throughout NIH and to integrate these areas of research more fully into others of the NIH health research enterprise, thereby improving our understanding, treatment, and prevention of disease. The following funding programs may have relevance to Consumer Demand activities, as they are initiatives to which OBSSR is contributing in order to improve communication and use of evidence-based health-related information (find these at: <http://grants1.nih.gov/grants/guide/index.html>):

- Community Participation In Research
- Understanding and Promoting Health Literacy
- Dissemination and Implementation Research in Health

OBSSR is in the process of updating its strategic plan and is seeking input from interested parties. Several areas of emphasis that have emerged during this process may facilitate efforts to increase consumer demand for and use of health-related information and interventions. One such area is research to strengthen our understanding of how the findings of health research are best disseminated to stakeholders, and how this information is then best translated and implemented as effective policies and practices. Increasing the understanding and adoption of interdisciplinary, systems-level methods and technologies to address public health problems has also emerged as a key priority.

Office of Portfolio Analysis and Strategic Initiatives (OPASI), Office of the Director, NIH

Dr. Raynard S. Kington, Acting Director

<http://opasi.nih.gov/>

Formally introduced in September 2005, OPASI will coordinate with NIH Institutes and Centers (ICs) and external stakeholders to address trans-NIH research priorities, and to help fill knowledge gaps. Although OPASI will not have grant-making authority, it will provide an “incubator space” to jump start trans-NIH initiatives and support ICs that will take the lead on priority projects on a time-limited basis (5 to 10 years). The Office will identify scientific investment opportunities based on proposals from individual scientists, stakeholders or organizations outside NIH, and on data about the burden of illness. The turnover of projects will ensure that sufficient funds are available for continuous development of new, trans-NIH efforts.

All NIH ICs are required to put an equal percentage of their budget into a Common Fund to support OPASI, growing from 1.1% in FY 2006 to ~1.7% in FY 2008. Over time,

contingent upon growth of the NIH budget, the Common Fund will increase up to 5% of the total NIH budget, dependent on and consistent with identified trans-NIH scientific opportunities and public health needs.

OPASI has recommended that the following criteria be considered when evaluating proposals:

1. Is the initiative truly transforming – will it dramatically change the content or the process of medical research in the next decade?
2. Would outcomes from the initiative be used by, and synergize the work of, many ICs?
3. Can the initiative be implemented by one or two ICs, or does it require participation from NIH as a whole?
4. Can the NIH afford not to do it?
5. Will the initiative be compelling to NIH stakeholders, especially the public?
6. Does the initiative position the NIH to do something that no other entity can or will do?
7. Does the initiative involve science that “falls between the cracks”?

During the summer of 2006, OPASI will hold stakeholder meetings across the U.S. to solicit feedback and to encourage development and submission of proposals. The first round of selected proposals will be funded in FY 2008.

NAQC's Quitline Survey - 2005

Linda A. Bailey

Project Update

In May 2006, NAQC shared its preliminary results from the 2005 quitline survey with members at regional meetings in San Diego and Atlanta. A powerpoint of the preliminary US findings is attached for CDR members. Final results will be posted on NAQC's website

(www.naquitline.org) and shared at the WCTOH via a publication entitled "Quitlines of North America and Europe" (available at booth #125) and also at a Saturday morning session (8:30 a.m.). Please join us for these events.

Some highlights from the preliminary results for the US include:

- *Product and service delivery design:* All 52 jurisdictions (states, DC, and Puerto Rico included) participated in the survey. Since 2004, the number of states offering proactive service has increased to 52, the number of states with fax referral has more than doubled, and the number of states providing free NRT has increased from 8 to 18.
- *Funding:* The range of funding for quitline services varied from \$40K to 4.2M, with a mean of \$828 and median of \$622. The median for 2005 is about \$100K more than in 2004. For quitline promotion, the budgets ranged from \$20K to 5.5M, with a mean of \$817 and a median of \$206. The median was about \$300 less than in 2004. For tobacco control programs, the budgets ranged from \$280K to 93.4M, with a mean of \$12.6M and a median of \$6.1M. [Note: We are exploring the decrease in median promotion budget, and think it may be due to the launch of new quitlines with funding only from CDC. The CDC funds can not be used for promotion, so some states may have very low or no promotion budgets.]
- *Utilization:* This is the first year we have collected utilization information in the survey. The mean number of calls to quitlines is 10.2K and the mean calls from tobacco users is 5500. For the 18 states that provide free medications, the number of free quit aids provided to unique tobacco users ranged from 7450 in NY to 50 in VT, with a median of 2200.

Harvard School of Public Health and
Dana-Farber Cancer Institute
Elizabeth Barbeau

Project Update

Increasing coverage for smoking cessation treatments through labor-management health and welfare funds

Tobacco use is largely concentrated among the working class, and unions are a viable channel for reaching this population. One way that labor unions can reduce tobacco's burden on their membership is to provide full financial coverage for cessation treatments through labor-management health and welfare funds. These funds, which are jointly managed by labor and management trustees, provide health insurance to 10 million unionized workers and their dependents in the US, through some 1,600 separate funds across the country. According to the one peer-reviewed study on these funds, published by our group, only 29% of funds affiliated with a single large national union covered any type of smoking cessation service, and very few provided comprehensive treatment coverage in accord with US Public Health Service guideline for treating tobacco dependence. The 1,600 health and welfare funds are not governed by any single entity and operate independently of one another. This means that each fund determines its own coverage policies, although funds share information with one another, providing the potential for development of similar coverage policies.

This one-year project, funded by the UCSF Smoking Cessation Leadership Center, builds upon our prior research in this area and aims to develop a national campaign to stimulate increased coverage for cessation treatments among union health and welfare funds. The major goals of our project are to: (1) engage high-profile labor-management health and welfare funds and other key stakeholders in devising a national campaign strategy and related messages for increasing coverage and demand for tobacco cessation treatments through these funds; and (2) identify several high-profile funds that have adopted benefits plans that meet the US Public Health Service guideline for treating tobacco dependence, investigate why they opted to provide coverage, and promote their 'stories' to begin to change social norms within labor. We will seek additional project funding to implement and evaluate the effects of the national campaign on coverage and on plan member use of cessation treatments.

These insurance funds are critical to policy efforts on smoking cessation for two reasons. First, health and welfare funds are unique policy targets for systems-level interventions. By design, these funds cover workers throughout their adult working years and into retirement; workers are covered even as they move between employers, as is the case for construction workers on short-term assignments with different employers, for example. This means that health and welfare funds bear fully the costs of tobacco-related and other diseases that occur, and more importantly, reap the financial benefits of diseases that are prevented. The rapid turnover experienced by traditional health insurers presents a financial disincentive for prevention efforts; health and welfare funds, in contrast, capture returns on investment associated with prevention. The lack of turnover sets these health and welfare funds apart from most other health insurers in which

benefits paid for by one plan may be accrued by another as members change jobs and plans. Furthermore, the vast majority of health and welfare funds are self-insured, meaning that they bear fully the costs and benefits of their coverage decisions. In essence, these funds resemble a would-be national health plan in which beneficiaries would be covered throughout the lifecourse and all costs and benefits would be accrued to one entity. The rising costs of health care have become a major bargaining issue between labor and management, making it harder for labor to win wage increases. Effective prevention of tobacco-related health care costs may provide an attractive incentive for both labor and management fund trustees to improve coverage of cessation treatments. The funds are jointly governed by an equal number of labor and management trustees, and our project will involve representatives from each group so that our messages and strategies are responsive to both audiences.

A second important reason to study tobacco cessation services in health and welfare funds is that they provide health insurance to millions of workers employed in blue-collar and service occupations-- workers who are at greatest risk of smoking. In 2000, 35% of blue-collar workers were smokers, compared to 20% of white-collar workers, with occupational class remaining a significant predictor of smoking after controlling for education, income, race/ethnicity, sex, and age. Furthermore, blue-collar workers smoke more heavily and are less successful in quitting despite a similar rate of quit attempts, compared to other workers. Based on the prevalence of smoking among blue collar and services workers and the number of unionized workers in the US (16.3 million), most of whom work in blue collar and service occupations, we estimate that unions represent 5.6 million of the roughly 44.5 million smokers in the US. It is essential that workers interested in quitting tobacco use have access to affordable treatment, and for many unionized workers, treatment can be covered through health and welfare funds. In a separate study underway, with funding from the Robert Wood Johnson Foundation, we are conducting a national survey of health and welfare funds to assess the nature and extent of coverage of cessation treatments, and factors that promote or inhibit coverage. The project described herein extends that research study by providing us with resources to act upon our findings to bring about increased coverage.



SMOKING AND PREGNANCY: THE HARMS OF CONTINUED SMOKING AND THE BENEFITS OF QUITTING

A recent study in the journal Tobacco Control found coverage of cessation services for pregnant women on Medicaid led to “higher rates of quitting and continued cessation.”¹

Key Points

- Tobacco use during pregnancy causes serious harm to the fetus.
- Tobacco cessation saves lives.
- Tobacco cessation saves money – preventing just one smoking-related low birth weight baby can result in the avoidance of more than \$40,000 in health care expenditures.²

The Problem

According to the U.S. Surgeon General, a pregnant woman who smokes is 1.5 to 3.5 times more likely than a non-smoker to have a low-birth weight baby.³ Numerous studies have found that smoking and exposure to secondhand smoke among pregnant women is a major cause of spontaneous abortions, stillbirths, and sudden infant death syndrome (SIDS) after birth.⁴ According to a meta-analysis of published studies, tobacco use is responsible each year for 19,000 to 141,000 spontaneous abortions; 1,900 to 4,800 infant deaths caused by perinatal or pre-birth disorders; and 1,200 to 2,200 deaths from SIDS.⁵ Almost one quarter of all SIDS deaths have been attributed to prenatal maternal smoking; and fetal mortality rates are 35 percent higher among pregnant women who smoke than among nonsmokers.⁶

Health Benefits to Infants of Cessation During Pregnancy

- According to the U.S. Surgeon General, infants of women who quit smoking by the first trimester have weight and body measurements comparable to infants of nonsmokers.⁷
- Prenatal smoking cessation programs have been shown to have a protective effect on intrauterine growth retardation.⁸

Disproportionate Impact on Medicaid

- Conservative estimates indicate that at least one out of every ten pregnant women smoke, accounting for half a million births per year.⁹ However, according to the Centers for Disease Control and Prevention (CDC), pregnant women on Medicaid are 2.5 times more likely to smoke than pregnant women not on Medicaid¹⁰ and a separate study found that Medicaid provides health insurance coverage to 60-70% of all pregnant smokers.¹¹
- The total cost to Medicaid (and tax payers) of adult smoking in 1997 was estimated to be more than \$17 billion, or 12.1% of all Medicaid expenditures (this estimate excludes neonatal health care costs).¹²
- According to joint estimates by the CDC and the Centers for Medicare and Medicaid Services, smoking-attributable neonatal health care costs for Medicaid total almost \$228 million, or about \$738 per pregnant smoker.¹³

Estimated Costs of Interventions to Reduce Prenatal Smoking

- In a managed care setting, a comprehensive smoking cessation benefit (counseling and pharmacotherapy) costs less than \$5.92 per member per year (about \$0.40 per month).¹⁴
- A 15-minute counseling session provided to a pregnant woman by a nurse, along with written materials, costs approximately \$6.00 per patient.¹⁵

Budget/Economic Benefits of Prenatal Smoking Cessation Interventions

- For every \$1 spent on smoking cessation for pregnant women, an estimated \$3 in reduced neonatal intensive care costs could be saved.¹⁶
- A single percentage point decline in smoking prevalence among pregnant women would prevent 1,300 cases of low birth weight among babies annually and save \$21 million in direct medical costs (1995 U.S. dollars).¹⁷
- According to the CDC, if 25% of pregnant smokers on Medicaid receive counseling that achieves an 18% quit rate, almost \$10 million in excess Medicaid neonatal health care costs could be averted. If participants receive one counseling session that costs \$30 and this results in an 18% quit rate, Medicaid could save almost \$3.50 in averted neonatal medical expenditures for every \$1 spent on counseling pregnant smokers to quit.¹⁸

Comparison to Other Preventive Services

- Evidence-based tobacco cessation can more than double or triple a smoker's chances of quitting successfully compared to quitting "cold-turkey".¹⁹
- A study in the July 2001 *American Journal of Preventive Medicine* ranked the effectiveness of various clinical preventive services recommended by the U.S. Preventive Services Task Force, using a one to ten scale, with ten being the highest possible score.²⁰ Of the thirty preventive services evaluated, tobacco cessation ranked second in its degree of effectiveness, scoring a nine out of 10 (the highest ranking was for childhood vaccines which scored a 10). Among other preventive services covered by Medicaid, colorectal cancer screening received a score of eight and mammography screening scored a six.

What Should A Medicaid Cessation Benefit for Pregnant Women Look Like?

A tobacco cessation benefit for pregnant women who use tobacco should be consistent with the recommendations of the U.S. Public Health Service's (PHS) clinical treatment guidelines, *Treating Tobacco Use and Dependence*. According to the PHS guidelines, pregnant women should be offered "extended or augmented psychosocial interventions that exceed minimal advice to quit" and that such interventions should be conducted throughout the pregnancy.²¹ Pharmacotherapy (drug treatment) should only be considered "when a pregnant woman is otherwise unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking."²² Therefore, pregnant women (after consulting with their treating physician/health care professional) should have access to all FDA approved smoking cessation drugs to help them quit if the first-line intervention (counseling) does not succeed. Further, any proposal should remain current with the scientific literature and therefore should remain consistent with either the current version of the PHS guidelines or any subsequent revisions to those guidelines.

Campaign for Tobacco Free Kids, Matt Barry, May 5, 2006

¹ Petersen R et al, "Medicaid reimbursement for prenatal smoking intervention influences quitting and cessation," *Tobacco Control* 2006 ;15:30-34.

² Letter dated April 29, 2003 from James L. Reed, Consulting Actuary, Milliman USA, to Dawn Robbins, Tobacco Free Coalition of Oregon, Re: cost of selected conditions by state.

³ U.S. Department of Health and Human Services. Women and Smoking: a Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; Washington D.C.: For sale by the Supt of Docs., U.S. G.P.O. 2001.

⁴ On spontaneous abortions, see, e.g., Mendola, P., et al., "Risk of Recurrent Spontaneous Abortion, Cigarette Smoking, and Genetic Polymorphisms in NAT2 and GSTM1," *Epidemiology* 9(6): 666-668 (November 1999); Shiverick, K.T. & C. Salafia, "Cigarette Smoking and Pregnancy I: Ovarian, Uterine and Placental Effects," *Placenta* 20(4): 265-272 (May 1999); Ness, R. B., et al., "Cocaine and Tobacco Use and the Risk of Spontaneous Abortion," *New England Journal of Medicine* 340(5): 333-339 (February 4, 1999); Chatenoud, L., et al., "Paternal and Maternal Smoking Habits Before Conception and During the First Trimester: Relation to Spontaneous Abortions," *Annals of Epidemiology* 8(8): 520-26 (November 1998); Dominquez-Rojas, V., et al., "Spontaneous Abortion in a Hospital Population: Are Tobacco and Coffee Intake Risk Factors?," *European Journal of Epidemiology* 10(6): 665-668 (December 1994); Walsh, R.A., "Effects of Maternal Smoking on Adverse Pregnancy Outcomes: Examination of the Criteria for Causation," *Human Biology* 66(6): 1059-1092 (December 1994); Windham, G.C., et al., "Parental Cigarette Smoking and the Risk of Spontaneous Abortion," *American Journal of Epidemiology* 135(12): 1394-403 (June 15, 1992); Armstrong, B.G. et al., "Cigarette, Alcohol, and Coffee Consumption and Spontaneous Abortion," *American Journal of Public Health* 82(1): 85-87 (January 1992); Pattinson, H.A. et al., "The Effect of Cigarette Smoking on Ovarian Function and Early Pregnancy Outcome Of In Vitro Fertilization Treatment," *Fertility and Sterility* 55(4): 780-783 (April 1991); Himmelberger, D. U., et al., "Cigarette Smoking During Pregnancy and the Occurrence of Spontaneous Abortion and Congenital Abnormality," *American Journal of Epidemiology* 108(6): 470-479 (December 1978); Kline, J., et al., "Smoking: A Risk Factor for Spontaneous Abortions," *New England Journal of Medicine* 291(15): 793-96 (October 1977). See, also, Kline, J. et al., "Cigarette Smoking and Spontaneous Abortion of Known Karyotype: Precise Data But Uncertain Inferences," *American Journal of Epidemiology* 141(5): 417-427 (March 1995); Economides, D. & J. Braithwaite, "Smoking, Pregnancy, and the Fetus," *Journal of the Royal Society of Health* 114(4): 198-201 (August 1994); Fredricsson, B. & H. Gilljam, "Smoking and Reproduction: Short and Long Term Effects and Benefits of Smoking Cessation," *Acta Obstetrica Gynecologica Scandinavica* 71(8): 580-592 (December 1992). But see, also, Windham, G.C. et al., "Exposure to Environmental and Mainstream Tobacco Smoke and Risk of Spontaneous Abortion," *American Journal of Epidemiology* 149(3): 243-247 (February 1, 1999); Sandahl, B. "Smoking Habits and Spontaneous Abortion," *European Journal of Obstetric Gynecology and Reproductive Biology* 31(1): 23-31 (April 1989).

On still births, see, e.g., Raymond, E.G. et al., "Effects of Maternal Age, Parity, and Smoking on the Risk of Stillbirth," *British Journal of Obstetric Gynaecology* 101(4): 301-306 (April 1994); Ahlberg, G. Jr. & L. Bodin, "Tobacco Smoke Exposure and Pregnancy Outcome Among Working Women: A Prospective Study At Prenatal Care Centers In Orebro County, Sweden," *American Journal of Epidemiology* 133(4): 338-347 (February 1991).

On sudden infant death syndrome, see, e.g., Cooke, R.W., "Smoking, Intra-Uterine Growth Retardation and Sudden Infant Death Syndrome," *International Journal of Epidemiology* 27(2): 238-41 (April 1998).

⁵ DiFranza, J.R. & R.A. Lew, "Effect of Maternal Cigarette Smoking on Pregnancy Complications and Sudden Infant Death Syndrome," *Journal of Family Practice* 40(4): 385-94 (April 1995).

⁶ Pollack, H., "Sudden Infant Death Syndrome, Maternal Smoking During Pregnancy, and the Cost-Effectiveness of Smoking Cessation Intervention," *American Journal of Public Health* 91(3): 432-36 (March 2001); National Center for Health Statistics, "Medical and Life-Style Risk Factors Affecting Fetal Mortality, 1989-90," *Vital and Health Statistics* 20(31), August 1996.

⁷ U.S. Department of Health and Human Services. Women and Smoking: a Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; Washington D.C.: For sale by the Supt of Docs., U.S. G.P.O. 2001

⁸ Ershoff DH, Quinn VP, Mullen PD, et al. Pregnancy and medical cost outcomes of a selfhelp prenatal smoking cessation program in a HMO. *Public Health Reports* 1990; 105(4):340-7.

⁹ See, e.g., Markovic, R., et al., "Substance Use Measures Among Women in Early Pregnancy," *American Journal of Obstetrics & Gynecology* 183:627-32 (September 2000).

¹⁰ Lipscomb LE, Johnson CH, Morrow B, Colley Gilbert B, Ahluwalia IB, Beck LF, Gaffield ME, Rogers M, Whitehead N. PRAMS 1998 Surveillance Report. Atlanta: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 2000.

¹¹ Orleans TC et al, "Helping pregnant smokers quit: meeting the challenge in the next decade," *Tobacco Control* 2000;9(Suppl III):iii6-iii11.

¹² Zhang X, Miller L, Max W, Rice DP. Cost of smoking to the Medicare program. *Health Care Financing Review*, Summer 1999, Vol. 20, No. 4. 179-96.

¹³ Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Maternal and Child Health (MCH) SAMMEC software, 2002b. Available at: <http://www.cdc.gov/tobacco/sammec>.

¹⁴ Curry SJ, Grothaus LC, McAfee T, Pabniniak C. Use and cost effectiveness of smokingcessation services under four insurance plans in a health maintenance organization.

¹⁵ Windsor, RA, Lowe, JB, Perkins, LL, et al. Health education for pregnant smokers: its behavioral impact and cost benefit. *American Journal of Public Health*, February 1993, Vol. 83, No. 2. 201-6.

¹⁶ Ershoff DH, Quinn VP, Mullen PD, et al. Pregnancy and medical cost outcomes of a selfhelp prenatal smoking cessation program in a HMO. *Public Health Reports* 1990; 105(4):340-7; Marks JS, Koplan, JP, Hogue CJR, Dalmat ME. A cost-benefit/cost-effectiveness analysis of smoking cessation for pregnant women. *American Journal of Preventive Medicine* 1990;6(5):282-9.

¹⁷ Lightwood JM, Pibbs, CS, Glantz SA. Short-term economic and health benefits of smoking cessation: low birth weight. *Pediatrics* 1999; 104(6): 1312-20.

¹⁸ Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Maternal and Child Health (MCH) SAMMEC software, 2002b. Available at: <http://www.cdc.gov/tobacco/sammec>.

¹⁹ Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

²⁰ Coffield, A, et al. "Priorities Among Recommended Clinical Preventive Services," *American Journal of Preventive Medicine*, July 2001, 21(1).

²¹ Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

²² Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

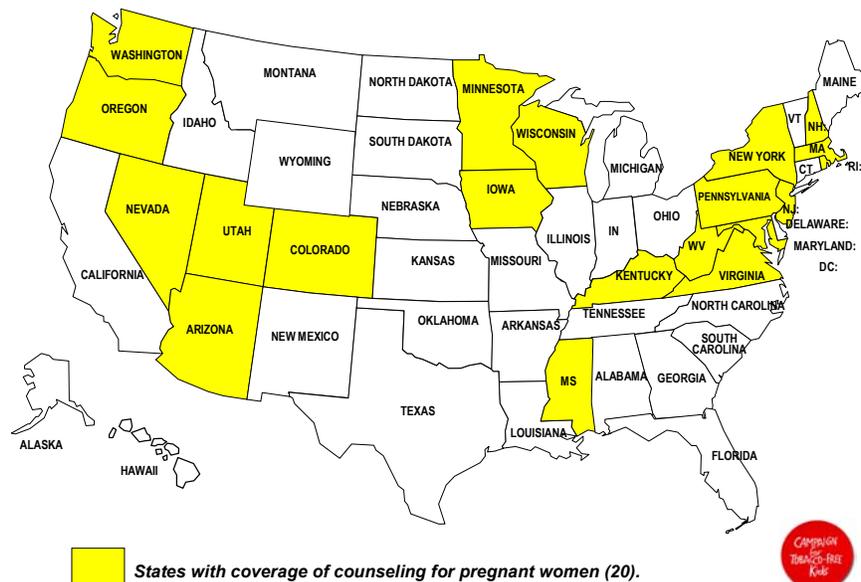


STATE MEDICAID COVERAGE OF TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN

According to a study published in the April 2006 issue of *Health Affairs*, only 20 States provide a Medicaid tobacco cessation benefit tailored specifically to the unique needs of pregnant women who smoke (see map below for which States provide coverage).¹ The same study reports that there are 13 States that offer comprehensive cessation services (defined as coverage of at least one FDA-approved nicotine replacement product, Zyban, and at least one form of counseling) to all Medicaid beneficiaries, and 6 of these States are not among the 20 States with targeted pregnancy programs. This is a good example of how coverage is sporadic and, even if it is deemed “comprehensive” it may not be tailored to address the unique needs of specific populations like pregnant women who smoke.

While the pregnant women in the States with targeted pregnancy coverage are fortunate to have access to the evidence-based treatment and services they need to help them quit their tobacco use and dramatically improve the chances they will give birth to a healthy baby, this still leaves the vast majority of pregnant women in other States with no coverage and no access to the evidence-based treatment they need. This study clearly illustrates the need for action at the national level to remove these geographic disparities and ensure that all pregnant women who smoke and who are on Medicaid, regardless of where they live, have access to all the evidence-based cessation services they need to quit smoking and to ensure a healthy baby.

State Medicaid Coverage of Tobacco Cessation (2003)



May 2006

¹ Halpin, HA et al, “Update State Report: Medicaid Coverage of Tobacco Dependence Treatments,” *Health Affairs*, Volume 25, Number 2, March/April 2006, pages 550-556.

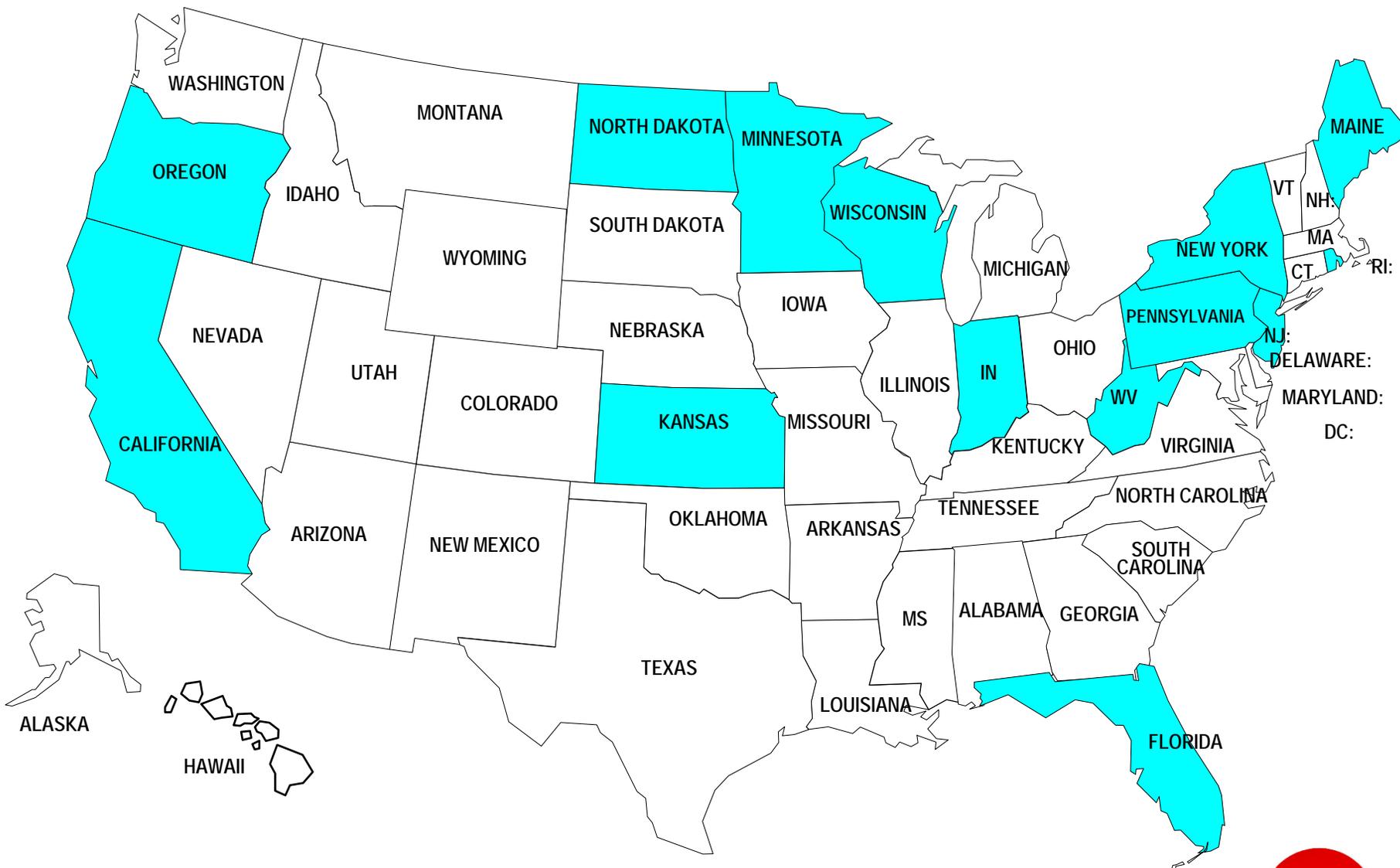
State Medicaid Coverage of Tobacco Cessation (2003)



States with coverage of counseling for pregnant women (20).



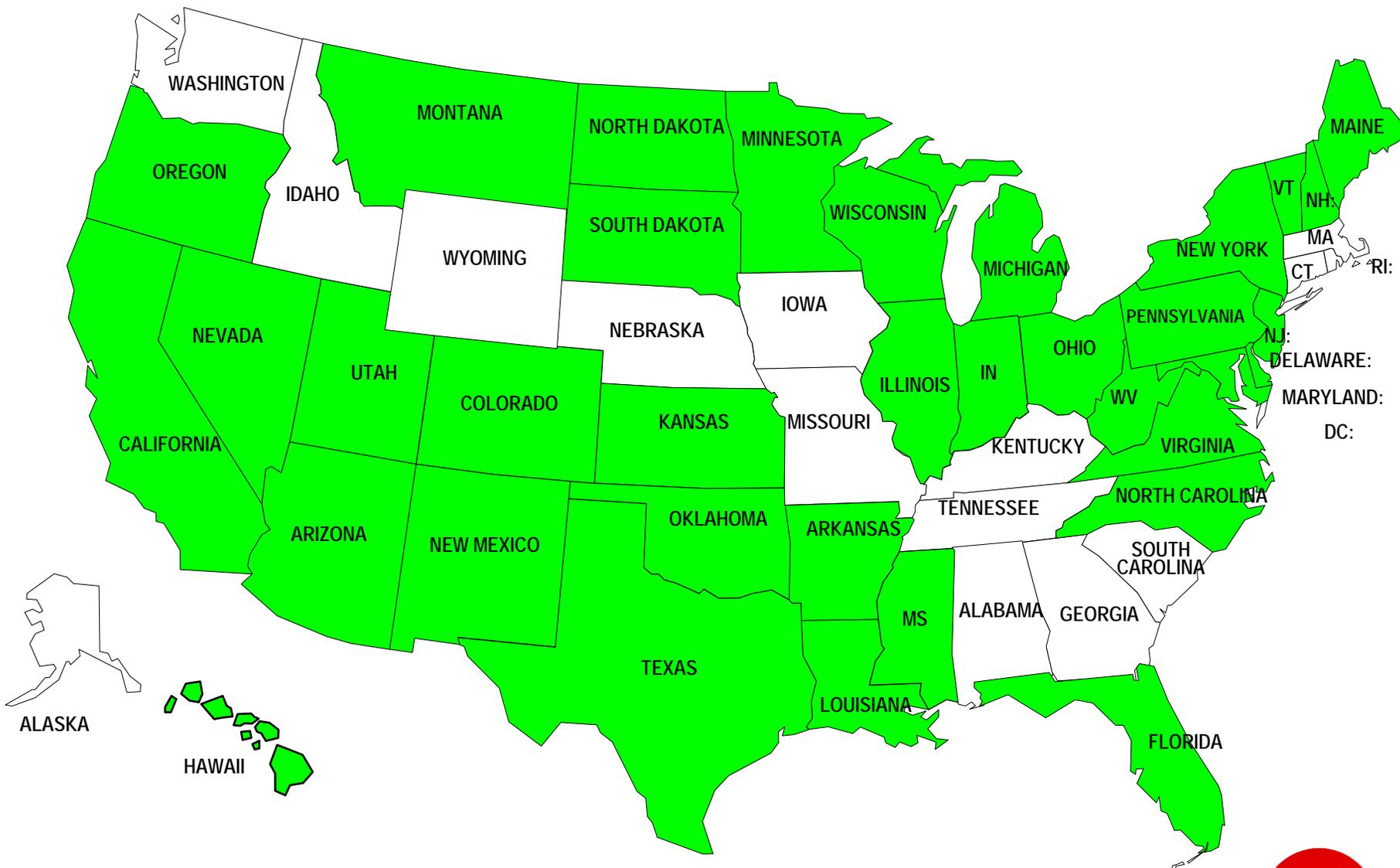
State Medicaid Coverage of Tobacco Cessation (2003)



 **States with coverage of at least one form of evidence-based counseling for all beneficiaries (14).**



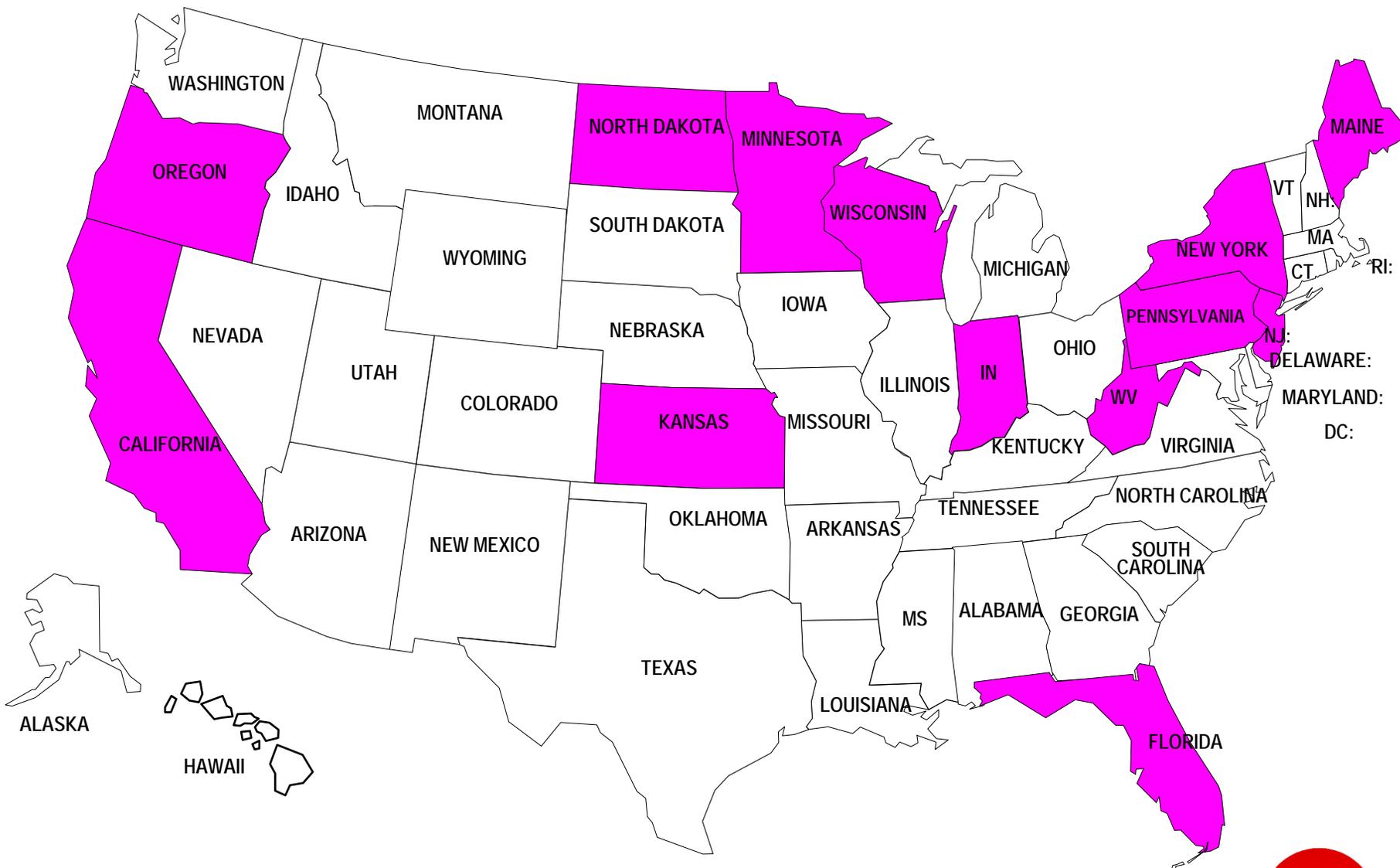
State Medicaid Coverage of Tobacco Cessation (2003)



 States with coverage of at least one FDA approved cessation drug for all beneficiaries (36).



State Medicaid Coverage of Tobacco Cessation (2003)



States with “comprehensive” (at least 1 NRT, Zyban, and at least one form of counseling) cessation coverage (13).



Evaluation of Database Opportunities for Driving Consumer Relationships

Sean Bell

Project Update

As part of the “Building Relationships with Smokers & Quitters Through Databases” Break Out Group, I focused my analysis on three areas:

1. What, if anything, are current quitlines doing to build long-term relationships with tobacco users who have engaged with those quitlines?
2. Try to find experts in the space that do relationship/permissions-based marketing, especially around health care.
3. Consider opportunities within Free & Clear to test options around strengthening relationships with consumers of our services (state or commercial).

Implications for Building Consumer Demand

Early findings have several implications for building consumer demand:

1. State Quitlines are doing little in terms of building long-term relationships with participants. There are several reasons for this.
 - a. There are HIPAA concerns in regards to using a person’s PHI to market to them further. While there are options for gaining permission to do so, there are significant legal hurdles, particularly the state is not a covered entity.
 - b. Participants are very suspicious about sharing information with a state quit line. Free & Clear has seen that, in some cases, the MDS has caused serious consternation with callers who view these types of questions as intrusive and not related to their tobacco use status.
2. Experts around permissions-based marketing for issues that may contain PHI are limited. Ongoing conversations are taking place, but examples that are similar to what we’re discussing are rare. I’m planning on meeting with one or two in the coming months and will report back what I find.
3. However, there are opportunities to use databases to let consumers link each other. Free & Clear has recently launched a Web-based component to its Quit For Life™ program that allows consumers to build links of “friends and allies.” This is the first step here, but one where we’re considering options to let consumers manage their relationships and support one another rather than relying on a “central authority” to do that for them.

Reaching Disparate Audiences

Given that this topic focused on technology, there are some inherent barriers around special needs populations, particularly SES, and their access to those technologies. However, there are two major issues that I continue to follow up on:

1. We need to remember that, while computer access is less prevalent with some disparate audiences, cell phone access isn’t. As more and more cell phones have basic data transfers built in (SMS, Web), we should look at methodologies for engaging people in these ways

as well.

2. The growth of the “Social Web” (often identified with such services as MySpace, Ebay, FaceBook, etc.) has led to the opportunity for specialized communities who may not have access to one another in person to “link up” around specific topics. Free & Clear will continue to investigate those options to see how opportunities to link consumers from disparate populations might develop.

Related Publications

If applicable, list the top one or two recent articles or news stories that relate to your topic.

The Campaign for Tobacco-Free Kids Matt Meyer

Project Update

State Tobacco Issues Update

The 2006 legislative cycle is well underway. After three years of declining state spending on tobacco control this year there have been some encouraging signs of progress in efforts to restore funding to state prevention and cessation programs. The most significant tobacco control progress so far this year has been on the clean indoor air front. Progress has been slower on raising tobacco taxes. Since 2002 over 40 states have raised their tobacco tax, some more than once. As of the date this is being written no state has yet raised its tobacco tax this year, but a one-dollar increase is currently being debated in Texas and tobacco taxes are on the agenda in a number of other states. Roughly one-third of the state legislative sessions have already adjourned for the year.

This report briefly summarizes what has happened this year. It also summarizes where major tobacco control policy issues will be front and center the rest of this year.

Prevention and Cessation Funding

Tobacco prevention funding deserves to be a priority because tobacco prevention and cessation programs do more than reduce tobacco use in the short run. They have also been critical in educating the public, media and policy-makers about smoke-free laws and tobacco taxes, they have been instrumental in involving diverse communities in tobacco control; and they are essential to the kind of change in public attitudes and social norms that are critical for long term permanent fundamental change.

So far, we have made progress this year.

Six states have increased funding or, in the case of New York, a funding increase appears almost certain. To date, the largest increase has been in New York. Governor Pataki of New York proposed virtually doubling the funding for the state's highly regarded prevention and cessation program from \$44 million to \$85 million a year. The proposal would put the funding level very close to the CDC minimum and potentially provide a major boost on this issue around the country. The proposal has been passed by both houses of the New York legislature, is supported by the leadership of both the House and Senate and does not appear to be in jeopardy. The 2004 tobacco tax increase approved by Colorado's voters provided for increased funding for tobacco prevention and cessation. Revenues from the cigarette tax increase have been so strong that the tobacco prevention program will gain additional revenue beyond amounts anticipated. Funding for the program will go from \$27 million to \$36 million. As a result, Colorado will for the time being overtake Maine as the nation's best-funded program relative to the CDC minimum.

In addition, New Mexico has increased program funding this year from \$6 million to \$7.2 million; Maryland has approved a funding increase from \$9.2 million back to its original level of \$21 million; Kentucky increased funding for its program from \$2.7 million to \$4.9 million. It is also likely that Iowa will shortly increase funding for its tobacco control program by close to \$ 1million from \$5.6 million to about \$6.6 million. Thus, overall increases this year total slightly more than \$66 million nationwide.

There has been no change in program funding this year in Washington State, Virginia, Nebraska, West Virginia, Indiana, Illinois, Georgia, Montana, Idaho, Utah, Oklahoma, North Carolina, Wisconsin, Hawaii, Rhode Island or Maine, states where the legislature has either completed its work or program funding does not appear to be an issue.

Tobacco Prevention Funding Decisions to be Made This Year

The rest of the year will be key as to whether this year represents a dramatic step forward or simply a good next step.

There are serious proposals pending in 3 additional state legislatures at this time to increase program funding. The proposal in Vermont would increase current funding of \$4.9 million by 5% or \$.245 million. The proposal in Massachusetts would increase funding for the program from \$4.3 million to \$15 million, a healthy increase but still far below the level at which the program was once funded. The proposal in Connecticut would for the first time provide direct tobacco program funding moving Connecticut from zero to \$2 million, a small amount but at least a start.

The biggest increases this year depend on the voters in California, Florida, Missouri and South Dakota where major ballot initiatives are pending. The initiative in Florida focuses solely on program funding and would increase Florida's commitment to tobacco control from \$1 million to approximately \$55 million a year by amending the Florida constitution to require that at least 15% of the tobacco settlement money received by the state be spent on tobacco prevention and cessation. The ballot initiative in California is part of a \$2.60 tax initiative. It would provide an additional \$150 million in tobacco program funding, plus \$32 million for tobacco research and \$28.5 million more for school based programs, an enormous increase by any standards.

The ballot initiative in Missouri would increase tobacco program funding from zero to about \$60 million. The ballot initiative in South Dakota would increase tobacco program funding from \$700,000 to \$5,700,000.

Supporting four major ballot initiatives this fall will be a massive challenge, but the potential benefit to public health is enormous. If we are successful, these victories could serve as an energizing catalyst to a new campaign next year when the states receive bonus MSA payments.

As of this writing, no state has cut prevention funding this legislative cycle, although there is a potential cut looming in Pennsylvania, and the funding for the Partnership for A Healthy Mississippi remains in limbo pending a court decision.

Cigarette Excise Taxes

As yet, no state cigarette tax increases have been enacted this year, but several opportunities remain. The general improvement in overall state revenues plus the fact that over 40 states have raised their tobacco taxes within the last four years has made the tax fights more difficult this year. Cook County has increased its tax by \$1 effective March 1. This increase doubled the Cook County tax to \$2 and brought Chicago's total federal, state and city tax on a pack of cigarettes to \$4.05, the highest in the nation.

A controversial tax has passed both houses of the legislature in Hawaii. It is uncertain whether it faces a veto by Governor Lingle. It would raise the tax by \$.20 per pack a year for six years with one-half of the revenues going into the general fund and some proceeds going to health programs, including the University of Hawaii's Cancer Research Center, community health centers and a new fund for trauma medical care.

There was a frustrating loss in Mississippi, one of fewer than 10 states that have not raised their tax on tobacco products since 2002. Twice both houses of the legislature passed innovative legislation increasing the cigarette tax while simultaneously reducing the tax on groceries; twice Governor Barbour vetoed it, and twice the legislature failed to override the veto. Lt. Governor Amy Tuck, the sponsor and champion of the tax proposal, has indicated a desire to try again in the 2007 session.

The Mississippi proposal to use tobacco taxes to decrease the regressive tax on basic groceries brought together an unusual coalition and was extremely popular. Thus, despite Governor Barbour's veto, this is a concept we are exploring in other states as a mechanism to energize efforts to increase tobacco taxes and bring new groups into the battle.

In New York Governor Pataki proposed raising the tax again, but met strong opposition from the Senate Republican leadership because of the Governor's failure to crack down on smuggling from Indian reservations. At the same time Pataki proposed the tax increase, he proposed to delay the implementation of a new law enacted last year that is designed to make it more difficult for Indians to sell cigarettes for use off the reservation without first paying the state tax. The tax is probably dead in New York for this year, but New York remains a strong possibility next year.

Pending Tax Opportunities

There are currently proposals to increase the tobacco tax in Vermont, South Carolina, New Jersey, Delaware, and Tennessee.

In Texas advocates have worked for more than a year on proposals to increase the tobacco tax by one dollar or more as part of Texas' need to come up with a new method of refinancing their education system. The issue is being debated as this is being written. At the present time a \$1 tax increase has been passed by the full House of Representatives and the Senate Finance Committee. Opponents have tried to have the size of the tax increase cut or have it phased in over time.

Tobacco taxes will also be a major issue this November. A \$2.60 tax increase is on the ballot in California, a \$.80 increase is on the ballot in Missouri, and a \$1 tax increase is on the ballot in South Dakota. All three of these measures include additional funds for tobacco prevention and cessation. These measures also include funding for a wide range of other public health measures.

Smokefree Legislation

This has genuinely been a year of unprecedented activity and progress in the battle to expand clean indoor air protection.

The long battle to make the nation's capital smokefree finally paid off in January. The City Council passed legislation that will make all workplaces smokefree in two phases: public places, workplaces and the dining areas of restaurants are smokefree as of April 4, while bars and bar areas of restaurants must be smokefree as of January 2007. There are some exemptions and potential loopholes that must be monitored carefully during the upcoming process of writing regulations, but overall it is a good bill.

Statewide smokefree laws have also already been enacted this year in New Jersey, Puerto Rico, Arkansas and Colorado and the law in Hawaii is awaiting the Governor's expected signature. The strong law in Utah was extended to cover bars and private clubs.

New Jersey became a smokefree state this spring after the legislature passed and the Governor signed a comprehensive bill that exempts only the gaming areas of casinos. The law took effect in April. Colorado passed an equally comprehensive bill and will join the list in July. Puerto Rico's Smokefree law goes one step further and also includes casinos. While advocates in Arkansas have been building support for a statewide clean indoor air law for some time, when Governor Huckabee decided to act, the proposal moved from concept to bill to law quicker than ever on a statewide bill. The bill makes most workplaces smokefree, but exempts stand-alone bars and businesses with three or fewer workers. During a one-week special session, the bill was introduced on Monday and signed by the Governor on the Friday. The Hawaii success is the result of a multi-year effort by a broad coalition of advocates.

Clean Indoor Air Battles Ahead

Two states will hold referendums on statewide smokefree initiatives this fall; Ohio and Arizona. The campaign in Ohio has taken a potentially difficult turn with the news that

an opposition group including R.J. Reynolds and other tobacco companies has filed a competing initiative that is riddled with loopholes. Should they succeed in getting on the ballot it would make the campaign significantly more difficult.

These battles continue to be tough. This year public health advocates came agonizingly close in a state that has always resisted tobacco control measures as part of its “Live Free or Die” mentality – New Hampshire, the last New England state without a comprehensive smokefree law. After a massive grassroots, media and lobbying campaign, a comprehensive bill passed the state House, but failed by a single vote in the Senate.

In local action, an opposition-inspired referendum was defeated in Appleton, WI, that would have rolled back that city’s comprehensive ordinance. Appleton is not a large city and not a national bellwether, but it is always important to demonstrate voter support in these instances. Local action has taken place in almost every region of the country in cities large and small from cities like St. Paul (MN) and Springfield (IL) to smaller communities like Starkville, MS, Beaumont and Laredo, TX and Speedway, Indiana and many others in between.

Looking ahead, advocates are continuing to work in Philadelphia, and Houston may be the next major metropolitan area to consider a comprehensive ordinance in the fall.

Second Chance for the States

Beginning in 2008, the 46 states, the District of Columbia, and the U.S. territories that were part of the 1998 Master Settlement Agreement (MSA) will receive annual bonus settlement payments totaling about \$900 million each year. The bonus payments are mandated by the terms of the settlement and will continue for at least 10 years.

These payments will provide states with a critical second chance to keep the promise of the tobacco settlement to use settlement dollars to fund tobacco prevention and cessation programs. A national effort is required to capitalize on these payments and give the states a second chance to use MSA money for tobacco prevention.

The need for well-funded tobacco prevention and cessation programs has never been greater – tobacco companies are spending a record \$15.4 billion a year to market their deadly and addictive products. State budgets are looking up, and several states are already experiencing increases in prevention funding. Our evidence base is also become stronger. A growing number of states and communities are experiencing significant tobacco use declines because of effective programs and we can demonstrate that these declines will produce significant health and economic benefits.

SMOKING CESSATION LEADERSHIP CENTER

PROJECTS AT A GLANCE

The Smoking Cessation Leadership Center (SCLC) is a national program office of the Robert Wood Johnson Foundation. SCLC aims to improve involvement of health professionals and health care institutions help smokers quit as well as to normalize smoking cessation.

GRANTS

American Academy of Family Physicians
American Academy of Physician Assistants
American Association of Critical Care Nurses
American Association for Respiratory Care
American College of Emergency Physicians
American College of Physicians
American Dental Hygienists' Association
American Society of Anesthesiologists*
American Society of Health-System Pharmacists
Dana Farber Cancer Institute
Joint Commission on Accreditation of Healthcare Organizations
Kaiser Permanente Northern California Tobacco Dependence Program
National Association of State Mental Health Program Directors (NASMHPD), Medical Directors Council
Organized Labor Project, Harvard University, School of Public Health
Pharmacists' Cessation Project, Yale University
Tobacco-Free Coalition of Oregon
Tobacco Free Nurses, UCLA School of Nursing
Veterans Health Administration - *grant received*

SELECTED PARTNERS

American Association of Retired Persons
American Cancer Society
American Heart Association
American Legacy Foundation
American Lung Association
California Dental Hygienists' Association
California Diabetes Program
California Smokers' Helpline
Center for Tobacco Control Research & Education
Free & Clear
GlaxoSmithKline
North American Quitline Consortium
Partnership for Prevention
Pfizer
United Behavioral Health
WellPoint
Wrigley

1-800-QUIT-NOW

SAMPLE PRESENTATIONS

American Dental Hygienists' Association
81st & 82nd Annual Meetings
American Public Health Association
Blue Cross – Blue Shield Association
Centers for Disease Control
Center for Tobacco Cessation
Health Research and Education Trust
Make It Your Business
National Association of Attorneys General
National Association of Community Health Centers
National Association of State Mental Health Program Directors
National Cancer Institute
National Conference on Tobacco or Health
National Oral Health Conference
Summer Institute Fellows Talk of Critical Care Nurses
World Conference of Family Physicians
World Conference on Tobacco or Health (2006)*
World No Tobacco Day, UCSF

LEADERSHIP SUMMITS

American Academy of Family Physicians
American Academy of Physician Assistants
American Association for Respiratory Care
American Dental Hygienists' Association
American Psychiatric Association*
American Society of Anesthesiologists*
JCAHO Smoking Cessation Technical Expert Panel
NASMHPD Smoking Policy and Treatment
National Nursing Leadership Task Force on Tobacco Control
National Pharmacists' Summit on Tobacco Cessation
VA in the Vanguard: Building on Success in Smoking Cessation

SCLC PUBLICATIONS

Should Emergency Departments Help Smokers Quit? Schroeder SA. *Annals of Emergency Medicine*.*

Tobacco still is oral health enemy number one. Schroeder SA. *JADA*. February 2006 – Vol 137.

Tobacco sales in pharmacies: Time to quit. Hudmon KS, Fenlon CM, Corelli RL, Prokhorov AV, Schroeder SA. *Tobacco Control*. October 2005.

VA in the Vanguard: Building on Success in Smoking Cessation Proceedings. Isaacs S, Schroeder SA, Simon, JA. October 2005.

What to do with a patient who smokes. Schroeder SA. *JAMA*, July 27, 2005 – Vol 294, No. 4.

Smoking Cessation Counseling in US Hospitals: A Comparison of High and Low Performers. Williams SC, Morton DJ, Jay KN, Koss RG, Schroeder SA, Loeb JM. *JCOM*, July 2005 – Vol 12, No 7.

An Agenda To Combat Substance Abuse. Schroeder SA. *Health Affairs*. July/August 2005. Vol 24, No 4.

Simplicity matters: Using system-level changes to encourage clinician intervention in helping tobacco users quit. Revell C, Schroeder SA. *N&TR*. April 2005. Vol 7, Sup 1

The Tobacco Buyout and the FDA. Schroeder SA. *New England Journal of Medicine*. 351:1377-80, 2004

Help Not Smoking at Work

Susan Swartz

Project Update

Since the last meeting, the Center for Tobacco Independence is partnering with the MaineHealth Employee Health Program to increase utilization of NRT and tobacco treatment for employees at Maine Medical Center. Specific components include the following:

- *To engage the consumer/employee:*
Focus placed on not smoking at work, rather than the more challenging goal of quitting.
- *Product and service delivery design*
The program will provide NRT for 1-week use periods, and allow for additional supply.
- *Promotion*
Colorful brochures (“Want to NOT SMOKE at work?”) to be placed at Employee Health and other sites; handed out with mandatory TB testing; ‘ads’ placed in employee newsletter
- *Policy*
The program leverages pharmacy benefits having no out-of-pocket expense (also promoted)
- *Research/Surveillance*
Participants will be asked consent to follow-up by email, to monitor NRT use, confidence and future quit behavior

Implications for Building Consumer Demand

Observation of a real-world offering of barrier-free access to NRT at a hospital worksite

South Carolina African American Tobacco Control Network Dianne Wilson

Project Update

SCAATCN has collaborated with Medical University of SC (MUSC) to design a Cessation Facilitator's Training geared towards communities of color. There are two stages to training with the first being introductory, learning to assess what stage a smoker is at in his/her quit attempt and secondly, delving more into the behavior change model. The objective is two fold in not only educating the facilitator about cessation but developing skills and knowledge in NRT, behavior change stages, dispelling myths, negative impact of smoking and issues related to secondhand smoke. Trained Facilitators are to use learned skills within their community settings by conducting educational programs and later cessation classes. To date two training have been held with another scheduled for August. Eventually, we are hoping to expand across the state, as long as resources are adequate.

The development of program is an attempt to broaden knowledge about cessation specifically in communities of color and to dispel myths that exist.

- *Product and service delivery design* In our training we provide information on NRT and other services that are available to enhance quit attempts (i.e quitline)

Implications for Building Consumer Demand

It is a way to reduce the overall mortality rate and helps the consumer understand cessation so that they can demand access to programs and services. This enlightenment increases opportunity for consumers to advocate for policies for cessation services.

Reaching Disparate Audiences

Our Cessation Facilitator Training is set up specifically for disparate communities since there is such a dearth of information and education around the issue of cessation.