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From Challenge to Opportunity

**Organizing, Financing and Delivering Statewide
Tobacco Cessation Services and Activities**



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Center for Tobacco Cessation

Policy Roundtable on Statewide Cessation Services

Editors

Linda A. Bailey, William L. Furmanski, Elizabeth W. Edsall



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CENTER FOR TOBACCO CESSATION

The Center for Tobacco Cessation (CTC) serves as the source of the best available science on tobacco cessation and works with national partners to expand the use of effective tobacco dependence treatments. The program, based in Washington, D.C., is supported by the American Cancer Society and The Robert Wood Johnson Foundation.

CTC seeks to influence the adoption and implementation of the recommendations from *Treating Tobacco Use and Dependence Clinical Practice Guideline* and *The Guide to Community Preventive Services: Tobacco Use Prevention and Control* by the public health, clinical, and business sectors. Among the program's activities are the assembly of roundtable and work group meetings to identify successful approaches to developing effective tobacco dependence treatment programs, the translation and dissemination of action-oriented information about effective tobacco dependence treatment, and development of a policy coalition to advocate for adoption and implementation of effective tobacco dependence treatment in the public and private sectors.

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Suggested citation:

CTC Policy Roundtable on Statewide Cessation Services, LA Bailey, WL Furmanski, EW Edsall, Eds. From Challenge to Opportunity: Organizing, Financing and Delivering Statewide Tobacco Cessation Services and Activities. Washington, D.C. December 2003.

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PREFACE

Tobacco cessation, and specifically treating tobacco dependence, is widely recognized as an important, and virtually essential, piece of the puzzle to improving health in the United States. Tobacco use has been identified as one of the nation's leading health indicators by the U.S. Department of Health and Human Services (HHS). The U.S. Preventive Services Task Force ranked assessment and counseling of adults for tobacco use as the second highest priority among its 30 clinical preventive services. And the Institute of Medicine in January 2003 listed tobacco dependence treatment in adults among its top 20 priority areas for national action.

A number of national efforts are underway to achieve the broad agenda necessary for helping the nation's smokers end their tobacco dependence. Most recently, the Interagency Committee on Smoking and Health, at the request of the Secretary of HHS, submitted its *National Action Plan for Tobacco Cessation*. And collaborative efforts in recent years by leading national public and private organizations led to development of three individual documents, known as "blueprints," to provide guidance and coordinate action on tobacco cessation for adult smokers, pregnant smokers, and young smokers.

While attention to tobacco cessation at the national level continues to expand, the Center for Tobacco Cessation (CTC) identified a need

to better understand the current environment for tobacco cessation at the state level. To do this, and to explore state-led efforts to help smokers quit, CTC convened in July 2002 a policy roundtable on statewide cessation services. The goal of this roundtable was to examine states' experiences in developing and implementing comprehensive approaches to cessation and to produce recommendations to expand statewide cessation efforts. The panel included 16 members, among them representatives from six states leading the way in cessation efforts—Arizona, California, Maine, Massachusetts, Oregon and Washington.

The roundtable also brought together experts in the organization, financing and delivery of health care at the national and state levels, public and private health care purchasing systems, tobacco control, clinical and community components of cessation, public health, community health programs and consumer health care. Over a series of three meetings, roundtable members discussed the critical success factors for cessation efforts at the state level, identified factors that inhibit or encourage activity, and developed recommendations to implement them.

Discussions by roundtable members were framed by two landmark documents that provide the current scientific framework and evidence based for what is effective for tobacco cessation. These documents include: *Treating Tobacco Use and Dependence: Clinical Practice Guideline* (USPHS, 2000) and *Guide to Community Preventive Services: Tobacco Use and Control* (Hopkins, 2001).

This report is intended for a variety of public health and health care professionals at the local, state and national levels including, but not limited to, state tobacco control programs, statewide tobacco control coalitions, public and private purchasers of health care, health care providers, researchers, national nonprofit/advocacy organizations and federal health officials.

The contents of the report include recommendations for developing and implementing a comprehensive cessation effort at the state level, as crafted by roundtable members. Each recommendation requires coordination, resources and commitment from multiple stakeholders. Taken singly, each component recommended in this report is a significant individual activity that will improve cessation services. However, when viewed as a whole, the multiple strategies and recommendations make clear the need to work on several areas simultaneously. The recommendations reflect the best and sometimes “promising” practices toward integrated, successful, tobacco cessation services. There are multiple options for success, and we encourage you to use the recommendations as a starting point in your state.

ACKNOWLEDGEMENTS

On behalf of the CTC Policy Roundtable, we would like to thank a number of individuals and organizations for their dedication to and outstanding support of the development of this report on organizing, financing and delivering statewide tobacco cessation services and activities.

First and foremost, CTC owes a debt of gratitude to two individuals who proved to be driving forces, not only behind both this project and the final report, but also the Center for Tobacco Cessation itself. We are indeed thankful for the leadership provided by C. Tracy Orleans of The Robert Wood Johnson Foundation and Tom Glynn of American Cancer Society. Without their combined vision and guidance, none of this work would have been possible.

We also extend thanks to John Pinney who, during a conversation with Linda Bailey, shared a copy of his 1990 report on Smoking Cessation: The Organization, Delivery and Financing of Services. His thoughtful comments and his report helped shape the idea for the roundtable and the title for the report. We believe the roundtable report demonstrates considerable progress since 1990 and hope he agrees.

We would like to acknowledge the important collaboration that has developed between the Center for Tobacco Cessation and the Pacific Center on Health and Tobacco. The work and experience of

each organization has influenced the other and has helped shape its products and activities.

Of particular note are the members of the roundtable, 16 dedicated individuals who shared their passion, insights, and expertise throughout the process. We are especially thankful to Lee Dixon, Angela Geiger, Donna Grande, Helen Halpin, Corinne Husten, Robert Leischow, Tim McAfee, Dearell Niemeyer, Jeanette Noltenius, Susan Swartz, Shalini Vallabhan, Traci Verardo, Donna Warner, and Linda Wertz. These individuals spent countless hours over and above their professional commitments to ensure that the report became reality, including participating in each of the roundtable gatherings and contributing through the development of the recommendations and review of the report content and related materials.

A distinguished panel of individuals assisted in preparation of this report by agreeing to serve as external reviewers. Their feedback and comments are reflected throughout the final document. The panel included Maris A. Bondi, Janet M. Corrigan, Michael C. Fiore, Lyndon Haviland, Brick Lancaster, Barbara Lardy, Scott J. Leischow, Myra Muramoto, Beverly Pringle, and Sherri Watson Hyde. We sincerely appreciate each of these individual's contributions.

Essential to the development of the report was a series of three meetings to convene roundtable members for learning and information sharing. These meetings included presentations exploring state experiences on delivery of tobacco cessation services, the organization, financing and delivery of health care services and key considerations for public and private purchasing of health care services, and addressing quality in cessation services. In some cases, roundtable members presented to their colleagues on the panel. Members who presented include Linda Bailey, Wendy Bjornson, Helen Halpin, Corinne Husten, Jeanette Noltenius, Tim McAfee, Susan Swartz, Traci Verardo, and Donna

Warner. In addition, the roundtable warmly welcomed other experts who agreed to present to the group, including Mary C. Ayesse, Maris A. Bondi, Claude Earl Fox, Emma Hoo, Rosemarie McIntyre, Karen Rezai, Abby C. Rosenthal, and Carol Schmitt.

We wish to express our sincere appreciation to the devoted project staff. As project manager and research associate, Elizabeth Edsall ensured the success of this project through her dedication, diligence and creativity. The project would not have been possible without her coordination of meetings, comprehensive review of the literature, drafting text, and assistance in editing. Thanks also to William Furmanski for his contributions during the meetings and as editor of the report. In addition, we would be remiss if we did not extend our appreciation to the staff of CTC who were essential to ensuring the success of this project through the planning and execution of the three meetings. These individuals include Craig Kirchoff, Carolyn Reyes, and Glenda Taylor.

We are extremely grateful to a handful of skilled writers and editors who crafted the extensive content compiled throughout the roundtable process and distilled it into compelling narrative. These individuals include writers Michele Chang and Maureen Miller, managing and copy editor Helen Glenn Court and assistant Jennifer Dorr, who coordinated compilation of the content in the report's multiple appendices.

Finally, we would also like to thank the following individuals for their generous support to this project: Elaine Arkin, who facilitated a meeting and reviewed parts of the report, and Elizabeth Laws, who attended meetings and served as liaison with the Pacific Center on Health and Tobacco.

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December 2003

FIGURE 1: WHAT WORKS IN TOBACCO CESSATION

1. Increasing the unit price of tobacco products
2. Smoking bans and restrictions
3. Mass media campaigns
4. Physician intervention – five A's
5. Counseling (individual, group, quitlines)
6. Pharmacotherapy (six FDA approved meds)
7. Reducing patient out-of-pocket costs
8. Reminder systems (for clinical settings)

EXECUTIVE SUMMARY

Cessation is a key component of our national effort to eliminate the health, social and economic consequences of the tobacco epidemic. Fortunately, there is a solid foundation of research to guide these cessation efforts.

Thirty years of research in tobacco cessation has provided a framework for what works, with state efforts serving as virtual laboratories for developing and evaluating comprehensive approaches to reduce tobacco use.¹ Today we have a strong evidence base for effective cessation activities. Two recently developed and nationally recognized guidelines—*Treating Tobacco Use and Dependence. A Clinical Practice Guideline*² and *Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health care systems. A report on recommendations of the Task Force on Community Preventive Services*³—identify effective clinical and public health interventions and recommend how best to use them. (Figure 1.) Success depends on how well these recommendations are implemented. Even with what we know about what works in cessation, translating these findings into policy and practice remains a challenge. A reported 70 percent of smokers want to quit. And approximately 41 percent try to do so each year.⁴ Regrettably, recent data show that fewer than 20 percent of tobacco users used a cessation aid such as over-the-counter nicotine

replacement therapies (NRT) in their most recent quit attempt.⁵ Tobacco users who are trying to quit are not getting the treatment they need to be successful.

The implications are sobering. Each year, tobacco use results in more than 400,000 premature deaths in the U.S. and costs in excess of \$157 billion in lost productivity and medical expenditures.⁶ We began the twenty-first century with about 46 million adult and five million young smokers.^{7,8} Although adult smoking prevalence had declined steadily for more than twenty years, from 42 percent in 1965 to 25 percent in 1990, the rate of decline slowed in the 1990s.⁹ Unless this rate of decline can be accelerated, it will be impossible to meet the *Healthy People 2010* goal of reducing cigarette smoking among adults by half (from 24 percent to 12 percent) in the first decade of this century.

The implementation of a comprehensive strategy to treat tobacco dependence would lead to a substantial decrease in prevalence rates and would reduce the number of deaths attributable to smoking. Many states recognize that cessation is a critical component of their statewide tobacco control programs. In recent years, a few pioneering states have developed comprehensive cessation efforts. But to help the millions of Americans who want to break free from dependence on tobacco, every state must be enabled to organize, finance and deliver a comprehensive approach to cessation.

Helping the millions of Americans who want to end their tobacco dependence requires not only state level efforts but also the concerted efforts of national organizations, public health and health care leaders, and researchers. Although this report focuses on expanding statewide cessation activities, members of the Roundtable acknowledge the critical importance of national leadership. The national and state efforts not only are complementary but also synergistic. Coordinated advances at the local, state and national levels are essential for progress in tobacco cessation.

THE CURRENT ENVIRONMENT: STATE AND NATIONAL CESSATION ACTIVITIES

Significant progress has been made over the past decade in developing and implementing national, state and local cessation efforts, through support from American Cancer Society (ACS), American Legacy Foundation (Legacy), Centers for Disease Control and Prevention (CDC), National Cancer Institute (NCI), and The Robert Wood Johnson Foundation (RWJF). These efforts have sought to expand cessation activities through funding, advocacy, partnership, technical assistance, and research. As state cessation activities have grown, similar growth has occurred at the national level. Key cessation activities by state government, managed care organizations, employers and the federal government are described below.

STATE EFFORTS. In the past decade, states have taken great strides in establishing public policies that encourage and support smokers in quit attempts (i.e., increased excise taxes, smoking restrictions and bans, and mass media campaigns) and in expanding the availability of treatment services that increase the likelihood of success in quitting (i.e., counseling and pharmacotherapy). Currently, sixteen states have excise taxes of \$1.00 or more on cigarettes. A majority of states have increased smoking restrictions and bans. Thirty-four states provide population-based cessation

counseling services through a statewide telephone quitline available to all residents. A growing number of states provide support to Medicaid beneficiaries by covering counseling services (10 states) and pharmacotherapy (35 states). (Table A.)

An ever-present challenge for statewide cessation efforts is the sustainability of state tobacco control funding. Although 2001 and 2002 were peak funding years for state tobacco control programs, the programs experienced dramatic changes in funding in the face of national economic declines and state budget deficits. Since early 2003, twenty-three state tobacco control program budgets have been cut, some by 90 percent or more. States with model programs have not been immune to cuts (e.g. Florida, Massachusetts, and Minnesota). Unfortunately, the major national funding organizations (RWJF, CDC, Legacy, NCI and ACS) are experiencing level or reduced budgets and are unable to compensate for state budget shortfalls. It is more important now than ever before to invest public health dollars with care.

EFFORTS BY EMPLOYERS AND MANAGED CARE

ORGANIZATIONS. Employers and managed care organizations are important stakeholders in tobacco cessation treatment. Employer-based health care benefits cover over 60 percent of Americans. Nearly 70 percent of all people in the U.S – commercial and public sectors – receive their health care through a managed care plan.

Recent surveys indicate that about 28 percent of employers provide some type of coverage for tobacco cessation. Of those surveyed, 16 percent covered counseling, 24 percent covered prescription pharmacotherapy, and 8 percent covered over-the-counter pharmacotherapy.¹⁰ Maintaining and enhancing coverage by employers is a challenge due to the increasing cost of health care benefits.

Managed care organizations have made significant progress in expanding cessation services. Over half of these health plans cover behavioral interventions and 86 percent cover pharmacotherapy.¹¹ More and more, tobacco cessation services are being integrated into regular medical care.

FEDERAL EFFORTS. The federal government has advanced a number of important initiatives on cessation recently. First, the Office of Personnel Management encouraged coverage of tobacco cessation services for all federal employees by the health care benefit providers. This resulted in coverage for more than 50 percent of the lives covered. Second, in 2002 Congress drafted legislation that would provide coverage for tobacco cessation services under Medicaid, Medicare and the Maternal and Child Health Block Grant program. Although the legislation was not enacted, it demonstrates an understanding of the importance of reimbursement for these services by some members of Congress. Third, the U.S. Department of Health and Human Services sought advice from the Interagency Committee on Smoking and Health (ICSH) about ways it could advance tobacco cessation efforts. This initiative is described in detail below.

In August 2002, the ICSH established a subcommittee on cessation and directed it to develop a series of recommendations to increase substantially the rates of tobacco cessation in the United States. After three public hearings and two additional meetings, the subcommittee published its National Action Plan for Tobacco Cessation.¹² (Figure 2.)

The action plan is an important policy document for tobacco cessation. It synthesizes knowledge about effective tobacco cessation treatments and gaps in treatment availability, and identifies appropriate roles for the federal government. The report lists ten ways in which the federal government can advance cessation through

TABLE A: STATE SNAPSHOTS: TOBACCO CESSATION STATUS AND ACTIVITY

(Compiled by the Center for Tobacco Cessation.)

STATE	POPULATION ¹ SMOKING PREVALENCE ² (MILLIONS)	ADULT TOBACCO SETTLEMENT REVENUES ³ (MILLIONS)	TOBACCO CONTROL INVESTMENT (MILLIONS) ⁴ (% OF CDC MINIMUM)	EXCISE TAX ⁵ (\$ PER PACK OF CIGARETTES)	SMOKING-ATTRIBUTABLE DIRECT MEDICAL EXPENDITURES ⁶ (MILLIONS)	Y/N	MEDICAID COVERAGE FOR CESSATION SERVICES ⁷ (COUNSELING FORMATS)	MEDICAID COVERAGE FOR CESSATION SERVICES ⁷ (MEDICATION OPTIONS)
Alabama	4.4	25.30%	\$179	\$0.36 (1%)	\$0.165	\$1,171	No	None
Alaska	0.6	25.00%	\$69	\$5 (62%)	\$1.00	\$132	Yes	None
Arizona	5.1	18.60%	\$337	\$18.27 (66%)	\$1.18	\$1,006	Yes	Zyban
Arkansas	2.7	25.20%	\$153	\$16.39 (92%)	\$0.59	\$633	Yes	Zyban
California	33.9	17.20%	\$2,200	\$88.35 (54%)	\$0.87	\$7,137	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
Colorado	4.3	20.10%	\$164	\$15 (61%)	\$0.20	\$1,026	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
Connecticut	3.4	20.00%	\$374	\$0.58 (3%)	\$1.51	\$1,273	Yes	None
Delaware	0.8	23.00%	\$56	\$5 (58%)	\$0.55	\$221	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
D.C.	0.6	20.90%	\$66	\$0 (0%)	\$1.00	\$190	No	Nasal Spray, Zyban
Florida	16.0	23.20%	\$954	\$37.50 (48%)	\$0.339	\$4,933	Yes	Group, Individual
Georgia	8.2	23.60%	\$269	\$19.07 (45%)	\$0.37	\$1,758	Yes	None
Hawaii	1.2	19.70%	\$114	\$10.25 (95%)	\$1.30	\$263	No	Nasal Spray, Inhaler, Zyban
Idaho	1.3	22.40%	\$54	\$1.27 (12%)	\$0.57	\$249	No	None
Illinois	12.4	22.30%	\$1,070	\$12 (19%)	\$0.98	\$3,205	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
Indiana	6.1	27.00%	\$329	\$32.50 (93%)	\$0.555	\$1,627	No	Individual
Iowa	2.9	23.30%	\$156	\$5.08 (26%)	\$0.36	\$794	Yes	None
Kansas	2.7	21.10%	\$201	\$0.50 (3%)	\$0.79	\$724	Yes	Group, Individual
Kentucky	4.0	30.50%	\$144	\$3 (12%)	\$0.03	\$1,170	No	None
Louisiana	4.5	24.10%	\$311	\$8 (30%)	\$0.36	\$1,151	Yes	Nasal Spray, Inhaler, Zyban
Maine	1.3	23.80%	\$151	\$15.17 (135%)	\$1.00	\$470	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
Maryland	5.3	20.60%	\$444	\$30 (101%)	\$1.00	\$1,533	No	Nasal Spray, Inhaler, Zyban
Massachusetts	6.3	20.00%	\$747	\$4.80 (14%)	\$1.51	\$2,765	Yes	None
Michigan	9.9	24.20%	\$1,200	\$0 (0%)	\$1.25	\$2,655	No	Zyban, Gum, Patch
Minnesota	4.9	19.80%	\$439	\$37.55 (131%)	\$0.48	\$1,610	Yes	Group, Individual
Mississippi	2.8	23.50%	\$214	\$20 (106%)	\$0.18	\$561	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
Missouri	5.6	27.20%	\$268	\$0 (0%)	\$0.17	\$1,668	No	None
Montana	0.9	18.90%	\$44	\$0.38 (4%)	\$0.70	\$216	None	Nasal Spray, Inhaler, Zyban, Gum, Patch
Nebraska	1.7	21.40%	\$111	\$7 (53%)	\$0.64	\$419	Yes	None
Nevada	2.0	29.10%	\$107	\$4.28 (32%)	\$0.80	\$440	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
New Hampshire	1.2	25.40%	\$71	\$3 (28%)	\$0.52	\$440	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
New Jersey	8.4	21.00%	\$942	\$30 (67%)	\$2.05	\$2,480	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
New Mexico	1.8	23.60%	\$63	\$5 (37%)	\$0.91	\$360	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
New York	19.0	21.60%	\$2,280	\$40 (42%)	\$1.50	\$6,380	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
North Carolina	8.0	26.10%	\$209	\$6.20 (15%)	\$0.05	\$1,924	No	Nasal Spray, Inhaler, Zyban
North Dakota	0.6	23.30%	\$47	\$2.50 (31%)	\$0.44	\$194	No	Zyban, Gum, Patch
Ohio	11.4	26.30%	\$940	\$27 (44%)	\$0.55	\$3,416	Yes	Inhaler, Zyban, Gum, Patch
Oklahoma	3.5	23.30%	\$144	\$2.45 (11%)	\$0.23	\$908	Yes	Zyban, Gum, Patch
Oregon	3.4	20.80%	\$185	\$11.09 (53%)	\$1.28	\$871	Funding Suspended 04/03	Nasal Spray, Inhaler, Zyban, Gum, Patch
Pennsylvania	12.3	24.30%	\$1,270	\$52 (79%)	\$1.00	\$4,053	Yes	None
Rhode Island	1.0	23.50%	\$149	\$3.30 (33%)	\$1.71	\$396	Yes	Group, Individual
South Carolina	4.0	24.70%	\$114	\$2 (8%)	\$0.07	\$854	No	None
South Dakota	0.8	22.00%	\$44	\$2.93 (34%)	\$0.53	\$214	Yes	Zyban
Tennessee	5.7	25.70%	\$293	\$0 (0%)	\$0.20	\$1,691	No	None
Texas	20.9	22.00%	\$1,140	\$12.50 (12%)	\$0.41	\$4,552	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
Utah	2.2	12.90%	\$92	\$7 (46%)	\$0.695	\$273	Yes	() Group, Individual, Telephone
Vermont	0.6	21.50%	\$79	\$5.20 (66%)	\$1.19	\$183	Yes	Nasal Spray, Inhaler, Zyban, Gum, Patch
Virginia	7.1	21.50%	\$162	\$22.20 (67%)	\$0.025	\$1,629	No	Nasal Spray, Inhaler, Zyban
Washington	5.9	20.70%	\$529	\$26.24 (79%)	\$1.425	\$1,528	Yes	None
West Virginia	1.8	26.10%	\$98	\$5.85 (41%)	\$0.55	\$539	Yes	Individual, Telephone
Wisconsin	5.4	24.10%	\$446	\$15.50 (50%)	\$0.77	\$1,580	Yes	Individual
Wyoming	0.5	23.80%	\$25	\$3 (41%)	\$0.60	\$106	Yes	None

ENDNOTES (TABLE A)

¹ U.S. Census Bureau, "State and County QuickFacts," last revised 30 May 2002; <http://quickfacts.census.gov/qfd>.

² CDC, Tobacco Control State Highlights 2002: Impact and Opportunity. Atlanta, GA: Smoking-Attributable Medicaid Expenditures. http://www.cdc.gov/tobacco/statehi/html_2002/direct_expenditures.htm & [medicaid.htm](http://www.cdc.gov/tobacco/statehi/html_2002/direct_expenditures.htm). Source: CDC, Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Adult SAMMEC software, 2002c. Available at: <http://www.cdc.gov/tobacco/sammecc>.

³ Campaign for Tobacco-Free Kids, et al., *Show Us The Money: A Report on the States' Allocation of the Tobacco Settlement Dollars*, January 2003. <http://tobaccofreekids.org/reports/settlements>.

⁴ Ibid. The dollar figure shows the amount of state funding for tobacco control for FY03. The figure in parentheses indicates the percentage of State funding compared to the CDC recommended annual funding (lower estimate).

⁵ Campaign for Tobacco-Free Kids, *2003 State Cigarette Excise Tax Rates & Rankings*, July 24 2003. <http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf>.

⁶ Center for Tobacco Cessation survey of states, 2002, (updated with program changes through Sept 2003).

⁷ CDC, "State Medicaid Coverage for Tobacco-Dependence Treatments—United States, 1994 and 2001". *MMWR*; 52(21):496–500, 2003; <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5221a3.htm>. and Center for Health and Public Policy Studies, State Medicaid Tobacco Dependence Treatment Survey, University of California, Berkeley, 2002.

FIGURE 2: ICSH RECOMMENDATIONS

FEDERAL INITIATIVES

- Establish a federally-funded National Quitline Network
- Launch an ongoing, extensive paid media campaign
- Include coverage for cessation treatment in federally-funded health care programs and for federal employees
- Invest in a new, broad, and balanced research agenda
- Invest in cessation training and education for clinicians
- Increase federal excise tax by \$2.00 per pack and dedicate at least half of the funds generated from the new excise tax to create a Smokers' Health Fund

PUBLIC-PRIVATE PARTNERSHIP INITIATIVES

- The Secretary should work with insurers, employers, and purchasers to provide tobacco cessation coverage as part of basic benefits packages
- The Secretary should advocate for systems-level changes and quality improvement with private sector colleagues
- The Secretary should work in partnership with national quality assurance and accreditation organizations and health care stakeholders to ensure a standard of care and measurement in all health care settings
- The Secretary should initiate and support partnerships between HHS and community-based organizations

direct activities (i.e., federal funding for states, national technical and research activities, and federal excise tax) and indirect activities (i.e., partnership activities with community-based organizations and health care providers and payers).

Taken together, these three federal initiatives demonstrate the kind of leadership role the federal government can play in tobacco cessation.

ROUNDTABLE RECOMMENDATIONS

Roundtable members' recommendations reflect the lessons learned from six states (Arizona, California, Maine, Massachusetts, Oregon and Washington) leading the way in cessation efforts and are informed by research findings and expert opinions. The recommendations are organized as a set of four action areas determined to be essential components of any comprehensive statewide cessation strategy. They include both macro- and micro-level changes, the first to improve state efforts and the second to leverage and implement those efforts.

- Organize comprehensive statewide cessation services and activities.
- Finance comprehensive statewide cessation services and activities.
- Deliver comprehensive statewide cessation services and activities.
- Evaluate comprehensive statewide cessation services and activities.

ACTION AREA 1

Organize comprehensive statewide cessation services and activities.

Each state is unique in its approach to public health, health care and tobacco control. As a result, no single organizational model will fit all states. The recommendations in this action area reflect the common

actions taken by states to organize comprehensive cessation services and activities.

RECOMMENDATIONS

1. Identify and convene key cessation stakeholders, from both public and private sectors and public health and health care areas, to develop and advance a comprehensive cessation effort at the state level.
2. Conduct statewide needs and resource assessments, including evaluation of existing capacity and inventory of available resources and services to inform strategy and program development.
3. Identify and seek financial and political support for capacity building and program implementation.

ACTION AREA 2

Finance comprehensive statewide cessation services and activities.

The complexities of financing our nation's health care system present one of the greatest challenges to successful implementation of effective tobacco cessation services. A lack of universal health insurance and a delivery system composed of multiple purchasers, payers and providers forms a barrier between effective treatment and the provision of that treatment. Financing cessation treatment is a key determinant in utilization and treatment delivery. It is essential that key stakeholders assume some level of financial accountability for cessation services and activities.

RECOMMENDATIONS

1. Increase health insurance coverage of effective tobacco dependence treatments. This includes the expansion of coverage for effective tobacco dependence treatments to all public beneficiaries by state and federal governments. In addition, employers should provide for expanded health insurance coverage for effective tobacco dependence treatments to all private insurance beneficiaries. And governmental and nongovernmental organizations should work collaboratively to provide access to effective tobacco dependence treatments for the uninsured.
2. Expand provider reimbursement for delivery of effective tobacco dependence treatments. Both public and private payers should provide reimbursement.
3. Eliminate or reduce out-of-pocket costs for cessation treatment. Both public and private payers should adopt such policies.
4. Dedicate a portion of the state's tobacco excise tax or Master Settlement Agreement funds to cover the costs of population-based cessation treatment. Legislators and governors should allocate these funds.
5. Fund state tobacco cessation quitlines. State and federal governments should include funding for quitlines in their budgets.

ACTION AREA 3

Deliver comprehensive statewide cessation services and activities.

A comprehensive statewide cessation effort includes the activities that encourage and support smokers in quit attempts (i.e., increased excise tax, smoking restrictions and bans, and mass media campaigns) and the treatment services that increase the likelihood of success in quitting (i.e., counseling and pharmacotherapy). Since multiple organizations deliver these services and activities, it is essential to develop an integrated approach. Innovative states have utilized quitlines as the hub of their comprehensive statewide cessation services, building referral and feedback capacity between the quitline and health care providers, and assuring flexibility in counseling services available to smokers who want to quit. In these states, the quitline not only has provided important cessation services, but also has increased the level of related activities among key stakeholders. Multiple portals for entry into the quitline should be available, since smokers seek treatment both in the community and through the health care system.

RECOMMENDATIONS

I. Enhance partnerships between cessation stakeholders and tobacco control advocates to promote sustained population-based tobacco control activities to create an environment that encourages cessation. These activities should include the following, for which there is evidence of success:

- Increases in the unit price of tobacco products (excise taxes)

- Mass media campaigns
- Clean indoor air ordinances/smoking bans in public and private places

2. Establish high quality quitline services in all states. At a minimum, the quitline should provide proactive telephone counseling services to smokers and referrals for those who seek face-to-face counseling. States should consider dispensing pharmacotherapy via the quitline and building referral and feedback capacity between the quitline and health care providers.

3. Improve health care systems' ability to provide effective tobacco dependence treatments by promoting internal health care system changes (making smoking a vital sign for all patient visits, adding smoking status to patients' permanent medical records, developing reminder systems, providing training for clinicians, and establishing protocols that assure delivery of the five A's—asking smoking status, advising to quit, assessing willingness to quit, assisting with cessation treatment, and arranging follow up care).

4. Promote changes external to the health care system that increase delivery of effective cessation treatments. For example, incorporate cessation into accreditation and other performance and quality care rating systems (e.g. HEDIS, CAHPS, JCAHO-ORYNX) and utilize purchasing power in the public and private sectors to expand cessation services to be covered and provided by a health plan/insurer.

5. Develop, operate, and market quitlines, community-based cessation services and clinic-based cessation services so they are widely accessible and offer effective treatments for people of all socio-economic status, educational level, racial and ethnic backgrounds and those who use different forms of tobacco.

Increase consumer awareness of and demand for cessation services via mass media, policy changes (e.g. tax increases and smoking bans), and efforts that reduce out-of-pocket costs for counseling and pharmacotherapy (e.g. NRT disbursement by quitline).

ACTION AREA 4

Evaluate comprehensive statewide cessation services and activities.

Evaluation of statewide cessation services and activities is an important factor in improving program services. Through evaluation efforts, states can identify strategies for improving the quality and reach of their treatment services. Evaluation results also are a critical component in payer decision making about coverage and reimbursement.

RECOMMENDATIONS

1. Strengthen surveillance capacity and evaluation measures (in accordance with OMB regulations and directives) at the individual program and statewide levels. State government, researchers and cessation program providers should lead an effort to standardize surveillance and evaluation measures for cessation.

2. Analyze evaluation information collected at the individual program and statewide levels to measure impact and degree of integration. State government, researchers and cessation program providers should lead this effort.

3. Utilize evaluation information for evidence-based decision-making to improve future performance at the individual program level and advance the statewide cessation effort. State government and cessation program providers should lead this effort.