Oregon Tobacco Control Integration Project
Final Report

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Component II

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Oregon Health Authority

Executive Summary

Tobacco use remains the leading killer of Oregonians, with 7,000 people dying annually from their tobacco use and an additional 800 dying due to exposure to secondhand smoke. Despite significant progress in reducing tobacco prevalence, disparities remain. Oregon adults who have not completed high school or who have incomes below the federal poverty line are three times more likely to smoke than Oregonians with higher income and educational attainment.

Smokers with fewer economic and educational resources are also disproportionately likely to be clients of Oregon's Department of Human Services (DHS) or Oregon Health Authority (OHA). DHS and OHA provide services to 1 million people—almost 1 in 4 Oregonians. However, Oregon's Tobacco Prevention & Education Program (TPEP) estimates that almost half of Oregon's adult smokers are DHS or OHA clients.

The Tobacco Control Integration Project (TCIP) is a partnership between Oregon's TPEP and all of the State Divisions delivering health and social services to low-income Oregonians. TCIP's goal is to reduce tobacco use disparities among Oregonians with fewer resources.

With funding from an American Recovery & Reinvestment Act (ARRA) grant, TCIP project staff helped Oregon State government agencies create tobacco-free environments and promote smoking cessation. Five of 10 proposed policy changes were passed during the two-year grant period, and much progress was made in the other five proposed areas. In addition, TCIP staff implemented a hard-hitting media campaign focused on helping low-income tobacco users quit.

Three of the policies that were adopted were high-intensity cessation efforts focused on a high prevalence, vulnerable population—people with addictions and mental health issues. A fourth policy requires all insurance plans serving Medicaid clients to provide annual documentation of the cessation services provided, creating greater accountability and, hopefully, standardization of benefits to the approximately 300,000 low-income adult beneficiaries, about one-third—or 100,000—of whom smoke. The fifth policy requires ongoing cessation messaging to home care and personal services workers —another population with high tobacco use. Approximately 18,000 low-income workers provide in-home and agency-based services to the frail elderly and people with developmental and physical disabilities.

The ARRA funding has ended, but TCIP's work continues. TCIP's mission has been integrated into a new cross-agency workgroup that involves the highest level of leadership at OHA and DHS, the two State agencies that provide health and social services to low income Oregonians. The new workgroup has chartered the project formerly known as TCIP, entitling it CAHIP—the Cross-Agency Health Improvement Project. CAHIP will use the TCIP model of working across agencies to pass policies that create healthier environments for clients, staff, and visitors through tobacco cessation and other health promotion efforts.

Program Description

Tobacco Use among Oregonians with Fewer Economic and Educational Resources

Tobacco use remains the leading killer of Oregonians, with 7,000 people dying annually from their tobacco use and an additional 800 dying due to exposure to secondhand smoke. Despite significant progress in reducing tobacco prevalence, disparities remain. Oregon adults who have not completed high school or who have incomes below the federal poverty line are three times more likely to smoke than Oregonians with higher income and educational attainment.

Smokers with fewer economic and educational resources are also disproportionately likely to be clients of Oregon's Department of Human Services (DHS) or Oregon Health Authority (OHA). DHS and OHA provide services to 1 million people—almost 1 in 4 Oregonians. However, Oregon's Tobacco Prevention & Education Program estimates that almost half of Oregon's adult smokers are DHS or OHA clients.[1]

Oregon's Response to the Problem of High Smoking Prevalence among Oregonians with Fewer Resources

Oregon's Tobacco Control Integration Project (TCIP) is a unique approach to reducing tobacco use disparities among Oregonians with fewer resources. TCIP is a partnership between Oregon's Tobacco Prevention & Education Program (TPEP) and all of the State Divisions delivering health and social services to low-income Oregonians.

The overall mission of TCIP is to reduce smoking prevalence among Oregonians with fewer educational and financial resources. The project aimed to achieve this by meeting four goals:

1. Increase the number of DHS/OHA-related facilities with written 100% smoke-free/tobacco-free campus policies.
2. Increase the number of policies within DHS/OHA that require the promotion of, access to, and delivery of cessation resources to clients and employees.
3. Implement a hard-hitting statewide counter-advertising campaign targeted at people experiencing fewer resources and educating about the dangers of secondhand smoke and manipulation by the tobacco industry, as well as encouraging quitting and calls to the QuitLine.
4. Raise the price of tobacco in Oregon by 10%.

This final evaluation report addresses Goals 1 and 2 in detail; information on Goals 3 and 4 are provided in the "Supporting Information" section (S2-S3).

[1] All abbreviations and acronyms used in this report are defined at first use. Because of the sheer volume of abbreviations used in State government, however, a table is provided in the Supporting Information section (S1) for the reader's use.

Methodology & Results by Objective

TCIP had 10 policy objectives addressing Goals 1 and 2: increasing the number of State facilities with 100% smoke-free/tobacco-free campus policies and increasing the number of policies requiring the promotion of, access to, and delivery of cessation resources to clients and employees. These policy objectives spanned multiple divisions of the Oregon State government, and each required different approaches. Overall logic models presenting links between activities, objectives, and goals can be found in the Supporting Information section (S4).

During the course of the grant, the Department of Human Services (DHS) underwent a major reorganization. As of July 1, 2011, DHS split into two administrative agencies—DHS and the Oregon Health Authority (OHA). DHS retained administrative control of services for Children, Adults & Families (CAF) and Seniors & People with Disabilities (SPD), while OHA assumed leadership for Public Health, Medical Assistance Programs (DMAP), and Addictions & Mental Health (AMH). This reorganization was an important backdrop to the cross-agency policy work that TCIP was working towards, and, in some cases, it prevented TCIP from moving forward as originally planned on specific policy objectives.

Overall, 5 of 10 policies were passed as originally written in the ARRA grant, and much progress was made towards achieving the grant goals in the areas where no policies were passed. In this section, each objective will be reported on individually or grouped with similar objectives.

Quick Assessment: Progress on 10 TCIP Policy Objectives

Policy Area	**Policies Adopted?**	**Comments**
Actively promoting smoking cessation and preventing secondhand smoke exposure among addictions & mental health clients and employees	**Yes**	Three policies passed, including mandates for 100% smoke-free campuses at all residential treatment facilities for addictions and mental health, provision of cessation resources at discharge, and prohibition of tobacco distribution from staff to clients.
Proactive cessation messaging to low income workers serving seniors and people with disabilities	**Yes**	Oregon Home Care Commission policy requiring quarterly messaging passed. Quarterly cessation messages distributed to all home care workers; proactive Quit Line calls to home care workers who self-identified as tobacco users.
Linking Oregon Health Plan clients to high quality cessation services	**Yes & No**	Policy passed requiring all plans serving OHP clients to provide annual documentation of cessation services provided to DHS clients; first report produced. Minimum standards for cessation developed, but no policy passed requiring all plans to adopt them.
Incorporating 100% SF/TF campus policy into contracts, Request for Proposals (RFPs), and RFP scoring	**No**	SF/TF policy was not incorporated into all contracts, RFPs, and RFP scoring, but a pilot was conducted inserting language into public health contracts and RFPs. The Portland State Office Building, a hub of State government activity in the Portland area, with 1,200 employees, passed a 100% SF/TF policy.
Proactive cessation messaging to DHS/OHA clients through varied media and CAF offices	**No**	Policies were not adopted, although client cessation materials were developed and made available to the CAF population. Cessation messages were delivered 3 times through payroll stubs and are ongoing through Quit Line Web buttons/links on State Web sites and a telephone hold message.

Objectives 1c, 2e & 2f: Actively Promoting Smoking Cessation and Preventing Secondhand Smoke Exposure among Addictions & Mental Health Clients and Employees

The three policy objectives were:

- **Objective 1c:** By Jan 30, 2012, establish an Addictions & Mental Health (AMH) policy requiring all clinics and treatment centers treating AMH clients or receiving DHS/AMH funds to have 100% SF/TF campuses.
- **Objective 2e:** By Jan 30, 2012, establish an AMH policy requiring a cessation plan that includes follow-up referrals and medications to all clients discharged from an AMH residential facility.
- **Objective 2f:** By Jan 30, 2012, establish an AMH policy prohibiting DHS staff from providing tobacco to clients.

Quick Assessment:
These three policies were adopted on October 1, 2011 and will be implemented in two phases: policies addressing 2e and 2f were implemented on Jan 1, 2012; the policy addressing 1c will be implemented on July 1, 2012.

Key Accomplishments:

- Key partnerships were developed between TCIP and AMH staff, including the formation of two workgroups that each met monthly for the duration of the grant: a policy workgroup and a peer-based tobacco cessation workgroup. Both workgroups had representation from AMH and public health leadership and staff, as well as AMH consumers, advocates, and community members.
- Secured strong commitment from AMH leadership for the policy changes, including multiple communications from the AMH Director supporting policy changes, development of a branded campaign for cessation among people with mental health and addictions called “Tobacco Freedom,” and designation of a .5FTE AMH staff member to assist with policy-related activities.
- Development and dissemination of Oregon Consumer/Survivor Council position statement supporting tobacco cessation efforts among AMH residents and clients/consumers (see S5).
- Tobacco policy survey conducted with 162 of 166 (98%) addictions and mental health residential treatment facilities in Oregon; gathered baseline data and assessed needs related to future policy implementation.
- Nine tobacco cessation and policy-related trainings conducted; 132 AMH facility staff members, 62 peer advocates and consumers, and 68 clinicians received training.
- Comprehensive 100% TF/SF campus policy and two cessation-related policies passed for all AMH residential treatment facilities on 10/1/11.

- Resources for policy implementation available to clinicians and other staff at AMH treatment facilities on an ongoing basis through Tobacco Freedom website: (http://www.oregon.gov/OHA/addiction/tobacco-freedom/main.shtml)
- Dissemination of results through a peer-reviewed publication "Promoting Smoke-free Environments and Tobacco Cessation in Residential Treatment Facilities for Mental Health and Substance Addictions, Oregon, 2010," published in Preventing Chronic Disease on Dec 15, 2011 (provided in Supporting Information, S6).

What Worked Well:
Efforts to promote adoption of tobacco cessation policies at AMH residential treatment facilities succeeded because of the strong partnerships that were formed between diverse AMH and public health stakeholders. Monthly meetings kept the many activities on track and created ongoing buy-in from all parties. Strong leadership from the AMH Director was key, as was ongoing consumer and advocate involvement. Commitment from leadership and consumers was demonstrated with tangible acts, such as the Director's memo to stakeholders endorsing the Tobacco Freedom campaign and proposed policy changes (see Supporting Information, S7) and an addictions and mental health client/consumer-sponsored contest to design artwork for the smoke-free facility signs at AMH residential facilities (www.flickr.com/photos/tobaccofreedom).

Joint AMH-public health efforts to ensure smooth implementation of the new policies, once adopted, also helped ensure wider support. Survey data helped identify areas on which to focus training and other types of support for facility staff. Over the two-year period, TCIP staff noted a shift in attitudes among AMH facility staff participating in training; early training participants seemed skeptical, while participants at later trainings expressed a greater spirit of receptivity and collaboration.

What Could Have Worked Better:
Although they are under the same overall administrative structure, mental health and substance abuse services have historically been siloed. For example, the two services have different sets of stakeholders and are governed by different Administrative Rules. Although the overall process was smooth, passing policies that covered both types of facilities took longer than expected because of some confusion among the different types of behavioral health providers.

In addition, in Oregon, behavioral health providers can't be reimbursed directly for smoking cessation services. Therefore, they need to refer these services out to a primary care provider. This extra step creates more work for them and may have been a barrier to earlier adoption of smoking cessation policies at AMH facilities.

Why It Matters:
As reported in Preventing Chronic Disease, 35% of Oregon adults who report "depression, anxiety, or emotional problems" smoke compared with 16% overall; national smoking rates

among people with serious mental illness or addictions are even higher. Adults with mental illness attempt to quit smoking at rates similar to others, but are less successful. Effective treatments for these populations are available, but concerns about interference with addiction treatment or exacerbation of psychiatric symptoms have inhibited mental health and substance addiction facilities from offering cessation services to patients.

Our survey of AMH facilities found that only 15% of facilities had comprehensive 100% SF/TF campus policies at their facilities before the statewide policy mandates were passed, and only 47% offered cessation resources at patient discharge. Most (82%) reported existing facility policies prohibiting tobacco distribution by staff to residents, but alcohol and drug facilities (96%) were significantly more likely to have such restrictions than either secure (73%) or non-secure mental health facilities (76%).

At the time of the survey, fewer than 10% of administrators objected to the three proposed future tobacco policies, and about equal numbers welcomed statewide mandates requiring them.

Smoke-free campus and cessation policies can help residents quit smoking long-term. Administrators at the 162 participating facilities reported that they served 2,499 residents, and employed 856 clinical professionals and 2,542 other staff members. At any point in time, approximately 6,000 people, including residents and staff, could benefit from the new smoke-free policies being implemented at all AMH facilities.

These three policies represent a high intensity strategy, with comparatively narrow reach. Although fewer DHS/OHA clients receive services in AMH residential treatment facilities compared to a program like the Supplemental Nutrition Assistance Program (SNAP), they receive intensive, 24-hour services, for a long duration. The average length of stay at Oregon residential facilities is approximately 100 days for alcohol and drug treatment and more than one year for mental health treatment, allowing residents to quit and stay quit beyond the relapse curve, thus enabling long-term cessation.

Case Study: Mental health advocate pushing for statewide Tobacco Freedom

Meghan Caughey of Alpine is helping the Oregon Addictions and Mental Health Division take a significant step forward in ensuring the health and well-being of the people it serves.

In July 2012, all AMH-funded residential treatment facilities statewide become tobacco free inside and out as part of Tobacco Freedom. The wellness initiative, which Caughey helped create, aims to reduce early death among mental health services consumers through the tobacco-free AMH policy and tobacco cessation resources offered to clients.

For Caughey, who has schizophrenia, the move represents an important shift in attitude about tobacco use within the mental health treatment community. According to the National Association of State Mental Health Program Directors, people with serious mental illness on average die 25 years younger than the general population, largely from conditions caused or worsened by smoking. Nearly half of all cigarettes consumed in the United States are by individuals with psychiatric disorders. An estimated 90 percent of people with schizophrenia smoke.

With help from TPEP's Tobacco Control Integration Project, Caughey, a peer wellness coordinator and consultant, is working to spread the word about Tobacco Freedom through the state's addictions and mental health community.

"My peers have told me that smoking is like their best friend," Caughey says. "We need to help people connect to other people instead of a pack of cigarettes."

Objective 2g: Proactive Cessation Messaging to Low Income Workers Caring for Seniors & People with Disabilities

The original policy objective was:

- **Objective 2g:** By Jan 30, 2012, establish a SPD/Home Care Commission policy requiring quarterly promotion of cessation benefits to Home Care Workers caring for SPD clients.

Quick Assessment:
This policy was unanimously passed by the Oregon Home Care Commission in January 2011.

Key Accomplishments:

- Comprehensive workgroup formed, including Home Care Commission members, local union members, home care workers, public health representatives, and people who hire home care workers. The workgroup met monthly.
- On-line marketing survey of home care workers conducted in October 2010; the main purpose was to test messages promoting tobacco cessation and preferred means of receiving communications. However, respondents were also asked about smoking status and whether they would be willing to receive free information on health and wellness, including smoking cessation and other health topics. (See Supporting Information Section, S8)
- Policy requiring quarterly cessation messaging to home care workers passed unanimously by Oregon Home Care Commission.
- Information shared in quarterly newsletters (the information source preferred by most HCW survey respondents) from January 2011 onward.
- Outbound Quit Line calls made to 130 HCW who identified as smokers on the survey and said they would like health information. Among the 67 reached, 29 (51.5%) enrolled in Quit Line services.
- Interest in tobacco-related policies generated among facilities serving elders and people with disabilities. Survey conducted among 139 nursing facilities and 451 community-based facilities serving those populations to assess readiness for smoke-free policy adoption and cessation training. Data indicate that a high proportion of staff smoke (27-28%), compared to about 5% of clients. Most administrators were willing to consider cessation-related policies, including adoption of smoke-free campuses, although they presented many concerns about implementation of such rules.
- Workgroup formed to clarify language in the Indoor Clean Air Act rules related to tobacco use at adult foster homes; cross-agency participation included SPD Medical Director and key stakeholders representing seniors & people with disabilities and public health.

What Worked Well:
The workgroup was initially resistant to any discussion of policy mandates. TCIP staff worked with the work group, initially providing cessation education, and then sharing more information about policy development and implementation. As attitudes towards policy changed among workgroup members, TCIP staff offered to coordinate a survey among HCW to assess their openness to receiving health messages and their preferred means for receiving them. Survey data indicated that a majority of HCW who smoke had tried to quit in the past year and were interested in receiving free information on smoking cessation and other wellness topics. Further, most workers said that they found the Home Care Commission to be a trusted source of information, and would prefer to receive messages through the Commission Web site, e-mails, and newsletter. These data helped move the workgroup towards ownership of the policy, as they wanted to ensure that their work on cessation would be "sustainable." Because the Home Care Commission is an independent body within State government, there were fewer people and less bureaucracy required to pass this policy than some of the proposed policies involving other Divisions. The policy was ultimately passed unanimously, and cessation messaging has been distributed quarterly to HCW through the newsletter.

Surveys at nursing facilities and community-based facilities serving seniors and people with disabilities were developed through a partnership between public health and SPD. The surveys provided valuable baseline data on smoking prevalence among clients and staff, and current facility policies and procedures related to tobacco use.

What Could Have Worked Better:
New relationships between public health and seniors and people with disabilities staff took time to build. SPD leadership was not as active on tobacco policy as leadership in other divisions.

Data indicate that SPD facilities are not as far along the stages of change as AMH facilities serving people with addictions and mental health. Although many SPD facility administrators expressed some level of support for 100% smoke-free campuses and other tobacco cessation-related policies, they also expressed numerous concerns about real or perceived barriers to implementing such policies. In addition, the low reported smoking prevalence among clients, combined with high prevalence among staff, did not provide facility administrators with the kind of motivation to institute such policies as was seen among AMH facilities, where clients have high smoking prevalence and tobacco-related morbidity and excess mortality.

Why It Matters:
The Oregon Home Care Commission is responsible for ensuring the quality of home care services that are funded by DHS for seniors and people with disabilities, and provided by homecare workers (HCW). The Home Care Commission serves as the administrative arm for Oregon's approximately 11,000 HCW.

The Commission establishes minimum standards, provides training, maintains a HCW registry, and serves as the employer of record for collective bargaining purposes.

By passing the policy requiring active promotion of tobacco cessation to their workers, the Home Care Commission established smoking cessation as a priority issue in their advocacy for employees.

HCW are generally low-income workers, with higher rates of tobacco use. Furthermore, HCW are links to the clients they serve, who may also have higher smoking rates. Initial collaboration with the Home Care Commission revealed that the statewide registry of homecare workers contained a field for smoking status. An initial examination of registry data showed that 28% of HCWs registered as smokers, compared with 17% of adult Oregonians. (Similarly, 27-28% of workers at SPD nursing and community-based facilities, respectively, were reported to smoke.) Therefore, cessation messages reach approximately 3,000 low income smokers on a quarterly basis, as well as many thousands of other HCW who may share the cessation information and resources with their families and clients who smoke.

In 2011, the Oregon Home Care Commission's administrative responsibilities expanded to include the approximately 7,000 personal support workers who care for individuals with developmental disabilities. Like HCW, personal support workers are reported to be low income, with high smoking prevalence: another population that will benefit from quarterly cessation messaging.

There are very little data on smoking prevalence and habits among people with developmental disabilities, but SPD workgroups are interested in expanding cessation efforts to this population, and have approached public health to procure or develop low- or zero-literacy materials appropriate to those with developmental disabilities.

Case Study: Family loss becomes home care commissioner's rallying cry

Roxie Mayfield, a disability advocate, hopes to help others avoid family legacies like hers.

"My mother died as a result of secondhand smoke. She died a typical smoker's death. And she never smoked a day in her life," the Eugene resident says.

As a member of the Oregon Home Care Commission, Mayfield is working with TPEP's Tobacco Control Integration Project on an effort to reduce or prevent tobacco use among the state's registered home care workers, 28 percent of whom smoke, according to the commission.

Launched in 2008, TCIP works to weave tobacco control into state Department of Human Services programs to reach nearly half of the estimated 550,000 tobacco users in Oregon, including those who are registered home care workers.

For Mayfield, a TCIP-Home Care Commission partnership is particularly important because, as someone with muscular dystrophy, she uses a wheelchair and relies on home care workers to help her get around.

"Everything possible should be done to fund programs to eliminate smoking from home care situations, particularly where people are vulnerable and have health conditions, like me, that can be adversely affected by tobacco use," she says.

Objectives 2c and 2d: Linking Oregon Health Plan Clients to High Quality Cessation Services

The two specific policy objectives were:

- **Objective 2c:** By Jan 30, 2012, establish a DMAP policy requiring all Managed Care Organizations serving OHP clients to provide documentation annually on how the tobacco cessation services provided to DHS clients meet or exceed tobacco cessation evidence-based standards.
- **Objective 2d:** By Jan 30, 2012, establish a DMAP policy requiring all Managed Care Organizations to provide a mechanism for referring DHS clients to tobacco cessation resources that is standard, consistent among Managed Care Organizations, and easily understood by providers.

Quick Assessment:
The policy in Objective 2c was adopted and the first report was disseminated in 2011. A cross-agency workgroup developed minimum standards to address Objective 2d, but the policy requiring their adoption by all plans was not passed.

Key Accomplishments:

- Key partnerships were developed, including a cross-agency workgroup that met monthly, and included the chronic disease prevention coordinator, stakeholders responsible for rules and contracts, and representatives from public health, the health plans, and the Division of Medical Assistance Programs (DMAP).
- TCIP staff made 7 presentations on tobacco cessation topics, such as return-on-investment of cessation, to Quality Improvement Coordinators and other DMAP stakeholders.
- DMAP adopted a policy requiring all MCOs serving OHP clients to provide documentation annually on how the tobacco cessation services provided to DHS clients meet or exceed tobacco cessation evidence-based standards.
- The first survey of all MCOs serving OHP clients was conducted in 2011 to determine what evidence-based tobacco cessation services MCOs are providing to clients, and the extent to which their clients are using those services. A copy of the report, "Survey of Oregon Health Plan Tobacco Cessation Services: 2011 Survey of Fully Capitated Health Plans and Dental Care Organizations," can be found in the Supporting Information section (S9).
- Cross-agency workgroup developed the Minimum Standards for Tobacco Cessation services, intended for use among all MCOs providing services to OHP clients. (See Supporting Information, S10)
- TCIP Lead secured a place on the new Coordinated Care Organizations workgroup and has introduced the Minimum Standards to the group.

What Worked Well:
Key partnerships were developed in the cross-agency workgroup that was formed around these policies. These relationships will continue as public health works to move the managed care organizations along the stages of change towards full adoption of evidence-based tobacco cessation services for members. Passing the policy requiring annual reporting of cessation services provided provides an important mechanism for tracking progress and orienting discussions around further cessation goals.

What Could Have Worked Better:
Efforts to promote these policies were hampered by budget cuts and reorganization of Medicaid services associated with national Health Care Reform. These efforts lacked a champion from the managed care side. Ongoing reorganization of MCOs to Coordinated Care Organizations (CCOs) added further confusion and complexity. Although the TCIP coordinator secured a seat on the planning body for the new CCOs, efforts to insert the Minimum Standards for Tobacco Cessation into the CCO charter were rejected. High-level leaders have their eyes on broader organizational and systems change issues at the moment.

Why It Matters:
The Oregon Health Plan provided health care coverage to more than 300,000 low-income adults in 2010. Adult Medicaid clients are twice as likely to smoke as Oregon adults overall.

In Oregon, tobacco dependence and cessation services have been covered by OHP since 1998, but there have been little data related to how health plans and providers provide those services, nor data on outcomes. The policy requires that such data be collected and reported. As a result, 2011 was the first year the Division of Medical Assistance Programs (DMAP) systematically assessed how contracted Managed Care Organizations screen for tobacco use and provide the required tobacco dependence and cessation services benefit to Oregon Health Plan members. These data will serve as a baseline for future monitoring and evaluation.

We found in the Survey of Oregon Health Plan Tobacco Cessation Services that tobacco cessation services provided to Oregon Health Plan members varies considerably by plan. While each Fully Capitated Health Plan provides some level of coverage for cessation counseling and medications, as required, many plans do not routinely promote these available benefits to members or ensure provider performance related to tobacco cessation, resulting in low utilization of services. Short of a policy requiring adoption of the minimum standards, annual reporting on these differences may generate healthy competition between plans, with consequent voluntary changes in policy and procedures.

In Oregon, direct Medicaid costs related to smoking are an estimated $287 million per year. This is equivalent to approximately 10 percent of total annual expenditures for Medicaid in Oregon. Reducing smoking prevalence among this population will improve population health and reduce State expenditures.

Objective 2b: Proactive Cessation Messaging to DHS Clients through Children, Adults & Families (CAF) Offices and Communications

The original policy objective was:

- **Objective 2b:** By Jan 30, 2012, establish a CAF policy requiring District offices to display and make available to clients appropriate cessation materials, including Quit Line referrals targeted at the client population.

Quick Assessment:
This policy was not adopted, but client cessation materials were developed and made available to the target population. A policy issue paper was written and submitted to the appropriate decision makers, but has not yet been approved.

Key Accomplishments:

- Key partnerships were built between TCIP and CAF Division leadership and case workers.
- Pilot projects were established in three CAF offices that demonstrated local leadership; local Wellness Committees formed to discuss strategies for integrating tobacco cessation into daily work with CAF clients.
- Quit cards and posters developed; posters and approximately 8,000 quit cards distributed to 16 district CAF offices for distribution through local offices. (See Supporting Information Section, S11)
- A brief exit survey conducted in July 2011 with clients exiting the CAF office in Eugene found that about half of clients (48%) saw the posters and/or Quit cards; 74% said they thought the messages were very or somewhat helpful to smokers trying to quit.
- A policy issue paper addressing ongoing distribution of Quit cards and other cessation materials was developed and forwarded to the Joint Policy Steering Committee for consideration.

What Worked Well:
TCIP staff developed partnerships with staff at local CAF offices in various parts of the State, and initiated grassroots efforts focusing on tobacco cessation. Local offices formed Wellness Committees, and several jurisdictions were enthusiastic about integrating tobacco cessation into their work with CAF clients. The cessation outreach materials were received positively by CAF staff and the policy issue paper is completed and in the right place to be reviewed and adopted should leadership decide to do so.

What Could Have Worked Better:
Ideally, CAF staff could have been trained to integrate a brief intervention based on motivational interviewing into their work with CAF clients at their benefits-related visits. For the most part, CAF line staff was willing to do this, but CAF administration vetoed it. Enrollment in the Supplemental Nutritional Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF) has increased at the same time as State budget cuts have necessitated staff

furloughs, meaning CAF staff have more work to do in less time. As such, CAF Administration was resistant to a policy that might increase staff workload.

Furthermore, during the course of this grant, CAF was disbanded as an administrative entity. Some of the existing partnerships developed during this grant will be maintained, but new players have been introduced, and new partnerships might need to be developed to continue progress towards this policy objective.

Why It Matters:
More than 500,000 adults received SNAP services in 2010, and another 105,000 received cash assistance benefits. These clients are required to periodically meet with case workers, providing opportunities for vast numbers of low income smokers to receive cessation messages. Furthermore, the tailored messaging focusing on the cost of smoking that was presented on the Quit cards and posters resonated with this group of low income individuals, according to anecdotal information and episodic client exit surveys.

However, despite its wide reach, the intervention itself was low intensity (e.g., casual exposure to cessation messaging) and the duration of exposure for most clients was short and infrequent (e.g., a brief introduction to a Quit card or poster when they visited the DHS benefits office). Without a way to easily integrate the cessation messaging into CAF policy, the intervention does not appear to be sustainable or cost-efficient.

Objectives 1a and 1b: Incorporating 100% SF/TF campus policy into contracts, RFPs, and RFP scoring.

The two policy objectives were:

- **Objective 1a:** By 5/30/11, establish a DHS policy requiring Divisions to incorporate language into appropriate DHS contracts and RFPs requiring information on 100% SF/TF campus policies or efforts to implement such.
- **Objective 1b:** By 5/30/11, establish a DHS policy that requires Divisions to incorporate language into the scoring component of appropriate RFPs that awards points for having a written policy establishing a 100% SF/TF campus.

Quick Assessment:
These policies were not adopted, as originally written. However, TCIP staff accomplished several related projects and policy objectives that moved the State of Oregon towards TCIP's goal of increasing the number of workplaces under State of Oregon influence with 100% SF/TF campuses.

Key Accomplishments:

- TCIP staff developed important partnerships with the Deputy Director and key staff in what was then called the Administrative Services Division (ASD). Although ASD was eliminated during the OHA/DHS reorganization (see more below, in "What Could Have Worked Better"), these relationships were important, as the former Deputy Director was the gatekeeper for making changes to relevant policies and procedures.
- The Deputy Director worked with TCIP staff to integrate optional TF/SF language into the vendor contracting and RFP processes through the then-DHS Office of Contracts and Procurement. The Deputy Director agreed to evaluate the efficacy of voluntary adoption of TF/SF language, in anticipation of the possibility of future mandated language.
- After ASD disbanded, TCIP staff developed a pilot to include SF/TF language into contracts and RFPs issued through Public Health. The pilot was established for one year and agreements were made to evaluate the effectiveness in July 2012, and consider mandating the changes permanently.
- TCIP staff, in partnership with tobacco prevention coordinators at local county health departments, conducted an assessment of all buildings providing DHS/OHA services across the state of Oregon (n=166). On-site audits checked for three signs of implementation of 100% SF/TF campuses: presence of "Tobacco-Free DHS" signs and absence of ashtrays and smoking shelters. About half of DHS/OHA properties (n=78, 47%) met the standards for 100% SF/TF campuses. Letters were sent to branch administrators regarding noncompliance issues, and local health department staff will continue to work with buildings which have not yet implemented 100% SF/TF campus policies.

- As of 10/1/11, the Portland State Office Building (PSOB) implemented a 100% SF/TF campus policy. Approximately 1,200 employees work at the PSOB, and it is the most visible hub of State government in the Portland area, with hundreds of daily visitors.
- TCIP staff initiated discussions with the Department of Administrative Services and has developed a proposal to mandate all State properties to become 100% SF/TF as of July 2012. Although the policy has not yet passed, it is being strongly considered in light of the PSOB becoming a smoke-free campus.

What Worked Well:
The ASD Deputy Director was supportive of tobacco cessation and the TCIP mission and he was the key gatekeeper for moving many of these policies forward. Collaboration with tobacco prevention staff at local county health departments made assessing DHS/OHA properties around the state far more cost effective and efficient. In addition, local county health departments are invested in moving noncompliant properties forward towards 100% SF/TF campuses, meaning that assessment is ongoing, and progress will continue beyond the ARRA grant period. This is another example of the importance of having infrastructure on which short-term, grant-funded activities can build.

What Could Have Worked Better:
One of the barriers to achieving the policy objectives, as written, was the dissolution of the Administrative Services Division (ASD) in July 2011, as part of the statewide DHS/OHA reorganization. Although the former ASD Deputy Director was involved with and supportive of TCIP from the start, and was the right person to be at the table, the reorganization left no clear channel for implementing changes, and no designated staff below him to shepherd projects through the necessary bureaucratic channels.

Although passing the 100% SF/TF policy at the PSOB was a major success, having more time between policy adoption and implementation would have been beneficial. A longer campaign promoting cessation resources and sharing educational messages with smokers may have benefited smokers and improved compliance immediately following policy adoption. However, anecdotal and observational data indicate that compliance with the policy three months post-implementation is good, and plans are being made to amend the building security contract at next renewal to include enforcement of the building-wide smoke-free policy.

Why It Matters:
More than 15,000 contracts are issued by the State of Oregon each year, representing a wide variety of vendors and services, ranging from translation of educational materials and cultural competency training to lab work to construction and armored vehicle service. Focusing on all State RFPs and contracts proved to be too wide a target. However, public health contracts are more appropriate vehicles for 100% SF/TF language, and by including mandatory language in all public health contracts in the one-year pilot, we will have "proof-of-concept" data by which we can assess the feasibility and utility of expanding these efforts beyond public health.

Similarly, we determined that a more appropriate focus for promotion of 100% SF/TF policies would be buildings under DHS/OHA control. First, we have more realistic means for adopting, implementing, and enforcing policies at State buildings through the partnerships developed through TCIP and through existing relationships with local health department staff. Second, establishing 100% SF/TF social norms at State buildings conducting DHS/OHA services seemed to be an important precursor to requiring such policies from vendors who do business with the State. Third, such policies could potentially protect more than 6,500 DHS/OHA employees, more than 750,000 DHS/OHA clients, and many members of the public who frequent these buildings on daily or regular basis.

Objective 2a: Proactive Cessation Messaging to DHS/OHA Clients through Varied Media

The original policy objective was:

- **Objective 2a**: By Jan 30, 2012, establish a DHS policy requiring Divisions to host cessation messages including Quit Line contact information on appropriate websites, telephone hold messages, and Division mailings.

Quick Assessment:
This policy was not adopted and progress towards promoting consistent cessation messages through these means proved unfeasible.

Key Accomplishments:

- Cessation messages were sent out to all State employees via pay stubs on three different occasions.
- Web buttons promoting and connecting users to the Oregon Tobacco Quit Line were added to some State Web pages; these proved difficult to track and monitor, so we cannot quantify how many were added and still remain viable.
- Cessation messaging promoting the Oregon Tobacco Quit Line was added to one telephone hold line.

What Worked Well:
Technically and conceptually, these projects should have been straightforward and simple to implement. TCIP staff received administrative support from the public health director to include the cessation messages on public health Web pages, but it still did not get done (see "*What Could Have Worked Better"* below).

What Could Have Worked Better:
TCIP staff was stymied by bureaucratic complexity on each of these projects. Messages were distributed on pay stubs three times, but this was not a simple or sustainable process. In order to accomplish this task, the ASD Director had to assign staff to hand-feed thousands of check stubs through a printer, as there was no way to add a message via an automated process.

Adding cessation resources to hold messages proved extremely difficult as three different switchboards are responsible for all of the hold messages provided on State phone lines. Two of the switchboards were simply not equipped to host outside messages. The third was administered by a contracted agency (e.g., a phone company), and adding, monitoring, and changing hold messages was not part of their contract. In the end, cessation messaging was added to only one hold line: the State Help Desk, which is accessed by State employees seeking assistance with technological problems.

It is technically simple to add the Quit Line Web buttons and links to cessation resources to existing Web pages, but there was no central point person responsible for administering the thousands of Web pages affiliated with DHS/OHA. Hundreds of people were responsible for

individual clusters of pages, and it was often difficult to locate appropriate gatekeepers. Sometimes, these people, though responsible for hosting Web pages, did not have the authority to approve new content, which added another layer of complexity. TCIP staff determined that there was a State template used as the foundation for every Web page, but efforts to get the Quit Line button added to that template failed. Finally, there was a major IT system change during the course of the grant, which meant TCIP staff needed to start over, as many of the original Web pages changed substantially.

As mentioned previously, the dissolution of the Administrative Services Division during the course of the grant further complicated efforts to change these cross-agency communications systems.

Why It Matters:
In 2010, DHS and OHA served more than 750,000 adults, many of whom use DHS/OHA Websites or phone lines to apply for benefits and access other needed resources. Therefore, many low-income smokers could potentially be exposed to cessation messaging through the Web or telephone hold messaging. These are, in theory, quick, simple, and cheap interventions, but they proved far too administratively complicated to continue to pursue as a sustainable strategy.

Conclusions

ARRA grant funds allowed us to collect data and develop key relationships that were used and will continue to be used to move agencies along the stages of change towards creating tobacco-free environments through environmental and policy change. Five of ten proposed policy changes were passed during the grant period. Three of the policies that were adopted were high-intensity cessation efforts focused on a high prevalence, vulnerable population—people with addictions and mental health issues. A fourth policy requires all insurance plans serving Medicaid clients to provide annual documentation of the cessation services provided, creating greater accountability and, hopefully, standardization of benefits to the approximately 300,000 low-income adult beneficiaries, about one-third—or 100,000—of whom smoke. The fifth policy requires ongoing cessation messaging to home care and personal services workers —another population with high tobacco use. Approximately 18,000 low-income workers provide in-home and agency-based services to the frail elderly and people with developmental and physical disabilities.

Although not discussed in detail in this evaluation report, implementing a hard-hitting media campaign targeting low-income smokers was also a major accomplishment of this ARRA grant.

Lessons Learned:

TPEP had built a strong foundation for conducting this work before receiving the ARRA grant funds. The ARRA grant funds provided the capacity to exponentially increase efforts aimed at achieving the TCIP mission, but this two-year project would not have been as successful if the program had not been well-positioned to "hit the ground running," once funded. Our experience with TCIP reinforced our belief that short-term grant funding, like the ARRA funds, can be tremendously helpful in developing the existing capacity of a program, but that such funding would not be useful if a program lacks necessary infrastructure.

We learned the importance of strong, high-level leadership for passing tobacco-related policies. Although all State agencies providing health and social services were represented on the TCIP Steering Committee, the agency that passed the most TCIP policies—Addictions & Mental Health—showed the strongest leadership. The Director repeatedly endorsed the cessation efforts, showed up personally to meetings and training sessions, and allocated agency resources in the form of dedicated staff, a Web site, and a positively-focused, branded campaign that promoted tobacco cessation. Other agencies did not demonstrate this level of leadership, and finding the "right person" who could make decisions often proved difficult and time-consuming.

Another lesson learned was that many individuals who work for the State—either as employees or contracted workers serving clients who receive State services—are also members of TCIP's target population of low income smokers. In some cases, workers were more likely to be smokers than the OHA/DHS clients they served. Efforts to create healthier environments that promote smoking cessation among clients receiving State services can also benefit workers who smoke, many of whom are also low income. Future cessation efforts targeting low-income

individuals through government agencies might make this relationship more explicit and intentional by partnering with worksite wellness programs.

Challenges and Contextual Factors:
Despite being primed for success because of TPEP's strong foundation, staff turnover was a challenge. Although the TCIP project manager and one of the program staff were long-term, experienced employees, two other program staff members were new and had to be oriented not only to the grant-funded project, but also to the larger context of tobacco control, public health, and State government in Oregon. Worse, because of the short-term nature of the grant, two of four individuals who filled the three limited-duration program staff positions took other permanent jobs before the grant ended, meaning that there was turnover and, at time, staff vacancies. Because the TCIP Project depended in large part on building new relationships across agencies, interrupting those relationships because of TCIP staff turnover was not ideal.

A similar challenge was posed by the amount of transition taking place in national health care and Oregon state government at the time of this project. The agencies with which TCIP staff worked underwent a major reorganization during the two-year grant period, with subsequent changes in leadership and other personnel. Although it is difficult, if not impossible, to control for the volatility of these large-scale transitions, it is an important contextual factor that must be considered when assessing projects that attempt wide-reaching policy and environmental changes.

Different Strategies for the Future:
TCIP staff determined that TCIP project activities followed—or should have followed—the lessons of "Policy Passage 101," albeit applied to a different setting. Although progress was made on all fronts, in some cases, staff time could have better focused. For example, TCIP Policy Objective 2a, which promoted proactive cessation messaging through various media, proved to be high-effort and low-yield. Ideally, the next time the program undertakes cessation efforts involving intergovernmental partnerships, staff will conduct a feasibility assessment, including some form of power mapping, before setting objectives, determining strategies, and beginning to conduct activities.

In future grants, we are also likely to narrow our focus. The TCIP grant proposed to pass 10 policy changes across multiple agencies. In our opinion, this project would have been a success had we only focused on policies affecting the addictions and mental health populations, where extremely high smoking prevalence and disproportionate tobacco-related morbidity made a powerful case for change, and strong leadership enabled bold policies to be passed.

The ARRA funding has ended, but TCIP's work continues. TCIP's mission has been integrated into a new cross-agency workgroup that involves the highest level of leadership at OHA and DHS, the two State agencies that provide health and social services to low income Oregonians. The new workgroup has chartered the project formerly known as TCIP, entitling it CAHIP—the Cross-Agency Health Improvement Project. CAHIP will use the TCIP model of working across

agencies to pass policies that create healthier environments for clients, staff, and visitors through tobacco cessation and other health promotion efforts.

Recommendations

1. The TCIP model of "finding" members of our target population by looking within our existing government programs should be replicated in other jurisdictions and expanded to include other health issues, like obesity prevention, where appropriate.
    - In Oregon, TCIP work will continue through the Cross Agency Health Improvement Project (CAHIP), a chartered project of the new Joint Policy Steering Committee. CAHIP will integrate tobacco prevention and cessation into other health promotion efforts.
    - The State Tobacco Prevention & Education Program will examine the feasibility of implementing the "TCIP model" at the local level by integrating this type of approach into local health department contracts related to tobacco control.

2. Secure grant funding for projects that have existing infrastructure to support and sustain the work.
    - This model of interagency collaboration for policy and environmental change is time- and labor-intensive. Budget adequate time and staffing, and leverage additional resources, wherever possible.
    - Organizational transitions occur in bureaucracies constantly; expect that projects will be disrupted. Be flexible and make contingency plans.

3. Because many employees and workers serving OHA/DHS clients are also low income smokers, smoking cessation efforts targeted at clients should also consider the needs of workers.
    - Where appropriate, formal partnerships with worksite wellness programs should be considered as a vehicle for promoting efforts to reduce smoking prevalence among low income Oregonians.

4. Assess levels of support for environmental and policy changes, where feasible, before adopting and implementing policies.
    - Support for policy changes often exists. Survey or interview data that describe the level of support can catalyze change. Similarly, data which describe potential barriers can help address concerns that could derail smooth policy implementation.
    - Baseline data can then be compared to post-implementation data to evaluate outcomes.

5. Cultivate nontraditional partnerships in order to reach hard-to-reach and/or under-served populations.
    - Smoke-free campuses for addictions and mental health clients are feasible and may be able to change norms and behaviors among these high prevalence populations.

Supporting Information

The following resources are provided in the Supporting Information section:

S1. List of Abbreviations and Acronyms Commonly Used in this Report
S2 Report on Statewide Media Campaign Targeting Low-Income Oregon Smokers
S3. Report on 2011-2012 Legislative Efforts to Pass Oregon Tobacco Tax
S4. TCIP Logic Models
S5. AMH Consumer/Survivor Position Statement on Tobacco Freedom
S6. Brief Report on Oregon's Policy Efforts among Addictions and Mental Health Facilities Published in Preventing Chronic Disease
S7. Sample Memo from Richard Harris, AMH Director, on Proposed Policy Changes
S8. Home Care Workers On-Line Survey Executive Summary
S9. Oregon Health Plan Tobacco Cessation Services: 2011 Survey of Fully Capitated Health Plans and Dental Care Organizations
S10. Oregon Minimum Standards for Tobacco Cessation
S11. Sample of CAF Client Cessation Messaging: Quit Cards & Posters
S12. DHS/OHA Adult Client Distribution of Services Graphic & A Note on Long-Term Evaluation Efforts

S1. List of Abbreviations and Acronyms Commonly Used in this Report

AMH	**Addictions & Mental Health**
ARRA	**American Recovery & Reinvestment Act**
ASD	**Administrative Services Division**
CAF	**Children, Adults & Families**
CAHIP	**Cross Agency Health Improvement Project**
CCO	**Coordinated Care Organizations**
DHS	**Department of Human Services**
DMAP	**Division of Medical Assistance Programs**
HCW	**Home Care Workers**
MCO	**Managed Care Organizations**
OHA	**Oregon Health Authority**
RFP	**Request for Proposal**
SF/TF	**Smoke-free/ Tobacco-free**
SNAP	**Supplemental Nutrition Assistance Program**
SPD	**Seniors & People with Disabilities**
TANF	**Temporary Assistance to Needy Families**
TCIP	**Tobacco Control Integration Project**
TPEP	**Tobacco Prevention & Education Program**

S2. Report on Statewide Media Campaign Targeting Low Income Oregon Smokers

ARRA grant funding has allowed TPEP to focus broadcast and social media efforts on low-SES Oregonians. In Year One of the funding period, TPEP media contractors conducted focus groups with low-income Oregonians to test messages and advertisements that would be successful in driving calls to the Quit Line and in encouraging quit attempts. Contractors also developed a media plan that would include outreach through broadcast, social and out-of-home advertising.

Broadcast media advertisements have been running since Year Two of the grant funding period and will run through the summer of 2012. A robust social media campaign including on-line and mobile applications and advertisements began in Year Two and have been increasing use of TPEP's new on-line live chat quit services. Both on-line and telephone registrations by low-income Oregonians have doubled during the funding period.

S3. Report on 2011-2012 Legislative Efforts to Pass a Statewide Tobacco Tax

Raising the price of tobacco is one of the most effective tools available to help smokers quit. For every 10% increase in the price of tobacco, there is a 4% decrease in the sale of tobacco, leading to lower consumption. A 10% price increase results in a 6 to 7% drop in the number of youth who start smoking. Raising the price is most effective for groups of people who are the most price-sensitive – youth and people who are struggling financially.

One of TCIP's major goals was to raise the price of tobacco by 10%. An increase in the state tax on tobacco is one of the only practical avenues available to reach this goal. Raising the tax on tobacco can only be achieved in partnership with leadership from other agencies, outside advocates and partners. TCIP worked to bring new partners into the movement by reaching out to the groups associated with the Divisions of OHA/DHS that are not traditionally strong supporters of raising the tobacco tax.

Through work with the Seniors & People with Disabilities Division, TCIP has been able to present both the program and the concept of raising the tobacco tax with the Governor-appointed Senior Services Commission, Home Care Commission and Disabilities Commission. Through work with the Division of Medical Assistance Programs, TCIP has presented this concept to the Medicaid Advisory Committee and the Oregon Health Plan Medical Directors. TCIP staff and steering committee members also created a fact sheet targeted to people working within the context of human services. The steering committee made it clear that the traditional, negatively-phrased Public Health frame wouldn't work as well with this target audience. The committee helped with a positive frame for the final version, with savings emphasized instead of costs.

With TCIP's help, these groups have a better understanding of the importance to the people they serve of raising the price of tobacco. They have information about the role price plays in spurring vulnerable people to quit. They have data to rely on when the argument is made that tobacco taxes are regressive. As one member of the Senior Services Commission put it: "*a tax on tobacco should be called a PRO-gressive tax, not regressive*."

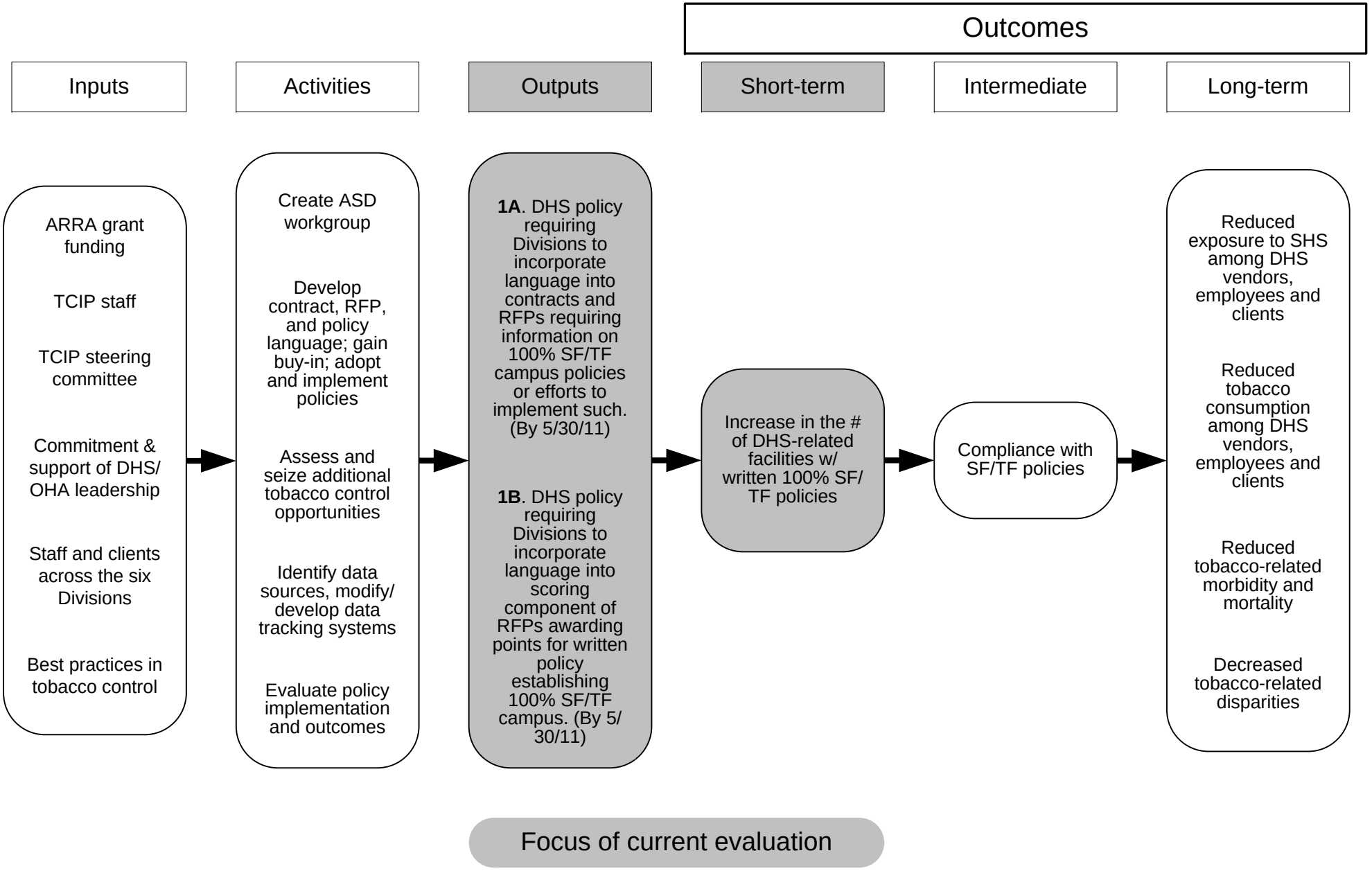
During the first week of Oregon's 2011 legislative session, the Governor submitted a bill which would increase the tobacco tax an additional $1.00 per pack with a portion dedicated to the Tobacco Prevention and Education Program. TCIP continues to work on building new partnerships and finding new voices to advocate for this tax and for tobacco prevention in Oregon.

S4. TCIP Logic Models

Attachment 1: TCIP Policy-Related Logic Models

Goal 1: Increase the number of facilities in which DHS has an interest with written 100% SF/TF policies

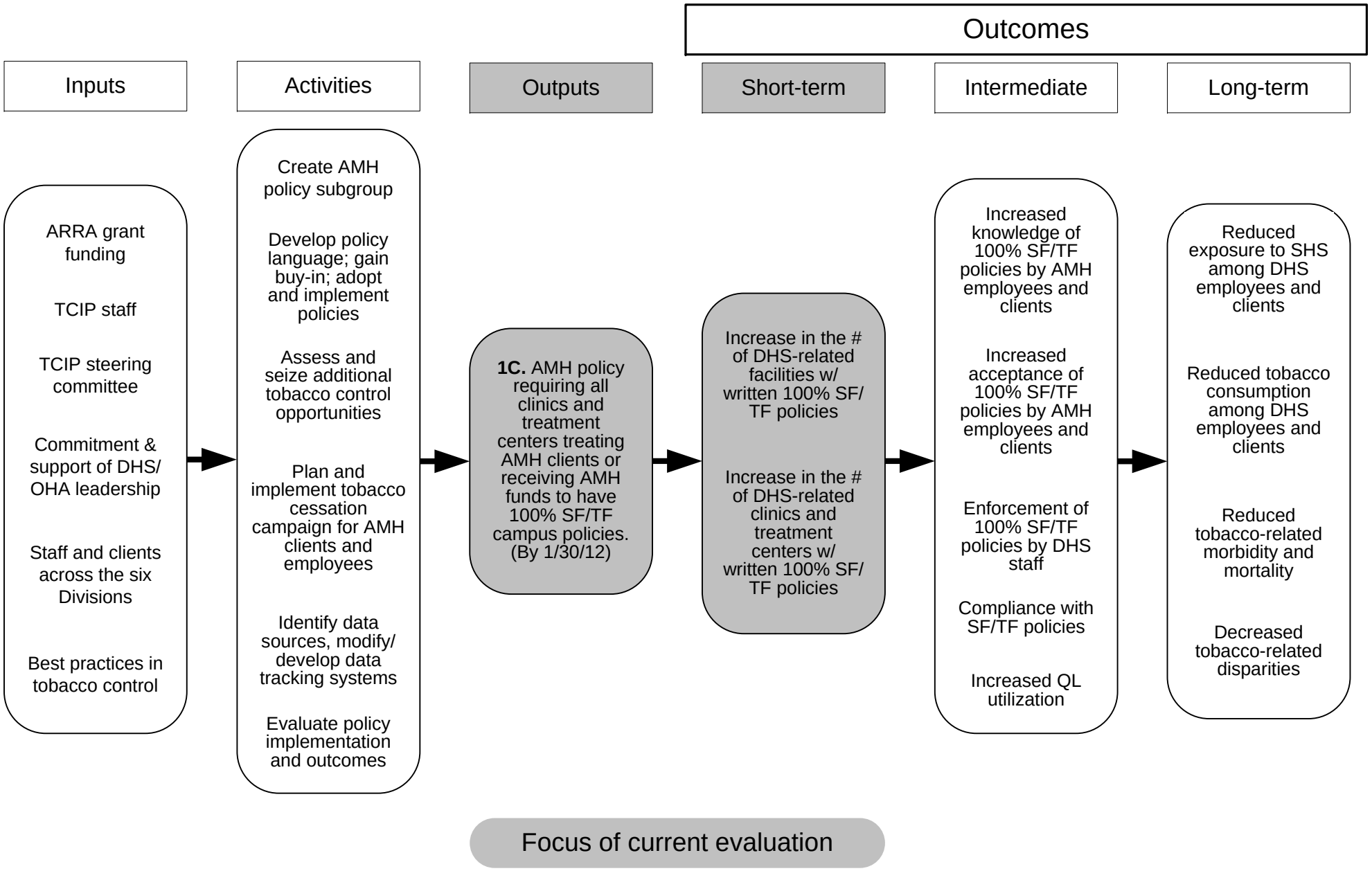
Objectives 1A and 1B: Incorporating 100% SF/TF campus policy language into contracts, RFPs, and RFP scoring



Attachment 1: TCIP Policy-Related Logic Models

Goal 1: Increase the number of facilities in which DHS has an interest with written 100% SF/TF policies

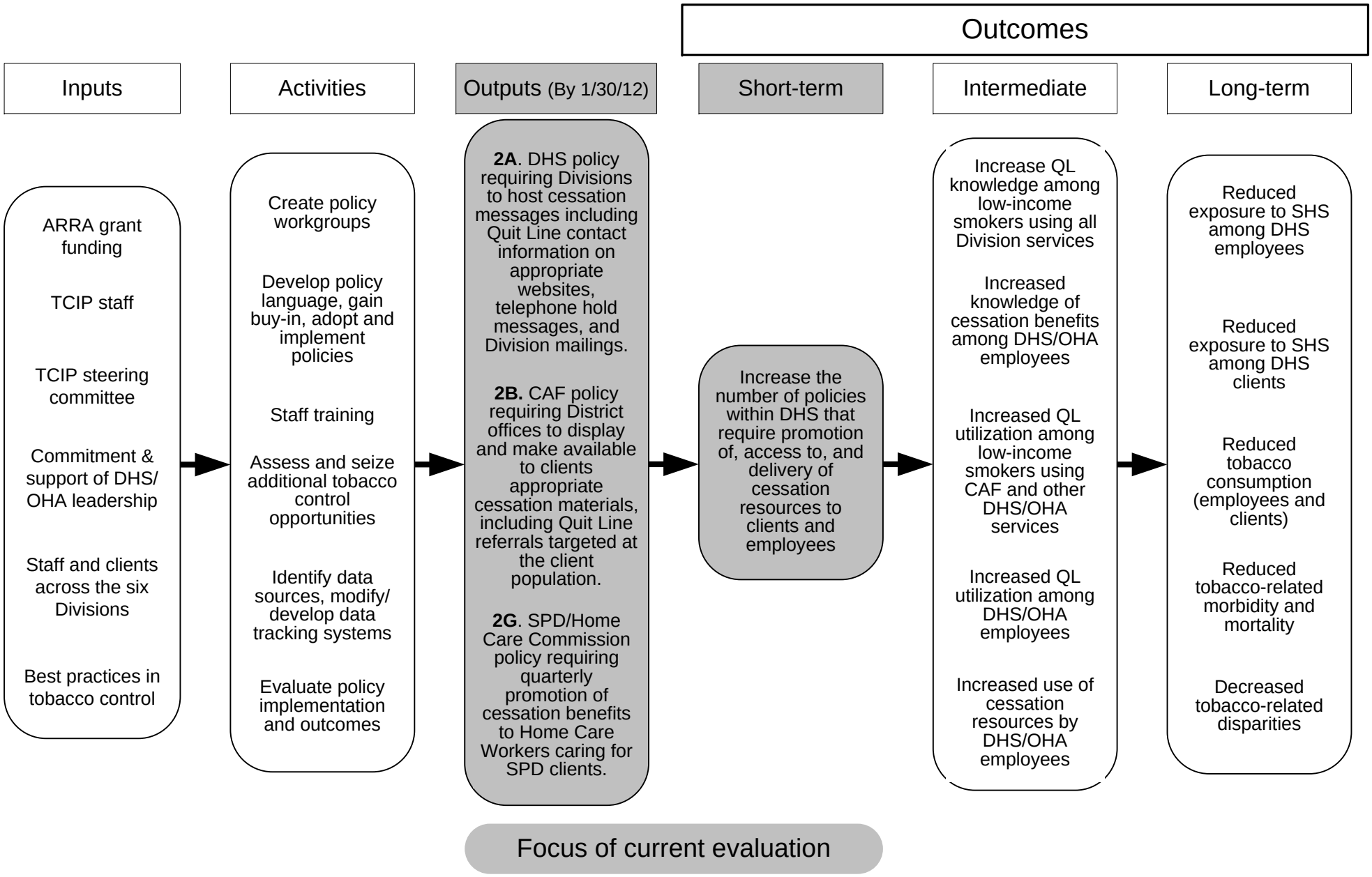
Objective 1C: Requiring 100% SF/TF campus policies at all AMH clinics and treatment centers



Attachment 1: TCIP Policy-Related Logic Models

Goal 2: Increase the number of policies within DHS that require promotion of, access to, and delivery of cessation resources to clients and employees

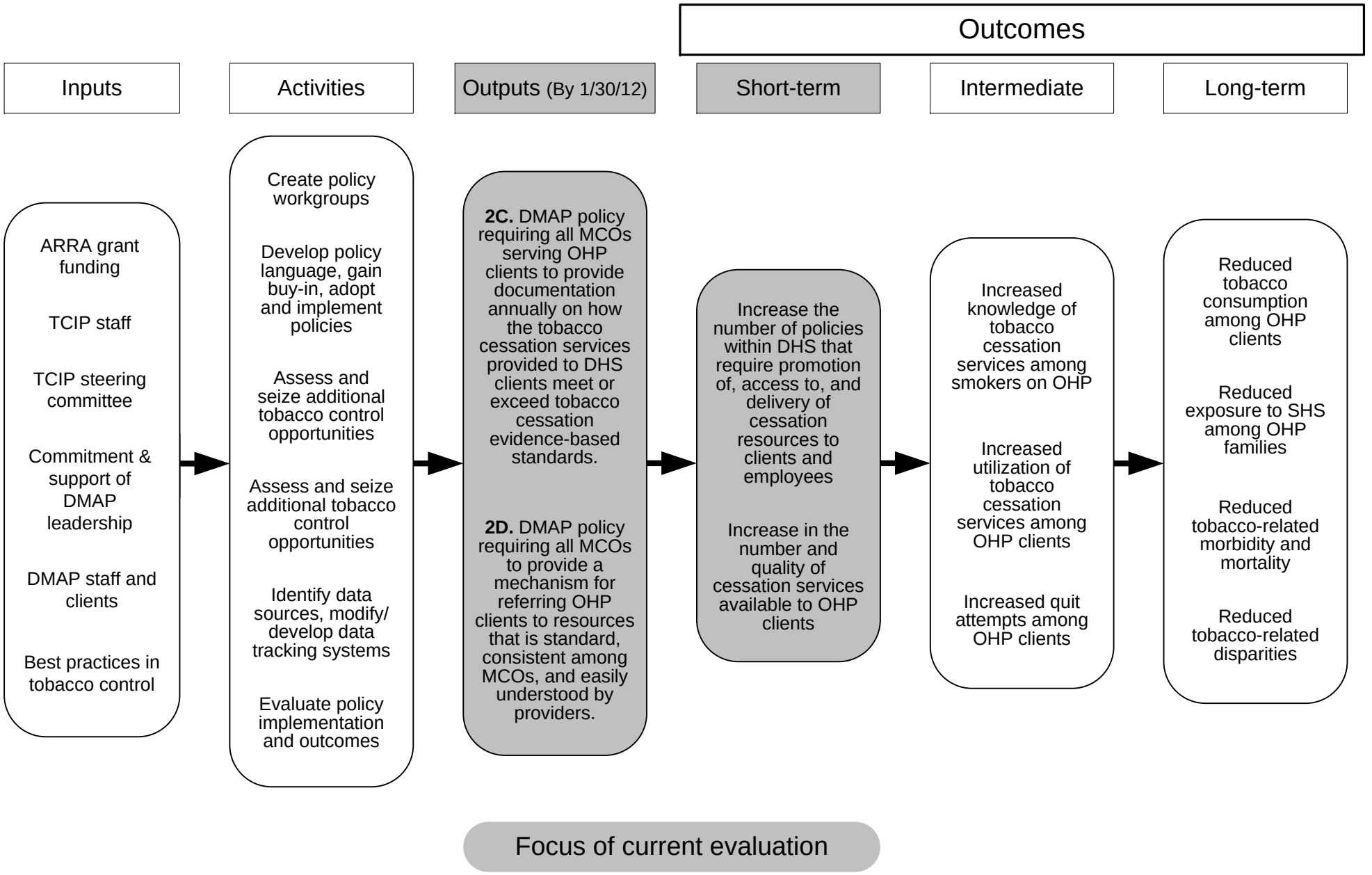
Objectives 2A, 2B, and 2G: Proactive cessation messaging to DHS/OHA clients and employees



Attachment 1: TCIP Policy-Related Logic Models

Goal 2: Increase the number of policies within DHS that require promotion of, access to, and delivery of cessation resources to clients and employees

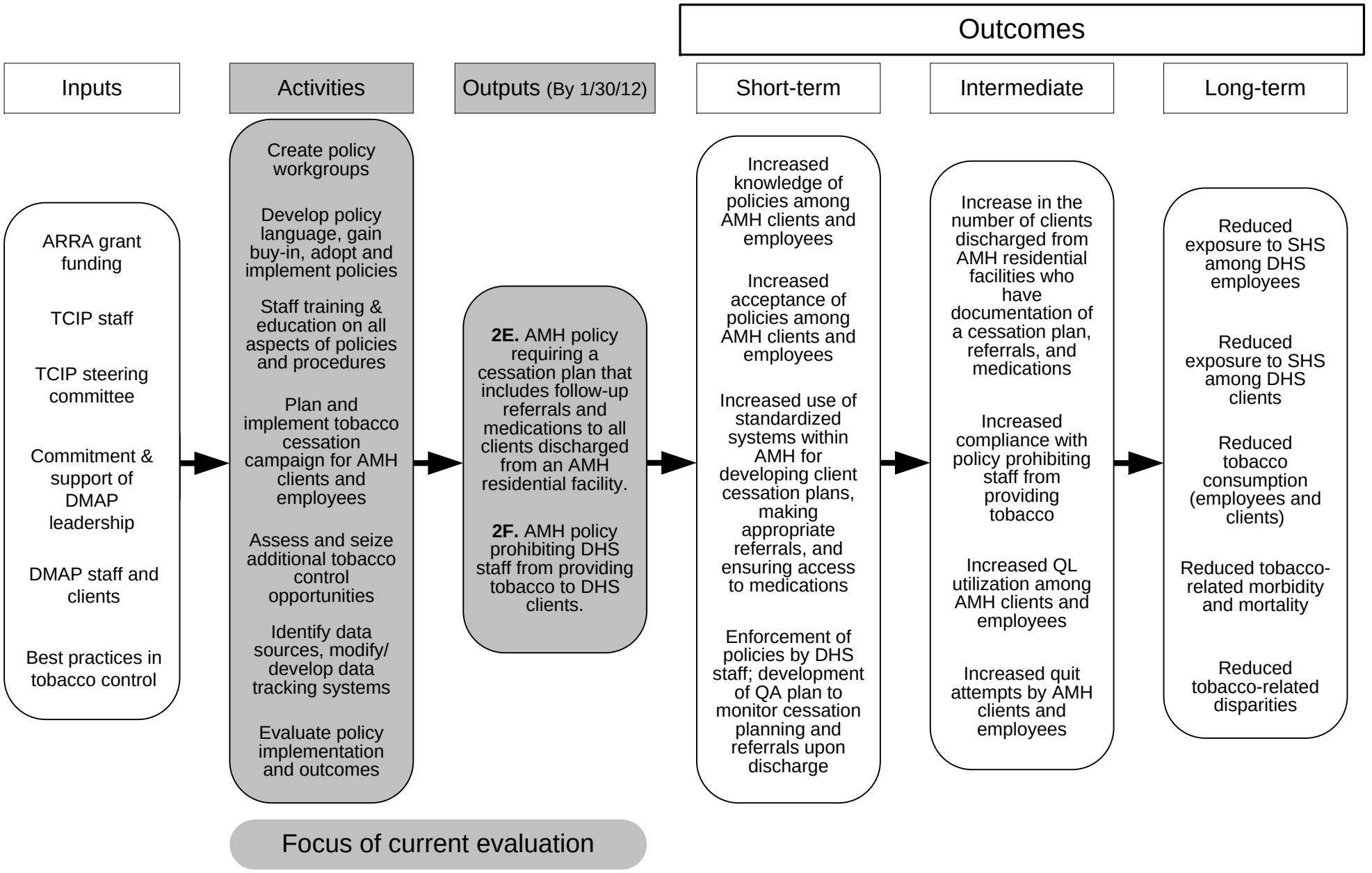
Objectives 2C and 2D: Linking OHP clients to high quality cessation services



Attachment 1: TCIP Policy-Related Logic Models

Goal 2: Increase the number of policies within DHS that require promotion of, access to, and delivery of cessation resources to clients and employees

Objectives 2E and 2F: Actively promoting smoking cessation and preventing secondhand smoke exposure among AMH clients and employees



S5. AMH Consumer/Survivor Position Statement on Tobacco Freedom

Freedom from Tobacco & Freedom to Choose*

In accordance with the values and tenets of the mental health consumer/survivor movement, it is the right of all persons to achieve optimal health, wellness, and to make choices including freedom from addictive substances.

The decision to quit smoking is a personal one which should be respected by peers, treatment providers, and health care practitioners. The person should be treated with respect and dignity when or if smoking cessation tools are desired. Coercive measures to encourage or mandate smoking cessation is counter to choice.

Research shows that tobacco is an addictive substance; therefore, we support patients who are involuntarily held within Oregon treatment facilities or residential programs to make the decision to become tobacco-free.

We encourage health care practitioners to support residents in all levels of publicly-financed treatment facilities to achieve tobacco freedom, and to provide affordable and accessible smoking cessation tools to peers who choose to quit.

For tobacco freedom to become a reality for those who choose it, supports must be furnished including but not limited to: tobacco replacement therapy; clinical treatment determined in partnership with a peer; peer support; addiction support groups that are tobacco free; easy access to quit lines and other telephone peer support such as warmlines; and, a complaint process to support peers to reach individual goals.

We, who are mental health service recipients and others of us who are former patients, are determined to reverse the tide of disease and early death among our peers.

We are concerned with national statistics which clearly indicate that persons with mental illness are about twice as likely to smoke as other persons but have substantial quit rates.[1]

It is the potential of all persons to recover and achieve wellness.

* This document was officially accepted through consensus by the Oregon Consumer/Survivor Council as a position statement of the Council.

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[1] Karen Lasser; J. Wesley Boyd; Steffie Woolhandler; David U. Himmelstein; Danny McCormick; David H. Bor **Smoking and Mental Illness: A Population-Based Prevalence Study** *JAMA.* 2000;284(20):2606-2610.

S6. Brief Report on Oregon's Policy Efforts among Addictions and Mental Health Facilities Published in Preventing Chronic Disease

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People. Saving Money through Prevention.™

PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY

BRIEF

Promoting Smoke-free Environments and Tobacco Cessation in Residential Treatment Facilities for Mental Health and Substance Addictions, Oregon, 2010

Linda L. Drach, MPH; Daniel Morris, PhD, MS; Cathryn Cushing; Cinzia Romoli, MS; Richard L. Harris, MSW

Suggested citation for this article: Drach LL, Morris D, Cushing C, Romoli C, Harris RL. Promoting smoke-free environments and tobacco cessation in residential treatment facilities for mental health and addictions, Oregon, 2010. [Erratum appears in Prev Chronic Dis 2012;9. http://www.cdc.gov/pcd/issues/2012/12_0052.htm.] Prev Chronic Dis 2012;9:110080. DOI: http://dx.doi.org/10.5888/pcd9.110080.

PEER REVIEWED

Abstract

We assessed tobacco-related policies and procedures at all state-funded, community-based residential mental health and substance addiction treatment facilities before implementation of new state policy requirements. We conducted telephone interviews with 162 of 166 (98%) facility administrators. Only 15% had voluntarily implemented 100% smoke-free campus policies, and 47% offered cessation resources at patient discharge; however, less than 10% expressed opposition to these future requirements. Smoking bans and cessation support in residential treatment facilities can reduce tobacco-related disparities among people with mental illness and addictions, but states may need to be the catalyst for policy implementation.

Objective

Although the disproportionate tobacco use prevalence among people with mental illness and substance use disorders is well documented (1,2), few policies exist in the United States that address this problem. In Oregon, 3 statewide policy changes are under way at community-based residential mental health and addiction treatment facilities: 1) requiring 100% smoke-free campuses, 2) prohibiting staff from distributing tobacco products to residents, and 3) mandating integration of smoking cessation into discharge planning. We assessed current tobacco-related policies and procedures at all state-funded, mental health and drug addiction residential treatment facilities before policy implementation.

Methods

In November 2010, Oregon's Addictions and Mental Health (AMH) and Public Health divisions partnered to collect baseline data from a census of state-funded, community-based residential treatment facilities for mental health and addiction (n = 166), to assess facility readiness to implement policy changes promoting tobacco cessation. Public health staff, with input from AMH partners, developed a brief survey that included 1 open-ended and 21 closed-ended items assessing policies and procedures related to indoor and outdoor smoking; evaluation of tobacco use at intake; promotion of cessation resources; and use of referrals, medications, and peer-based cessation support in residence and at discharge. This report focuses on the 3 statewide policy changes.

Two weeks before survey implementation, the AMH administrator sent a memorandum to treatment facility administrators, informing them of the upcoming survey and requesting their participation. The 166 facilities included 52 alcohol and drug treatment facilities (31.3%), 92 mental health treatment facilities (55.4%), and 22 secure mental health treatment facilities (13.3%). All provide 24-hour services. Secure facilities restrict a resident's exit by locking doors and gates. The average length of stay at Oregon residential facilities is approximately 100 days for alcohol and drug treatment and more than 1 year for mental health treatment (Oregon Health Authority, unpublished raw data, 2009).

Public Health staff conducted interviews by telephone with facility administrators or their designees. We analyzed data

by using SPSS 17.0 (SPSS, Inc, Chicago, Illinois). We grouped brief answers from the open-ended item into broad themes by using content analysis (3). The project was classified as exempt from institutional review board review.

Results

Ninety-eight percent of facilities completed surveys; 3 facilities could not be reached after multiple attempts, and 1 declined. Although all facilities reported indoor smoking bans, only 15% (n = 25) also prohibit outdoor smoking on all campus areas. Most (82%) reported existing policies prohibiting tobacco distribution by staff to residents, but alcohol and drug facilities (96%) were significantly more likely to have such restrictions than either secure (73%) or nonsecure mental health facilities (76%).

Approximately half of facilities (47%, n = 76) currently include follow-up referrals and cessation medications at discharge for residents who quit smoking in residence. These measures did not vary by facility type.

About 2 in 3 facility administrators (69%, n = 111) provided additional open-ended comments about tobacco-related policies. Most comments were neutral, but 2 sets of themes emerged from a subset of administrators. Administrators who favored smoke-free and cessation policies (n = 14) said that implementation and enforcement would be easier at the facility level with centralized leadership from the state:

> *"I'm pleased the state is going in this direction. . . . If we all go smoke-free at the same time, we can support each other and have less impact on the number of beds that are filled."*

> *"It just needs to be done with everyone at once, at a state level. It's the right direction."*

Administrators who opposed the policies (n = 10) cited residents' right to smoke and said smoking cessation is a lesser treatment priority:

> *"Forcing patients to stop smoking when there are so many other issues we have to deal with is ridiculous."*

> *"I hope they never try to outlaw smoking [here] because they're adults — not criminals — and smoking is not a crime."*

Discussion

Thirty-five percent of Oregon adults who report "depression, anxiety, or emotional problems" smoke (4) compared with 16% overall (5); national rates among people with serious mental illness or addictions are higher (1,2). Adults with mental illness attempt to quit smoking at rates similar to others, but are less successful (6). Effective treatments for these populations are available (7), but concerns about interference with addiction treatment or exacerbation of psychiatric symptoms (8) have inhibited mental health and substance addiction facilities from offering cessation services to patients.

This assessment showed that few residential treatment facilities for mental health and substance addiction voluntarily implemented 100% smoke-free campuses, and only half mandated the integration of smoking cessation into discharge planning. However, fewer than 10% of administrators objected to these future tobacco policies, and about equal numbers welcomed such statewide policy changes.

Smoke-free campus and cessation policies can help residents quit smoking long-term (9). State-level policies, coupled with provider education and access to cessation supports, may be the necessary impetus for facilities to adopt evidence-based practices that can reduce illnesses and deaths among these patient populations.

Our study had several limitations. Although assured confidentiality, facility administrators may have overstated the presence of smoke-free policies. Also, strong written policies are not always demonstrated in daily practice; these data should not be assumed to reflect enforcement, compliance, or nonadministrative staff support.

There is a growing recognition that integration of tobacco cessation into mental health and substance addiction treatment is both urgently needed and possible (10). States can play a key role in ensuring that widespread policies addressing these tobacco-related disparities among people with mental health and substance addictions are adopted, implemented, and enforced.

Acknowledgments

This work was supported by a grant (CDC-RFA-DP09-90101ARRA09 Component II) from the State Supplemental Funding for Healthy Communities, Tobacco Control, Diabetes Prevention and Control, and Behavioral Risk Factor

Surveillance System at the Centers for Disease Control and Prevention.

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S7. Sample Memo from Richard Harris, AMH Director, on Proposed Policy Changes

Oregon
Theodore R. Kulongoski, Governor

Department of Human Services
Addictions and Mental Health Division
500 Summer Street NE E86
Salem, OR 97301-1118
Voice 503-945-5763
Fax 503-378-8467

DATE: August 17, 2010

TO: Stakeholders

FROM: Richard L. Harris
Assistant Director

RE: Tobacco Freedom

As part of the Oregon Health Authority (OHA), it is the goal of the Addictions and Mental Health Division (AMH) to support and promote increased wellness. That is why I am pleased to announce Tobacco Freedom, a component of the AMH and Public Health Division's Wellness Initiative. Tobacco Freedom includes a policy that addresses tobacco-free AMH funded residential facilities as well as tobacco cessation resources and supports offered to both consumers and employees.

The goals of the initiative are to:

- Provide consumers and employees tobacco-free environments in all facilities receiving AMH funding.
- Increase access to peer-based tobacco cessation resources and supports and alternatives to tobacco use.
- Improve discharge planning from mental health or addictions treatment programs to promote continued abstinence from tobacco.

In addition to these goals, Tobacco Freedom will reduce exposure to secondhand smoke and bring AMH facilities into compliance with the Indoor Clean Air Act and Smoke-free Workplace laws.

People diagnosed with serious mental illness are dying 25 years early, on average. Sixty percent of these early deaths are due to medical conditions, many compounded by the use of tobacco. Almost half of all cigarettes sold in the United States are purchased by people diagnosed with mental illness. Tobacco Freedom is a step toward reducing this disparity.

I know that creating tobacco-free facilities will not be easy for everyone. I want to assure you that this will be a process with plenty of time for feedback from you, our consumers and partners. As part of the transition, we will provide cessation resources as well as toolkits and training on becoming tobacco-free. As always, we have access to the Oregon Tobacco Quit Line. This is a free call for anyone in the state with free resources when funding allows at 1-800-QUIT-NOW (1-800-784-8669). This service can also be accessed on-line at www.quitnow.net.

State employees have gold standard cessation benefits provided by PEBB and available by calling the Free and Clear Program at 1-866-QUIT-4-LIFE (1-866-784-8454). More information can be found on-line at: http://www.oregon.gov/DAS/PEBB/FreeClear.shtml.

Over the next year, in partnership with the Public Health Division, AMH will host opportunities to learn about Tobacco Freedom as well as offer training for Peer Wellness Coaches to expand their skills to include tobacco cessation. We encourage your feedback and your ideas on how to make this transition as smooth as possible. Please call LuAnn Meulink, at 503-945-6289, with your questions or comments. We anticipate announcing an e-mail address exclusively for Tobacco Freedom within the next few weeks.

Thank you for supporting us as we meet our wellness goals and reduce the impact of tobacco on AMH consumers and employees.

S8. Home Care Workers On-Line Survey Executive Summary

Homecare Workers Online Survey Executive Summary

December 16, 2010

Overview/Methodology

In October, the Tobacco Control Integration Project conducted an online marketing survey of Homecare Workers across Oregon. The survey asked Homecare Workers where they get information, their thinking about whether or not to quit smoking, the reasons they don't make that choice and the messages most likely to help them overcome those reasons. **Of 5,515 contacted, 1,030 Homecare workers participated**, representing a 19 percent response rate, which is a positive rate for an unsolicited research survey.

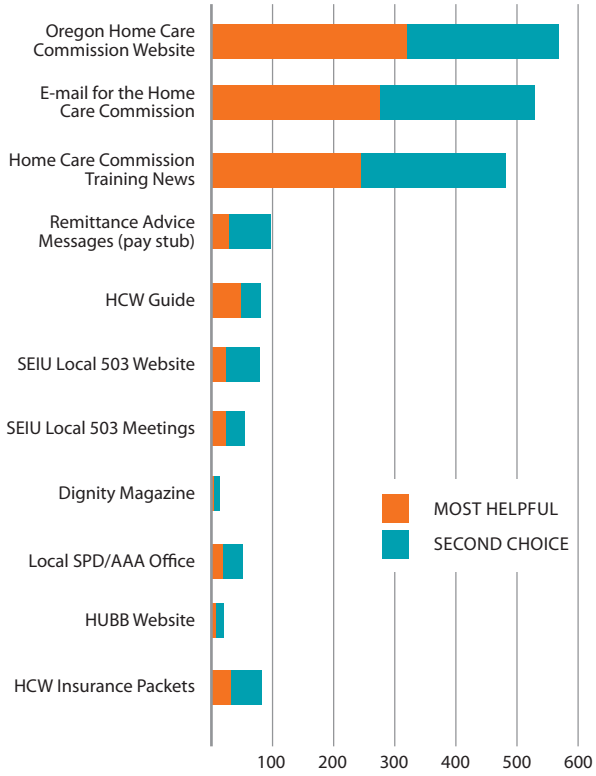
Findings

1. **Respondents rely on the Home Care Commission (HCC) to keep them informed** on current news and information about the Homecare Worker program:
   - 68.9% said that they rely on email from the Home Care Commission.
   - 61% use the Homecare Commission Training News
   - 54.5% relied on the Oregon Home Care Commission website

2. When asked to rank communication tools, **Homecare Workers consider the HCC tools to be the most helpful:**
   - 542 found the Oregon Home Care Commission website most helpful
   - 530 said e-mails from the Home Care Commission
   - 483 indicated the Home Care Commission Training newsletter.

3. The percentage of Homecare Workers who **said they smoke** (23.6 percent) is **higher than the statewide average of 17 percent.**

4. **More than half** of the smokers **report they have tried to quit in the last year.**



5. **The vast majority (81 percent) of respondents who indicated they were smokers on the registry and referral system would be willing to receive free information on health and wellness topics** that include quitting smoking, losing weight and stress relief.
   - Smokers also understood the serious health, social and financial costs of smoking cigarettes. Eleven respondents indicated that they just quit smoking in the last year.
   - Comments from current smokers, particularly those who want to quit, indicated four general reasons why they want to quit smoking:

     Health
     "I know its killing me and don't know how to quit."
     "Well, I cough all the time, I get winded really easy, it costs to much, it is dirty, stinky and the worst habit I ever had."

     Stigma
     "Smoking is a nasty habit I would love to quit."
     "I am my own worst enemy when it comes to smoking. I don't smoke in my house and I don't like anyone to see me smoking—I guess you could say I am a closet smoker."
     "There never seems to be the right time to quit. And when I do try to quit, there are stressers that spring up that cause me to pick up that smoke."

     Family
     "I hate smoking, but it has been extremely hard to quit. My family wants me to quit. It is not a good example for my child."
     "I have quit during both of my pregnancies and while breastfeeding, but always started smoking again due to high stress levels."

     Cost
     "I enjoy smoking but not any of the side effects (spend money, stink, can't breathe…other health reasons) I really want to quit!"
     "Costs a fortune! Have less energy, too dependent on cigs! Makes me stink! Clothes smell!"
6. Respondents who are **smokers responded most favorably to messages that included both the financial and health benefits** of quitting smoking (e.g. "Save money. Enjoy better health. Feel great about yourself.").
7. While responses to reasons for calling the Quit Line were relatively even, **respondents responded best to the offer of free smoking cessation aids.**

Recommendations

1. **Continue communication through the Oregon Home Care Commission** website, e-mails and training newsletter.
2. In messages, **call out the tangible benefits of the Quit Line** such as free smoking cessation aid and quitting plans.
3. **Incorporate both the health and financial impact** of smoking into messages.
4. Include the option of **receiving free cessation aid and help with quitting in the HCW registry**.
5. **Allow the Quit Line to contact the smokers** who said they would like to receive information on quitting.

S9. OREGON HEALTH PLAN

Tobacco Cessation Services: 2011 Survey of Fully Capitated Health Plans and Dental Care Organizations

Oregon Health Plan

Tobacco Cessation Services: 2011 Survey of Fully Capitated Health Plans and Dental Care Organizations

This report provides a summary of how Oregon Health Plan Managed Care Organizations provide tobacco dependence and cessation services to their members, a required benefit since 1998. Content includes assessment of tobacco use, marketing and promotion of services, available services, community resources, cultural competency, policy, and quality assurance and evaluation. This survey was fielded in January/February 2011.

Oregon Health Authority

May 2011

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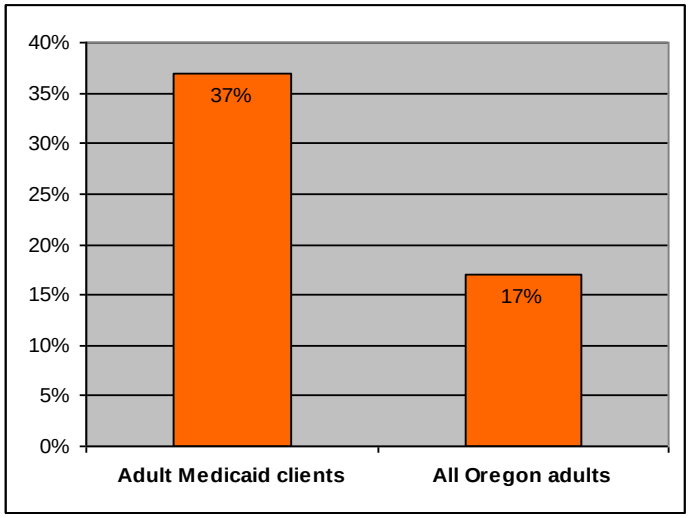
INTRODUCTION

Tobacco use is the leading cause of preventable death and disease in Oregon. Each year, tobacco use kills almost 7,000 Oregonians and secondhand smoke causes an additional 800 deaths. Adult Medicaid clients are nearly twice as likely to smoke as Oregon adults in general.[1]

Adult Smoking Status, 2007



Studies have shown that economic status is the single greatest predictor of tobacco use.

Certain racial and ethnic groups, low literacy populations and those living in poverty bear a disproportionate burden of tobacco use, related illnesses and deaths.

The economic burden of tobacco is devastating. In addition to the negative health effects, the economic burden of tobacco use is also significant. Tobacco use costs Oregonians more than $2 billion annually in direct medical expenditures and lost productivity due to early death.[2] In Oregon, direct Medicaid costs related to smoking are an estimated $287 million per year. This is equivalent to approximately 10 percent of total annual expenditures for Medicaid in Oregon.

Tobacco users want to quit smoking. In Oregon, among adult current smokers, 69 percent would like to quit smoking and 47 percent have tried to quit in the past year. [3] While quitting is not easy, and may take several attempts, studies show that tobacco users are two times more likely to quit successfully if they receive help, specifically counseling and medication.[4]

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[1] Behavioral Risk Factor Surveillance System (BRFSS) 2007, Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2007.

[2] Smoking-Attributable Morbidity, Mortality and Economic Costs (SAMMEC) 2004

[3] Tobacco Prevention and Education Program. *Oregon Tobacco Facts & Laws.* Portland, Oregon: Oregon Department of Human Services, Oregon Public Health Division, 2010

[4] Treating Tobacco Use and Dependence: 2008 Update – Clinical Practice Guidelines. U.S. Department of Health and Human Services, Public Health Service.

About the Tobacco Cessation Services Annual Survey

2011 is the first year the Division of Medical Assistance Programs (DMAP) has systematically assessed how contracted Managed Care Organizations screen for tobacco use and provide the required tobacco dependence and cessation services benefit to Oregon Health Plan members.

The Oregon Health Plan – Managed Care Plan Tobacco Cessation Services Annual Survey 2011 replaces the Tobacco Cessation Matrix, which was used until 2009. Survey content was based on Clinical Practice Guidelines, Treating Tobacco Use and Dependence: 2008 Update.

Information collected in this survey can be broadly summarized in the following categories:

- **Assessment**: How tobacco users are identified, how is tobacco use status documented
- **Counseling**: What types of cessation counseling are available, the extent of the benefit, and how counseling services are accessed (e.g., referrals, provider initiates, etc).
- **Pharmacotherapy**: What types of tobacco cessation products are available, how many courses per year are available, and any requirements for accessing these products (e.g., prior authorizations, co-payments, etc).
- **Outreach**: How cessation services are promoted to tobacco users, how staff and providers are trained, and what special efforts and resources are in place to meet the tobacco dependence treatment needs of special populations (e.g., non-English speaking members, limited formal education, limited health literacy).
- **Quality Assurance and Evaluation**: What quality assurance standards are in place, types of monitoring or assessment systems, evaluation of services, and any available metrics for calendar year 2010.

This report provides a high-level summary of these categories for each of the Fully Capitated Health Plans, and a brief summary for each of the Dental Care Organizations, reflecting the applicable categories and services they provide Oregon Health Plan members.

Abbreviations and Acronyms used in this report

5As – A set of clinical practice guidelines for treating tobacco use and dependence in patients: Ask, Advise, Assess, Assist, and Arrange (Follow-up).

ACOG – American Congress of Obstetricians and Gynecologists

ADAPT – Chemical dependency and substance abuse service provider

CAHPS – Consumer Assessment of Healthcare Providers and Systems Survey

ED – Emergency Department

EHR/EMR – Electronic Health Record/Electronic Medical Record

ENCC – Exceptional Needs Care Coordinator

FCHP – Fully Capitated Health Plan

IP – In-Patient

MVBCN – Mid-Valley Behavioral Care Network

NRT – Nicotine Replacement Therapy

OHP – Oregon Health Plan

PA – Prior Authorization

PCP – Primary Care Provider

Rx – Prescription

TPEP – Tobacco Prevention and Education Program

Fully Capitated Health Plans Survey Summary

Tobacco cessation services provided to Oregon Health Plan members varies considerably by plan. While each Fully Capitated Health Plan provides some level of coverage for cessation counseling and medications, many plans do not routinely promote these available benefits to members or ensure provider performance related to tobacco cessation, resulting in low utilization of services.

Assessment

- While all 15 plans have some method of identifying tobacco use status, only two report systematically assessing tobacco use status for every member.
- All 15 plans have some method of documenting tobacco use status at the provider level: four use electronic medical records to document tobacco use, and one plan is currently able to identify tobacco using members at the plan level.

Counseling

All 15 plans provide some form of cessation counseling, and all 15 cover individual counseling with primary care providers, however:

- Twelve plans cover individual counseling with other health professionals (e.g., nurse, health educator).
- Twelve plans cover group counseling in any form (primary care providers, other health professionals, specific curricula – such as the American Lung Association's Freedom From Smoking program).
- Eight plans cover any form of telephonic counseling (via Quit Line vendor or "in-house")

Pharmacotherapy

All 15 plans provide coverage for nicotine patches, Wellbutrin, and Chantix.

- Of the other four FDA-approved medications for smoking cessation: Twelve plans cover nicotine gum; ten cover nicotine lozenges; six cover nicotine nasal spray; and six cover the nicotine inhaler.
- Five plans provide coverage for all seven FDA approved smoking cessation medications.

Regarding access to pharmacotherapy products:

- Thirteen plans require a prior authorization for at least one of their covered products.
- Six plans require enrollment in a counseling program to receive covered products.
- Three plans require a documented quit date set before receiving covered products.

CareOregon

Assessment

- **Tobacco users are identified through:** 5As brief intervention during PCP visits; Case Management; Medical charge review; Pharmacy claims for NRT; Emergency room and inpatient claims with tobacco dependency claims.
- **Tobacco use status is documented in:** Clinical medical file (or EMR) with PCP.

Tobacco Use Prevalence: 36%

CAHPS 2010

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	10 sessions/12 mos.	None needed
✓	Individual with other health professional	10 sessions/12 mos.	None needed
✓	Group with PCP	10 sessions/12 mos.	None needed
✓	Group with other health professional	10 sessions/12 mos.	None needed
	Group with specific curriculum	--	--
✓	Telephonic with quit line vendor	1 enrollment/12 mos.	None needed
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year*	Co-Payment
✓	Nicotine Gum	1	No
✓	Nicotine Patch	1	No
✓	Nicotine Lozenge	1	No
✓	Nicotine Nasal Spray	1	No
✓	Nicotine Inhaler	1	No
✓	Bupropion SR	1	No
✓	Varenicline	1	No

Prior Authorizations: Required for lozenge, nasal spray, and inhaler to control costs (more expensive than generic NRT products).

Other Requirements: None

*1 course = 12 weeks

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Proactive phone contact to members filling NRT Rx; "While You Were Smoking" outreach to identified tobacco users w/asthma related ED visits or IP stays.
- **Staff/Provider Training:** Prescription pads and benefits summary sheets sent to contracted chemical dependency and mental health providers; Information in Provider webpage/ newsletter; Quality Improvement coordinates clinic staff training.
- **Cultural Competency:** Materials and Quit Line counseling in Spanish; Materials are below 6th grade reading level; Outreach to chemical dependency and mental health providers.

Available Materials

- CareOregon website
- "You Can Quit Smoking" and "Good Information for Smokers" – US DHHS
- "Quit For Life" educational packet – Free & Clear
- "Need Help Putting Out that Cigarette" booklet - ACOG

Quality Assurance & Evaluation

In 2010:

- 3,460 members used NRT alone or with counseling
- 1,891 received Stop Smoking packet
- 1,803 were referred to Free & Clear; 640 enrolled (from all referral sources).
- 643 used counseling alone or with NRT
- 21% of Free & Clear program enrollees were quit (30 day quit rate)

- **Quality Assurance Standards:** None are in place at this time.
- **Monitoring & Evaluation:** No formal assessment of provider performance; Optional cessation metrics for Primary Care Renewal Clinics (14 of 17 participating clinics reported these; eight clinics met target of 85% patients screened for tobacco use).
- **Number/Percent of Tobacco Users:** Using CAHPS and claims data.

"Although the concept is strongly supported, none of the [Primary Care Renewal] clinics have been able to report on the cessation counseling metric yet – due to a lack of reliable data and/or sources for the data. We are keeping the metric as an option."

Contact Information

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Cascade Comprehensive Care

Assessment

- **Tobacco users are identified through:** Member self-report; Chart notes; Claims data; Intake assessment at clinics.
- **Tobacco use status is documented in:** Chart notes.

Tobacco Use Prevalence:
39%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	Self
✓	Individual with other health professional	No limits	Self
	Group with PCP	--	--
	Group with other health professional	--	--
✓	Group with specific curriculum	No limits	Self, PCP
	Telephonic with quit line vendor	TPEP 1-call	--
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year	Co-Payment
✓	Nicotine Gum	152 pieces	No
✓	Nicotine Patch	100 patches	No
✓	Nicotine Lozenge	152 pieces	No
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	No limit	No
✓	Varenicline	24 weeks	No

Prior Authorizations:
Required for all Products to ensure attendance in smoking cessation program

Other Requirements:
Program enrollment; Quit Date; Must see doctor to access second course of NRT.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):**
  Notice of tobacco cessation classes in member handbook; Identified tobacco users receive an invitation letter to next session of classes.
- **Staff/Provider Training:**
  Training is done in annual PCP staff education classes; Notices of tobacco cessation policy mailed to all PCP offices.
- **Cultural Competency:**
  No special efforts or resources to meet tobacco dependence treatment needs of specific populations; Mental health smoking cessation project in progress.

Available Materials

- Freedom From Smoking workbook and cd

Quality Assurance & Evaluation

In 2010:

- 406 identified tobacco users
- 375 invited to cessation classes
- 40 attended cessation classes
- 0 referred to other counseling
- 45 received pharmacotherapy

- **Quality Assurance Standards:**
  None are in place at this time.
- **Monitoring & Evaluation:**
  Not evaluating provider performance (e.g., referrals, motivational interviewing).
- **Number/Percent of Tobacco Users:**
  No way to identify and count every tobacco user. Claims data does not capture every tobacco users.

"We do not have a way to identify and count every tobacco user on our plan at this time. Our claims report is vastly under reported as not all providers code for tobacco abuse."

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CENTRAL OREGON INDIVIDUAL HEALTH SOLUTIONS

Assessment

- **Tobacco users are identified through:** Wellness Survey for new members; Providers and Nurse Case Managers; Members contacting Cessation Coordinator; Pharmacy claims
- **Tobacco use status is documented in:** Medical record. No reportable field in electronic medical records for documenting tobacco use.

Tobacco Use Prevalence: 41%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
✓	Individual with other health professional	No limits	None needed
✓	Group with PCP	No limits	None needed
✓	Group with other health professional	No limits	None needed
✓	Group with specific curriculum	No limits	None needed
	Telephonic with quit line vendor	TPEP 1-call	None needed
✓	Telephonic with "in house" staff	No limits	None needed

Pharmacotherapy

	Product	Courses/Year*	Co-Payment
✓	Nicotine Gum	960 pieces	No
✓	Nicotine Patch	70 patches	No
✓	Nicotine Lozenge	960 pieces	No
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	168 tabs	No
✓	Varenicline	Case by case	No

Prior Authorizations:
Only required for Varenicline if exceeding FDA recommended limits (> 12 weeks)

Other Requirements: None

*Approximately a 10-12 week supply

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Information on tobacco cessation included in member newsletters.
- **Staff/Provider Training:** Providers sent letters with 5As outline, Clinical Practice Guideline website, and reminder to ask patients about tobacco use status at each visit.
- **Cultural Competency:** MH Providers have been offered cessation training; Materials available in Spanish; interpreters available; Reading level taken into account for materials.

Available Materials

- No information available

Quality Assurance & Evaluation

In 2010:

- 1,986 diagnosed tobacco users received any cessation services
- 24 received provider counseling
- 227 accessed cessation services
- 852 received pharmacotherapy

- **Quality Assurance Standards:** Standards for Counseling, Pharmacotherapy, and Community-based Resources.
- **Monitoring & Evaluation:** Medical records are reviewed for documentation standards, including annual assessment of tobacco use status and advice to quit.
- **Number/Percent of Tobacco Users:** Using CAHPS data.

"The only quit rate that is tracked is related to the assistance provided to members by the COIHS Tobacco Cessation Coordinator. No members remained tobacco free as a result of assistance from the COIHS Tobacco Cessation Coordinator in 2010."

Contact Information

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DOCTORS OF THE OREGON COAST SOUTH (DOCS)

Assessment

- **Tobacco users are identified through:** 3As brief intervention during PCP visits; Daily review process by DOCS UR Team.
- **Tobacco use status is documented in:** Progress notes, referral requests for NRT, and case management notes.

Tobacco Use Prevalence: 42%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
✓	Individual with other health professional	10 sessions/3 mos.	Self, Any*
	Group with PCP	--	--
✓	Group with other health professional	10 sessions/3 mos.	Self, Any*
✓	Group with specific curriculum	10 sessions/3 mos.	Self, Any*
✓	Telephonic with quit line vendor	1 enrollment/12 mos.	None needed
✓	Telephonic with "in house" staff	10 sessions/3 mos.	None needed

**Any healthcare provider can refer to services*

Pharmacotherapy

	Product	Courses/Year*	Co-Payment
✓	Nicotine Gum	1	No
✓	Nicotine Patch	1	No
	Nicotine Lozenge	--	--
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	1	No
✓	Varenicline	1	No

Prior Authorizations:
Required for nicotine gum and Varenicline

Other Requirements:
Must attend a Quit Tobacco Use 101 workshop to receive pharmacotherapy. Workshop can be repeated to access additional pharmacotherapy.

*1 course = 3 months

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Annual health survey assesses interest in cessation. Interested members receive flyer listing available services; Quit Tobacco Use 101 workshop publicized in local media; Customer service and case management.
- **Staff/Provider Training:** Quarterly provider education sessions and 1:1 calls.
- **Cultural Competency:** Interpreter services in 6 languages; Individualized services for members with limited education and/or health literacy; Collaboration with Mental Health and ADAPT to meet members needs, onsite case management.

Available Materials

Quit Tobacco User Services Flyer is updated annually and available at:

- All providers' offices
- Customer Service
- Workshops
- ADAPT

Quality Assurance & Evaluation

In 2010:

No metrics available.

- **Quality Assurance Standards:** None are in place at this time.
- **Monitoring & Evaluation:** Provider performance monitored through the referral process.
- **Number/Percent of Tobacco Users:** Unable to report.

"DOCS made the decision to partner with ADAPT to provide a more 'robust' offering of tobacco cessation services to meet the needs of our membership."

Contact Information

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DOUGLAS COUNTY IPA (DCIPA)

Assessment

- **Tobacco users are identified through:**
  Provider visits.
- **Tobacco use status is documented in:**
  EMR office visit note and provider chart notes.

Tobacco Use Prevalence: 46%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
	Individual with other health professional	--	--
	Group with PCP	--	--
✓	Group with other health professional	No limits	None needed
✓	Group with specific curriculum	No limits	Letter
	Telephonic with quit line vendor	TPEP 1-call	--
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year	Co-Payment
	Nicotine Gum	--	--
✓	Nicotine Patch	2	Yes
	Nicotine Lozenge	--	--
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	2	Yes
✓	Varenicline	2	$3

Prior Authorizations:
Required for nicotine patch, brand name Bupropion, and Varenicline to monitor compliance and progress, and ensure referrals to behavioral programs.

Other Requirements:
Letter of intent to attend local smoking cessation class.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Cessation literature, including information about classes and medications, is sent out in new member packets, member handbook, and available online.
- **Staff/Provider Training:** Information and articles on Provider web pages and newsletter.
- **Cultural Competency:** Materials available in a variety of languages upon request; Cessation program for members with mental health and chemical dependency issues through ADAPT.

Available Materials

- Quit Smoking Video

Quality Assurance & Evaluation

In 2009:

- 24 members completed a 6-week course of NRT.

- **Quality Assurance Standards:** Standards for Educational Materials and Community-based Resources.
- **Monitoring & Evaluation:** Provider performance is not assessed.
- **Number/Percent of Tobacco Users:** Not currently tracking.

Contact Information

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FAMILY CARE, INC.

Assessment

- **Tobacco users are identified through:**
  Health Risk Assessments; PCP visit assessment
- **Tobacco use status is documented in:**
  Health Risk Assessments; Pharmacy reporting

Tobacco Use Prevalence: 38%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	Self, PCP
✓	Individual with other health professional	No limits	Self, PCP
	Group with PCP	--	--
	Group with other health professional	--	--
	Group with specific curriculum	--	--
✓	Telephonic with quit line vendor	2 enrollments/12 mos.	Self, PCP
✓	Telephonic with "in house" staff	No limits	Self, PCP

Pharmacotherapy

	Product	Courses/Year	Co-Payment
✓	Nicotine Gum	1	No
✓	Nicotine Patch	1	No
✓	Nicotine Lozenge	1	No
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	1	No
✓	Varenicline	1	No

Prior Authorizations:
Not required

Other Requirements:
None

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Tobacco Cessation brochures distributed at health fairs, provider offices, new member enrollment packet, babycare packet, and online.
- **Staff/Provider Training:** None.
- **Cultural Competency:** Materials available in Spanish; Interpreter services available; Alternative formats and accommodations available upon request.

Available Materials

- FamilyCare website

Quality Assurance & Evaluation

In 2010:

No metrics available.

- **Quality Assurance Standards:** None are in place at this time.
- **Monitoring & Evaluation:** Provider performance is not assessed.
- **Number/Percent of Tobacco Users:** Not currently tracking.

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InterCommunity Health Network

Assessment

- **Tobacco users are identified through:** Patient inquiries during office visits.
- **Tobacco use status is documented in:** Medical record at PCP office.

Tobacco Use Prevalence: 43%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
✓	Individual with other health professional	No limits	None needed
	Group with PCP	--	--
	Group with other health professional	--	--
	Group with specific curriculum	--	--
✓	Telephonic with quit line vendor	1 enrollment/12 mos.	None needed
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year	Co-Payment
✓	Nicotine Gum	16 weeks	No
✓	Nicotine Patch	16 weeks	No
✓	Nicotine Lozenge	Per PA	No
✓	Nicotine Nasal Spray	Per PA	No
✓	Nicotine Inhaler	Per PA	No
✓	Bupropion SR	16 weeks	No
✓	Varenicline	16 weeks	No

Prior Authorizations:
Required for lozenge, nasal spray, and inhaler to ensure appropriate utilization.

Other Requirements:
None.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Cessation brochure to all new and re-enrolled members; Cessation resources listed in quarterly member newsletter.
- **Staff/Provider Training:** Annual provider education; Policies and procedures in provider manual and website.
- **Cultural Competency:** Materials translated into other languages as requested; Member materials written at or below 6th grade reading level.

Available Materials

- Tobacco Cessation Brochure
- Newsletter Articles:

- Allergies & Smoking
- Strokes & Smoking
- Insomnia & Nicotine
- Sleep Apnea & Tobacco
- Osteoporosis & Smoking
- Benefits of Quitting Smoking to Help Avoid Type 2 Diabetes
- Benefits of Quitting Smoking to Prevent Heart Disease in Women

Quality Assurance & Evaluation

In 2010:

43% tobacco use prevalence.

No other metrics available at this time.

- **Quality Assurance Standards:** Standards for Educational Materials and Cultural Competency.
- **Monitoring & Evaluation:** Provider performance is not assessed at this time.
- **Number/Percent of Tobacco Users:** Unknown. Using CAHPS data when available.

"IHN has had a Tobacco Cessation Policy since 1997."

Contact Information

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Corvallis, OR 97330

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Kaiser Permanente

Assessment

- **Tobacco users are identified through:** Verbal inquiry (Medical Assistants are expected to ask every member at every office visit).
- **Tobacco use status is documented in:** EMR, under social history.

Tobacco Use Prevalence: 31.8%

KPNW January 2011

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
	Individual with other health professional	--	--
	Group with PCP	--	--
	Group with other health professional	--	--
✓	Group with specific curriculum	No limits	None needed
✓	Telephonic with quit line vendor	1 enrollment/12 mos.	None needed
✓	Telephonic with "in house" staff	No limits	None needed

Pharmacotherapy

	Product	Courses/Year	Co-Payment
✓	Nicotine Gum	No limits	No
✓	Nicotine Patch	No limits	No
	Nicotine Lozenge	--	--
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	No limits	No
✓	Varenicline	No limits*	No

Prior Authorizations:
Not required

Other Requirements:
Must also be enrolled in a behavioral program.

*only available if other medications have been tried and were unsuccessful.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Newsletter articles; Member handbook; Health Education Services catalog; Customized cessation messages in the "after visit summary" handout.
- **Staff/Provider Training:** Information available through KPNW internal website; Workflow prompts built into EMR; Information in staff emails, presentations and regional trainings.
- **Cultural Competency:** Materials and counseling available in Spanish; Interpreter services available; Materials are below 8th grade reading level.

Available Materials

- "Willingness to Quit" tool on www.kp.org
- Brochures for medical offices
- Flyers for exam rooms and lobbies

Quality Assurance & Evaluation

In 2010:

- 288 calls from OHP members
- 20 enrolled in online program
- 16 enrolled in Quit Line
- 50 received NRT, 187 received Bupropion, 10 combination, and 30 received Varenicline.

- **Quality Assurance Standards:** Standards for Counseling, Pharmacotherapy, Community-based Resources, and Educational Materials.
- **Monitoring & Evaluation:** Successful performance is measured by evaluating the clinical outcome of tobacco use prevalence in membership.
- **Number/Percent of Tobacco Users:** 31.8%

"Any and all patient care staff is responsible for identifying tobacco users."

Contact Information

Anita Lesser
7201 N Interstate Ave.
Portland, OR 97217

phone: 503.286.6716 option 2
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email: healthcoach@kp.org

LANE COUNTY IPA (LIPA)

Assessment

- **Tobacco users are identified through:** Office visits
- **Tobacco use status is documented in:** Provider clinical dictation; Claims for tobacco cessation counseling.

Tobacco Use Prevalence: 44%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	Self, PCP
	Individual with other health professional	--	--
	Group with PCP	--	--
	Group with other health professional	--	--
	Group with specific curriculum	--	--
✓	Telephonic with quit line vendor	1 enrollment/12 mos.	Self
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year	Co-Payment
✓	Nicotine Gum	6 months	No
✓	Nicotine Patch	90 days	No
✓	Nicotine Lozenge	6 months	No
✓	Nicotine Nasal Spray	6 months	No
✓	Nicotine Inhaler	6 months	No
✓	Bupropion SR	90 days	No
✓	Varenicline	168 days	No

Prior Authorizations:
Required for gum, lozenge, nasal spray, inhaler, and Varenicline.

Other Requirements:
To access gum, nasal spray or inhaler, member must demonstrate tried/failed first-line medications (patch, Bupropion, and Varenicline).

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Member newsletter article.
- **Staff/Provider Training:** Information provided in newsletters and phone conversations with staff and providers; Through provider relations representative.
- **Cultural Competency:** Member newsletter available in Spanish; Materials written at 6th grade level; Providers educated on using plain language.

Available Materials

- Quit Line contact info
- Description of services

Quality Assurance & Evaluation

In 2010:

- 438 members received counseling
- 70 accessed Quit Line counseling
- 1,502 received pharmacotherapy

- **Quality Assurance Standards:** None.
- **Monitoring & Evaluation:** Not evaluating provider performance.
- **Number/Percent of Tobacco Users:** No way to assess the total number of tobacco users or those asked about tobacco use status without conducting a chart review.

"Many members are not motivated to quit, no matter how bad their health is impacted."

Contact Information

Michelle Martinez
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Eugene, OR 97403

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Marion-Polk Community Health Plan

Assessment

- **Tobacco users are identified through:** Office visits.
- **Tobacco use status is documented in:** Electronic Health Record, in social history.

Tobacco Use Prevalence: 34%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	Self, PCP
✓	Individual with other health professional	No limits	Self, PCP
✓	Group with PCP	No limits	Self, PCP
✓	Group with other health professional	No limits	Self, PCP
✓	Group with specific curriculum	No limits	Self, PCP
	Telephonic with quit line vendor	TPEP 1-call	Self
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year*	Co-Payment
	Nicotine Gum	--	--
✓	Nicotine Patch	2	No
	Nicotine Lozenge	--	--
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	2	No
✓	Varenicline	1	No

Prior Authorizations:
Required for patch after the first course. Required for Varenicline.

Other Requirements:
Quit Date, Enrollment in behavioral program.

*2-3 weeks/course for the patch; 6 months/course for Bupropion.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Member handbook; Tobacco use information on mvipa.org; HealthCoach4Me.com (GlaxoSmithKline).
- **Staff/Provider Training:** Information in the provider manual and Policy Tech system.
- **Cultural Competency:** Materials at 6th -8th grade reading levels; Mental health providers with MVBCN provide addiction counseling.

Available Materials

Information on Tobacco Use at www.mvipa.org includes:

- The Real Cost of Smoking video
- The Benefits of Quitting
- Cessation coverage details
- Patient Toolkit (GSK)
- Links to ACS and CDC materials

Quality Assurance & Evaluation

In 2010:

446 members received pharmacotherapy for tobacco cessation.

- **Quality Assurance Standards:** None at present. All PCPs will be in compliance with Meaningful Use requirements in the future.
- **Monitoring & Evaluation:** Not evaluating provider performance at this time.
- **Number/Percent of Tobacco Users:** Could report on members managed by MPCHP providers using EHR and extrapolate results to all members. Not tracking quit rates.

Contact Information

Roberta Morgan
2995 Ryan Drive SE
Salem, OR 97301

phone: 503.587.5145
email: roberta@mvipa.org

MID-ROGUE IPA (MRIPA)

Assessment

- **Tobacco users are identified through:** Monthly report regarding prescriptions for cessation; Member chart notes; Health Risk Assessment questionnaire; Case/Disease management intake questionnaire
- **Tobacco use status is documented in:** Spreadsheet (Rx data and member assessments)

Tobacco Use Prevalence: 40%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
✓	Individual with other health professional	No limits	None needed
✓	Group with PCP	No limits	None needed
✓	Group with other health professional	No limits	None needed
✓	Group with specific curriculum	No limits	None needed
	Telephonic with quit line vendor	TPEP 1-Call	None needed
✓	Telephonic with "in house" staff	No limits	None needed

Pharmacotherapy

	Product	Courses/Year*	Co-Payment
✓	Nicotine Gum	2	No
✓	Nicotine Patch	2	No
✓	Nicotine Lozenge	2	No
✓	Nicotine Nasal Spray	2	No
✓	Nicotine Inhaler	2	No
✓	Bupropion SR	No limit	No
✓	Varenicline	6 months	No

Prior Authorizations:
Required for lozenge, nasal spray and inhaler – demonstrate why member cannot tolerate patch or gum. Required for Varenicline after 3 courses.

Other Requirements:
None.

*1 course = 8 weeks

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** New member, ENCC, and maternity packets; Flyers at OHP events; Member newsletters; Outreach for new parents, pregnant members, and Babies in the Library project; Cessation support in obesity pilot project.
- **Staff/Provider Training:** Annual training for staff on policies; Information in provider newsletters and intranet; 5As training available for interested providers; Faxes to all PCPs.
- **Cultural Competency:** Materials in Spanish; Interpretive and sign language services available; Printed information at the 6th grade reading level; 2011 PIP with mental health organization to help members with mental illness quit tobacco.

Available Materials

- Cessation Class Flyer
- I Quit Book
- Thinking about Quitting Book
- Quitting for Life Handbook
- Quit Smoking for Baby & You
- Quitting Smoking (trifold)
- Health Consequences of Smoking

Quality Assurance & Evaluation

In 2010:

- 961 prescriptions for tobacco cessation products were filled
- 31 members participated in face-to-face or group counseling
- >1,000 members called Smoking Cessation Facilitator
- 27% Quit Rate

- **Quality Assurance Standards:** Standards for Pharmacotherapy, Educational Materials, and Cultural Competency.
- **Monitoring & Evaluation:** Evaluates tobacco cessation program annually. Tracking quarterly indicators.
- **Number/Percent of Tobacco Users:** Unknown.

"Mid Rogue offers comprehensive services without barriers to all our OHP members and counseling to the community."

Contact Information

Cynthia Ackerman or Malinda Wilson
740 SE 7th Street
Grants Pass, OR 97526

phone: 571.471.4106
fax: 541.471.3789
email: cackerman@mripa.org, mawilson@mripa.org

ODS Community Health, Inc.

Assessment

- **Tobacco users are identified through:** Monthly medical and pharmacy claims review; OHP Health Risk Assessment; Pharmacy Data; Health Coaching Programs screening.
- **Tobacco use status is documented in:** Spreadsheet tracking all members who receive cessation information.

Tobacco Use Prevalence: 35%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	10 sessions/3 mos.	None needed
✓	Individual with other health professional	10 sessions/3 mos.	None needed
✓	Group with PCP	10 sessions/3 mos.	None needed
✓	Group with other health professional	10 sessions/3 mos.	None needed
	Group with specific curriculum	--	--
	Telephonic with quit line vendor	TPEP 1-Call	None needed
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year	Co-Payment
✓	Nicotine Gum	12	No
✓	Nicotine Patch	12	No
✓	Nicotine Lozenge	12	No
✓	Nicotine Nasal Spray	12	No
✓	Nicotine Inhaler	12	No
✓	Bupropion SR	12	No
✓	Varenicline	12	No

Prior Authorizations:
Required for all products to ensure safe and appropriate use of the medication.

Other Requirements:
None.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Identified tobacco users receive letter explaining benefits, health risks, and Quit Line flyer; Health Coaching programs.
- **Staff/Provider Training:** Regular provider mailings; Provider handbook; Provider website; Provider workshops; Motivational Interviewing trainings; Annual customer service staff trainings.
- **Cultural Competency:** Materials in Spanish; Printed information below the 6th grade reading level and reviewed for health literacy criteria.

Available Materials

- Benefits Letter
- Quit Line Flyer
- Health Risks of Secondhand Smoke

Quality Assurance & Evaluation

In 2010:

- 85 members enrolled in Quit Line counseling.

- **Quality Assurance Standards:** Standards for Pharmacotherapy, Educational Materials, and Cultural Competency. .
- **Monitoring & Evaluation:** Assesses tobacco use screening annually.
- **Number/Percent of Tobacco Users:** Unknown.

"It is not possible to determine a quit rate for ODS OHP medical members with the current data available."

Contact Information

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Portland, OR 97204

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Oregon Health Management Services (OHMS)

Assessment

- **Tobacco users are identified through:**
  All members are asked about tobacco use status at least annually. Chart review, utilization review, case management, and authorization process may also be used to identify tobacco users.
- **Tobacco use status is documented in:**
  Medical record.

Tobacco Use Prevalence: 46%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
✓	Individual with other health professional	No limits	PCP initiates
	Group with PCP	--	--
	Group with other health professional	--	--
✓	Group with specific curriculum	No limits	None needed
	Telephonic with quit line vendor	TPEP 1-Call	--
✓	Telephonic with "in house" staff	No limits	None needed

Pharmacotherapy

	Product	Courses/Year*	Co-Payment
	Nicotine Gum	--	--
✓	Nicotine Patch	2	No
	Nicotine Lozenge	--	--
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	2	No
✓	Varenicline	2	No

Prior Authorizations:
Required for all products to ensure that drug utilization is within OHMS guidelines and also to initiate internal case management for tobacco cessation.

Other Requirements:
None.

*1 course = 90 days

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Member handbook; Flyers for cessation classes displayed and mailed out periodically; Identified tobacco users receive proactive calls from ENCC and Smoking Cessation Counselor.
- **Staff/Provider Training:** Provider manual, newsletter, and website; Regular training on procedures and benefits related to cessation; Provider meetings.
- **Cultural Competency:** Translator available as needed; Collaborative project to improve outreach to mentally ill population for tobacco cessation services.

Available Materials

Educational mailing to members wishing to quit includes:

- Congratulatory letter
- Cessation Class information
- Health Benefits of Quitting Smoking – ALA
- Partners for a Healthy Baby

Quit Line brochures available.

Quality Assurance & Evaluation

In 2010:

At least 153 unique members received pharmacotherapy for tobacco cessation.

- **Quality Assurance Standards:** Standards for Counseling, Pharmacotherapy, and Educational Materials.
- **Monitoring & Evaluation:** Provider performance is not assessed at this time.
- **Number/Percent of Tobacco Users:** OHMS will begin reporting on tobacco users referred to counseling services in 2011.

"Also notable is that 23% of those who smoke are under the age of 35."

Contact Information

Jennifer Johnstun
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Grants Pass, OR 97526

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email: jen@ohms1.com

Providence Health Assurance

Assessment

- **Tobacco users are identified through:**
  Vital signs assessment during office visit; Health Risk Assessment for all new OHP members.
- **Tobacco use status is documented in:**
  Case Management electronic file; Patient chart.

Tobacco Use Prevalence: 36%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
✓	Individual with other health professional	No limits	None needed
	Group with PCP	--	--
	Group with other health professional	--	--
✓	Group with specific curriculum	No limits	Self, PCP
✓	Telephonic with quit line vendor	No limits	Self, PCP
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year*	Co-Payment
✓	Nicotine Gum	1	No
✓	Nicotine Patch	1	No
✓	Nicotine Lozenge	1	No
✓	Nicotine Nasal Spray	1	No
✓	Nicotine Inhaler	1	No
✓	Bupropion SR	1	No
✓	Varenicline	1	No

Prior Authorizations:
Required for all products to ensure member is enrolled in smoking cessation program or medical rationale on file.

Other Requirements:
Enrollment in a cessation program or medical rationale why member cannot participate.

*1 course = 8 weeks (NRT, bupropion) or 12 weeks (varenicline)

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Member mailing to identified smokers twice/year. Care Management sends information to members interested in quitting. Providers distribute printed materials.
- **Staff/Provider Training:** Provider Relations staff trains providers on guidelines, including tobacco cessation.
- **Cultural Competency:** Counseling and materials available in other languages; Member materials are 6-8th grade level.

Available Materials

Mailing to identified tobacco users includes:

- Reasons to Quit
- Links to Providence's smoking cessation website

Quality Assurance & Evaluation

In 2010:

- 998 members were identified as tobacco users
- 100% of identified tobacco users received mailer with cessation resources
- 180 received Quit Line counseling
- 46 enrolled in cessation classes

- **Quality Assurance Standards:** Standards for Counseling, Pharmacotherapy, and Educational Materials.
- **Monitoring & Evaluation:** Provider performance is not assessed at this time.
- **Number/Percent of Tobacco Users:** Unknown.

"OHP members have always had tobacco cessation services and deterrent medications covered in full."

Contact Information

Tracy Scharn
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Beaverton, OR 97005

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fax: 503.574.8140
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TUALITY HEALTH ALLIANCE

Assessment

- **Tobacco users are identified through:** Health Risk Assessment for new members; Chart review; Claims data review
- **Tobacco use status is documented in:** Medical record.

Tobacco Use Prevalence: 31%

CAHPS 2007

Counseling

	Cessation Counseling	Level of Service	Referral
✓	Individual with PCP	No limits	None needed
✓	Individual with other health professional	No limits	None needed
	Group with PCP	--	--
	Group with other health professional	--	--
✓	Group with specific curriculum	No limits	None needed
	Telephonic with quit line vendor	TPEP 1-call	None needed
	Telephonic with "in house" staff	--	--

Pharmacotherapy

	Product	Courses/Year*	Co-Payment
✓	Nicotine Gum	2	No
✓	Nicotine Patch	2	No
✓	Nicotine Lozenge	2	No
	Nicotine Nasal Spray	--	--
	Nicotine Inhaler	--	--
✓	Bupropion SR	2	No
✓	Varenicline	2	No

Prior Authorizations: Required for additional courses after initial two courses.

Other Requirements: None.

*1 course = 6 weeks

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Quarterly newsletter includes cessation class listing; Identified tobacco users are notified of group cessation classes at Tuality Health Education Center.
- **Staff/Provider Training:** Quarterly clinical meetings with providers, office managers and referral specialists; Provider newsletter; Provider website.
- **Cultural Competency:** All literature and educational material is provided in English and Spanish, other languages and translators available if requested; Notices of classes provided at 6th grade level.

Available Materials

- Quit Line Brochures
- Health Education Center class and event catalog
- Educational Materials

Quality Assurance & Evaluation

In 2010:

- 380 members identified as tobacco users.
- 231 members received pharmacotherapy

- **Quality Assurance Standards:** Standards for Pharmacotherapy, Educational Materials, and Cultural Competency.
- **Monitoring & Evaluation:** Provider performance is not assessed at this time.
- **Number/Percent of Tobacco Users:** Unknown.

"THA Case Management is notified when a member completes a class and will do follow up calls to support the member in the process and maintenance of smoking cessation."

Contact Information

Barbara Carey
THA PO Box 925
Hillsboro, OR 97123

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Dental Care Organizations Survey Summary

Contracted Dental Care Organizations (DCOs) are required to provide tobacco dependency and cessation services by developing and implementing evidence-based guidelines that reference accepted published standards for tobacco interventions in a dental office setting.

As a minimum, contracted DCOs shall use the "2A's and an R" model:

- Ask patients about their tobacco-use status at each visit and record information in the chart;
- Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help;
- Refer patients who are ready to quit utilizing internal and external resources to complete the remaining three A's (Assess, Assist, Arrange) of the standard intervention protocol for tobacco users.

Assessment

- Of the eight DCOs, seven have some method of identifying tobacco use status. Four DCOs ask about tobacco use on health history forms or new patient forms.
- Seven DCOs record tobacco use status in patient charts or medical history forms.

Counseling

- Seven DCOs provide tobacco cessation counseling through dental providers, dental assistants, and/or registered hygienists.
- Seven DCOs refer patients to the Quit Line, and five DCOs make referrals to medical providers, primary care tobacco counselors, or other resources.

ACCESS DENTAL PLAN, LLC

Assessment

- **Tobacco users are identified through:** Primary Care Dentists, Hygienists and support staff make inquiries at the time of service; Patient also completes a health history form with an indication of tobacco use and type.
- **Tobacco use status is documented in:** Patient chart.

In 2010:

Tobacco cessation counseling was provided to approximately 100 unique patients.

Counseling

Individual counseling with provider and hygienists. No limitation on frequency of counseling services.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** No special promotion or outreach.
- **Cultural Competency:** Print materials available in Spanish and English; Tobacco cessation materials online available in 5 languages; Will translate any documents upon request.
- **Quality Assurance:** Reviews utilization data to determine frequency of tobacco cessation codes charged. Follow up with providers.

Available Materials

- Quit Line information
- Commercial Products
- ADA Flyers

Contact Information

Kevin Boie
14210 NE 20th Ave, Suite 2204
Vancouver, WA 98686

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fax: 360.573.4022
email: kboie@accessdentalplan.net

Advantage Dental Services

Assessment

- **Tobacco users are identified through:** Questions on new patient forms: "Do you use tobacco products" If yes, "Do you want to quit?"
- **Tobacco use status is documented in:** Patient forms

Counseling

Individual counseling with providers.

Outreach & Training

Promotion of Cessation Services (past 12 months):

- If patient shows interest in quitting, dental hygienist conducts 5As.
- Patients are also referred to the Quit Line and back to their medical provider for additional information.

Available Materials

DCO does not hand out any materials.

Contact Information

R. Mike Shirtcliff
442 SW Umatilla Ave, Suite 200
Redmond, OR 97756

phone: 866.268.9616
fax: 541.504.3907
email: mikes@advantagedental.com

Capitol Dental Care/Managed Dental Care

Assessment

- **Tobacco users are identified through:** Medical history questions, asked by providers and dental office staff
- **Tobacco use status is documented in:** Patient chart

Counseling

Individual counseling with provider regarding oral cancer, oral cancer screening, referral to other resources (dependant on provider awareness and interest).

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Quit Line pamphlets in dental offices; Information on website; Occasional member mailings.
- **Staff/Provider Training:** Tobacco related policies covered at doctor meetings, provider newsletters, and on plan website. Provider performance is not assessed.

Available Materials

- Quit Line brochures
- Oral Cancer brochures

Contact Information

Sarah Bell
3000 Market Street NE, Suite 228
Salem, OR 97301

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fax: 503.581.0043
email: bells@interdent.com

Family Dental Care

Assessment

- **Tobacco users are identified through:** Providers, including dental assistants and registered hygienists; Health History question.
- **Tobacco use status is documented in:** Health History forms.

Family Dental Care is aware of 6 teen and 788 adult tobacco users (40% adult prevalence).

80% have been asked about tobacco use status.

Counseling

Individual counseling is available through the Quit Line. Dental Providers do not offer cessation counseling services.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Referrals to the Quit Line; Mailed flyer; Posters in offices.
- **Cultural Competency:** Translation services available.

Available Materials

ADA flyers and new materials currently being developed.

Contact Information

Dennis Perala
8770 SW Hall Blvd, #200
Beaverton, OR 97008

phone: 503.644.1110
fax: 503.641.6431
email: osseousdr@hotmail.com

MULTICARE

Assessment

- **Tobacco users are identified through:** Providers, including dental assistants and registered hygienists. Providers are directed to ask about tobacco use at every visit.
- **Tobacco use status is documented in:** Encounter forms; Patient charts. Counseling is documented as procedure code D1320.

Tobacco Counseling was offered to 448 OHP members in August 2010 (358 were MultiCare).

Additional data available.

Counseling

Individual counseling with providers, hygienists, and dental assistants is available during visit. Providers refer patients to a primary care social worker/tobacco counselor, or to the Quit Line.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** No special promotion or outreach.
- **Cultural Competency:** Materials available in Spanish and Russian.

Available Materials

Tobacco education pamphlets and Quit Line brochures available in all clinics.

Contact Information

Nancy Carey
426 SW Stark Street
Portland, OR 97204

phone: 503.988.3663 x26288
email: nancy.carey@co.multnomah.or.us

ODS Community Health, Inc. (Dental)

Assessment

ODS OHP Dental expects its participating dentists to Ask, Advise, Assess, Assist and Refer members who use tobacco products for help through their primary care physician and their OHP medical plan.

Counseling

ODS asks that all providers take an active part in tobacco cessation services based on the5As.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** Refer patient to medical plan and/or to the Quit Line.
- **Cultural Competency:** No information available.

Available Materials

No information available.

Contact Information

Charlene Yoder
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Portland, OR 97204

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email: yoderch@odscompanies.com

Willamette Dental

Assessment

- **Tobacco users are identified through:** Any provider with direct patient care, including dental assistants and registered hygienists; Medical and dental history.
- **Tobacco use status is documented in:** Medical and dental history (voluntary diagnostic code for providers to use).

Currently, Willamette Dental has record of 3,587 current OHP tobacco users.

Counseling

Individual counseling with providers, hygienists, and dental assistants. Clinician policies support use of the 5As.

Inquiry on tobacco use status made at every appointment, as part of updating medical and dental history, as well as through an oral health risk assessment at each appointment.

Outreach & Training

- **Promotion of Cessation Services (past 12 months):** No special promotion or outreach.
- **Cultural Competency:** Materials available in Spanish.

Available Materials

Willamette Dental education material available on the intranet and at each office.

Contact Information

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Hillsboro, OR 97124

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S10. Oregon Minimum Standards for Tobacco Cessation

2012 Tobacco Cessation Minimum Standards of Service (TCMSS)

Basis for Recommendations

Oregon Action Plan
OHA/OHPB Triple Aim

- Improve the life-long health of Oregonians
- Increase the quality, reliability and availability of care for all Oregonians
- Lower or contain the cost of care so its affordable for everyone

Oregon Medicaid Fee for Service Tobacco Cessation Benefits

Helping Benefit Oregon Smokers (HBOS)

- Health systems and community task force

2008 Clinical Practice Guidelines for Tobacco Cessation Services

1. Minimum Standard of Care for Tobacco Cessation Services to OHP members:

a) Asking clients about the use of tobacco and tobacco products or exposure to secondhand smoke at every clinic visit and documenting findings in the client health record;

b) Advising identified tobacco users to quit and then assess the clients' willingness to make a quit plan at subsequent clinic visits;

c) Making available to tobacco users who want to quit evidence-based treatment that includes:

- A selection of FDA approved medically appropriate medications indicated for tobacco cessation;
- Coverage for documented multiple quit attempts and extended treatment options annually, with no lifetime limit;
- Cost effective treatment options at low or no client out-of-pocket expenses, including co-payments;
- Provide access to an MCO contracted evidence-based tobacco cessation quit line telephonic counseling services;
- Provision of tobacco cessation counseling directly with a medical provider or provider led group setting;

2. Reducing the Prevalence of Smoking among Oregon Health Plan Members:

- Contracted Managed Care Organizations shall complete the survey tool yearly which will include metrics reflecting assessed members tobacco use, and planned actions to reduce tobacco prevalence.

S11. Sample of CAF Client Cessation Messaging: Quit Cards & Posters

Quitting is easier with help.

Call: 1-800-QUIT-NOW (1-800-784-8669)
Español: 1-877-2NO-FUME (1-877-266-3863)
https://www.quitnow.net/oregon/

S12. DHS/OHA Adult Client Distribution of Services Graphic & A Note on Long-Term Evaluation Efforts

One of our evaluation questions at the beginning of the grant was: is the Oregon Health Plan (OHP) population a good proxy for DHS clients as a whole? If not, could another sub-population receiving DHS services be used as a proxy to assess intermediate and long-term outcomes in the population of low income individuals accessing DHS/OHA services?

The Division of Medical Assistance Programs (DMAP) maintains comprehensive data on OHP clients, including smoking status, use of tobacco cessation services, demographics, and co-morbidities. Hence, the idea of using DMAP clients as a proxy for the DHS population as a whole was appealing, as those data are largely unavailable for clients accessing other types of DHS services, such as SNAP.

We examined data collected from all OHA/DHS programs, in order to assess how DHS/OHA services overlap across the major program areas. In 2010, 754,845 adults were served by DHS/OHA programs; about half of these clients (48%) only received services from one program. The vast majority of clients receiving Medical Assistance Program services also receive other DHS/OHA services; only 3.9% of DHS/OHA clients receive DMAP services alone. However, DMAP clients are older and more likely to be female compared to the OHA/DHS client population as a whole.

Service data showing significant client overlap across service categories supports the notion that many DHS/OHA clients have the potential to receive cessation messages in multiple places if policies are in place to ensure that consistent messaging is ongoing. This is a good thing.

However, we determined that the interventions undertaken among various subpopulations of DHS/OHA clientele would be best measured by assessments within those subpopulations. For example, smoking rates among the AMH residential population would best be measured by chart review or surveys of those facilities after policy implementation.

Overall smoking prevalence among low-income Oregonians will continue to be assessed through subanalysis of BRFSS data.

See the following graphic depicting Oregon DHS/OHA distribution of services.

754,845 Adults* Served by DHS/OHA in 2010

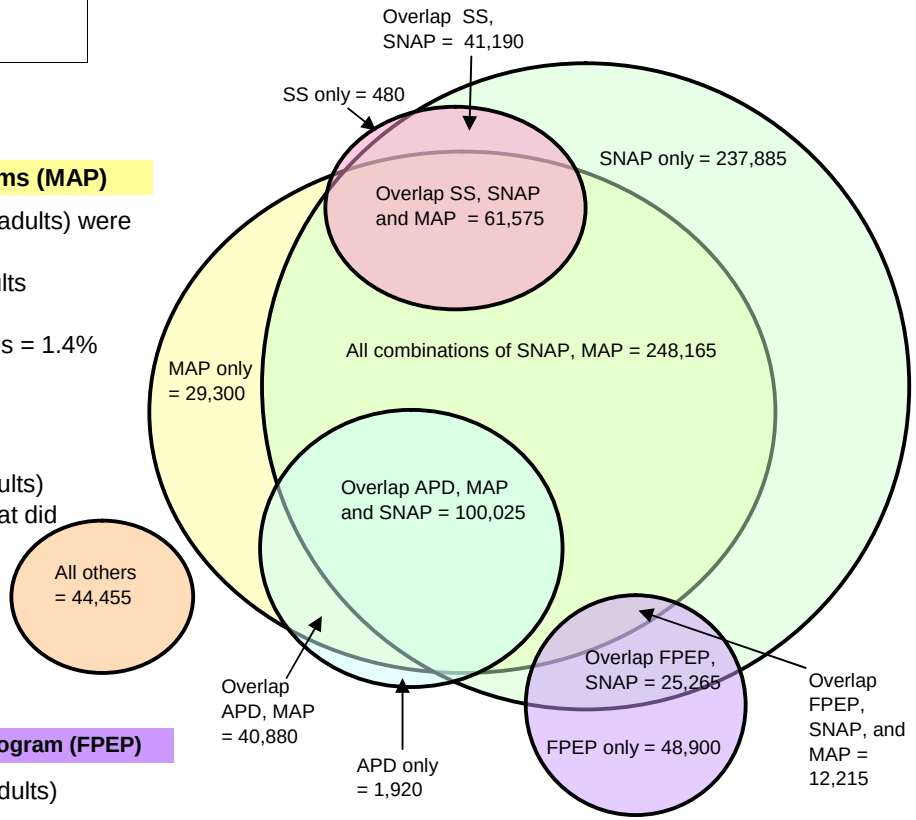
This graphic shows how services to adults overlap across major program areas.

Participation by number of programs

One program	47.9%
Two programs	23.9%
Three programs	20.1%
Four programs	6.5%
Five or more	1.6%

Program areas include:

OHA	DHS
Alcohol & Drug	Aged & Physical Disabilities
Family Planning	Developmental Disabilities
Medical Assistance	Self Sufficiency
Mental Health	Supplemental Nutrition Assistance
Women, Infants, Children	Vocational Rehabilitation



Medical Assistance Programs (MAP)

333,565 adults (44.2% of all adults) were eligible for MAP in 2010

- MAP only = 3.9% of all adults
- MAP and SNAP = 7.8%
- MAP and two other services = 1.4%

Supplemental Nutrition Assistance Program (SNAP)

572,375 adults, (75.7% of all adults) received SNAP benefits at some time during 2010

- SNAP only = 31.5% of all adults
- SNAP and MAP = 7.8%
- SNAP and two other services = 1.3%

All Others

44,455 adults (5.9% of all adults) received services/benefits that did not include MAP, SNAP, SS, APD or FPEP
(see program list, top right)

Self Sufficiency Programs (SS)

105,340 adults (14.0% of all adults)

- Self sufficiency only = <1%
- Self sufficiency and SNAP = 5.5%
- Self sufficiency, SNAP and MAP = 8.2%

Family Planning Expansion Program (FPEP)

89,820 adults (11.9% of all adults)

- FPEP only =6.5%
- FPEP and SNAP = 3.3%
- FPEP, SNAP and MAP = 1.6%

Aged and Physical Disabilities (APD)

143,835 adults (19.1% of all adults)

- APD only = <1%
- APD and MAP = 5.4%
- APD, MAP and SNAP = 13.3%

* Adults = individuals 19 years and older

Source: OFRA, Integrated Client Services Data Warehouse
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