Northwest (HHS Region 10)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Addressing Equity in Tobacco Dependence Treatment

Fall 2020

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SAMHSA
Substance Abuse and Mental Health Services Administration

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ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Partnership with NW ATTC

- Serves Alaska, Idaho, Oregon, and Washington.
- Located at the University of Washington's Alcohol & Drug Abuse Institute
- The NWATTC seeks to accelerate community-based implementation of evidence-based practices (EBPs) for treatment and recovery by:
  - Sponsoring **training** online and in-person to enhance clinical knowledge and skills, and adoption of EBPs,
  - Providing intensive **technical assistance** to support systems change and organizational efforts to implement EBPs,
  - Offering **consultation** for systems-level change in the emerging new landscape for behavioral health care,
  - Disseminating **science-based information** on EBPs, cultural competence, and more.

https://attcnetwork.org/centers/northwest-attc/home

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Look for NWATTC surveys in your inbox!

Every survey helps NWATTC to improve and continue offering programs.

It only takes **1 minute** to complete!

Tim McAfee, MD, MPH

- Former Director and Senior Medical Officer, Office on Smoking & Health (OSH), Centers for Disease Control and Prevention
  - Currently, Consultant with CDC OSH on media & web development
- Chief Medical Officer and Founder, Free & Clear (now part of Optum), largest provider of phone and web help to smokers
- Primary Care Physician and former Director, Center for Health Promotion, Group Health (now Kaiser)
- Affiliate Faculty, Department of Health Services, University of Washington

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Health Equity and Disparity Issues in Tobacco Dependence Treatment

Tim McAfee, MD, MPH
Former Director, Senior Medical Officer
Office on Smoking & Health, CDC
Affiliate Faculty, Health Services, UW SPH
University of Washington ● Tobacco Studies Program ● Nov 9, 2020

Disclosures (none required)

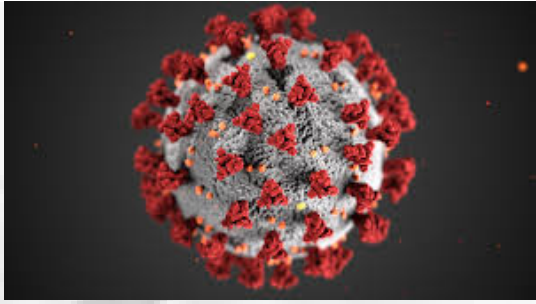
- Worked directly or indirectly for the federal government over the past decade
  - Federal government raised $13.8 Billion dollars in tobacco tax revenue in 2017
- Pharma industry relationships: None
- Counseling “industry” (quitlines): None X 10 years
- Friends, family, colleagues & patients killed by smoking: **Many**

To Cover:

1. **What is Tobacco "Treatment"**
2. **Health Inequity Issues facing smokers**
3. **Treatment-Related Population Disparities**
4. Potential Solutions Exist
   - Mass Medicaid
   - VA Prospective Treatment
   - *Tips* National Media

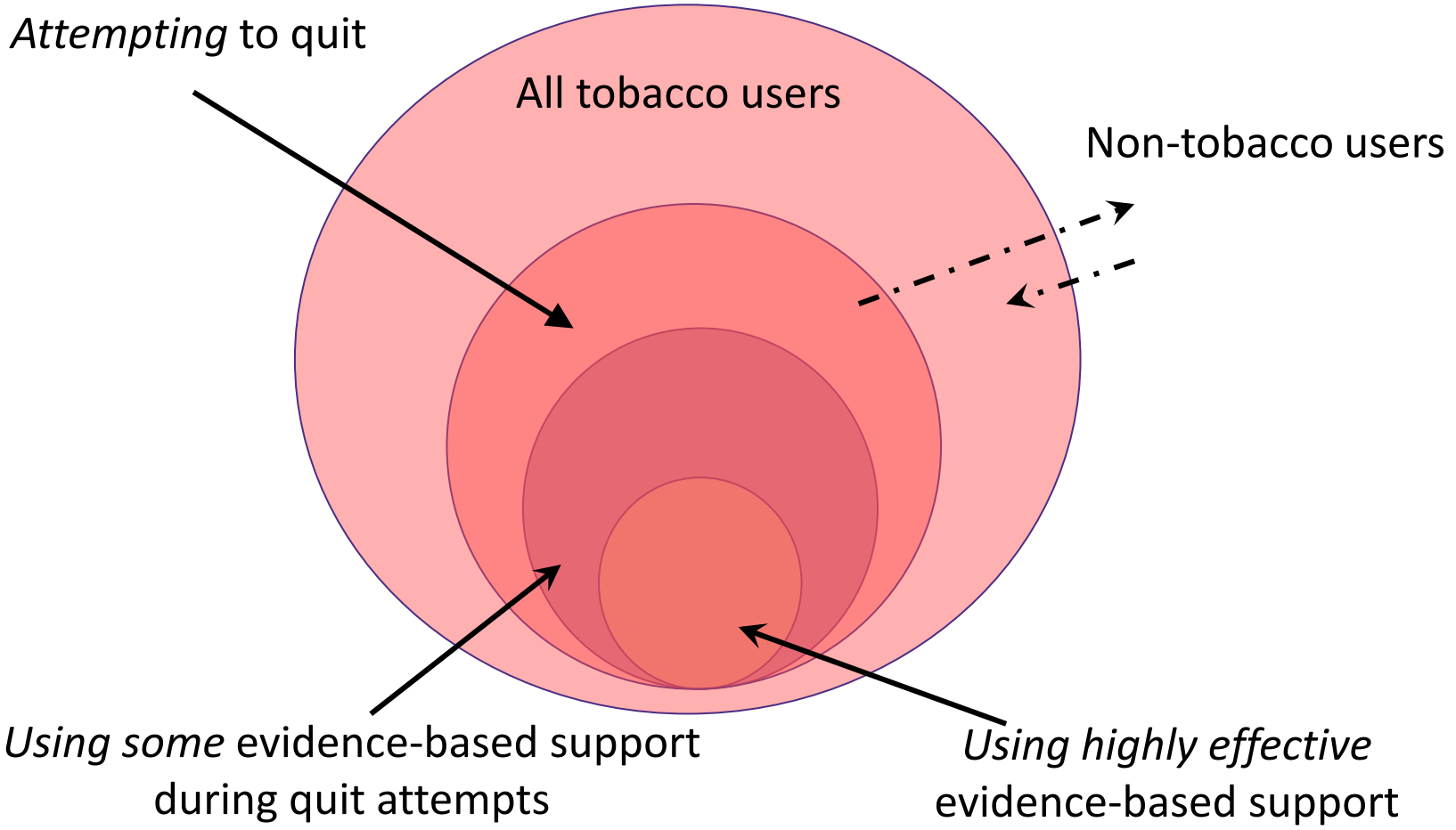
Conclusions

But first, some viral lessons

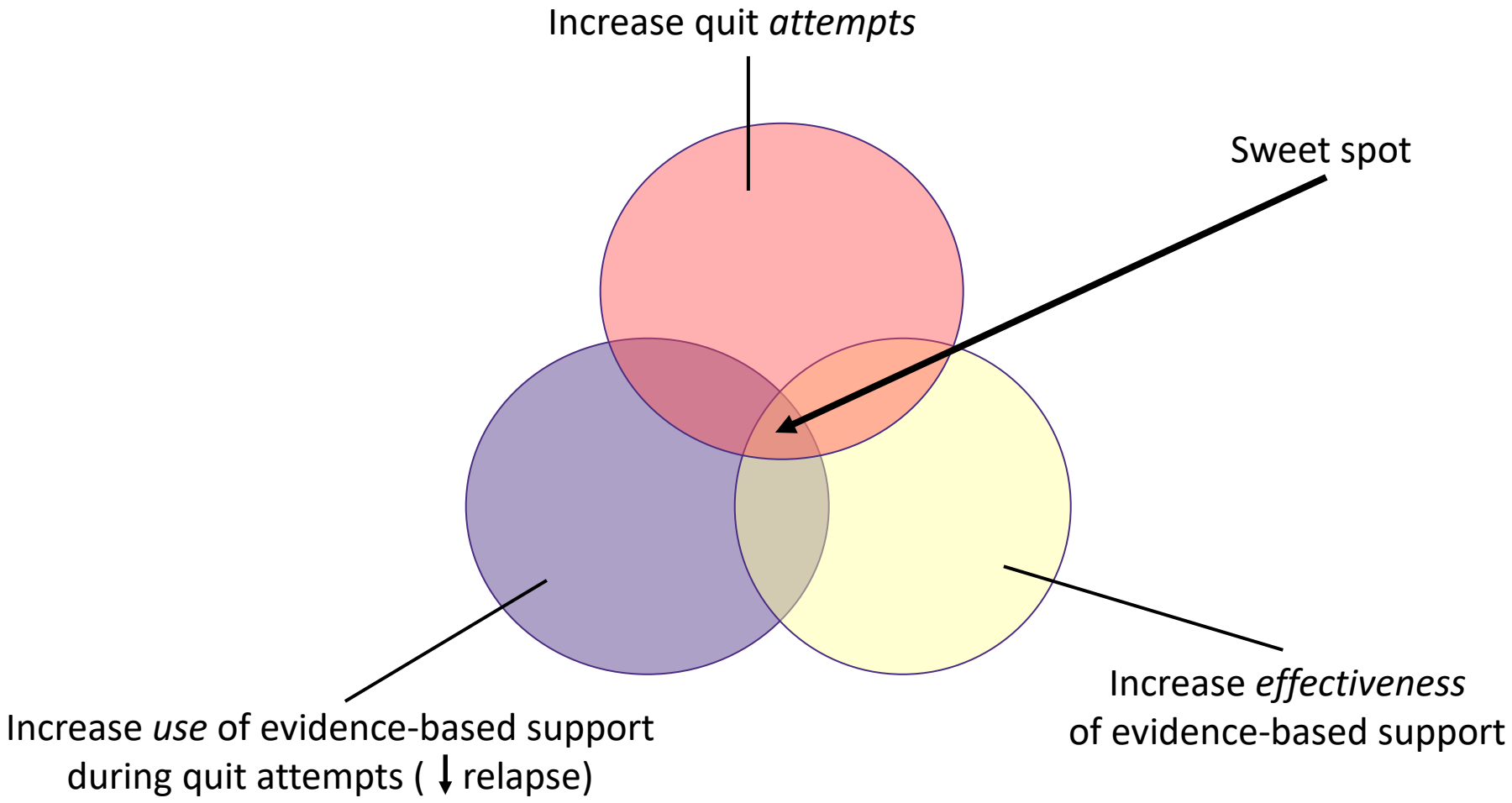


- **What COVID and cigarettes have in common:**
  - Both kill hundreds of thousands of Americans/year
  - Efforts to deny and minimize health impact
  - Efforts to suggest control would devastate economy
  - Prevention & treatments exist that decrease infection & mortality
  - Death rates correlate with age and chronic conditions
  - Health equity issues abound
- **Some differences between COVID and cigarettes:**
  - R&D for prevention/treatment fast tracked vs slow boat
  - Cigarettes manufactured and promoted by humans
  - No daily tallies of new smokers and smoking deaths
  - Cost for inpatient COVID treatment: $10-20K ($14-40 B uninsured)
  - COVID will be mostly wrapped up in a couple years

Tobacco Use in a Population?



How Do We Increase Total Long-term Quits in a Population ??



So What Works?

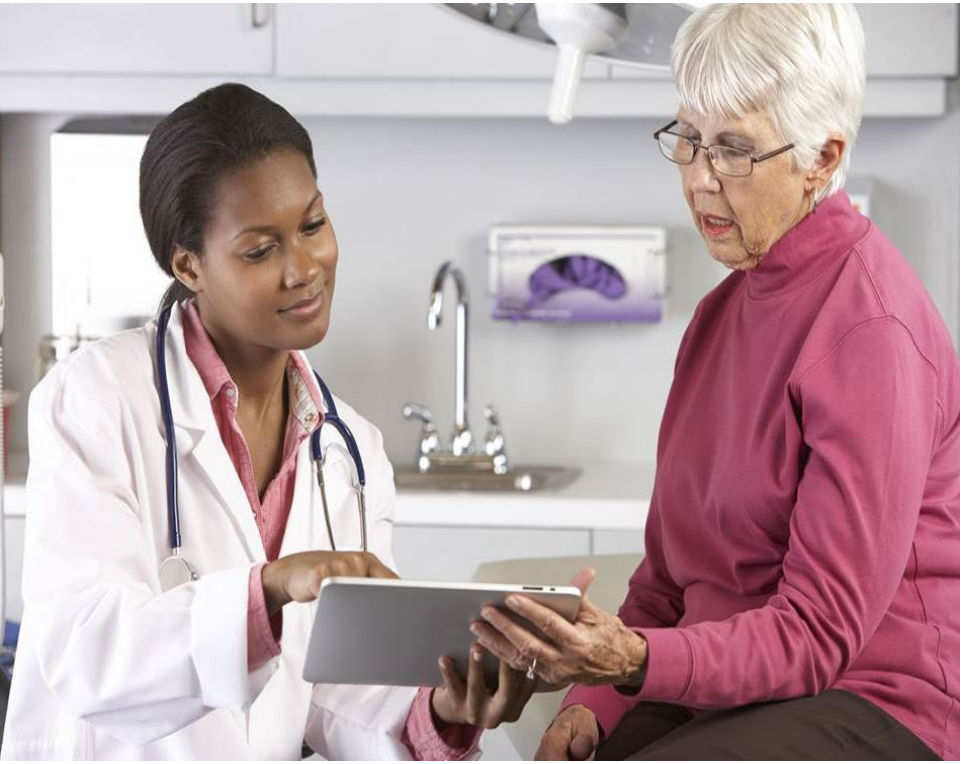
- Increase quit attempts
  - Comprehensive clinic system interventions (5As)**
  - Mass media campaigns*
  - State/local comprehensive tobacco control
- Increase use of evidence-based support
  - Promotion &removal of access barriers
  - More patient-friendly
- Increase effectiveness of support/treatment
  - Combine modalities
  - Increase dose/duration/instruction

What Clinical Interventions Helps Tobacco Users Quit

- Brief advice to quit from a health care professional
- Counseling: individual, group, telephone
- 7 FDA-approved medications
- Systems & policies that support the delivery of all of the above
  - E.g. health insurance coverage without barriers

Source: Fiore MC, Jaen CR, Baker TB, et al. (2008). Treating tobacco use and dependence: 2008 update. U.S. Public Health Service Clinical Practice Guideline. Rockville (MD): U.S. Department of Health and Human Services, 2008.

Benefits of Clinician Intervention



Patients expect it

Increases satisfaction with care

Improves patient outcomes

Covered as a preventive service

Cost effective

Can be fun and rewarding

Even very brief interventions increase the odds that a patient will try to quit and succeed

1 Solberg, LI et al.Patient Satisfaction and Discussion of Smoking Cessation During Clinical Visits. Mayo Clin Proc. 2001;76:138-143. 2 Cummings SR, Rubin SM, Oster G. The cost effectiveness of counseling smokers to quit.JAMA 1989;261:75–79. 3 Fiore MC, Jaén CR, Baker TB, et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update.* (Vol. May 2008). Rockville, MD. 4 Tsevat J. Impact and cost-effectiveness of smoking interventions. American Journal of Medicine 1992;93:43S–47S.

What Is "Counseling"?

Components

Motivation

Support

Practical advice

Development of a quit plan

Settings

One-on-one clinician interventions

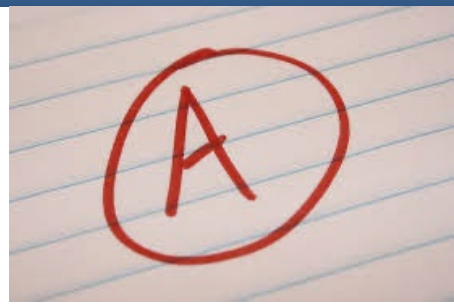
Individual or group counseling sessions

Referral resources (quitlines, mHealth, etc.)

Dosing: More & repetition is better!

Quitlines Can Extend Clinical Reach

- Evidence-based intervention
- Tailored services:
  - Counseling
  - NRT (sometimes)
- Free & confidential
- Multiple languages
- Increases ease of access
  - 33% callers uninsured
  - 33% callers Medicaid/care
- Clinician Referral – via web in WA state



Evidence Strength

Effectiveness of FDA-approved Smoking Cessation Medication

Results from meta-analyses comparing to placebo at 6-month postquit:

Medication	No. of Studies	OR	95% CI
Nic. Patch (6-14 wks)	32	1.9	1.7-2.2
Nic. Gum (6-14 wks)	15	1.5	1.2-1.7
Nic. Inhaler	6	2.1	1.5-2.9
Nic. Spray	4	2.3	1.7-3.0
Nic. Lozenge		1.95	1.61-2.36
Bupropion	26	2.0	1.8-2.2
Varenicline (2 mg/day)	5	3.1	2.5-3.8
Patch (>14 wks) + ad lib NRT (gum or lozenge)	3	3.6	2.5-5.2

Combination NRT & varenicline have the highest effectiveness

Source: Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

System changes increase cessation intervention

Health System Interventions:

- Integrate tobacco dependence treatment into the clinical workflow

- Leverage electronic health records and e-Referrals

- Engage the whole care team

- Measure performance and recognize/reward success

- Implement tobacco-free campus policies

Sources: Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs. 2014. Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Agency for Healthcare Research and Quality, 2008

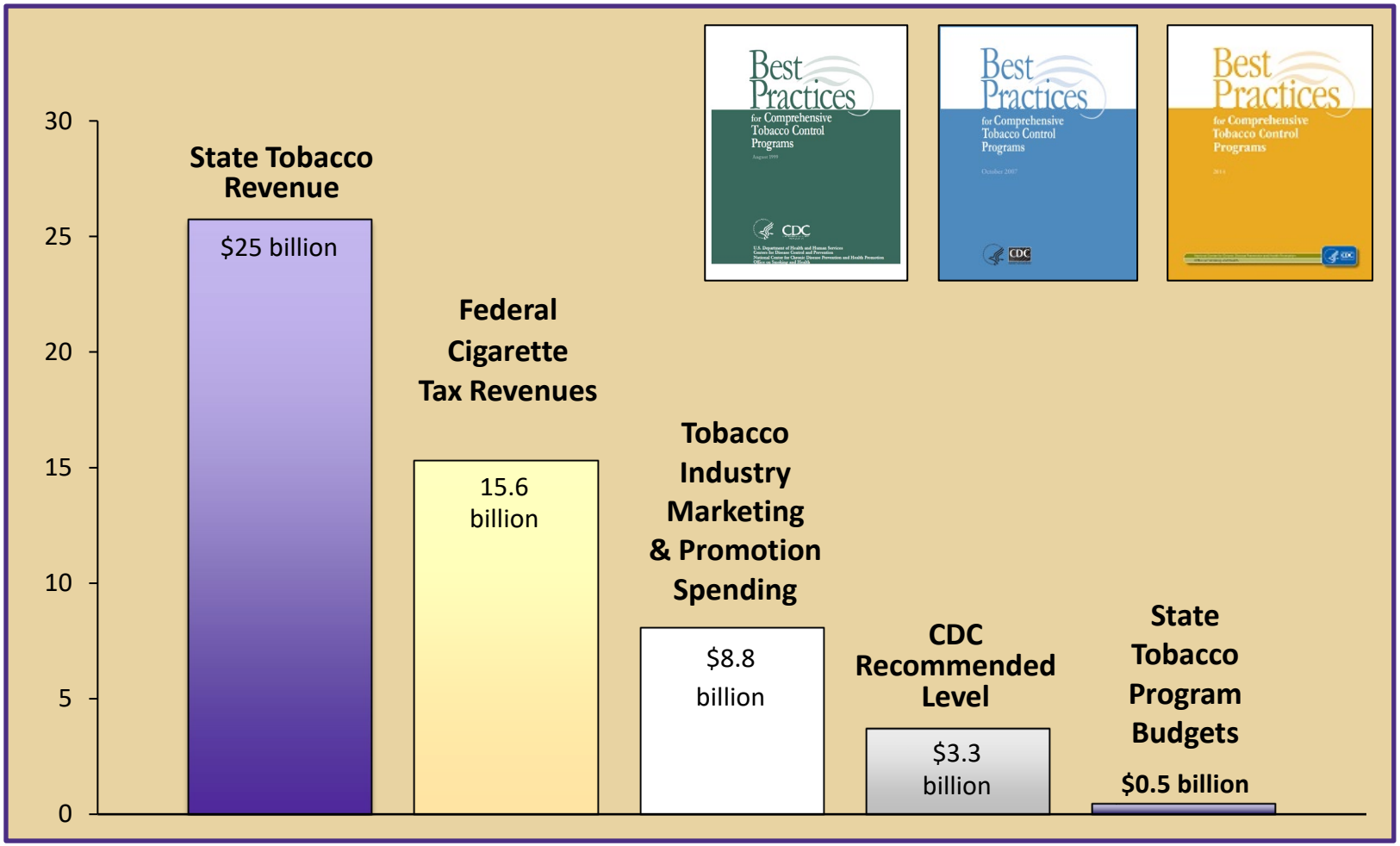
People with tobacco dependence experience health inequities

Health Inequity Issues facing smokers

- 2-3x more likely to die at all ages
- Life expectancy 10+ years lower
- Tobacco treatment research & delivery not prioritized
- Adoption of evidence-based treatments agonizingly slow
- Users of an addictive product are taxed, but revenue not applied to treatment (or prevention)
- Under ACA, tobacco users now one of the only groups that insurers can charge higher premiums
- Environment supports addiction, undercuts quitting

END GAME

Fully fund comprehensive statewide tobacco control programs at CDC-recommended levels



Source: Campaign for Tobacco Free Kids, Federal Trade Commission, 2012 Tax Burden on Tobacco Report, CDC's Best Practices for Comprehensive Tobacco Control Programs.

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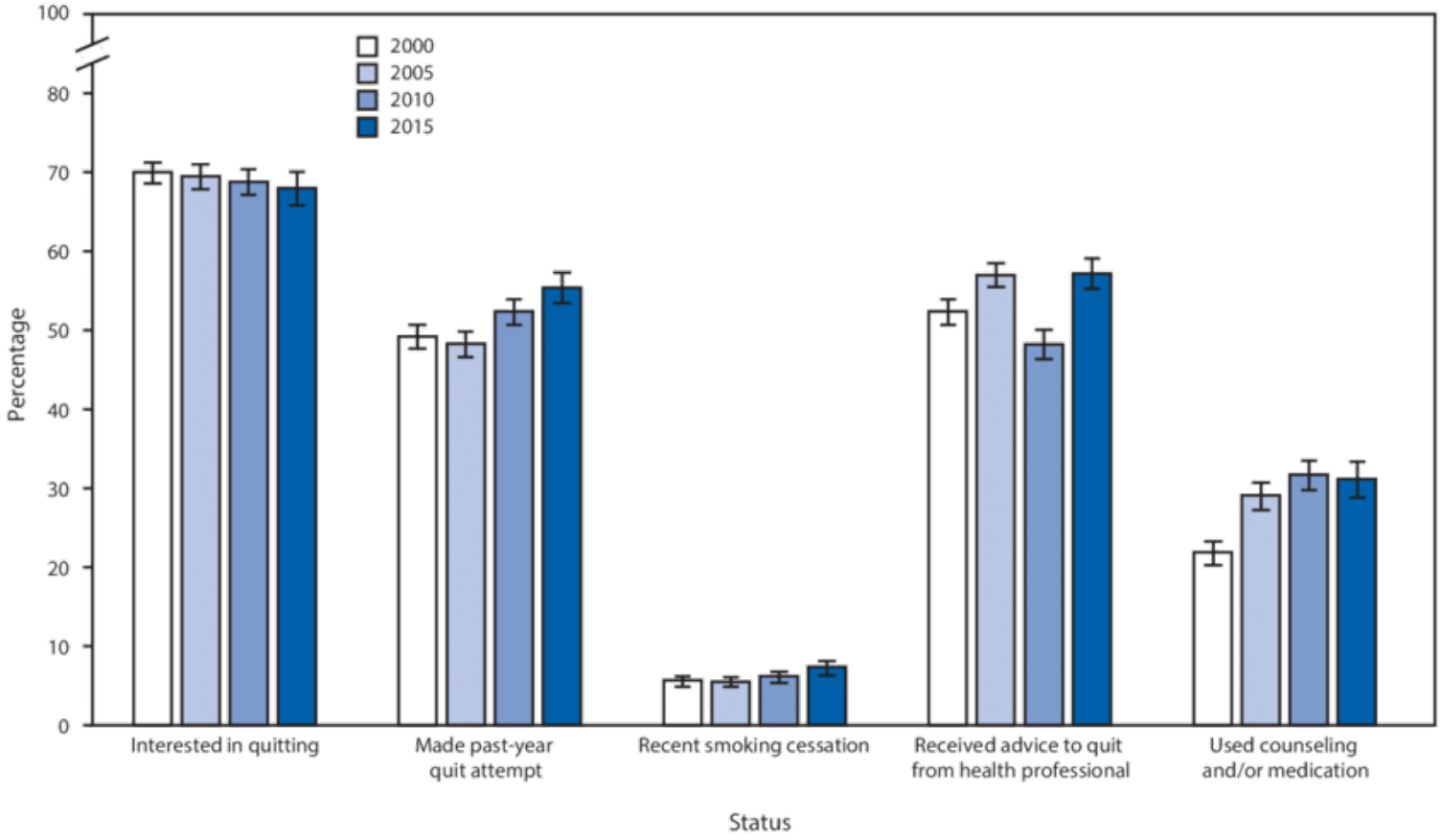
Adults Who Smoke:

- Want to quit (68%+)
- Try to quit (55% in 2018)
- Are unlikely to succeed (5-10% per attempt)
- Less than 1/3 of people quitting got evidence-based help



Babb S, Malarcher A, Schauer G, Kasman A. January 2017 MMWR. Morbidity and mortality weekly report 65(52):1457-1464

If you are a smoker you…

- Pay for other people's healthcare and roads through taxes and a tobacco "settlement"
- May be denied coverage, awareness or access to well-proven treatments that can quadruple your chance of success
- May have to pay more for your healthcare solely because you are a smoker, while your neighbor with diabetes, alcoholism, or obesity does not
- Are exposed to marketing and access to a deadly, highly addictive product

"Health inequities are differences in **health** status or in the distribution of **health** resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. **Health inequities** are unfair and could be reduced by the right mix of government policies." WHO

Changing the Cost-Benefit Calculus

- Tobacco easily accessible
- Smoking in public legal
- Unfettered advertising
- Poor access to cessation help
- Cigarettes designed to addict

Potential Solutions Exist

What has been done to overcome inequities?

- Jury-rigged solutions
  - NGO-sponsored group cessation classes to help quitters
  - Healthplans/providers provide help without reimbursement
  - State-sponsored Quitlines outside of healthcare
- Systematic approaches
  - 5A health system approach
    - Integration with quality improvement/assurance & community
  - Mandated coverage under ACA/CMS
  - Media campaigns linking to treatment
    - Web, quitlines, and “talk with your doctor” with resource tag

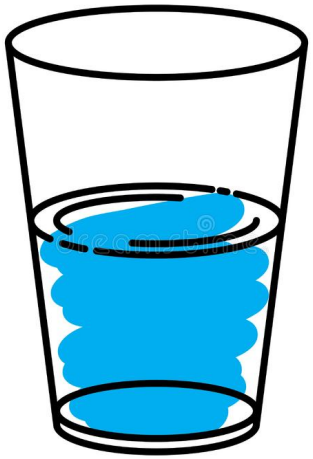
Expanding cessation in primary and specialty care settings

Depend on healthcare access:

- Health systems support
- Healthcare provider training
- In-person counseling
- Medication availability
- ACA coverage requirement

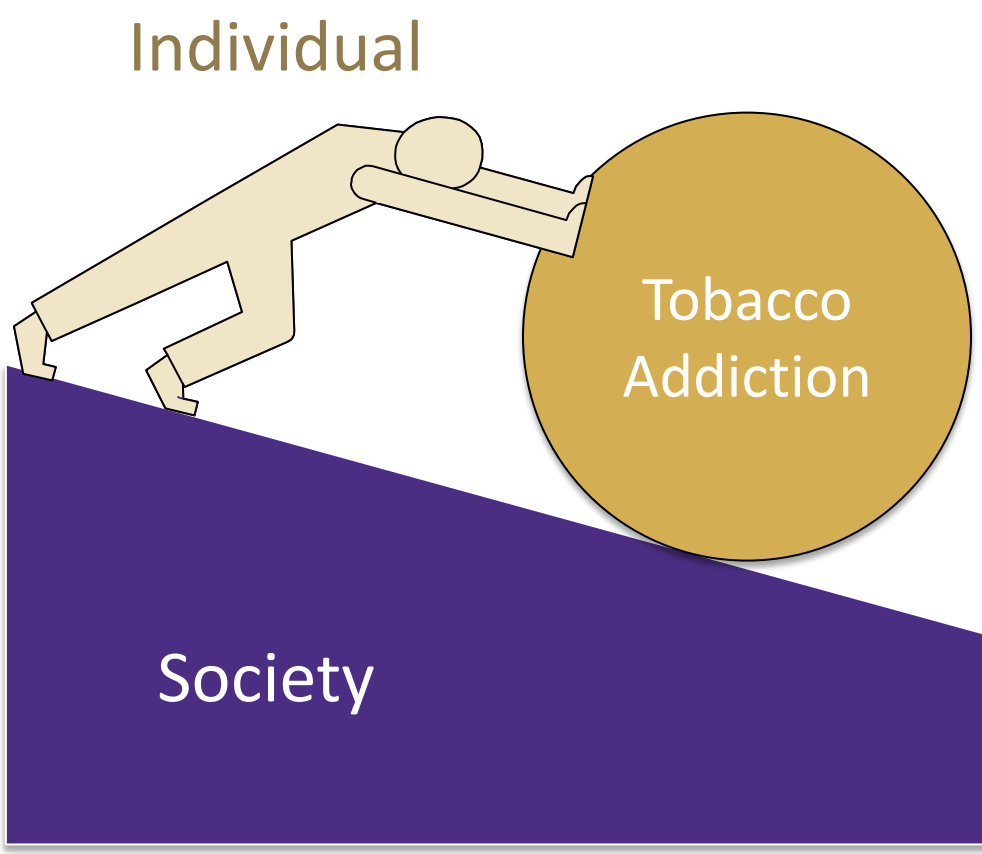
Healthcare access not required:

- Quitlines
- Web/text support
- Environmental/policy change



Half Full, or Half Empty?

Changing the Cost-Benefit Calculus



- Tobacco more expensive and less accessible
- Smoke-free policies
- Counter-marketing and promotion restrictions
- Cigarettes made less addictive
- **"Convenient" access to help**

Some populations face health equity treatment access disparities

Treatment-Related Population Disparities

- Similar to other tobacco control issues
- Geography
  - South/lower Midwest – higher uninsured, fewer state services
  - Rural
- Mental health/substance abuse/chronic diseases
  - Historic biases against providing tobacco treatment
- Low Socio-Economic Status (SES)
- Race/ethnicity/sex/sexual orientation

https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Documents/FactSheets/achieving-health-equity-v1.pdf

Socio-Economic Status (SES) influences a person's ability to access and receive healthcare

- Low-SES smokers less likely to receive cessation assistance from a health care provider
- Cost and lack of coverage a barrier to cessation treatment
- Hard to access resources
- Distrust of medical establishment
- Environment more tobacco-use friendly

Hiscock, R., Bauld, L., Amos, A., Fidler, J. A., & Munafo, M. (2012). "Socioeconomic Status and Smoking: A Review," *Annals of the New York Academy of Sciences*, *1248*(1): 107–123.

Race/ethnicity

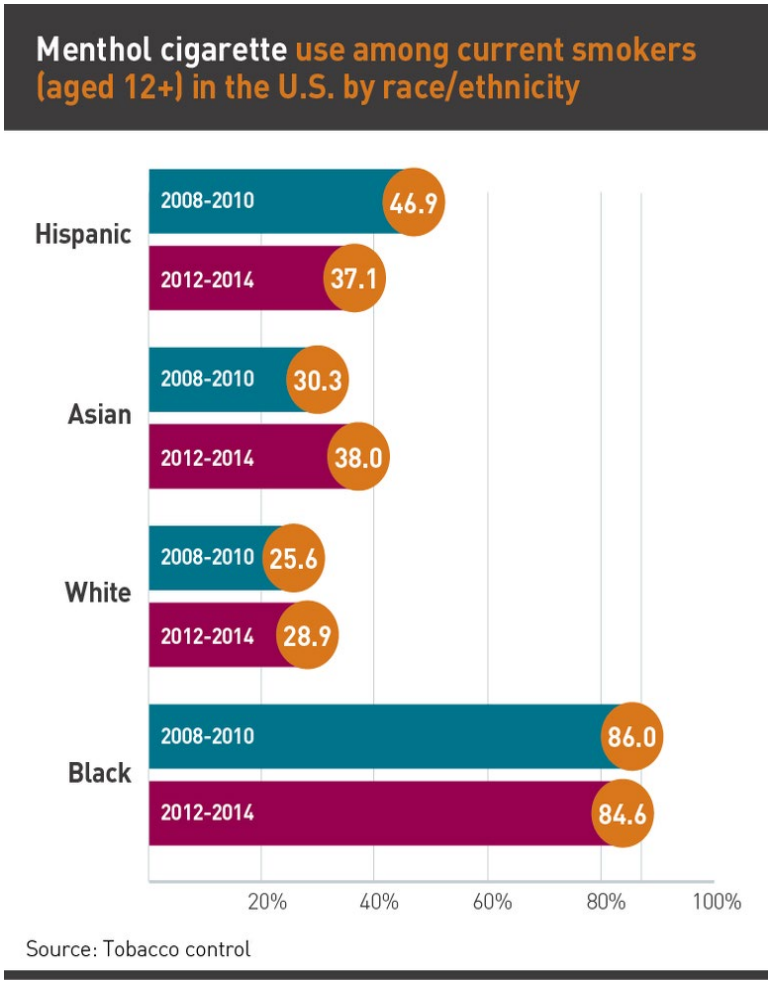
- American Indians
  - Lowest quit attempt rates
  - Lower quit success rates
  - Highest prevalence (30+%)

- African-Americans
  - Higher quit attempt rates
  - Lower quit success rates
  - Menthol implicated in lower quit success
  - Lower utilization of healthcare-associated treatment
  - Similar success rates when do use treatments
  - Quitlines used at higher rates

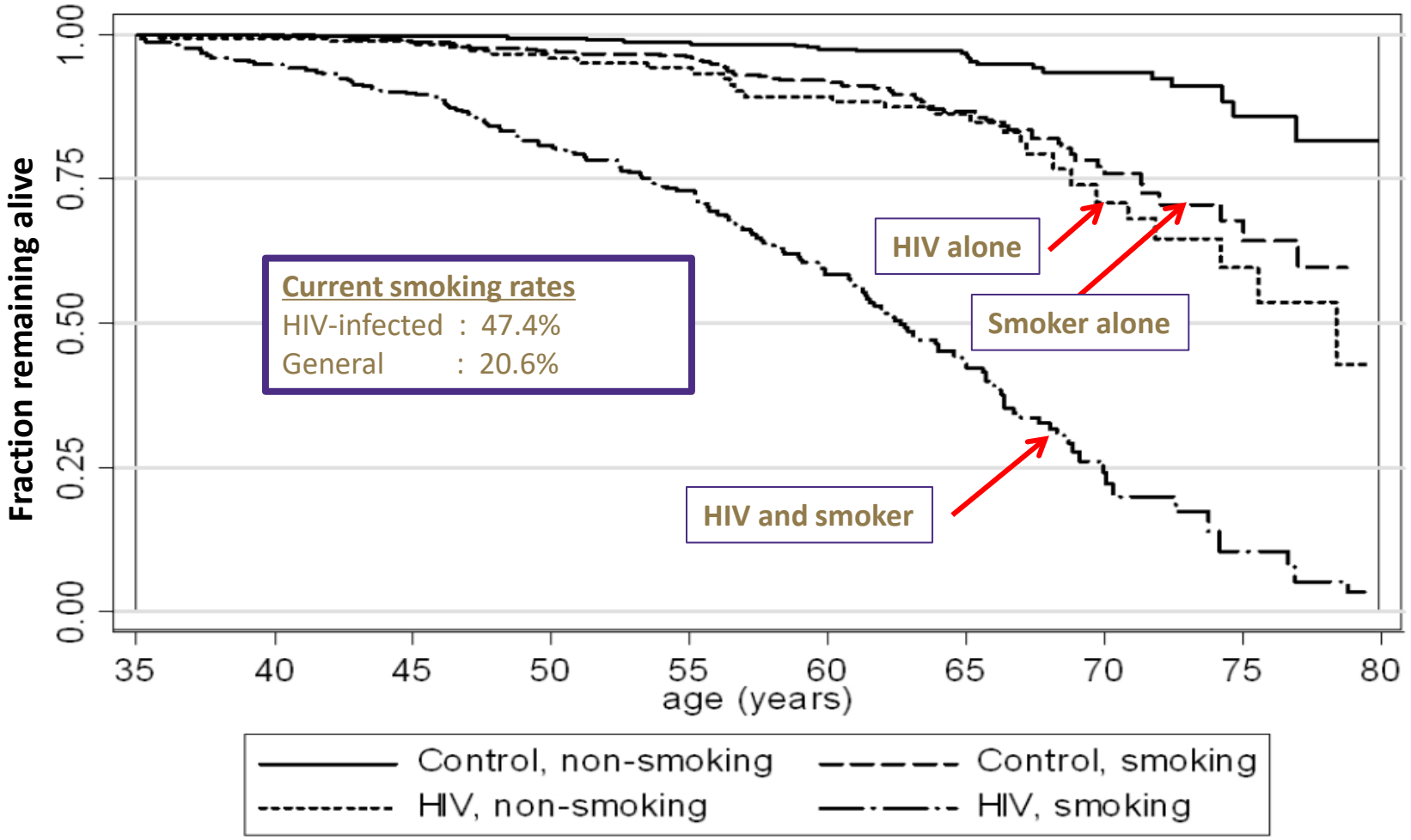
https://truthinitiative.org/research-resources/targeted-communities/why-tobacco-racial-justice-issue

Menthol:

- Easier to initiate smoking
- Harder to quit
- Decades-long promotion by tobacco industry targeting African-Americans with menthol
- Menthol exempted from most flavor restrictions



All-Cause Mortality Among Persons with HIV Infection and Smokers, Denmark 1995-2010 (n=13,563)



Helleberg, 2012, Clin Infect Dis , published ahead of print DOI: 10.1093/cid/cis933
https://www.hiv.gov/hiv-basics/staying-in-hiv-care/other-related-health-issues/smoking

Potential Solutions Exist

Solutions – Massachusetts Medicaid

- As part of "Romneycare":
  - Generous smoking cessation benefit
  - Strong promotion and systematic access
  - 37% of Medicaid recipients in Massachusetts used the benefit
  - Among adult Medicaid members in Massachusetts, prevalence fell from 38% to 28% after the state implemented comprehensive cessation coverage
  - ~50% reduction in cardiovascular hospitalizations
- Insurance-based coverage of smoking cessation treatments increased quit attempts, use of treatments, and successful cessation

CDC (2014). State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Coverage – United States, 2008–2014. MMWR, 63(12): 264–269.

Solutions – VA Proactive Treatment Trial

- 6400 current smokers identified via VA EMR
- Randomized to usual care or proactive outreach:
  - Offer of telephone or in-person cessation services via mail and phone recruitment
- One-year abstinence 13.5% proactive vs 10.9% usual
- Logistic regression OR 1.27 (1.07-1.57)

Fu et al. Proactive tobacco treatment and population-level cessation: a pragmatic randomized clinical trial. JAMA Internal Med. 2014;174(5):671-677.

Solutions: *Tips* Campaign with treatment referral

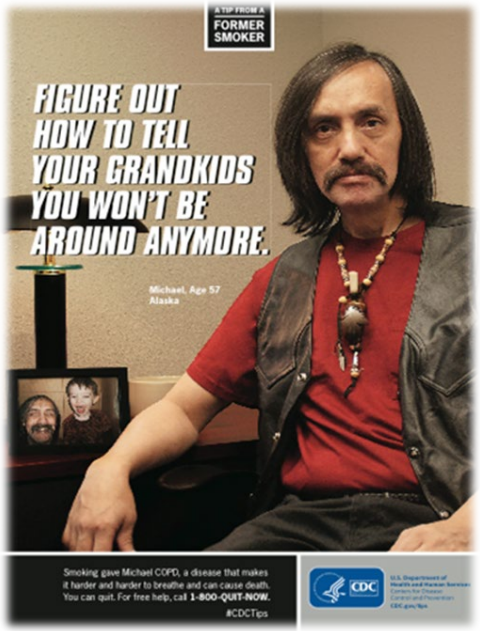
- Large national media ad buy for over a decade
- Goals:
  - Raise awareness of the negative health effects caused by smoking and exposure to secondhand smoke
  - Encourage smokers to quit
  - Let people know that free help is available by calling 1-800-QUIT-NOW

Tips Campaign Targeted Populations

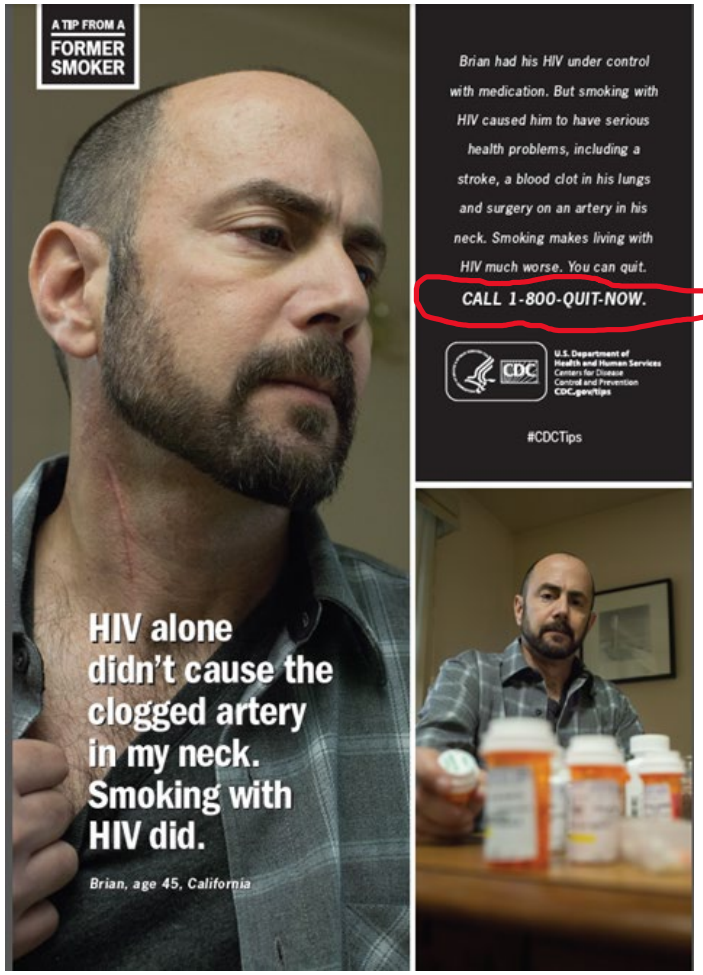
- Those of low socio-economic status
- African Americans
- Hispanics/Latinos
- Asian Americans
- American Indians/Alaska Natives
- LGBTs
- Mothers and pregnant women
- Specific years have also targeted:
  - Dual users of e-cigarettes
  - Mental illness
  - Military/veterans

Ads Show the Diversity of U.S. Smokers

- Finding: Race/ethnicity of ad participants does not affect ad receptivity among respondents
  - However, it's important that specific populations see themselves in the overall campaign



Include People From Target Population Who Have Had Relevant Experiences

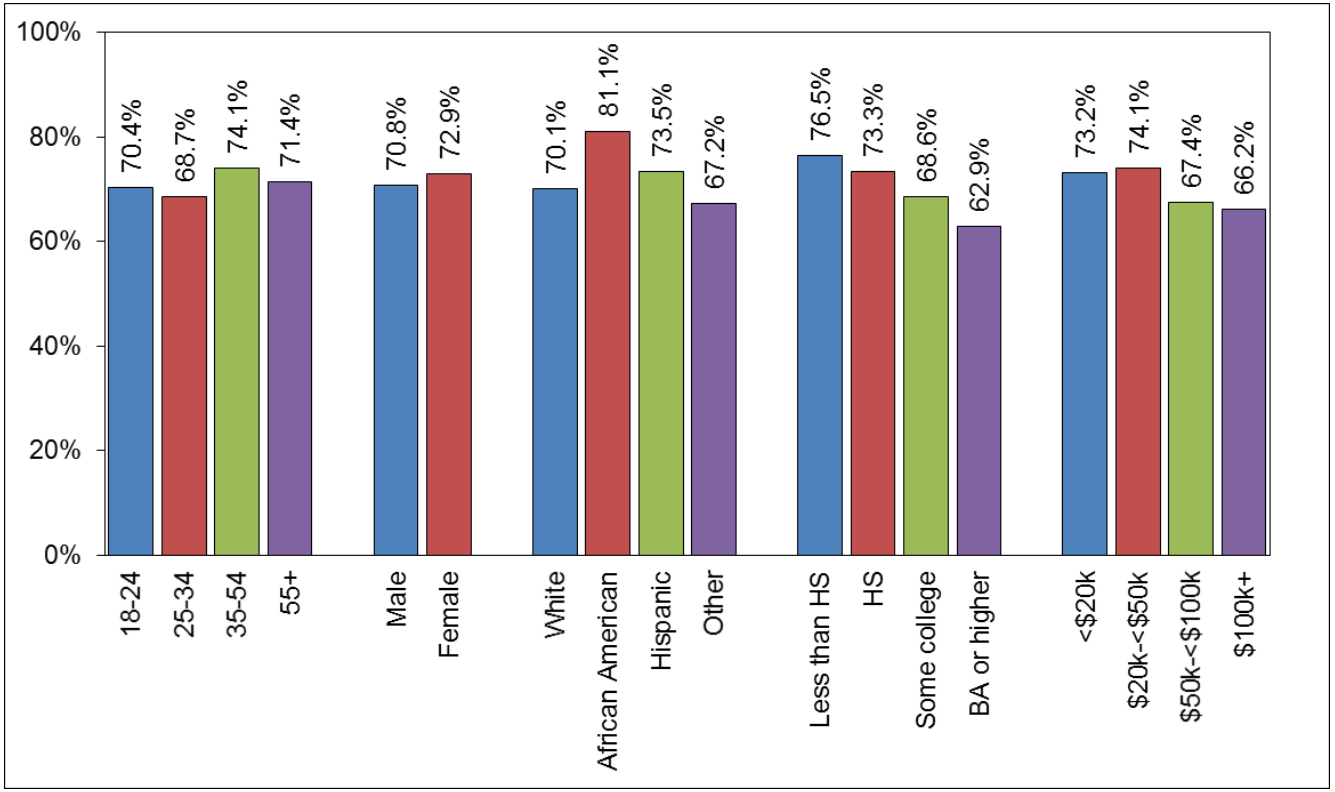


Help quitting made available on all ads

Develop Formats that Align with Media Consumption Preferences

Tips Awareness among Various Demographics

- Highest awareness rates among lower SES and African Americans:
- Example: 2014 *Tips* Awareness Among Smokers



Reactions and Receptivity to *Tips* ads by Race/ethnicity

- African Americans, Hispanics more likely to rate *Tips* ads as:
  - convincing
  - attention grabbing
  - powerful, etc.
- African Americans, Hispanics have greater emotional reactions and motivation to quit after seeing ads
- Race/ethnicity of ad participants not significant determinant of overall reactions/receptivity to ads
  - Suggests strong, compelling messages matter most

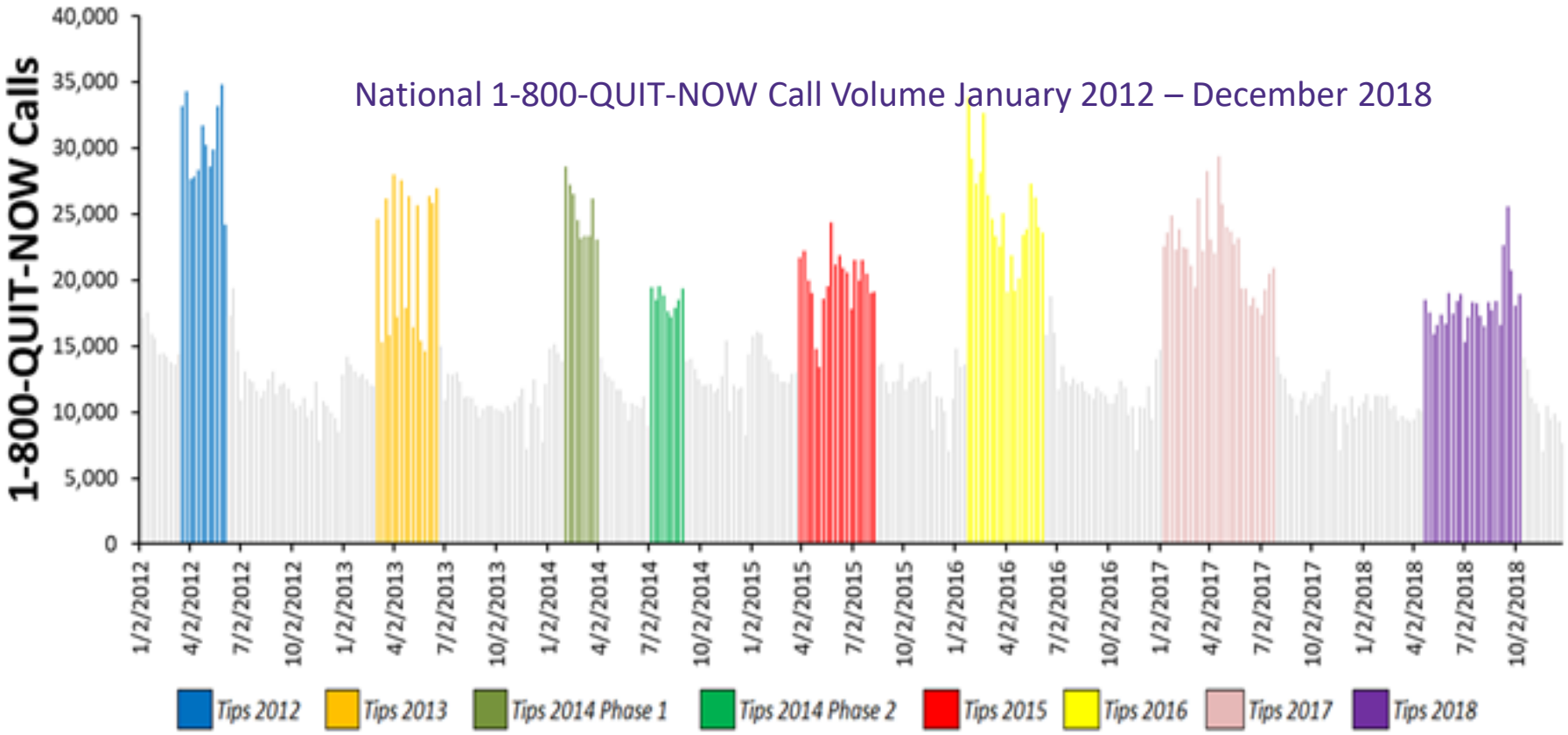
"You can quit. For free help, call 1-800-QUITNOW"

OR

"You can quit. For free help, visit www.cdc.gov/tips"

Tips Drives Quits: Campaign Results 2012-2018

An estimated 1 million people quit permanently



THE LANCET

Articles

The Lancet, Early Online Publication, 9 September 2013

Effect of the first federally funded US antismoking national media campaign

Tim McAfee, Kevin C Davis, Robert L Alexander Jr, Terry F Pechacek, Rebecca Bunnell

Summary

Background Every year, smoking kills more than 5 million people globally, including 440 000 people in the USA, where the long-term decline in smoking prevalence has slowed. The US Centers for Disease Control and Prevention (CDC) delivered a national, 3-month antismoking campaign called Tips From Former Smokers (Tips) that started in March, 2012, in which hard-hitting, emotionally evocative television advertising was featured, depicting smoking-related suffering in real people. We aimed to assess the effects of the Tips campaign.

Methods We undertook baseline and follow-up surveys of nationally representative cohorts of adult smokers and non-smokers. The national effect of the Tips campaign was estimated by applying rates of change in the cohort before and after the campaign to US census data.

Published Online September 9, 2013 http://dx.doi.org/10.1016/S0140-6736(13)61686-4

See Online/Comment http://dx.doi.org/10.1016/S0140-6736(13)61839-5

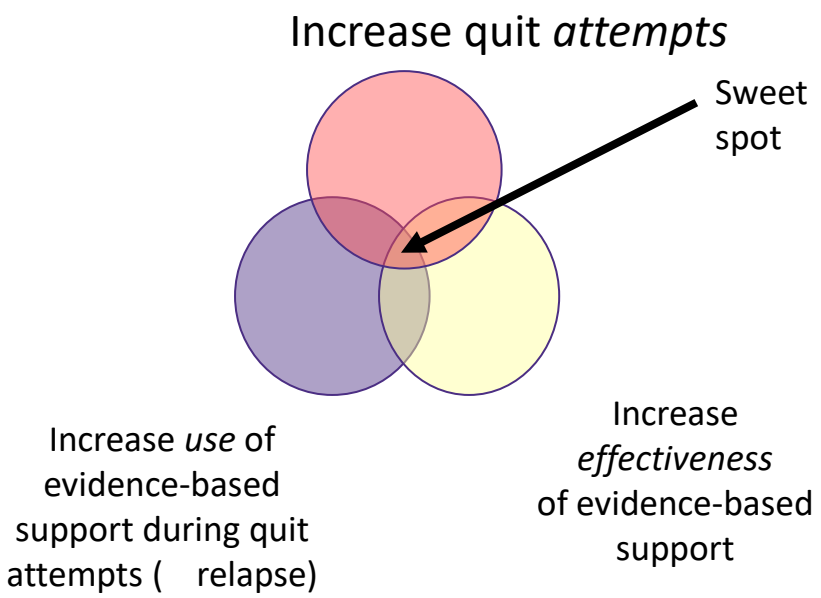
Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention,

Saw at Least One Ad	Quit Attempts	Quit at End of Campaign	Likely to Quit Permanently
80% smokers 75% non-smokers	1.6 million additional (12%) more	More than 200,000	100,000

2013 Media Market Randomized Trial
Increased dose effects

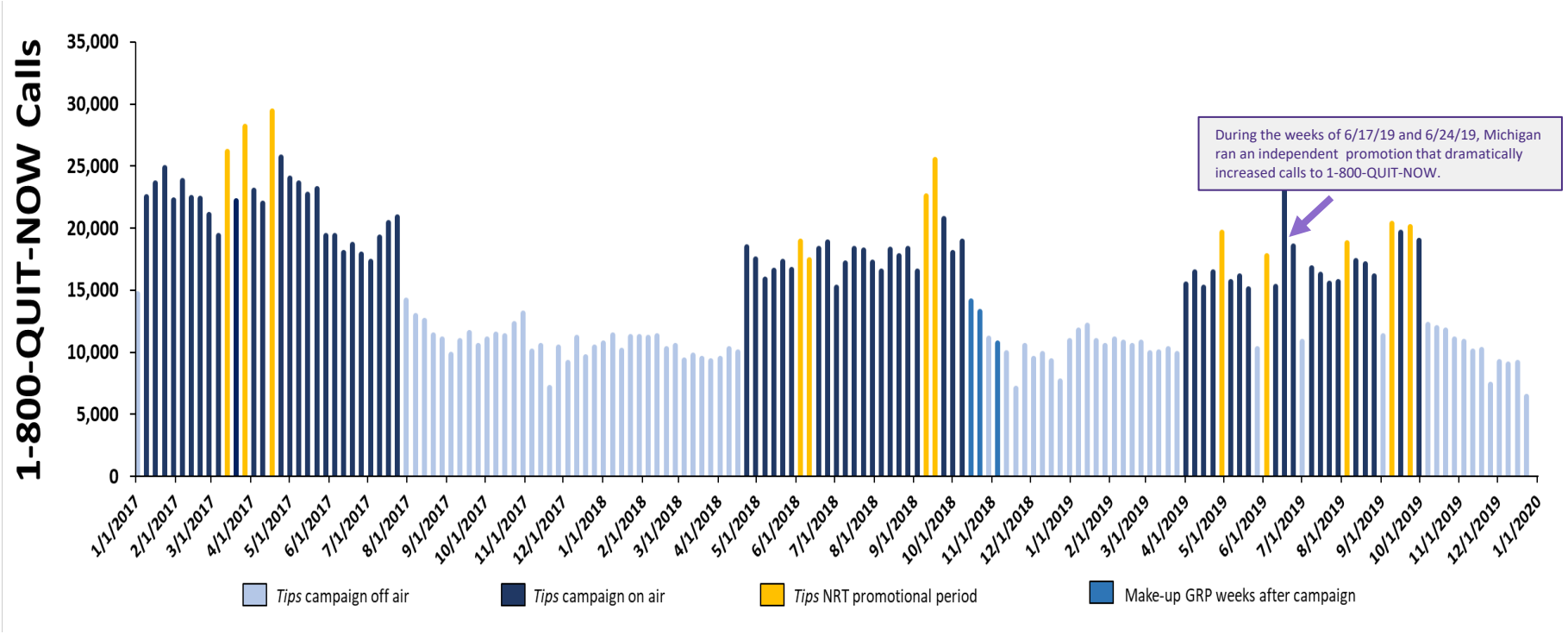
- Provided increased exposure dose to 67 randomly selected media markets in US
- Detected an effect on quit attempts, ad awareness, and disease knowledge
- Effect on quit attempts markedly larger in African-Americans:
  - From 31.8% standard dose to 50.9% with higher dose
- Also higher in those with non-mental chronic disease

McAfee T, Davis KC, Shafer P, *et al.* Increasing the dose of television advertising in a national antismoking media campaign: results from a randomised field trial. *Tobacco Control* 2017;**26:**19-28.



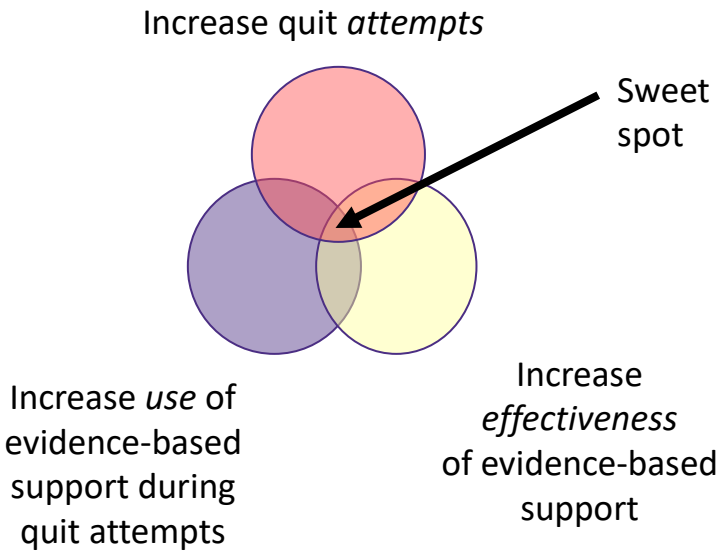
Example of *Tips* Ad Featuring an Offer of Free Cessation Medication

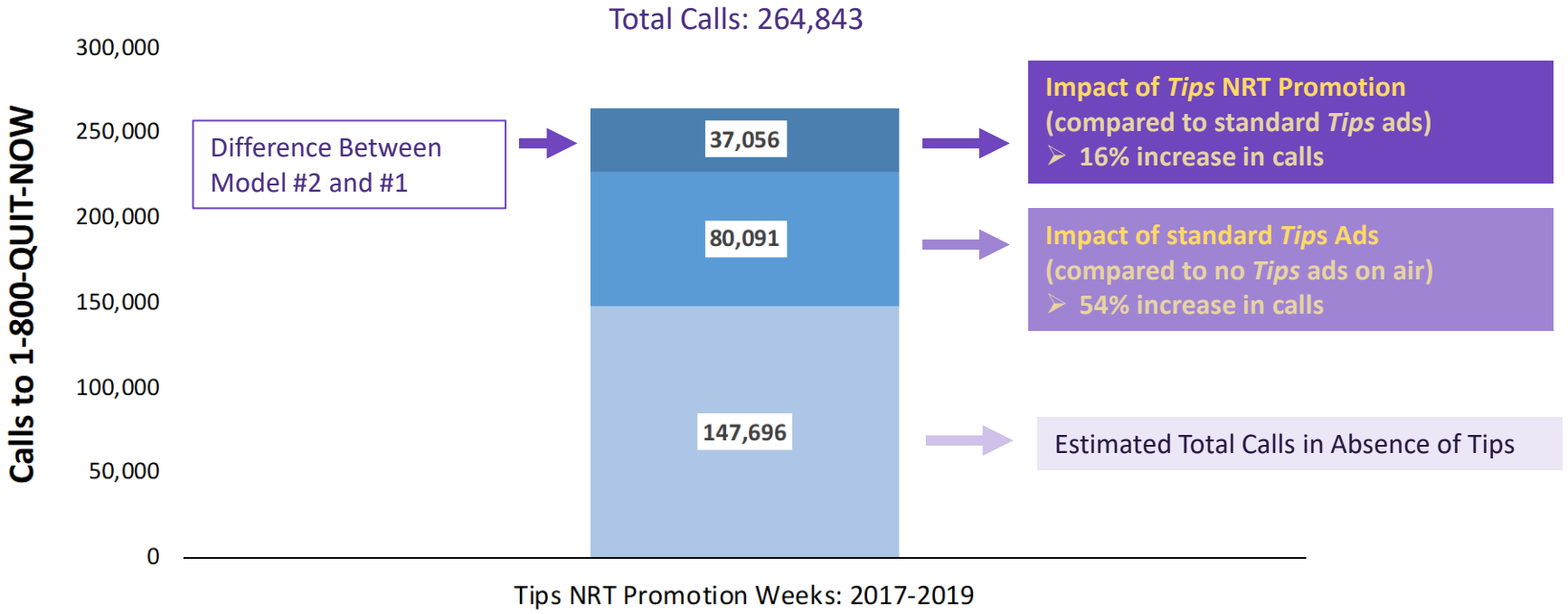
Results: Weekly 1-800-QUIT-NOW Call Volume, January 2, 2017 – December 29, 2019



Zhang L et al. The Impact of Adding An Offer of Free Cessation Medication to National Antismoking Advertisements on Quitline Calls to 1-800-QUIT-NOW. SRNT 2020 presentation, CDC OSH.

Results: Impact of the 2017-2019 NRT Promotions on Quitline Calls to 1-800-QUIT-NOW during 15 NRT Promotion Weeks





What you can do:

- Ensure your healthcare setting:
  - systematically identifies tobacco use status
  - Has barrier-free resources available for tobacco users
  - Includes resources appropriate for populations of concern
  - Includes metrics on tobacco use treatment in QI
- Remain empathetic and committed to helping *all* tobacco users quit
  - A health equity issue
  - An opportunity often wasted
- Be aware of and battle against continued disparities impacting groups that are subjected to racism and other forms of discrimination

Conclusions

- Effective treatments exist
- “Treatment” is multi-faceted:
  - Medications, counseling, healthcare system, and environmental support
  - Increasing quit attempts and use of treatment support **= quit success**
- Smokers/tobacco users suffer from health inequity, healthcare access disparities, and social justice concerns
- Barriers to treatment use have decreased but are still high
- Multiple sub-populations, including those with high smoking burden, have worse access barriers and lower use of treatments
- Solutions exist, but have not been sufficiently applied

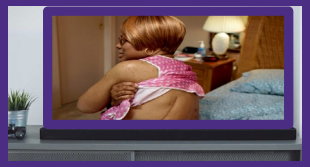
Resources

WA state quitline – free 5-call coaching, free 2 weeks of NRT for un/under-insured. Many with Medicaid or private insurance can get more. Funding-dependent.

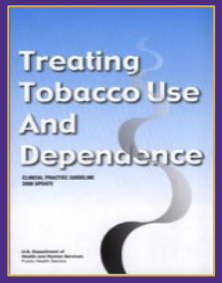
Patients can access by calling: 1-800-QUIT-NOW
or in WA by visiting www.quitnow.net
You can refer directly online:

https://www.quitnow.net/mve/quitnow?qnclient=washington

Clinic system improvement:
https://www.cdc.gov/tobacco/basic_information/for-health-care-providers/index.html



In-clinic resources:
https://www.cdc.gov/tobacco/campaign/tips/partners/health/index.html



Comprehensive reviews of tobacco treatment:

Treating Tobacco Use and Dependence: Clinical Practice Guide

UpToDate: Rigotti – Overview of Smoking Cessation in Adults
Pharmacotherapy for Smoking Cessation

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Contact Info

Tim McAfee, MD, MPH

Tobacco Studies Program

- mtt4@cdc.gov
- 206-422-2664