AMERICAN LUNG ASSOCIATION.

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Pamela Lemos
Office on Smoking and Health
Centers for Disease Control and Prevention
477 Buford Highway. Mail Stop F-79
Atlanta, GA 30341

Re: Request for Information on Effective, Large-Scale, Sustainable Approaches To Help People Quit Using Tobacco by Employing Evidence-Based Treatment Options (Docket No. CDC 2017-0103)

Dear Ms. Lemos:

The American Lung Association appreciates the opportunity to submit comments in response to the Centers for Disease Control and Prevention's (CDC) Request for Information on Effective, Large-Scale, Sustainable Approaches To Help People Quit Using Tobacco by Employing Evidence-Based Treatment Options.

The American Lung Association is the oldest voluntary public health organization in the United States and is committed to eliminating tobacco use and tobacco-related disease. Across all 50 states and the District of Columbia, Lung Association volunteers and staff help smokers quit through health education programs and through policy changes. Lung Association staff have also served as tobacco cessation subject matter experts at national conferences and CDC meetings..

The American Lung has decades of experience with providing tobacco cessation services. Over a million Americans have quit smoking using the American Lung Association's *Freedom From Smoking* program. The program, often referred to as the gold-standard for tobacco cessation, is available as an in-person group clinic, a self-help guide, by telephone and online in our newest option, Freedom From Smoking Plus. The Lung Association's Lung Helpline is staffed by nurses, respiratory therapists and smoking cessation counselors and has operated the Illinois Tobacco Quitline since 2001.

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The Lung Association also has significant expertise on tobacco cessation coverage policy. For the last four years, the organization's state Medicaid coverage data of tobacco cessation treatment has been the official CDC source for this information. This data is used to measure progress for the Healthy People 2020 goal, TU-8: *Increase comprehensive Medicaid insurance coverage of evidence-based treatment for nicotine dependency in States and the District of Columbia*.

Tobacco is the leading cause of preventable death and disease in the United States and quitting smoking is the single best thing a person can do to enhance the length and quality of their life. Unfortunately, on average, it takes a person more than eight quit attempts to quit for good. The Lung Association is encouraged by the RFI from CDC to look for innovative, evidence-based strategies for helping smokers quit.

> ***Question 1: How can CDC leverage emerging technologies to deliver evidence-based cessation interventions through new and innovative platforms that have broad reach, especially among younger adults, those with low income, and adults with chronic and/or behavioral health conditions?***

The American Lung Association believes it is important to meet patients and this case tobacco users where they are. Low-income adults and adults with serious psychological distress smoke at rates well above the national average. Low-income adults smoke at a rate of 26.1 percent as opposed to the general population that smokes at a rate of 15.1 percent. While the national smoking rate has steadily declined, adults with serious psychological distress smoke at a rate of 40.6 percent, a rate which has remained nearly consistent for the past ten years. It is imperative that special considerations be taken to improve access to evidence-based tobacco cessation treatment for these populations.[1]

One innovative way to meet people where they are at is through technology. The emergence and nearly ubiquitous use of smart phones has made communication more accessible for people in general. Most younger adults use smart phones (92 percent) and social media (86 percent). However, with 77 percent of all adults using a smartphone and 69 percent of all adults using social media, it is not solely limited to the younger age group.[2] Engaging smokers in social media is an innovative way to reach people who may be difficult to reach.

Engaging people through mobile technology is not a new idea. There are hundreds of apps to help people quit smoking. However, only a small percentage of those apps use evidence-based cessation techniques and an even smaller percentage has been proven effective through a research trial. The Lung Association encourages CDC to explore ways to help patients differentiate the apps that use evidence-based treatment and those that do not. For example, the California Smoker's Helpline just rolled out an app that was tested and has the same efficacy as traditional phone calls, as has the Food and Drug Administration in conjunction with the National Cancer Institute. To roll this out nationwide, a true evidence-base for which apps work and which do not should be developed. Additionally, any app should be equally available on different

technology platforms, operating systems and brands because if patients are unable to use the apps on their device, they are useless.

The American Lung Association has worked with partners to develop an app that helps people quit smoking – Quitter's Circle. This app helps patients quit and it also connects patients to healthcare providers via telehealth. Telehealth allows patients to connect with medical providers on their time and from their home or any other location.

One form of telehealth can bring cessation services to patients who need them the moment they are ready to quit. Telehealth can also remove the cost for transportation and childcare for low-income individuals to see their healthcare provider. However, there are many barriers to telehealth, including reimbursement for providers and access to broadband for some patients. The Lung Association encourages CDC to explore some of these barriers and seek ways to overcome them. The Veteran's Administration has an excellent telehealth program that could serve as an example.

It is also important to recognize that while many Americans have access to broadband technology and high-speed internet, not everyone does. This is especially applicable to low-income patients, who smoke at higher rates than their counterparts. When leveraging these emerging technologies, it is paramount that policies address the technology gaps that currently exist. Federally Qualified Health Centers (FQHCs) can provide patients with an internet connection so patients can utilize telehealth services. Social services such as food banks, as well as public libraries and churches can partner with public health to encourage patients to quit smoking and potentially provide the technology to connect patients with cessation services.

Technology has changed America and how people can access health services. There is enormous potential for hand-held technology to connect patients to providers and help them quit smoking but to realize the full reach of this technology, priority populations, including low-income Americans, need to be able to access it. By partnering with other organizations that serve these populations, the CDC can help connect more patients with cessation services and help them quit.

> ***Question 2: What are some innovative approaches to reduce the cost—in time, staffing, and funding—of providing effective cessation services to people who want to quit using tobacco?***

While providing smoking cessation is an effective tool to reduce costs to the healthcare system over time, there are ways in which innovative approaches can continue to reduce overall costs (in time, staffing and funding) while continuing to provide effective cessation services to those who wish to quit. The American Lung Association believes that some key ways to do this include utilizing new technologies, strengthening quitlines, streamlining and expanding billing options, and standardizing processes.

New technologies are a great way to reach more people. With the advent of social media, more information is readily available, providing the ability to strategically target certain segments of the

population. Facebook, Twitter and Instagram are all effective tools at promoting cessation, reaching many people at a relatively low cost.

In a study conducted in 2013[3], researchers looked how tobacco control programs were using social media and found that many of them were not doing so effectively. Social media platforms can target strategic and specific populations but most of these programs are not implementing plans to do this. This is an easy and cost-effective way to increase the promotion of cessation services.

For example, between 2009 and 2012, the California Smoker's Helpline used online advertising to promote its services to targeted healthcare professionals in California. This program utilized web banner ads and other online marketing tools and sourced data to micro-target individuals who were likely to be health professionals. The goal of this effort was to increase the number of health professionals making referrals to the quitline. Although it is difficult to track the number of calls that resulted from this campaign, the helpline was able to track the amount of promotion material that was requested as a result, which increased by almost 40 percent over the course of the campaign[4]. The Lung Association believes that using digital advertising to promote cessation services to both patients and healthcare providers is an effective tool to increase enrollment in those services.

One potential drawback in using online avenues to promote cessation services is that in many cases, this leads to a change in modality. There is a drop off in response when a user is forced to change from receiving resources online to receiving resources via phone. One way that this can be addressed is through the creation of online interventions, where a person interested in quitting could seamlessly access the cessation intervention from the online promotional messaging, without having to pick up a phone. The Lung Association believes that increasing the availability of these programs will decrease costs while maintaining the efficacy of the programs.

One such program is the American Lung Association's new Freedom From Smoking Plus. This online program helps participants create a personalized quit plan with evidence-based quit smoking techniques and is available on their desktop computer, tablet or smartphone. Participants also receive full support from experts at the Lung Helpline, available by phone, email and online chat. The Freedom From Smoking program as a whole has been proven to be effective and the Lung Association believes this new modality will maintain that record and reach new audiences. This program can be used as a tool to increase successful quit attempts and lower costs to the health care system.

It is important to note that any new program should incorporate current best practice guidelines, rather than reinvent the wheel. Currently, new systems of outreach and intervention are utilizing the current best practice protocol for telephone interventions. For instance, the California Smokers' Helpline utilized their best practices for telephone interventions for their text, mobile chat and video interventions. This allows them to streamline their process and lower costs while continuing to encourage best practices.

The utilization of new technology like social media is predominantly focused on increased access to quitlines but there are also many ways that quitlines themselves can streamline services and reduce costs. One such way would be to automate the intake process to free up time to spend counseling more patients, rather than collecting information. Another option would be to allow for remote counseling. By allowing counselors to work from their homes, overhead costs are decreased.

Beyond utilizing new technologies and improving the quitline, broader system changes are necessary to ensure that cessation is made accessible and affordable for everyone. There are several system changes that can be adopted, including streamlining the billing system, and creating consistency and standardization in benefits and referral systems.

Currently, there are many challenges involved in billing of cessation services that not only create a barrier for patient to access treatment, but increase costs to the system as a whole. At present, the ability for any health provider, including quitlines, to bill for tobacco cessation interventions varies greatly by state and health plan. In some state Medicaid programs, only primary care providers are able to prescribe medication and reimbursed for cessation counseling, limiting the ability for other doctors and health professionals to provide important interventions and avoid the need for additional appointments and increased costs. It is important to increase the types of health professionals who can provide cessation treatment to reduce costs.

This problem is especially acute in the behavioral health setting, where many providers are unable to receive reimbursement for their tobacco cessation efforts. Approximately 40. 6 percent of people suffering from serious psychological distress also use tobacco products—making smoking is a leading cause of death for this community. The Lung Association strongly believes that those receiving treatment in these behavioral health settings should also be able to receive smoking cessation treatments. However, in many of these facilities, behavioral health providers are unable to receive reimbursements for those services. This barrier must be removed in order to improve the health of these individuals during their treatment.

Furthermore, encouraging payors to work with quitlines to set up a reimbursement mechanism for the services provided by the quitline will also help to lower costs to the system overall. In many cases, the payors should already be covering the services provided by the quitline.

However, in many instances, quitlines are unable to receive reimbursement. The Lung Association recommends that quitlines be able to bill for those services so health plans can reimburse quitlines for working to improve the health of their enrollees. In some instances, quitlines may have pre-developed relationships with health delivery systems that could help streamline this process. The Lung Association encourages CDC to explore what other barriers to reimbursement exist.

The Lung Association believes that through standardization, costs to the health care system will be decreased. There are two main places that standardization related to tobacco cessation would be the most beneficial: in the services that are provided, and in the referral system.

First, there is a lack consistency among health plans regarding what cessation benefits are provided and what barriers to access exist. This makes it confusing for those responsible for promoting cessation benefits and complicates any referral system. The Lung Association recognizes the importance of standardized benefit across all health plans, ideally a comprehensive, barrier-free benefit as outlined by the Tri-Department guidance[5]. This would simplify promotion and prescribing cessation treatments for all patients.

When Massachusetts instituted a comprehensive cessation benefit for all their Medicaid enrollees, it found a significant return on investment. Within the first two and a half years of implementing this new benefit, the smoking rate declined by 26 percent and there were far fewer hospitalizations. And for every dollar spent on cessation, the system experienced savings of more than three dollars. The Lung Association strongly supports a comprehensive tobacco cessation benefit that utilizes proven interventions that everyone can access without barriers.[6,7]

By creating a standardized process in which healthcare providers could easily feed into the quitlines, unnecessary paperwork, outreach, and coordination could be eliminated. By utilizing new technology, strengthening quitlines, streamlining and expanding billing options, and standardizing processes, staffing and funding costs to the health care system can be lowered, while still ensuring that patients have access to effective cessation treatments.

***Question 3: How might standardization of quitline services achieve greater efficiency while also preserving state quitlines' "brands", flexibility, and capacity for innovation?***

The American Lung Association, which operates the Illinois Tobacco Quitline, suggests exploring the opportunity to develop one standardized model for the current 11 tobacco quitlines providers across the country that operate the 51 state quitlines. This would allow for all quitlines to report, research and improve outcomes in a unified manner. Currently each quitline follows custom protocols and models developed based on recommended guidelines from CDC, the North American Quitline Consortium (NAQC) and other evidence-based programs.

The Lung Association recommends that CDC review "specialty areas" currently operating within each of the existing quitlines. For example, the American Lung Association's quitline team is made up of 80 percent medical staff (nurses and respiratory therapists) who can specialize with assisting chronic disease clients. Other quitline teams may specialize more with Medicaid clients, corporate workplace clients, behavioral health clients or other priority populations. The development of the Spanish Tobacco Quitline and Asian Tobacco Quitline is a great example of how this process is already underway to better serve populations with unique needs.

As mentioned previously, the American Lung Association strongly supports a comprehensive tobacco cessation benefit for all patients, including three forms of counseling and all seven Food and Drug Administration (FDA)- approved medications. Policies that make it easier for health plans to contract with the state quitline to fulfill the phone counseling requirement of the Affordable Care Act are needed.

The Lung Association encourages CDC to work with hospitals and health systems to implement quitline referrals for admitted patients who smoke and encourage the adoption of the Joint-Task Force Recommendation. Like other cessation services, quitlines need to meet patients where they are, both in their readiness to quit and their actual physical location. This may require expanding quitline referrals into clinics, medical offices, urgent care, dental, public health and other medical services. The automatic referral generating method (charted as a tobacco user by a clinician in the health care setting) will help every healthcare provider enhance quality of care to each client.

Removing barriers (barrier free engagement) and extending the length of services (tobacco intervention and medication) for targeted special populations is essential if progress is to continue in tobacco control. Issues including behavioral/mental health and substance abuse often require different approaches to helping clients quit. As overall smoking rates have declined, the prevalence of smoking among people with behavioral health conditions has remained high. Although people with behavioral health conditions represent about 25 percent of the U.S. adult population, they consume nearly 40 percent of all cigarettes smoked. This disparity is causing serious health consequences and complicating the treatment courses for smoking cessation and other health issues.

Focusing on evidenced-based interventions and research outcomes will improve standardization. CDC could aide in this by developing requirements for minimum standards for quitlines and providing key resources creating a national standard of care for every patient that calls a quitline.

The unified approach to best practices will have an added benefit for the quitline counselors. CDC could create a standardized training and certification method that would allow a universal approach to various issues that occur during a counseling session. These trainings could include information on diversity, behavioral health, professionalism and how to handle a “hot topic” that a patient may bring up. This standardization will allow the state quitlines to collaborate with each other to provide the best services to patients around the country.

CDC should also explore other ways quitlines can offer counseling. In addition to the toll-free support lines, web-based support can help reach more smokers, including virtual counseling via Skype or other telehealth options. These extra touch points allow each quitline to customize a quit plan for each client and reach different client populations.

A partnership of quitlines would allow for enhanced capabilities including sharing of workloads during times of crisis, information, clients who relocate, and internal resources. A quitline that does not offer medical services a client may need could refer clients to a quitline that does offer

the different services in a partnership program. The needs of the patient would be met with greater efficiency and effectiveness while allowing each quitline to retain its unique identity.

> ***Question 4: What communication channels and communication strategies should CDC consider employing to ensure that both tobacco users, including those belonging to high-risk and disadvantaged populations, and health care providers are aware of and have access to evidence-based cessation resources?***

A central focus of communication strategies to educate tobacco users about evidence-based cessation resources should be meeting people where they are. CDC should start by sharing messaging and educational materials through communication channels frequently used by the high-risk populations that it hopes to reach, by, for example, advertising available resources on social networking platforms popular with these groups. CDC should also work with states and partners to share these resources at physical locations that high-risk populations are likely to visit, such as check cashing facilities, laundromats, churches, and behavioral health treatment facilities. It is also important for all resources to be culturally sensitive, available in different languages, and easily understandable by individuals at different reading levels.

The Lung Association encourages CDC to continue to support and build upon its highly effective "Tips from Former Smokers" ("Tips") campaign, which has motivated millions of people to make a quit attempt and approximately 500,000 smokers to successfully quit since its launch in 2012.[8] The "Tips" campaign has already produced resources tailored for specific priority groups including different racial groups, LGBT communities, people with mental health conditions, veterans and pregnant women. CDC should continue to adapt these resources to additional high-risk populations, as well as share existing resources through traditional and social media and other new platforms.

For healthcare providers, integrating information about evidence-based cessation resources directly into electronic heath records (EHRs) could be an effective strategy to remind providers to discuss tobacco cessation with their patients.[9] Providers need clear, easily accessible information about the cessation benefits that their patients' private health insurance or Medicaid plan covers so that they can make the best treatment recommendations. EHRs could also be set up to allow healthcare providers to automatically refer any patient who expresses interest in cessation to a tobacco quit line, whose staff could then follow up with the patient directly. These strategies would help to reduce barriers that providers face to discussing tobacco cessation with their patients.

***Question 5: What role should CDC, state and local health departments, not for profit institutions, traditional healthcare providers, and/ or professional healthcare partner organizations, play in ensuring that high-risk populations (such as smokers living below the poverty level or those with behavioral health conditions) have access to tailored cessation services of appropriate intensity to help them successfully quit?***

There is no question that tremendous progress has been made over the last 50 years in the prevention of tobacco-related death and disease. But the tobacco control community cannot rest because not all communities have benefitted equally and much work remains. Some specific groups within the population suffer a disproportionate burden from tobacco use including people living below the poverty level and people with serious psychological distress. In addition to having higher tobacco prevalence – at 26.1 percent and 40.6 percent[10] respectively, these two priority populations also face special challenges in quitting and may need a longer treatment period and/or a more intensive treatment to help them quit for good. The American Lung Association encourages CDC to write funding opportunity announcements requiring those receiving federal funding to consider health equity and incorporate strategies to reduce health disparities in their work.

The American Lung Association also believes that many of these quitting challenges could be reduced if federally-funded tobacco cessation projects were encouraged to plan their cessation intervention with the active engagement of multi-sectoral community leadership team. This team should include representatives from the target community, local or state health department, healthcare providers, insurers, community organizations, nonprofits and when appropriate, local or state government. The Lung Association has been involved in several projects using this approach and knows it can be an effective way to address and overcome some of the specific challenges faced by these high-risk populations.

In Kentucky, the American Lung Association was fortunate to be part of an extended effort to provide cessation services to the behavioral health population. There were multiple projects and strategies supported by several different funders but these projects coordinated and complemented one another thanks to an active statewide coalition. Advocacy organizations worked with the state government to eliminate barriers to accessing cessation such as copays, limits on quit attempts and counseling requirement for medication. The state's Tobacco Prevention and Cessation Program made eight weeks of free nicotine replacement therapy (NRT) available to people discharged from state mental health and substance abuse facilities. The American Lung Association worked with community behavioral health facilities to provide the Freedom From Smoking program and nicotine replacement therapy to their clients. Thanks to their coordinated efforts, tobacco users in the behavioral health community started their quit attempt with a Freedom From Smoking clinic and were then enrolled in quitline services, which meant they received up to 15 weeks of NRT and counseling. This extended duration was highly effective as evidenced by the enrollment numbers, calls to the quitline and quit rates.

The American Lung Association also encourages innovation and adaptability when providing cessation services to these high-risk populations. Too often, populations have been neglected because of a perception that population needs a tailored intervention and a lack of tailored interventions that meet CDC's high evidentiary standards. This is not to say that evidence-based interventions that have been proven effective are not important. However, if there aren't established best practices for addressing the cessation needs of a specific population, CDC should encourage funded projects to work with the target community. Together, the partners should examine the needs and capacity of the community and extrapolate from existing programs and research to decide on and then deliver a cessation intervention. That intervention should be rigorously evaluated, both to determine if the work should continue and so that it may contribute to the eventual development of best practices for serving this community and ending this tobacco use disparity.

> ***Question 6: How can CDC support state and local health departments, traditional healthcare providers, not for profit health institutions, and professional healthcare partner organizations to ensure that evidence-based tobacco cessation interventions are integrated into primary care and behavioral health care settings on a consistent and sustainable basis?***

There are a number of strategies the American Lung Association recommends to the CDC to support state and local health departments, traditional healthcare providers, not for profit health institutions, and professional healthcare partner organizations to ensure that evidence-based tobacco cessation interventions are integrated into primary care and behavioral health care settings on a consistent and sustainable basis.

According to the Office of National Coordinator for Health Information (ONC) Technology[11], electronic health records (EHRs) improve the quality of health care and enhance efficiency. However, EHRs, depending upon the software used by medical practices, do not readily communicate with each other, which significantly reduces their potential impact on coordination of care. In addition, in many rural parts of the country, healthcare facilities lack the necessary infrastructure, and still use paper medical records. In both cases, this can create a barrier for primary care providers to do more than ask patients their smoking status and advise them to quit. CDC could play a crucial leadership role nationally to advocate that EHR software systems have the capacity to communicate with each other and coordinate cessation services. CDC could also provide technical assistance to states to establish best practice communications and coordination to facilitate referrals. For example, is there a way to set up an automatic referral of tobacco users to 1-800-QUITNOW?

Primary care and behavioral health care staff must be trained to increase knowledge of the use of EHR for referrals which could ultimately improve efficiency and outcomes. For example, JSI Research and Training Institute, Inc. reviewed Vermont's Tobacco-Free Mental Health and Substance Abuse (MHSA) Initiative[12] in 2016. It noted that while most MHSA centers had the ability to capture data regarding tobacco use status, others were more advanced and able to capture whether there was a self-management plan in place as well as capture the plan. While

tobacco use status and the presence of a plan could be queried, the actual plan could not. In addition, asking and recording tobacco use status is not uniformly or consistently done.

Department of Health and Human Services (HHS) agencies could encourage non-profit hospitals and healthcare systems through required Community Needs Assessments to prioritize tobacco cessation in their quality measures. This could lead more hospitals to invest in cessation resources and reimburse providers for outcomes, not services. This approach could be mirrored in behavioral health settings.

While smoking rates in people with serious mental illness is disproportionately higher than the general population, healthcare providers in behavioral health care do not always make tobacco cessation a priority. Federal agencies including Substance Abuse and Mental Health Services Administration (SAMHSA) should provide technical assistance to states to encourage tobacco cessation treatment at all treatment facilities through licensing and/or funding. Requiring all behavioral health facilities to be accredited by the Joint Commission would encourage them to use quality measures requiring screening and treating tobacco. According to a survey conducted by the Vermont Cooperative for Practice Improvement & Innovation of Community Rehabilitation and Treatment Centers (CRT), Vermont's Department of Mental Health does not have medical billing codes available for tobacco cessation. Based on conversations the Lung Association has had with various states, this appears to be part of a trend across the country. Working with its sister HHS agencies, CDC could play a vital role in changing that paradigm.

CDC and SAMSHA could also support and encourage states to implement tobacco-free grounds on the campuses of all treatment facilities. A number of states, including Vermont, require adoption of this policy for all alcohol and substance abuse treatment facilities. While implementation has had its challenges, the Howard Center, with multiple campuses in the state of Vermont has successfully implemented tobacco-free campus policy. In fact, while the buildup to full implementation had its share of skeptics, a staff member of the center reported that that implementation was "like any other Wednesday" and that clients and staff asked "what took so long" which has surprised and pleased the facility's leadership.

Finally, with many states directing little or no money for comprehensive tobacco control, it is crucial for CDC to continue developing and sharing media campaigns through the Media Campaign Resource Center. Finding a way to fund and run national ads ("Tips From Former Smokers") is crucial for all states, but in particular for those with little or no state funding. In addition, states may not have or have lost the ability to evaluate and perform surveillance. It is crucial that states have easy access to updated CDC resources (Best Practices for Tobacco Control), reports (U.S. Surgeon General Reports) and data (OSH data).

***Question 7: How can the public health sector most effectively maximize the impact of public and private insurance coverage of cessation treatments as part of efforts to ensure that all tobacco users have barrier-free access to these treatments?***

The public health sector has immense potential to maximize the impact of public and private insurance coverage of cessation treatments by engaging public and private plans to provide a comprehensive and consistent cessation benefit. Public health can promote cessation benefits widely, coordinate steps towards comprehensive coverage and identify systems-level initiatives to implement and ensure that tobacco cessation is consistently integrated into healthcare delivery.

**Return on Investment**

One way the public health sector can increase the impact of public and private insurance coverage of cessation treatments is to provide specific, evidence-based recommendations and analyze data on cessation use and health outcomes. The public health sector can research return on investment (ROI) data and conduct case studies to reinforce that comprehensive smoking cessation benefits increase use of evidence-based cessation treatments, reduce smoking rates, improve health outcomes and decreases costs. ROI data addresses concerns from health plans that covering cessation benefits would be too costly. Helping smokers quit have consistently been shown to save money for both private and public health plans that cover cessation treatments, which can encourage plans to provide comprehensive cessation coverage but there need to be additional studies to further make the case

CDC produced a case study examining the effect of expanding cessation coverage in Massachusetts through its Medicaid program, MassHealth.[13] The case study found that for every $1 in program costs, MassHealth had $3.12 in medical savings, resulting in a $2.12 ROI for every dollar spent.[14] MassHealth also found reduced smoking prevalence and reduced hospitalizations among users of the pharmacotherapy benefit.[15] These are all positive outcomes and financial incentives the public health sector can utilize to appeal to plans to provide a comprehensive and consistent cessation benefit.

The positive return on investments is not limited to public plans like Medicaid. The public health sector should emphasize that private insurance coverage has also been shown to save money when it provides cessation treatments. One study found that Florida employers could save $1.90 to $5.75 for every $1 spent on cessation treatments and another study found a net savings of $542 per smoker who quits after accounting for the costs of providing a cessation program and the savings gained from smokers quitting.[16] Private plans also stand to benefit by providing comprehensive cessation coverage and helping smokers quit.

**Outreach and Educational Campaigns**

*Consumers* – Smokers may attempt to quit multiple times and utilize different treatments each time before they are quit for good. Public health campaigns build awareness and can be a great avenue to advertise available benefits. Widespread education campaigns can be effective and if

coupled with the cessation treatments needed to quit, the number of people who smoke can be further reduced. The CDC study on MassHealth's experience found that providing a comprehensive cessation benefit through Medicaid had an effect on the vulnerable, underserved and low-income population that was traditionally viewed as hard to reach.[17] The broad public health campaign launched by Massachusetts' Department of Public Health (DPH) played a large role in helping MassHealth recipients quit smoking by launching direct mailings, radio ads, transit ads and regular communications targeting consumers.[18] Public health departments and organizations can target promotions on cessation benefits to improve health outcomes for low-income populations.

Medicaid enrollees smoke at a rate of 27.8 percent, nearly three times that of people with private insurance.[19] In addition, despite a steady decline in overall smoking prevalence, the same trend is not observed in the Medicaid population.[20] The smoking prevalence has shown no detectable decline within the Medicaid population, which needs a targeted and sustained campaign to raise awareness of resources available to them to help them quit smoking. Medicaid is an important source of coverage for low-income individuals and providing comprehensive cessation benefits without barriers through Medicaid has immense potential to help this population quit smoking. The public health sector needs to play a role in promoting the cessation benefits through broad educational campaigns and ensuring that people utilize the benefits available to them. If patients know what is available to them, they can talk to their providers to attain the benefit. Having a comprehensive cessation benefit would streamline this – if patients know that they can receive any of the pharmacotherapies and counseling services, they can have a conversation with their healthcare provider about what would work best for them instead of trying to navigate what treatments are covered under their health plan.

*Providers and Health Systems* - Massachusetts' DPH also initiated a broad publicity and outreach campaign with MassHealth targeting healthcare systems and facilities. Evidence-based cessation treatments are greatly underused not only by smokers, but healthcare providers as well. Although even brief cessation advice and counseling by healthcare providers is effective, less than half of smokers (48.3 percent) who saw a healthcare professional in 2010 reported receiving advice to quit.[21] Healthcare providers have a unique opportunity to bridge the gap between the number of smokers who want to quit (70 percent) and the number of smokers who successfully quit smoking (10 percent) by providing advice to quit and prescribing appropriate pharmacotherapy.[22] However, providers lack awareness of the availability of evidence-based cessation treatments and specific plans that cover such treatments, translating into a lack of use of these treatments. The public health sector can help increase awareness among providers and patients on the availability of evidence-based cessation treatments through their health plan and make it easier for providers to prescribe appropriate pharmacotherapy and counseling advice.

MassHealth provided tools and promotional materials to raise awareness among providers and educate them on the cessation services they can offer to their patients. Providers were given fact sheets, detailed Frequently Asked Questions (FAQs) with rate and billing codes, pharmacotherapy pocket guides and intake and assessment protocols.[23] These resources that the public health

sector can provide are helpful to providers, who often do not know that health plans cover cessation and are further confused by the different cessation benefits for each patient's health plan. Protocols for billing for these services are also unclear for providers, who could be encouraged by reimbursement to do more to provide cessation advice and counseling. Again, having a standard, comprehensive cessation benefit without barriers would ease the difficulty of targeting specific populations for public health campaigns – consistent and comprehensive coverage is easier to promote and makes it easier for both providers and patients to understand what cessation benefits are available to them.

**Electronic Health Records**

Another way to better integrate cessation into healthcare practice and ease the burden on providers is through the use of electronic health records (EHR), which can facilitate system-level changes to reduce tobacco use and make the delivery of cessation treatments standard practice in healthcare. EHRs can prompt providers to collect information about tobacco use, provide advice to quit, prescribe medications and refer patients to cessation counseling. The public health sector can work with EHR companies to integrate these cessation prompts and ensure that the system provides healthcare providers with suitable cessation treatment options for their patients. Public health can utilize EHRs' unique opportunity to track utilization and patients' experience with different types of cessation treatments, allowing providers to recommend different treatment options if necessary and refer patients to suitable counseling services.

**Fostering Collaborations**

Public health organizations can connect recommendations for comprehensive cessation benefits with increased coverage and foster collaborations between departments to promote coverage. CDC's 6|18 Initiative partners the CDC with stakeholders like healthcare purchasers, payers and providers to address six high-burden health conditions with 18 proven effective interventions, one of which is reducing tobacco use through expanding access to evidence-based tobacco cessation treatments, removing barriers impeding access to these treatments, and promoting increased utilization of covered treatment benefits by tobacco users.[24] The American Lung Association strongly supports the 6|18 Initiative and urges CDC to continue and expand it.

In early 2017, CDC held a 6|18 convening and invited state agencies and organizations to work on one of the six issues. South Carolina officials chose to work on reducing tobacco use because of the high smoking prevalence in its Medicaid population which also contributes to other medical conditions. Two of its agencies, its Medicaid program and public health department, worked together to assess the barriers to cessation treatments in the Medicaid program and how it impeded smoking cessation for Medicaid recipients.

As of July 1, 2017, the South Carolina Department of Health and Human Services (SC DHHS) enhanced tobacco cessation coverage for full-benefit Medicaid beneficiaries to align with recommendations from the CDC and the American Lung Association. South Carolina Medicaid beneficiaries can now receive the seven FDA-recommended medications without prior authorizations and copays and individual, group and phone counseling. CDC's 6|18 Initiative

provides an opportunity for meaningful conversations between stakeholders to partner and collaborate on improving health and controlling costs. However, public health collaborations do not have to be limited to large-scale, federal efforts.

Public health groups can create dialogue and partnerships with other stakeholders working to address smoking and improve health. For example, MassHealth worked with the Massachusetts' DPH to promote the nearly comprehensive cessation benefit to its Medicaid enrollees. Another opportunity for public health groups to collaborate externally is in the behavioral health space: smoking is closely tied with behavioral health – 44 percent of the cigarettes sold in the U.S. are consumed by behavioral health populations – providing a unique opportunity to integrate smoking cessation interventions with behavioral health and for the public health sector to work with behavioral health groups.[25]

Bringing partners, including non-traditional partners, together provides opportunities to address cessation collaboratively and to amplify the message that comprehensive cessation coverage is needed across populations, especially within high-smoking, vulnerable populations. The public health sector can identify these populations and their need for cessation services and work with stakeholders to bridge the gap and increase utilization.

Quitting Smoking is the single best thing a person can do for their health, but it is very difficult for most people. The American Lung Association believes cessation treatments should be available to meet smokers where they are. There are many innovative ways to accomplish this, whether it be through technology, developing non-traditional partners or enhancing relationships with partner organizations. The Centers for Disease Control and Prevention has the ability to foster partnerships and encourage evidence-based innovation. The Lung Association appreciates the opportunity to provide comment and looks forward to continuing to work with CDC on its cessation efforts.

Sincerely,

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President and CEO

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