



Helping Benefit Oregon Smokers

Meeting Summary

July 20, 2010

A. BENEFIT DRAFT REVIEW

1. Covered as part of core benefit; available annually.
2. Evidence based
 - a. Agreement that the benefit recommendations should be based on existing evidence
3. Age range
 - a. SB 734 covers health plan members age 15+.
 - b. Health Services Commission recommends screening and preventive services for children and adolescents age 10+.
 - c. HEDIS includes separate measures for adults 18+ and children 10-18.
 - d. Evidence base is clear for adults (18+), less clear for people under age 18.
 - e. Agree to age range of 15+.
 - f. Clinical Practice Guideline recommendations for children and adolescents (see attached). Should we include as is or make changes?
 - i. Screen pediatric and adolescent patients and their parents for tobacco use.
 - ii. Consider counseling interventions shown to be effective with adults and tailored to be developmentally appropriate.
 - iii. Consider NRT and bupropion for adolescent patients if there is evidence of tobacco dependence and a desire to quit.
 - iv. Advise parents to limit exposure to second-hand smoke
 - g. Also recommend ALA adolescent program: Not On Tobacco
4. Identifying smokers in health plans
 - a. Health Risk Appraisal: gaining prominence in Oregon. Governor's wellness committee recommending that employers encourage employees to complete, growing trend among employers, coordinate recommendations with trends in Oregon. Some employers are requiring the HRA with insurance cost differential for those who don't fill out HRA or who are smokers (Can we add more details about trends in Oregon here?).
 - b. Self-referral: health plans send out information to members to prompt self-referrals. Include examples in document. Increased visibility of benefit within health plan communication recommended.
5. Behavioral programs
 - a. Coverage
 - i. Need to cover multiple options: individual, telephone, groups.
 - ii. Group programs need to be specific to tobacco to be reimbursed rather than part of a general wellness program.

- iii. List of providers eligible to provide services and be reimbursed should be broad and will include ***providers credentialed in the system.***
 - iv. Recommended providers include: MDS, Nurses, Dentists, DO's, NP's, Psychologists, Social workers, PA, Pharmacists, DOA, Dental hygienists, Respiratory therapists, Health educators.
 - v. Important to connect mental health and substance use providers with benefit. How to include for reimbursement?
 - vi. Need to include some language about contracted programs that meet evidence based requirements eligible for reimbursement (e.g. Free & Clear, Freedom From Smoking).
- b. Content
- i. 3 courses of treatment per year
 - 1. Definition of course of treatment: Up to 10 weeks x 3?

Evidence base shows greatest effect with combination of 8+ sessions and medications. Most programs see average use around 4-5 sessions, some use more, some less. How to word so that it is clearer that Benefit should be sufficient to cover enough sessions for those who need longer treatment? Most people will use fewer.

 - a. OHP covers up to 10 sessions a quarter (every 12 weeks)
 - b. Quitline provides 5 sessions per enrollment
 - c. Freedom from Smoking provides 11 sessions per group.
 - ii. Hypnosis and acupuncture are not recommended; inconclusive evidence.
- c. Pharmacotherapy
- i. Cover FDA approved medications; prescription and OTC.
 - ii. Three courses of treatment annually – number of weeks vary by medication from 8-12.
 - iii. Keep as all FDA approved medications both prescription and OTC and combination therapy.
- d. Copay
- i. Charging co-pay may be inversely related to access and outcomes i.e. more copay, less access, fewer quit.
 - ii. **Background:** early data on copays (see attached Curry et al article) shows that full coverage (no out of pocket costs) yields the best results for health plans. This led to advocating for eliminating copays. Subsequent articles analyzed for 2009 Cochrane review (see attached) are more mixed. Results show that full coverage yields better results than no coverage. There was too little pooled data to distinguish between relative benefits of partial coverage (e.g. level of copays) and full coverage (no copay).
 - iii. Each one is different – moving outside of existing structure may increase cost upfront. Is the shift in cost going to employer, then shifted to employee? Need examples of about co-pay requirements in individual health plans.

B: COMMUNICATION STRATEGIES

GOALS

- All health plans understand and adopt the final benefit recommendation.
 - Agreed that these recommendations serve the good of the community
 - Standardization across plans is improved.
 - The \$500 benefit is maximized. The emphasis is less on the \$500 and more on effectively helping people quit.
 - There is a shared understanding of the evidence base for cessation, how smokers quit, and what works best.
 - Those plans that are restricted to the \$500 lifetime benefit alter their structure to align with the recommendation.
- The recommendation is adopted as a benchmark and standard of care for all groups that provide healthcare so that as they develop new benefits, they adopt HBOS's.

AUDIENCES

The below grid shows key audiences grouped into three core categories. These audiences need to be paired with the reasons why they would be motivated to adopt and champion these recommendations to help refine and target key messaging and strategies.

NOTE FOR HBOS MEMBERS:

THESE GROUPS WERE UPDATED BASED ON THE 7/29/10 WORKSESSION. PLEASE ADD AUDIENCES TO ANY OF THE THREE CATEGORIES—PROVIDORS OF CARE; EMPLOYERS; CONSUMER-FOCUSED.

PLEASE ALSO PROVIDE YOUR INSIGHTS AS TO THE REASONS WHY EACH OF THESE AUDIENCES WOULD WANT TO ACCEPT AND CHAMPION THESE RECOMMENDATIONS. THIS WILL HELP US REFINE MESSAGES AND STRATEGY.

<p>Providers of Care Health Plans Providers & associations Program providers (ALA, QL) Oregon Health Authority Consultants & Brokers Oregon Education Benefit Group OHIP improvement committee OMA</p>	<p>Reasons why the audience would want to adopt and champion the recommendations.</p>
<p>Employers Oregon Business Association (OBA) Business Alliance Chambers of Commerce Oregon Business Council (OBC) Associated Oregon Industries Oregon Healthy Kids</p>	<p>Reasons why the audience would want to adopt and champion the recommendations.</p>

Insurance Brokers Employers (large and small) OAB ONA OPC AQI	
Consumer-Focused Patient advocates Pharmaceutical companies Policy advocates Schools and PTA's Pharmacy purchasing groups Health Leadership Council	Reasons why the audience would want to adopt and champion the recommendations.