Tobacco Cessation

Incentivizing Enrollment in the Arizona Smoker’s HelpLine (ASHLine)

Background and Basic Concept

There is more evidence than ever before that quitlines are effective in helping tobacco users quit. In 2007, the CDC issued a guidance document, *Best Practices for Comprehensive Tobacco Control Programs*, in which CDC recommends that a key component of any effort to reduce the toll of tobacco include action to sustain, expand and promote quitline services.

The ADHS Bureau of Tobacco and Chronic Disease (BTCD) funds the Arizona Smokers’ Helpline (ASHLine) as the core component in a statewide strategy to reduce tobacco prevalence on a statewide basis. The ASHLine provides individualized coaching based on a standardized schedule of calls that is designed to help people through the quit process until they are quit for 90 days. This provides them the opportunity to have coaching during the two highest risk periods for relapse – the first 10 days and the 60-90 day window. Typically, a caller will receive calls for 5 – 6 months to reach their 90 days quit.

Currently, Arizona law requires that all AHCCCS members be offered any FDA approved tobacco cessation medication at no cost to the client. There were over 6,000 AHCCCS members who utilized the tobacco cessation medication benefit between July 1 -September 30, 2010. However, only 10 percent of this group enrolled in the ASHLine for coaching during this time period.

BTCD will provide a Tiered-Incentive Program for AHCCCS members who use tobacco to utilize the behavioral coaching services offered by the ASHLine. The program will incentivize incremental successes in the quit process, including ASHLine enrollment, continued participation, and quitting tobacco for 30, 60, and 90 days. The program will also conduct an analysis of 12-month quit rates. The specific incentives will be determined on the basis of focus group findings conducted with chronic adult tobacco users. There is strong evidence that this program design is critical to promoting and enhancing cessation efforts, increasing quit rates, and improving the overall health and cost burdens of this population.

Evidence-Based Research Supporting Quitlines

Quitlines greatly increase the chances that a smoker will quit successfully. Studies show that ASHLine clients who have received behavioral coaching services have significantly higher quit rates (QR = 38.2%) than those who did not receive such coaching, where only three to five percent of smokers are able to quit without assistance. This success differential far surpasses the U.S. Public Health Service’s recently updated clinical practice guideline which found that quitline counseling can more than double a smoker’s chances of quitting, and that quitline counseling combined with medication (such as nicotine replacement therapy) can more than triple the chances of quitting. While the ASHLine is considered to be the highest caliber of quitlines in North America, even the most modest efforts across the nation bear witness to the fact that quitlines are the most cost-effective way to reach a large number of smokers and dramatically increase success rates in quitting.
A representation of the anticipated workload for AHCCCS in implementing the concept:

The anticipated workload for AHCCCS will be minimal as all program design, implementation and evaluation will be related to an expansion of current programs, with member outcomes administered by ADHS - BTCD. ADHS currently funds and works closely with AHCCCS to offer tobacco cessation that includes nicotine replacement therapies and medications. AHCCCS provides BTCD with utilization data on a quarterly basis, and meets with the program and evaluation staff of BTCD and the ASHLine to assess and monitor program status. BTCD and AHCCCS will build on the progress achieved over the past two years to implement and monitor the incentives program. The data collection and evaluation will be handled by BTCD and the ASHLine, with quarterly data and assessment being provided to AHCCCS on enrollment, completion, and quit rates for all AHCCCS members enrolled in the program.

A Few Citations


Chronic Disease Self-Management

Incentivizing Enrollment in the Chronic Disease Self-Management Program (CDSMP)

**Background and Basic Concept**

The Institute of Medicine summarized the situation in a 2000 report on health promotion: “It is unreasonable to expect people to change their behavior when so many forces in the social, cultural, and physical environment conspire against such change.”

Incentivizing the participation of AHCCCS members through expansion of the Stanford Chronic Disease Self Management Program (CDSMP) will provide an opportunity for members to build skills and gain the confidence to actively participate in their health management. The ADHS Bureau of Tobacco and Chronic Disease (BTCD) will build on the current infrastructure and capacity to deliver CDSMP workshops to include AHCCCS members through expansion of partnerships offering workshops in local communities across Arizona.

BTCD will provide a Tiered-Incentive Program for AHCCCS members who are diagnosed with a chronic disease to utilize the CDSMP at a locale that is accessible to their place of residence. The program will incentivize incremental successes in the disease self-management process, including enrollment in CDSMP, demonstrated program adherence, and demonstrated reduction in risk factors (e.g. blood pressure, cholesterol and glucose levels, weight, and tobacco use). The program will conduct assessments at client progress at 30, 60, and 90 days, and will conduct an analysis of continued reductions and/or maintenance after twelve months. The specific incentives will be determined on the basis of focus groups findings conducted with adults with chronic disease. There is strong evidence, as noted below, that this program design is critical to promoting and enhancing disease self-management efforts, and improving the overall health and cost burdens of this population.

**CDSMP Components**

The CDSMP is a lay-led participant education program offered in communities in the United States and several other countries. Participants are adults experiencing chronic health conditions such as hypertension, arthritis, heart disease, stroke, lung disease, and diabetes; as well as family members, friends and caregivers when appropriate. The program provides information and teaches practical skills on managing chronic health problems. The CDSMP gives people the confidence and motivation to effectively manage the challenges of living with a chronic health condition.

The program goal is to enable participants to build self-confidence to assume a major role in maintaining their health and managing their chronic health conditions. The CDSMP focuses on problems common to individuals suffering from chronic diseases, and builds patient knowledge and skills through coping strategies such as action planning and feedback, behavioral modeling, problem solving techniques, and decision-making.

Individuals are taught to manage their conditions in ways that are most appropriate to their specific life situations and interests. AHCCCS members will acquire new skills reducing stress, adhering to healthy diets,
managing sleep and fatigue, using medications correctly, exercising, and communicating successfully with their healthcare providers.

**Health Outcomes and Evidence Supporting Health Outcomes**

Over a two-year period, investigators from the Agency for Healthcare Research and Quality (AHRQ) compared health behaviors, health status, and health services use among patients aged 40 to 90 years (average age, 65) who had completed the CDSMP (Lorig et al., 1999). When compared to baseline measures taken for the six months prior to the CDSMP, researchers found that CDSMP participants had: increased exercise; used better coping strategies and symptoms management; improved communication with their physicians; improved their self-rated health, disability, and social activities; reported less health distress; felt more energetic and less fatigued; experience less disability; and required fewer physician visits and hospitalizations.

Self-efficacy, the degree to which people believe they can perform the behavior required to produce a desired outcome, is crucial to successful disease management. (Lorig et al., 1999). The more self-efficacy people have, the more control they have over their behavior (Lorig et al., 1999; Lorig, Mazonson, & Holman, 1992). Therefore, increasing self-efficacy contributes to better decision-making processes, stronger motivation, and perseverance (Lorig et al., 1992). The increase in patients' perceptions of their self-efficacy is associated with reduced health care use (Lorig et al., 2001a).

**A representation of the anticipated workload for AHCCCS in implementing the concept:**

The anticipated workload for AHCCCS will be minimal as all program design, implementation and evaluation will be related to an expansion of current programs, with member outcomes administered by ADHS -BTCD. Currently, the Arizona Living Well Institute (ALWI), in partnership with BTCD, implements all the training and activities of the CDSMP. Key AHCCCS staff are on the leadership committee and are actively involved in the decision-making process. All data collection and evaluation of the program will be conducted by BTCD and ALWI, with oversight from the leadership committee. BTCD will build on the current partnership with AHCCCS (i.e. tobacco cessation program) to provide CDSMP data on a quarterly basis, and assess and monitor the implementation, utilization, and outcome of the program.

**A Few Citations**


