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HEALTH INSURANCE COVERAGE FOR TOBACCO DEPENDENCE

Part II. Survey of Managed Care Organizations in Texas

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INTRODUCTION

This report is the second in a series designed to ascertain the extent and nature of tobacco cessation coverage provided to Texans through their Managed Care Organizations (MCOs).

A survey of the largest MCOs in the state was conducted in the Fall, 2002. The study consisted of two phases. In Phase I medical directors were identified and contacted by phone to answer a short questionnaire. This questionnaire ascertained their organization's study eligibility, background information about HMO/PPO services provided, and the name of the individual recommended for completion of the more extensive Phase II questionnaire. Phase II, based on a modified edition of a national survey developed by the American Association of Health Plans (1), examined the scope and nature of tobacco cessation services provided in Texas.

METHODS

Participants

A two-step process was used to identify eligible MCOs. The original sample was derived using the list of the top 40 Managed Health Care Organizations for 1999, published by the Texas Department of Insurance. This list was based on the percentage of market share derived from total written premiums. First, the 40 largest companies were evaluated for inclusion in the study based on criteria determined by the study committee. This process resulted in an initial sample of 21 eligible organizations (see Figure 1).

Figure 1. Criteria for HMO Inclusion or Exclusion

Inclusion	1) HMOs with $\geq$0.5% of the written premium market share on the Texas Department of Insurance Top 40 HMO Lists (1999 and 2001).
Exclusion	1) HMOs listed on the Texas Department of Insurance Top 40 HMO Lists (1999 and 2001) that no longer offer services in Texas. 2) HMOs listed on the Texas Department of Insurance Top 40 HMO Lists (1999 and 2001) that have merged with other insurance companies or have been bought out by another insurance company. 3) HMOs listed on the Texas Department of Insurance Top 40 HMO Lists (1999 and 2001) that specifically specialize in dental coverage. 4) HMOs that are totally comprised of specialized health plans such as: CHIP, Veteran's Affair, Medicaid, Medicare, Indian Health Services, catastrophe, indigent health care, or disability.

Second, the 1999 and 2001 Top 40 lists were examined to determine if all eligible HMOs were included. Any company representing over 0.5% of the market in 2001 that was not included in the 1999 list was added to the sample pool. This resulted in the addition of five organizations for a new total of 26 HMOs. After the exclusion of organizations not eligible, a final sample of 17 was determined.

Of note, the tracking of eligible companies over the two-year period, as presented in Table 1, emphasizes the transitory status of managed care organizations. When the 1999 Top 40 HMO list was initially analyzed for selection, six companies were excluded because they focused exclusively on dental benefits, two companies were no longer conducting business in Texas, and eleven had been bought out or had merged with other insurance companies. Even after adding companies from the 2001 list, three additional HMOs went out of business, one merged with another company, and five focused entirely on special populations.

Table 1. Profile of HMOs Eliminated from Study

1999 Top 40 HMO List	
Purchased by or merged with other companies	11
Exclusively provide dental care	6
No longer conducting business in Texas	2
2001 Top 40 HMO List	
Focus exclusively on special populations (e.g. Medicare, Medicaid, and CHIP)	5
Out of business	3
Merged with another company	1

Instruments

For Phase I, a short questionnaire (see Appendix A) was developed to gather basic demographic and contact information about the identified organizations. Either the Medical Director or a designee reported numbers of overall enrollees, the nature of the plans provided by the MCO (i.e., HMO, PPO, or both), and the approximate percentages of enrollment in each. Additionally, participants were asked if they offer insurance coverage for State of Texas Employees. If they responded "yes," they were then asked the following: 1) what percentage of State Employees are covered; 2) existence of a tobacco cessation written protocol or policy for enrollees; 3) entities within the organization responsible for cessation services; and 4) future plans for tobacco cessation programs.

For Phase II, a 20-item survey instrument (see Appendix B) was developed and administered in the Fall, 2002. The Phase II questionnaire was based on a national questionnaire used by the American Association of Health Plans, with modifications made for Texas (1;2) . The questionnaire consisted of seven parts: 1) Identification of the number of Texans enrolled in their most typical, best-selling health insurance plan; 2) Clinical guidelines used with regard for smoking cessation; 3) Benefit design/coverage; 4) Information systems and measurement of provider and patient practices; 5) Cessation programs and prevention activities; 6) Barriers; and 7) Future goals for tobacco control. The instrument included multiple choice, fill in the blank, and open response questions.

Organizations were requested to complete the Phase II questionnaire with regard to their best-selling commercial health care product. "Best-selling" was defined as "the general medical/surgical package with the largest number of commercial members."

Procedures

The survey was conducted in two phases during the Fall, 2002. Initially, general contact information such as the name, phone number and e-mail address of the Medical Director was identified and confirmed by phone prior to Phase I contact. Participants, in most cases medical directors, were notified of the study through an introductory letter and a copy of the survey for review. As follow-up to the introductory letter, a project representative contacted organizations by telephone.

Once Phase I information was collected, the original contact person, either agreed to personally complete the more detailed Phase II questionnaire or indicated an individual in their organization to contact to complete the survey. The identified individual was then contacted by phone, fax, or email and asked to complete the Phase II survey instrument. Interestingly, many Phase I contacts preferred that an e-mail edition of the Phase II questionnaire be sent to them. This was then personally forwarded to the Phase II designee with a note of support for survey completion. This approach was very effective.

Analysis

SPSS software was used in all analysis. Frequencies and percentages are used to describe study results.

RESULTS

Section 1. Background

A. Participants

Among the 17 organizations in the final sample, 13 (76%) completed and returned the survey. Based on the 2001 Top 40 Managed Health Care Organizations in Texas provided by the Texas Department of Insurance, this collective group of respondents represents 63% of the written premiums and 59% of the market share of written premiums in Texas for the year 2001. Furthermore, the sample includes nine of the top ten HMOs in regard to total ending enrollment published by the Texas Department of Insurance for the second quarter, 2002.

The majority (62%) of those persons completing the survey were Medical Directors. Other respondents included: Director of Health Services, Quality Department Manager, Quality Review Coordinator, Senior Vice President, and a State Manager of Health Management.

B. Description of Participating Organizations

Most (62%) of the responding organizations offered both HMO and PPO plans. The remaining participants (38%) only offered HMO plans to enrollees. Five (38%) of the responding organizations provide some health care coverage to State of Texas employees. Typically, state employees were only 10-15% of enrollees.

C. Number of Texans Enrolled in Most Typical, Best-Selling Plans

Approximately one-third (31%) of participants reported their typical best-selling plan reached less than 25,000 Texans, while another third (31%) served ≥ 500,000 Texans. The remaining plans reached between 25,001 and 250,000 enrollees (see Table 2).

Table 2. Enrollment in Most Typical, Best-Selling Health Insurance Plans

Total enrollment	N*	%
Less than 25,000	4	31%
25,001 – 50,000	2	15%
50,001 – 100,000	1	8%
100,001 – 250,000	2	15%
250,001 – 500,000	0	0
More than 500,000	4	31%

*N=13

D. Presence of an Organizational "Home" for Tobacco Control

Almost half (46%) of the 13 organizations had no department or entity responsible for directing tobacco control activities. *Only one plan had full-time staff for tobacco control; this consisted of two staff positions.* The remaining HMOs reported responsibilities were distributed among the following departments or entities: Quality Assurance, Quality Department – Medical Management, Medical Management, Clinical Operations, Health Care Quality – Health Management, Health Promotions Department, and the Utilization Department.

None of the participants indicated the presence of the following: tobacco control task force, health education/promotion department, wellness division, pharmacy and therapeutics committee, or committee to supervise behavioral interventions.

Most HMOs (77%) viewed tobacco control primarily as a medical concern; the remaining three (23%) viewed it as a subset of a comprehensive wellness message.

Section 2: Benefits Design/Coverage

A. Use of Clinical Guidelines

Over two-thirds (69%) of the organizations did not have a written tobacco cessation protocol or policy for their enrollees. Among the four organizations who reported using a guideline to develop their tobacco cessation plan, only two used a national clinical guideline for planning. One used the 2000 Public Health Service (PHS) *Clinical Practice Guideline: Treating Tobacco Use and Dependence* (3) or the 1996 AHCPR *Smoking Cessation: Clinical Practice Guidelines* (4). Two additional plans used internal or "home grown" guidelines or part of a preventative health guideline.

B. Coverage of Tobacco Cessation Pharmacotherapies

More than half (54%) of participants reported full coverage for at least one form of pharmacotherapy (i.e., nicotine replacement therapy, Bupropion/Zyban or Wellbutrin). Among the seven who provided full coverage, Wellbutrin was the most likely to be in formulary, as presented in Table 3. While Wellbutrin was the most frequently covered approach, it is not known to what extent the coverage was specifically intended for tobacco cessation. Co-payments varied by plan, with most in the range of $10 - $20.00.

Table 3. Pharmacotherapies Covered by Participating Plans

Pharmacotherapy	Fully Covered N*	In Formulary N*
Wellbutrin	7	3
Bupropion (Zyban)**	4	2
NRT only with enrollment in cessation program	3	1
NRT available by prescription	2	0

Multiple Responses
*N=17/n=7, **One plan marked that Bupropion was covered, but not Zyban.

C. Limits on Coverage

Five HMOs reported annual or lifetime limits on various pharmacotherapies (see Table 4). When limits existed, refills were limited to three months, three refills, or one course per plan lifetime. Five of the seven plans covering Wellbutrin (see Table 3) did not report limits on refills and two of the four companies covering Bupropion did not report limits to coverage. Most HMOs covered NRT by prescription alone or in conjunction with cessation program enrollment reported limits.

Table 4. Limits to Coverage for Pharmacotherapies

Pharmacotherapy	Enforce Limits N*	Refills Allowed by Plan
NRT: Prescription gum, patches, nasal spray, inhaler	2	1 course per plan lifetime,
NRT: Only with enrollment in cessation program (e.g., face-to-face counseling, telephone counseling, clinics)**	3	3 refills, 3 months
Bupropion (i.e., Zyban)**	2	3 months, Unlimited
Wellbutrin	2	Unlimited

Multiple Responses
*N=13/n=5
**Differences among plans in each category are noted in "Allowable Refills"

D. Tobacco Cessation Intervention Coverage

Organizations were requested to indicate all behavioral interventions they cover. As presented in Table 5, the intervention covered most often was face-to-face counseling, followed by individual

counseling for pregnant women. Less frequently covered behavioral interventions included: group counseling or classes, self-help materials, telephone counseling, acupuncture, hypnosis and self-referral to the American Lung Association. Only one plan indicated limited mandates of three months for face-to-face and group counseling.

Two plans covered multiple (five of the seven) items listed; two covered three of the seven items; three covered two items each; and the rest covered only single items.

Table 5. Tobacco Cessation Intervention Coverage

Behavioral Interventions	Fully Covered N*	Annual Limit
Face-to-face counseling	6	3 months**
Individual counseling for pregnant women	5	
Group counseling or classes	3	3 months**
Self-help materials booklets, videos, audiotapes, tailored mailings	3	
Acupuncture	2	
Telephone counseling	2	
Hypnosis	1	
Other – Comments:	2	
1) Self-referral to the American Lung Association 2) Anything the physician needs to do in the way of counseling is paid for. A newsletter to enrollees about smoking risks is sent out, as are wellness-related printed materials. The PCP is expected to do verbal counseling.		

Multiple Responses
*N=13/n=9, **Only one plan indicated that limits were mandated.

E. Intervention Counseling

Among the nine plans that covered the interventions listed in Table 5, intervention counseling was provided by a variety of health professionals. The most common form of counseling was face-to-face counseling from the patient's PCP; it was provided by six organizations.

F. Self-Referrals

Almost two-thirds **(**62%) of the thirteen respondents reported their plans did not have provisions for patient self-referrals to tobacco cessation counseling services.

Section 3: Information Systems and Measurement

A. Current Information System Applications

Eight (62%) participants stated the medical groups they contract with maintain an information system for individual patients (e.g. patient encounters and/or clinical information). The most common use of the information system by seven of the eight participants was for collection of

general information for administrative or billing use. Only three of the eight plans with information systems for individual patient data collected information addressing tobacco issues.

B. Required Provider Data Collection

The three organizations that collected tobacco-related data most frequently recorded the following in their system: 1) The prescription of pharmacotherapy and 2) Documentation that the provider advised the patient to quit smoking. Two of the three also recorded smoking history.

C. Required Provider Activities

Approximately two-thirds of the 13 HMOs require the providers they contract with carry out multiple tobacco-related documentation activities. A majority of HMOs require their providers ask new patients about their smoking status (69%) and document smoking status in the patient's medical records (69%). Less than a third require their providers to include smoking status as a vital sign or require smoking status be recorded on an electronic medical record.

D. Methods to Identify Individual Smokers

Even with current information systems and provider requirements, 85% (n=11) of the plans currently are not able to identify individual enrollees who smoke. Only one plan indicated it knew the percentage of enrollees who use tobacco products. They estimated that tobacco users comprised approximately 20% of their enrollees.

Of the two plans reporting that they could identify individual smokers, one reported using their system for random medical record review, electronic medical records, enrollment information, and health risk appraisal. The other company identified smokers only as needed based on pre-authorization or as an in-patient care issue through notes acquired from the individual doctor. This HMO stated they could identify individual enrollees who smoke, but indicated it would be difficult to do so because it would require asking for notes about each patient from each physician. This data was not reported to be routinely collected.

Section 4: Cessation Programs and Prevention

A. Specific Plan Strategies to Address Smoking Cessation at Key Intervention Periods

When asked about specific strategies to address smoking cessation, over a half of participants did not have strategies to address smoking cessation during key intervention periods such as adolescence, pregnancy, postpartum visits, pediatric visits, post-MI, during treatment for other chronic illness, or during hospitalization. Eight (62%) did not report *any* specific strategy. The intervention period addressed most often was smoking cessation during pregnancy, but only by a limited number of organizations (see Table 6).

Those plans reporting intervention periods to address smoking cessation typically noted multiple intervention periods. For example, of the five respondents who reported one or more key times, two marked all possible intervention periods, while the remaining three ranged between three and four key intervention periods.

Table 6. Presence of Strategy to Address Smoking Cessation at Key Times

Intervention Periods	N*
Pregnancy	5
Pediatric Visits	4
Treatment for other chronic illness	4
Post-MI	3
Adolescence	3
Hospitalization	3
Postpartum visits	2

Multiple Responses
*N=13/n=5

B. Activities Required of Providers

Among the responding 13 organizations, seven (54%) did not require any tobacco-related activities from their providers (see Table 7). The activity required most was to strongly advise all patients to quit, but less than half of organizations had this requirement.

Table 7. Activities Required by Plan Providers

Activities	N*
Strongly advise all patients who smoke to quit.	6
Refer the patient who smokes to intensive treatment when the physician considers it appropriate or the patient prefers it.	3
Arrange for follow-up with patients who are trying to quit smoking.	3
Have literature about smoking cessation and the health risks of smoking readily available in waiting rooms and exam rooms.	1
Encourage parents who smoke to provide a smoke-free environment for their children at home and in day care.	1
Refer smoking patients to the Texas Department of Health funded American Cancer Society Tobacco Quitline.**	1

Multiple Responses
*N=13/n=6,
**One plan added, "We utilize the American Lung Association."

C. Systems Implemented

Nine (69%) of the respondents did not implement *any* of following systems: Provider training, incentives, provider monitoring and feedback, patient incentives for adherence, elimination of pre-authorization requirements for medications, or on-site individual or group counseling/classes. Only two HMOs noted having implemented a system for provider monitoring and feedback, elimination of pre-authorization requirements, or on-site individual or group counseling/classes.

D. Awareness of the TDH/American Cancer Society Quitline

Most of the HMOs (54%) were not aware of the American Cancer Society Quitline (see Table 8).

Table 8. Awareness of the TDH Quitline

Level of Awareness	N*	%
Not aware	7	54%
Aware but don't encourage use**	3	23%
Aware and directly encourage member use***	2	15%
Aware and encourage provider referrals	1	8%

*N=13
**Told it does not cover their area.
***Encourage use of the American Lung Association program.

E. Interest in working with TDH to Promote the Quitline

A majority (77%) of the plans indicated interest in working with TDH to promote the Quitline. Another HMO was currently developing a national program and wished to wait to see what was in its own program prior to expressing interest in the Quitline.

Section 5: Barriers

A. Limiting Factors for HMO Plans

Seven of the 13 HMOs (54%) stated the main barriers to their organizations' ability to address tobacco control were due to a lack of resources (e.g., staff, funding, competing priorities). Another four stated both resource and system barriers existed. One of these four HMOs reported multiple barriers: 1) resource and system barriers, 2) delay of economic return, and 3) lack of purchaser demand.

B. Factors Limiting Providers

Factors most limiting plan providers were perceived by the HMOs to be: 1) time constraints during patient visits, 2) frustrations due to low quit success rates, and 3) perceptions of tobacco control as a low priority relative to other issues. The majority of organizations reported three or more provider barriers (see Table 9).

Table 9. Factors Limiting Providers' Ability to Address Tobacco Control

Factors	N*	%
Time constraints during patient visits	7	54%
Frustration due to low quit success rate	5	39%
Low priority relative to other issues	5	39%
Lack of provider performance feedback	3	23%
Lack of reimbursement for cessation counseling/assistance	3	23%
Poor training in smoking intervention	3	23%
Physician perception of lack in skills to deliver an effective message	2	15%
Lack of reimbursement for smoking cessation medication	2	15%
Financial and resource barriers	1	8%
Other: We do not get feedback on this from physicians	1	8%

Multiple Responses
*N=13

Section 6: Influence of the Texas Tobacco Settlement

In response to an open-ended question about how the Texas settlement with the tobacco industry influenced their plan's tobacco cessation programs, participants overwhelmingly reported that the Texas Tobacco Settlement has had no influence on their programs. The two that reported any influence noted that this influence was primarily positive through the funding of the CHIP program (Child Healthcare Insurance Program).

Section 7. Future Goals for Tobacco Control Activities

When requested to describe their future goals for tobacco control activities in both the Phase I phone interview and the Phase II written survey, five of the responding HMOs indicated no future goals. Others indicated they will continue with the status quo. This included continuation of activities such as:

- Referral of members to the American Lung Association.
- Provision of a newsletter and other educational materials.
- Partnership with central Texas schools to prevent tobacco use by minors (Stand Tall Against Tobacco with Texas A&M University).
- Continue partnership with an external vendor (Free and Clear), which has been in place for seven years. Plans exist to extend this program to their PPO in January, 2003.
- Publicizing the ACS Quitline.

- Provision of information to providers regarding preventive health documentation.

Future possibilities for tobacco control activities that were mentioned include:

- Development of a personal nurse program to develop relationships with members on an individual basis.
- Development of a more comprehensive program which uses multiple treatment modalities such as the telephone quitline and support groups.
- Experimentation with discounts for those accountable for preventative health measures.
- Working with community organizations such as the Texas Cardiovascular Council to identify resources, best practices and opportunities to reduce smoking.
- Enlisting a physician champion for each market.
- Encouragement of the Texas Department of Insurance to allow increases in premiums for tobacco users.
- Initiation of a national smoking cessation program after completion of implementation of a new Diabetes Disease management program.
- Provision for provider and patient training.

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Reports are available on the HNETS website: www.uh.edu/hnets

APPENDIX A

NAIC #

Phase I – Demographic Information

Name of Managed Care System	
Title of Respondent	
Telephone Number	
Email or web address	
Number Enrolled Overall	
HNETS interviewer:	

1. What type of plans do you offer in Texas?

   ☐ HMO only
   ☐ PPO only
   ☐ HMO and PPO

2. **If** both HMO and PPO plans, what is the overall percentage for each? (skip if #1 is no)

   _____HMO
   _____PPO

3. Do you provide healthcare coverage for state of Texas employees as well as private employers and other commercial business? ☐ yes ☐ no

HMO	% or ☐ N/A
PPO	% or ☐ N/A
HMO and PPO	% or ☐ N/A

4. Within your organization, which departments or entities have primary responsibility for directing tobacco control activities (including services, clinical education)?

☐ There are no tobacco control entities	☐ Pharmacy and Therapeutics Committee
☐ Tobacco Control Task Force	☐ Quality Assurance
☐ Health Education/Promotion Department	☐ Behavioral
☐ Wellness Division	☐ Other: Specify _____

5. Does your organization have a written tobacco cessation protocol or policy for **enrollees**?

   ☐ yes ☐ no

6. Contacts for phase II

HMO: Name _____ Title _____
Phone _____ Email _____

PPO: Name _____ Title _____
Phone _____ Email _____

7. What are your managed care organization's future plans for implementing tobacco cessation services for enrollees? _____

APPENDIX B

University of Houston

Managed Care Organizations:
Survey on the Provision of Tobacco Cessation Services

In Partnership with

Texas Department of Health

ALL RESPONSES ARE CONFIDENTIAL

No plan-identifiable data will be released by UH or TDH. Survey data will be published only in aggregate form that does not allow for identification of specific health plans.

Please return the survey within 5 business days to:

micourt@flash.net
("Save" the file as a Word document on your hard drive and then email it as an attachment)
or by fax to 512-388-5327
or mail to:
University of Houston
Texas Tobacco Prevention and Control Study
Melynda Boerm
3855 Holman, Garrison #104
Houston, Texas, 77204-6015

For this survey, answer the following questions about your plan's "best-selling," managed care product in Texas. "Best-selling" means the general medical/surgical package with the largest number of commercial members.

What is the number of Texans enrolled in your most typical, best-selling health insurance plan? **(Check one)**

- ☐ Less than 25,000
- ☐ 25,001 – 50,000
- ☐ 50,001 – 100,000
- ☐ 100,001 – 250,000
- ☐ 250,001 – 500,000
- ☐ 500,001 or more

SECTION 1. Clinical Guidelines

1. Does your plan have a written clinical guideline concerned with smoking cessation? **(Check one)**

- ☐ Yes. Our plan uses the 1996 U.S. AHCPR Practice Guideline on Tobacco Cessation.
- ☐ Yes. Our plan uses the 2000 Public Health Service (PHS) Guideline on Tobacco Use and Dependence.
- ☐ Yes. Our plan uses an internal or "home grown" guideline.
- ☐ Yes. Other. Please specify:_____
- ☐ No.

SECTION 2. Benefits Design/Coverage

2. Which of the following tobacco cessation pharmacotherapies are covered by your plan?

Intervention	Fully covered?		Copayment	In formulary?	
	Yes	No		Yes	No
Nicotine replacement therapy (NRT): Over the counter gum and/or patches	☐	☐	$ _____	☐	☐
NRT: Prescription gum, patches, nasal spray, inhaler	☐	☐	$ _____	☐	☐
NRT: Only with enrollment in cessation program (e.g., face-to-face counseling, telephone counseling, clinics)	☐	☐	$ _____	☐	☐
Bupropion (i.e., Zyban)	☐	☐	$ _____	☐	☐
Wellbutrin	☐	☐	$ _____	☐	☐

3. Are there limits on coverage for pharmacotherapies?

	Yes	No	Per Annum?	Lifetime limit?	Number of refills allowed?
Nicotine replacement therapy (NRT): Over the counter gum or patches	☐	☐	$	$	_____
NRT: prescription gum, patches, nasal spray, inhaler	☐	☐	$	$	_____
NRT: only with enrollment in cessation program (e.g., face-to-face counseling, telephone counseling, clinics)	☐	☐	$	$	_____
Bupropion (i.e., Zyban)	☐	☐	$	$	_____
Wellbutrin	☐	☐	$	$	_____

4. Which of the following tobacco cessation interventions are covered by your plan?

Intervention	Fully covered?		Co-payment	Is there an annual limit?		Is there a lifetime limit?	
	Yes	No		Yes	How many sessions?	Yes	How many sessions?
Telephone counseling	☐	☐	$ _____	☐	_____	☐	_____
Face-to-face counseling	☐	☐	$ _____	☐	_____	☐	_____
Group counseling or classes	☐	☐	$ _____	☐	_____	☐	_____
Individual counseling for pregnant women	☐	☐	$ _____	☐	_____	☐	_____
Self-help materials (booklets, videos, audiotapes, tailored mailings)	☐	☐	$ _____				
Acupuncture	☐	☐	$ _____	☐	_____	☐	_____
Hypnosis	☐	☐	$ _____	☐	_____	☐	_____
Other: Please describe: _____	☐	☐	$ _____	☐	_____	☐	_____

5. If your plan has a tobacco counseling component, who primarily provides the patient smoking cessation counseling for the following interventions? **(If no, skip to question 7)**

	Provider (check only one)					Other
Intervention	Patient's PCP	Nurse	Psychologist or psychiatrist	Certified Health Education Specialist (non-clinician) [CHES]	Community Program	Please specify:
Telephone counseling	☐	☐	☐	☐	☐	_____
Face-to-face counseling	☐	☐	☐	☐	☐	_____
Group counseling or classes	☐	☐	☐	☐	☐	_____
Group counseling or classes for pregnant women	☐	☐	☐	☐	☐	_____

6. Are patients able to self-refer to your plan's smoking cessation counseling services?

☐ Yes
☐ No

SECTION 3. Information Systems and Measurement

7. Does your plan or the medical group(s) that you contract with maintain an information system that contains patient encounter and clinical information for an individual patient?

☐ Yes
☐ No **(Go to question 8)**

7.a If yes to Question 7, which information is maintained in the system? **(Check all that apply.)**

☐ General information based on administrative or billing data
☐ Clinical information including tobacco issues (not based on billing data)

7.b If the system maintains clinical information addressing tobacco issues, what type of information is recorded? **(Check all that apply.)**

☐ Smoking history
☐ Current smoking status
☐ Household member smokers
☐ Provider advised patient to quit
☐ Provider counseled to quit
☐ Scheduled follow-up visit
☐ Prescribed pharmacotherapy
☐ Stage of change
☐ Other. Please describe: _____

8. Are the *providers* in your plan required to carry out any of the following activities?

Activity	Yes	No	Does not apply
Ask new patients about their smoking status	☐	☐	☐
Include smoking status as a vital sign (i.e. ask about smoking status at every visit)	☐	☐	☐
Document smoking status in the patient's medical record	☐	☐	☐
Record smoking status on electronic medical record	☐	☐	☐

9. Can your plan identify individual enrollees who smoke?

☐ Yes
☐ No **(Go to question 10)**

9.a How frequently does your plan collect this information? **(Check one)**

☐ Annually
☐ Every other year
☐ Other. Please specify: _____

9.b What method do you use to identify individual smokers? **(Check all that apply)**

☐ Medical record review (random sample)
☐ Electronic medical record
☐ Administrative data review
☐ Telephone survey
☐ Enrollment information
☐ Mail-based survey
☐ Health risk appraisal
☐ Other. Please specify: _____

9.c What percentage of enrollees use tobacco products? _____

SECTION 4. Cessation Programs and Prevention

10. Does your plan have a specific strategy to address smoking cessation during:

	Yes	No
Adolescence?	☐	☐
Pregnancy?	☐	☐
Postpartum visits (relapse prevention)?	☐	☐
Pediatric visits (second hand smoke)?	☐	☐
Post-MI?	☐	☐
Treatment for other chronic illness?	☐	☐
Hospitalization?	☐	☐

11. Are the providers in your plan required to carry out any of the following activities?

Activity	Yes	No	Does not apply
Strongly advise all patients who smoke to quit	☐	☐	☐
Refer the patient who smokes to intensive treatment when the physician considers it appropriate or the patient prefers it.	☐	☐	☐
Arrange for follow-up with patients who are trying to quit smoking	☐	☐	☐
Ensure that support staff are trained to counsel patients about smoking	☐	☐	☐
Have literature about smoking cessation and the health risks of smoking readily available in waiting rooms and exam rooms	☐	☐	☐
Encourage parents who smoke to provide a smoke-free environment for their children at home and in day care	☐	☐	☐
Refer smoking patients to the Texas Department of Health funded American Cancer Society Tobacco Quitline	☐	☐	☐

12. Has your plan implemented systems for any of the following? **(Check all that apply)**

☐ Provider training in effective smoking cessation interventions
☐ Provider incentives that promote tobacco cessation assessment and intervention (e.g., financial, resources, practice tools).
☐ Provider monitoring and feedback
☐ Patient incentives for use of/adherence to recommended cessation treatment
☐ Elimination of pre-authorization requirements for smoking cessation medications
☐ On-site smoking cessation individual or group counseling/classes

13. Is your healthcare system aware of a Texas Department of Health -funded American Cancer Society Tobacco Quitline? If so, do you encourage its use?
(Check all that apply)

☐ No, not aware
☐ Yes, aware but don't encourage use
☐ Yes, aware and encourage provider referrals
☐ Yes, aware and directly encourage member use

14. Is your healthcare system interested in working with the Texas Department of Health on encouraging awareness and use of an American Cancer Society tobacco Quitline to promote tobacco cessation?

☐ Yes
☐ No

15. Does your plan fund a tobacco control program staff position? **(Check all that apply)**

- ☐ Yes, full-time How many positions: _____
- ☐ Yes, part-time How many positions: _____
- ☐ No

16. Which of the following would you say most represents your organization's view of tobacco use, of any kind? **(Check one)**

- ☐ A personal life choice
- ☐ A medical concern
- ☐ A subset of a comprehensive wellness message

SECTION 5. Barriers

17. Which of the following most limits your plan's ability to address tobacco control? **(Check one)**

- ☐ Resource barriers (e.g., staff, funding, competing priorities)
- ☐ System barriers (e.g., poor data collection, reporting, record maintenance)
- ☐ Both resource and system barriers
- ☐ Delayed economic return
- ☐ Lack of purchaser demand
- ☐ Lack of patient demand
- ☐ Few or no barriers exist for our plan
- ☐ Other. Please describe: _____

18. Which of the following most limits the ability of providers you contract with to address tobacco control? **(Check all that apply)**

- ☐ Time constraints during patient visits
- ☐ Physician perception of lack in skills to deliver an effective message
- ☐ Poor training in smoking intervention
- ☐ Lack of provider performance feedback
- ☐ Lack of reimbursement for cessation counseling/assistance
- ☐ Lack of reimbursement for smoking cessation medications
- ☐ Frustration due to low quitting success rate
- ☐ Low priority relative to other issues
- ☐ Financial and resource barriers
- ☐ Other, please specify: _____

SECTION 6. Tobacco Control

19. Please describe how the state of Texas' settlement with the tobacco industry has influenced your plan's health insurance. _____

_____

_____

_____

20. Please describe your future goals for tobacco control activities. _____

_____

_____

_____

_____

In the event that there is a need to clarify a given response, please list your name, job title, and contact information below.

Name: _____ Title: _____

Phone: _____ Email: _____

Thank you for completing this survey.

If completing this survey via email, please "save" the file as a Word document on your hard drive and then email it as an attachment to:

micourt@flash.net

Or mail or fax the completed survey to:

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