

**North Carolina Institute of Medicine
Task Force on Prevention
May 8, 2008
Meeting Minutes**

Chairs: Leah Devlin, DDS, MPH, State Health Director, NC Department of Health and Human Services; William Roper, MD, MPH, CEO, UNC Health Care System, and Dean, UNC School of Medicine

Task Force Members/Steering Committee Members: Alice Ammerman, Tom Bacon, Danielle Breslin, Moses Carey, Johanna Chase, Steve Cline, Leah Devlin, John Frank, Bob Greczyn, Greg Griggs, Verla Insko, Polly Johnson, William Lawrence, Peter Lehmann, Jennifer MacDougall, Michael Lewis, Meg Molloy, Peg O'Connell, Ruth Petersen, Mary Piepenbring, Marcus Plescia, Fran Preston, William Pully, Kelly Ransdell, George Reed, Bill Roper, Carol Runyan, Meka Sales, Pam Seamans, Vandana Shah, Jackie Sheppard, Michael Tarwater, Kristie Thompson, Lisa Ward, Charles Willson, Joyce Young

The goal of this meeting was to provide task force members with information needed to develop actionable recommendations to prevent death and disability in North Carolina due to tobacco use. Each meeting of the Prevention Task Force will follow a similar format such that the problem is defined, current North Carolina efforts are presented, and opportunities for improvement are provided. A discussion of recommendations follows the above-mentioned presentations.

Evidence-Based Strategies and Promising Practices (by phone)

David Hopkins, MD, MPH, Coordinating Scientist and Chief Medical Officer, Community Guide Centers for Disease Control and Prevention

In order to develop the most cost-effective prevention plan for North Carolina, the Task Force will target practices and programs that have been *proven* to be effective, when they exist. For some topics (such as tobacco), a number of practices have been proven to be effective. For others, the evidence base may not exist and we may have to look at programs with a weaker evidence base.

Dr. Hopkins conceptualized three levels of evidence:

1. Evidence-based programs, which have been shown *to be* effective
2. Best practices, which *can be* effective; and
3. Promising practices, which *might be* effective.

Evidence-based programs and practices are based on evidence collected from systematic reviews of scientific literature. Best practices may be based on evidence from literature, other reviews, interventions and evaluations from state practice, and group expertise. Promising practices might be based on primary evidence from published scientific literature, may include or be based on other sources, such as an expert panel, and usually includes information from programs and practices. Promising practices are usually easy, inexpensive, and popular. They may not have a long-term, meaningful impact on the population, but they can help to get the ball rolling.

Defining the Problem of Tobacco Use in North Carolina

Adam Goldstein, MD, MPH, Professor, Family Medicine, Director, Tobacco Prevention and Evaluation Program, UNC School of Medicine

Dr. Goldstein provided a comprehensive overview of the burden of tobacco use on North Carolina. Key figures include

- Tobacco use is the leading cause of preventable death in NC.
- NC ranks in the lower one-third in terms of adults who smoke. In 2006, there were 1.475 million smokers in North Carolina. More than 1 of 5 NC adults (22%) smokes versus 20% in the US.
- There is no safe level of secondhand smoke (SHS) exposure, not even short-term. About 2000 North Carolinians die from SHS exposure every year. SHS direct/indirect costs in NC are close to \$250 million.
- Tobacco use costs NC \$2.5 billion in 2004 in medical costs.
- Radical change is needed to reach Healthy People 2010 goals for percent of NC adults who smoke and for percent of workplaces with formal no-smoking policies.
- Current disparities exist within SHS exposure measures, smoking rates among young adults, and smoking rates among people with lower incomes, less education, and disabilities.

North Carolina Initiatives to Reduce Tobacco Use

Sally Herndon Malek, MPH, Head, Tobacco Prevention & Control Branch (TPCB), NC Division of Public Health

The Guide to Community Preventive Services, Clinical Preventive Guidelines: Treating Tobacco Use and Dependence (AHRQ), and CDC's Best Practices for Comprehensive Tobacco Control Programs are sources of evidence-based tobacco prevention and control strategies.

Current tobacco prevention and control efforts in NC include:

- **Public Policy:** North Carolina can or has adopted policies to promote tobacco-free environments and to reduce smoking.
 - **Tax:** A 10% increase in price reduces overall consumption by approximately 4% (consumption decreases even more for youth). Furthermore, researchers say that the tax stops experimentation from turning into addiction in youth. During the period NC raised its tax (2005-2006), revenues increased from \$39 million to \$196 million. NC's tobacco tax revenues go into the NC General Fund.
 - **State Laws:** Current laws require that 100% of schools are tobacco free by August 2008; prohibit smoking in state government buildings; prohibit smoking in long-term care facilities; and allow the UNC system to be smoke free.
- **Community and Environment.** Other settings are becoming smoke-free on a voluntary basis:
 - Project Assist coalitions (funded by TPCB) are integral to the state's tobacco prevention and control infrastructure.

- Almost all NC hospitals are voluntarily 100% tobacco-free. Smoke-free worksite policies and cessation benefits are becoming more common in NC workplaces.
- Clinical Care.
 - Only a little more than one-third of NC adults who currently smoke have discussed medical cessation treatment with a health professional (although more NC adults report being advised to quit). Health care providers should ask, advise, and refer every patient. State resources and tools include
 - The NC Quitline (Current NC quitline funding only allows NC to reach less than 1% of smokers. CDC recommends states have enough funding to reach 4-6%.)
 - NC Prevention Partners' (NCP) *Starting the Conversation* tool – brief screening and referral tool for tobacco use
- Statewide report cards show NC needs to make major improvements :

Vandana Shah, Executive Director, NC Health & Wellness Trust Fund

Obesity, health disparities, and tobacco are the three main focus areas of the Health and Wellness Trust Fund (HWTF).

- Tobacco use prevention and cessation initiative includes: community/school grants, statewide services, mass media (Tobacco-Reality-Unfiltered (TRU) campaign), QuitlineNC and related outreach, and tobacco-free colleges.
 - External evaluation of all components
- Since 2003, community grants total more than \$29.4 million to over 60 community and school-based organizations. Grantees use a multi-faceted approach that includes preventing youth initiation, eliminating exposure to SHS, promoting cessation, and eliminating disparities.
- The 100% tobacco-free schools movement is a NC success story. Since the HWTF began funding prevention efforts in 2003, middle school smoking has dropped 51.8% and high school smoking has dropped 30.4%.
- “Call it Quits” campaign, launched in 2007, led to a 7x increase in QuitlineNC call volume.
- NC quitline resources have been developed for health care providers; nearly 10,000 will be reached.
- Recently funded a DPH adult cessation initiative aimed at pregnant women.
- Tobacco-Free Colleges initiative was begun by the HWTF in December 2005. To date, 18 campuses have passed either 100% tobacco-free campus policies or 100-ft perimeter policies.

The HWTF will begin debt service repayment in 2009-2010, which will consume a sizable portion of the program budget. At that time, the HWTF may have \$14-15 million for tobacco prevention and control efforts.

Comments/Responses

- BCBSNC put substantial one-time support into the state’s quitline. Most HWTF quitline funding goes to young adults and primary care providers. There is only \$127k from CDC to cover most adults.

- Providing nicotine replacement therapy (NRT) through QuitlineNC would be a great step to take, but the NC Medical Board thinks that offering NRT through an out-of-state quitline would violate the Medical Practice Act.
- Increased excise taxes and the tobacco-free hospital movement drives people to the NC quitline.
- Insurance incentives are effective in helping people to quit.
- Tobacco-free schools is the strongest evidence-based initiative for youth. Focusing on school-based health curricula is intuitively appealing, but curriculum changes by itself is not evidence-based.

Furthering North Carolina's Progress

Danny McGoldrick, Vice President, Research, Campaign for Tobacco-Free Kids

NC has seen greater progress in youth (rather than adults) because that is where the efforts are.

The “trifecta” for tobacco prevention and control includes smoke-free policies, tax, and program funding. These lead to dramatic decreases in consumption.

Tax

- A tax disproportionately reduces consumption in youth, pregnant women, low-income persons, and minority populations.
- A 10% price increase leads to nearly 7% decline in youth prevalence, a 2% decline in adult prevalence, and a 4% decline in overall consumption (pack sales).
- NC has the 5th or 6th lowest cigarette tax in the nation. A \$1 increase in the tax would mean (of the NC children alive today), the state would have 125,000 fewer youth smokers saving 40,400 kids from a premature death caused by tobacco. This would also lead to 71,600 fewer adult smokers saving 18,900 adults from smoking-related deaths.

Smoke-Free Laws

- Protect everyone, prompt smokers to quit, increase number of successful quit attempts, reduce the number of cigarettes smokers smoke, discourage kids from starting, and do not hurt business.

Comprehensive Prevention and Cessation Programs

- NC funding falls well below what the CDC recommends for tobacco prevention and control. Overall, NC spends \$19.6 million versus the \$106.8 million recommended by the CDC.
- Comprehensive state programs include community-based programs, public advocacy and counter marketing, programs to help smokers quit, and surveillance and evaluation.

Comments/Responses:

- Tobacco tax and revenue quickly become “de-linked.” It is important to be clear what the money will be spent on or else every organization will be competing for it.

Discussion of Potential Recommendations

- 1) Increase cigarette tax by \$1/pack
 - Increase taxes on other tobacco products by comparable amount
 - \$106.8 million of revenue should be dedicated to the *tobacco prevention and cessation programs, to be used in part to support the NC quitline for adults and others who need it, and to mass media campaigns*
- 2) Comprehensive statewide smoke-free laws (worksites, public places, bars, and restaurants)
- 3) Support continued HWTF funds to support tobacco prevention and control
- 4) General Assembly should appropriate \$XX to the NC quitline to reach 4-6% of tobacco users and to allow direct distribution of NRT; \$XX to support mass media campaign. Funding should come from \$1.00 increase in cigarette taxes, or directly from General Funds
- 5) Need to work with NC Medical Board, NCMS, or General Assembly to change state law to allow distribution of NRT through the quitline
- 6) Support CDC recommendation of \$106.8 million for tobacco prevention and control
- 7) Encourage payers and providers to support comprehensive tobacco cessation efforts