Addressing Tobacco in Managed Care: **The Path Ahead**

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CONFERENCE REPORT

Robert Wood Johnson Foundation

Purpose Of This Paper

On September 23, 2005, America's Health Insurance Plans (AHIP), with support from the Robert Wood Johnson Foundation (RWJF), brought together health insurers, practitioners, researchers, policy-makers and funders from the private sector, public health and health care delivery to discuss the results of RWJF's national program, *Addressing Tobacco in Managed Care* (ATMC) and new tobacco control challenges, innovative resources and the application to other health priorities. Several investigators who had received ATMC research grants took part as well. The purpose of this "capstone" meeting, organized by AHIP in its role as the national technical assistance office of the ATMC program, was to propose and explore ideas for future actions to sustain and capitalize on ATMC's achievements.

George J. Isham, M.D., M.S., chief health officer and medical director of HealthPartners in Minneapolis, Minn., facilitated the meeting, "Addressing Tobacco in Managed Care: The Path Ahead." Carmella Bocchino, R.N., M.B.A, senior vice president, medical affairs of AHIP and director of the national technical assistance office, and C. Tracy Orleans, Ph.D., senior scientist, senior program officer and distinguished fellow at RWJF, introduced the meeting. Attachment 1 provides a list of attendees.

AHIP and RWJF sought to generate ideas on three topics:

1. The impact the changing health care marketplace will have on tobacco-use screening and intervention.
2. The state of the business case and return on investment (ROI) decision tools for tobacco cessation.
3. The lessons from integrating tobacco-use screening and intervention into basic health care that can be applied to obesity.

The meeting consisted of panel presentations on each of these topics, followed by general discussion. This paper synthesizes the discussion at the meeting on these three topics and presents a set of recommendations for future steps to which each participant contributed. The report of this meeting (and panelist presentation summaries) is available on the AHIP *Web site*.

Background: The ATMC Program

RWJF launched ATMC in 1997 to take advantage of developments in the health care delivery system that presented an exceptional opportunity to promote the integration of effective smoking cessation interventions into basic health care. These developments included the Agency for Health Care Policy and Research's (AHCPR) 1996 clinical practice guideline on smoking cessation, the National Committee on Quality Assurance's (NCQA's) inclusion of a tobacco-related measure in its core Health Plan Employer Data and Information Set (HEDIS®) measures of health plan quality (RWJF grants contributed to both developments), and the growth of managed care itself, with its concomitant emphasis on preventive care, centralized systems of care and feedback of performance data to providers.

RWJF designed ATMC with a research component managed by a national program office at the Center for Tobacco Research and Intervention, University of Wisconsin Medical School. This research focused on evaluating the effectiveness of replicable organizational strategies to reduce tobacco use in patients. In 2000, the U.S. Public Health Service issued its Clinical Practice Guideline,

Treating Tobacco Use and Dependence, providing a new framework for evaluating and promulgating these strategies. A formal Capstone Meeting on the research component of ATMC took place on May 3, 2005. The report of this meeting is available on the ATMC national program office Web site and on RWJF's Web site.

RWJF also included a second, innovative technical assistance component in its design of ATMC: a national technical assistance office to be directed and staffed by AHIP (at that time called the American Association of Health Plans) under the direction of Bocchino and her colleagues Barbara Lardy, M.P.H., and Bob Rehm, M.B.A. ATMC's national technical assistance office staff and consultants (including Ronald Davis, M.D., M.P.H., Abby Rosenthal, M.P.H., and Carol McPhillips-Tangum, M.P.H.) worked with health plans that sought to integrate effective smoking cessation interventions into basic health care, and conducted four surveys (1997, 2000, 2002 and 2003) of its member plans to assess the impact of ATMC in influencing programs, policies and benefit designs of health plans. In addition the national technical assistance office organized annual meetings for ATMC involving health plan leaders, researchers and policy makers, and it administered an annual tobacco control awards program providing national recognition for health plans with exemplary tobacco-cessation programs and initiatives.

The AHIP Meeting

In her introductory remarks, RWJF's Orleans stressed the value of AHIP's technical assistance and leadership as she summarized the measurable progress made integrating tobacco-use screening and intervention into routine health care since the beginning of ATMC[1]:

- 62 percent of smokers now report being advised by their physicians to quit, vs. 40 to 50 percent in the mid-1990s. Rates are highest in health plans reporting HEDIS tobacco measures.
- 98 percent of surveyed members of AHIP provide full coverage for any behavioral or pharmacotherapy (vs. 75 percent in 1997).
- 40 state Medicaid programs cover tobacco cessation treatment (vs. 24 in the mid-1990s).
- Medicare and the VA Health System now cover smoking cessation counseling.
- There is a national portal for smoking cessation quitlines serving smokers in all 50 states and the District of Columbia, and giving providers and their patients unprecedented, universal access to free and effective cessation counseling.
- New CDC and Cochrane reviews and recommendations, based in part on ATMC-funded research, have identified healthcare policy and systems changes that can substantially improve the delivery, use and impact of proven tobacco-cessation interventions.

1 Results from ATMC have been published in two special supplements of the journal *Nicotine and Tobacco Research*, the first in 2002 (Volume 4 Supplement 1) and the second in April, 2005 (Volume 7 Supplement 1).

- NCQA's HEDIS tobacco measures have been incorporated into several national quality improvement and pay-for-performance measurement sets (e.g., the Ambulatory Care Quality Alliance, the National Quality Forum-Endorsed National Voluntary Consensus Standards for Ambulatory Care and the Doctor's Office Quality project).

Now is the time, Orleans said, with the Institute of Medicine highlighting tobacco use as one of 20 priority conditions for national health care quality improvement (consistent with new system-based models for the delivery of planned chronic illness care) to move forward to "build tobacco-use screening and interventions into the DNA of health care quality improvement."

ATMC's NTAO director Bocchino joined Orleans in urging the meeting's participants to think creatively about the future. ATMC has given the health care system new models for conducting systems-change research, as well as experience with new types of partnerships for change–in this case involving representatives from managed care, academia and public health. The models and partnerships supported through ATMC have created an important vehicle and infrastructure for exchanging ideas among the different parts of the health care delivery system.

The Impact of the Changing Health Care Marketplace: Consumer-directed Health Plans (CDHPs)

Health insurance plans, care providers and employers now confront a number of market-driven changes. The days' first panel, consisting of Michael Parkinson, M.D., M.P.H., of Lumenos, Andrea Gelzer, M.D, M.S., of Cigna and Daniel Green, M.B.A., of the federal Office of Personnel Management, highlighted the most significant changes and began a discussion of their potential impact.

All three participants cited the growth of new high-deductible health plan models designed to give consumers more responsibility for managing their health care spending while offering lower premiums. While Green is not seeing much interest in these consumer-directed health plans (CDHPs) among the federal workforce, Gelzer and Parkinson both predicted such models will become more common in both employer-sponsored plans and in the individual market. Parkinson stressed that CDHPs, if structured well, can become powerful tools to drive the use of preventive services (including tobacco-use treatment) and evidence-based practices. Consumers, he believes, will respond to the savings they may achieve through lower health-service utilization by using and demanding more preventive services.

For this equation to be effective, however, Parkinson cautioned, consumers must have access to good health care information and decision support tools as they make their health care choices.

A second key ingredient is leadership: employers, for example, can compound the financial incentives CDHPs offer consumers with additional incentives of their own, including full funding of preventive care such as tobacco-use treatment services. They will only be willing to do so, however, if they see that such actions will result in their companies incurring lower health care costs overall.

Gelzer sees the change broadly as a movement from "a co-pay to a co-insurance model," driven primarily by employers' demanding reduced health insurance

costs. Keeping employers engaged in tobacco-cessation services will require proving the case that such services do reduce employers' costs. CDHPs will require that the message of cost-effectiveness be driven home to consumers as well. Tools such as differential premiums for smokers and non-smokers, when combined with first-dollar coverage for smoking-cessation treatment, may deliver this message effectively.

Meeting facilitator George Isham then asked for others' observations on the impact of this "shift from a cross-subsidy system to individual planning system." While some participants generally agreed with the potential of CDHPs to strengthen the use of tobacco treatment services by providing a direct incentive for people to change non-healthy behaviors, many questioned whether this potential will be realized, citing a number of concerns:

- *How will consumers, in fact, know the cost implications of their behaviors?* Currently, the health care system does not have a way to gather and share this information. Such a tool was described by participants as "the next generation," and participants disagreed on whether such a tool would, in fact, be easy to create.

- *There are two types of incentives.* Some are effective in bringing about behavior change; others drive people to actions that will cover an expected cost differential. These two types are not fungible and should not be confused.

- *Behaviors around tobacco use are not rational.* Financial incentives will not, in fact, be enough to get people to quit or demand and seek effective treatment. The public health system needs to partner with the health care delivery system, using policy and environmental changes that have been found both to prevent smoking initiation and to promote cessation and the use of proven quitting treatments, products and services (e.g., tobacco price increases, clean indoor airs laws, tobacco cessation media campaigns, telephone Quitlines and treatment co-pay reductions). Coordinated actions by public health agencies and health plans that motivate and support quitters' efforts and equip them with tools and products can double or triple the quit rates achieved by motivated "unaided" quitters.

- *Incentives are problematic for many segments of the tobacco-using population.* Incentives that derive from lower overall health care costs will not motivate younger tobacco users who do not identify themselves as high-risk and also are healthy and therefore not currently incurring high costs. In addition, about 40 percent of tobacco users have psychiatric co-morbidities and much more complex cessation-treatment needs. Finally, the financial and tax incentives in CDHPs, which in most cases involve funds that are not used in one year and are carried into the next–building a reserve in a Health Savings Account, may not be direct enough to have an impact on behavior for many tobacco users.

The growth of CDHPs and differential premium products is already affecting the way the parts of the health care delivery system interact. Employers, health plans, consumers and providers are taking on new roles as the locus of health care decision-making changes. The impact of this alteration of roles may be profound. In this future, asked Isham, what entity will serve to integrate the work of payers and providers? Given the concerns expressed above, how will the health care system keep a range of health-related incentives in alignment, and how can health plans make optimal contributions to this work?

The State of the Business Case and of Return on Investment (ROI) Decision Tools for Tobacco Cessation

Why is it important to calculate the ROI for tobacco-cessation services? As one participant put it, tobacco is the "dream case" for showing that an investment in prevention reduces morbidity–and related costs–in the long term. And yet, the health care delivery system still struggles to act on existing evidence for the economic benefit of this investment.

Panelists Carey Vinson, M.D., M.P.M., of Highmark, Steven Foldes, Ph.D., of Blue Cross and Blue Shield of Minnesota, Jeffrey Fellows, Ph.D., Center for Health Research, Kaiser Permanente Northwest, and Corrine Husten, M.D., M.P.H, of the Centers for Disease Control and Prevention (CDC) each stressed the importance of building the business case for tobacco-cessation services. For Vinson, convincing employers and payers of the value of tobacco-cessation interventions will in turn help physicians believe that these interventions can indeed be effective. Husten agreed that employers and payers need more convincing.

The business case has not been made, said Foldes, because existing large-scale calculations of the overall value to society–like those provided by the CDC's Smoking Attributable Mortality, Morbidity and Economic Cost (SAMMEC) model–do not help build an understanding of the local implications of decisions about tobacco use. Citing an "exclusive focus on a parochial perspective," how this plays out in "my health plan, or my employer group," Foldes suggested that the true contribution of ROI calculations will be their ability to use the strong statistical evidence to tell a local story. This story may be simple–a comparison, for example, between the results of an intervention and no intervention–but the details of telling the story may be complex, as the power of the ROI calculation will be directly related to its sensitivity to a specific local situation.

Blue Cross and Blue Shield of Minnesota and Kaiser Permanente Northwest have each developed models for calculating the ROI of tobacco cessation services. Foldes described the MediSave Smoking Cessation module, the Minnesota plan's tool, showing its ability to tailor calculations by factors such as zip code, age and sex, ethnicity, plan benefits, risk factors, other non-medical factors and a range of cessation interventions.

Fellows then presented a live demonstration of the web-based ROI Calculator tool developed at the center based on research that evaluated a cohort of over 200,000 Kaiser Permanente Northwest members over six years. Among other findings, the research showed that investing $.18–$.79 per member, per month, to offer a tobacco-use treatment program involving the "5 As," (ask, advise, assess, assist, arrange) plus Quitline support and nicotine replacement therapy (when compared to existing practice of only asking about tobacco use and advising users to quit) generates a positive net ROI of over $1.70–$2.20 per member, per month, after five years. More information about the calculator and the tool itself is available *online*.

The demonstration of two powerful tools that make the business case for tobacco use cessation services and show how this case can be shaped into a local story led facilitator George Isham to ask meeting participants why this information is not being taken up by the business community and driving a widespread adoption of tobacco-cessation benefits. Participants offered a number of answers:

- Tobacco cessation is competing with many other services in an environment where employers want, above all, to reduce costs.

- Employers don't have the knowledge, or good sources of information, about which services are effective either clinically or economically.

- Employers face resistance from consumers when they try to take away any benefits, making it almost impossible for employers to replace even ineffective services with evidence-based and cost-effective tobacco cessation programs.

- Small employers often are ill-equipped to customize or negotiate benefit designs, often deferring to their brokers or insurers and gravitating to price-sensitive basic benefit packages that their employees can afford.

Decision-making is equally complex in publicly-funded programs, noted several participants:

- "Political decisions and rational decisions are not the same."

- Making a business case may, as in Kentucky, lead to added coverage for tobacco-cessation services for the state's Medicaid beneficiaries. More often, however, an ROI calculation may take a secondary role as a tool that provides back-up evidence rather than commands attention to the issue.

- The real challenge in getting a tobacco-cessation treatment benefit into Medicare was "convincing CMS even to look at it."

- The political environment demands more than a business case; the economic analysis needs to be translated into a clear story–with locally-based examples–of the potential health and economic impact of the policy change.

Getting Business Leader Sign-On

If we are talking about getting attention, summarized Isham, then we are really talking about leadership. How do we get business leaders to understand and promote the value of tobacco-cessation services?

- One option is to enlarge the ROI calculation to include estimates of the risks of not offering tobacco-use services–the potential costs of lawsuits, for example, or the loss of market share–and thereby make it more likely to attract attention.

- The health care delivery system needs to reach out to a wider range of business leaders: local Chambers of Commerce, for example, or the National Association of Manufacturers.

- Reports about the ROI of tobacco-cessation services need to be published in Fortune and the *Harvard Business Review*, not just in medical journals.

- Small businesses buy their insurance through brokers so brokers need to understand the value of prevention–Providence Health System in Oregon targets a "Make it Your Business" campaign to brokers and small employers.

- New models of collaboration may help: if the need for an initial investment in tobacco-cessation services continues to be a barrier, perhaps related organizations would be willing to provide the start-up costs for a piece of the ultimate return.

- Physicians need to promote the value of tobacco-cessation services in their health plans and communities.

- Consumers need to demand these services.

- Ex-smokers who used tobacco cessation products and services to quit smoking need to come forward and testify to their value and to the benefits of a smoke-free life.

The Lessons from Tobacco that Can Be Applied to Obesity

Health care in America is still driven by a medical model that focuses on the diagnosis and treatment of disease rather than on its prevention. Tobacco use is a behavior, and one of the difficulties in integrating services for tobacco-use cessation treatment into basic health care is because it is seen primarily as a behavioral risk for chronic disease rather than as a chronic addictive condition in its own right. Preventive health behavior change interventions are, in addition, among the hardest to integrate into routine health care due to the lack of provider training, systems supports and reimbursement for effective health behavior change counseling. Finally, people seeking to change their health behaviors need supportive community environments.

The same conditions apply to obesity. The treatment of obesity currently primarily involves individuals and individual providers grappling with clinical interventions (screening, counseling, drugs and surgery) unable–on their own–to produce lasting behavior change. The past two decades of progress in tobacco control have shown that obesity control will require medical interventions, reinforced by health care system supports and combined with broad policy and environmental changes that contribute to healthy eating and activity patterns.

Panelists Steven Woolf, M.D., M.P.H., of the department of Family Medicine at Virginia Commonwealth University, Lisa Latts, M.D., M.B.A., of WellPoint (and an ATMC investigator), Beverly Green, M.D. M.P.H., of the Group Health Cooperative, and RWJF's Orleans explored these and other similarities between screening for and treating obesity and tobacco use.

- Effective treatments for each, for example, include both behavior change and medication.

- Effective treatment extends beyond the primary care physician's office to other treatment settings, modalities (the University of Kentucky Medical Center uses telephone counseling, so effective in tobacco-use treatment, in its treatment of obesity) and providers.

- Panelist Beverly Green reminded the meeting that "Tobacco as a Vital Sign" was an effective strategy to engage providers in tobacco cessation, and the same approach (i.e., "Body Mass Index as a Vital Sign") could be applied to obesity.

Interestingly, health plan system supports now in place for the treatment of tobacco use have yet to be either harnessed or expanded to also address obesity. Physicians, moreover, generally do not believe that any intervention they can make will be effective in getting their patients to lose weight, although, as one participant noted, that was exactly the situation with tobacco 20 years ago. Research to identify obesity treatments that work is greatly needed, as is the

translation of this evidence into practice. Some participants suggested that this research may show small actions to be effective, but until the research and the results exist, what Isham characterized as "physician nihilism" will persist.

This lack of evidence also limits the health care delivery system's ability to assess the potential ROI of obesity treatment. An ROI calculation requires the costs of the condition–obesity–to be arrayed against the costs and benefits of what Jeffrey Fellows calls "credible interventions" to determine the true return.

As with tobacco, environment plays an important role in obesity, one that needs to be better understood.

- Is there an industry or business promoting obesity in the same way tobacco companies promote smoking and other tobacco use?
- If so, what strategies does it use and how can these be countered?
- How can industry be involved in finding solutions?
- What about attitudes towards obesity? Can these be changed as attitudes towards smoking have been changed?
- What kinds of policy and environmental changes (e.g., changes that promote physical activity or improve access to healthy foods) will prove most effective in preventing or reversing the nation's rising obesity levels?

While individuals may seek treatment for obesity, as a society, observed Steven Foldes, we have successfully marginalized physical activity in our daily lives, through the design of suburbs and automobile use. Convenience and fast foods have shaped our attitudes towards eating. For tobacco, changing these attitudes was recognized as essential. As a result, smoke-free public spaces have become the social norm. The challenge ahead is to change the social norms around eating and physical activity.

Finally, looking at the two conditions together led participants to question the health care delivery system's ability to act truly as an integrated system among and across behavioral issues of all types. Participants feared a situation where obesity treatment and tobacco use cessation would compete for a small pool of funds earmarked for "wellness." As Steven Woolf put it, "health behaviors and risk factors come in packages of people," and these people must be helped by coordinated and systemic treatments and other solutions. Orleans agreed, emphasizing the need for innovative interventions that will help patients and providers address multiple behavioral risks, urging that it should not be a matter of addressing "tobacco *or* obesity" but "tobacco *and* obesity."

What To Do Next?

Isham concluded the meeting by asking each participant to write down one or two specific actions that, based on the day's discussion, he or she would recommend. The participants responded with a total of 61 ideas (Attachment 2), ranging from the concrete and simple (posting the materials from this meeting on a Web site) to the abstract and complex (developing new models for the better integration of all levels of health care). The ideas fall into nine categories:

1. Disseminate and fully institutionalize ATMC results.
2. Place tobacco-use cessation in a broader context: Expand practice-based research into health behavior change.
3. Create a broader behavior-change model and approach (focus on integration of services and systems and on health plan–community linkages).
4. Work to increase the demand for tobacco-use cessation and other health behavior change services among policymakers and consumers.
5. Change the structure and/or role of the insurance system.
6. Explore further the application to obesity of what has been learned about tobacco-use cessation.
7. Take specific actions to address obesity.
8. Raise the visibility of the health impact of obesity.
9. Create new consortia linking researchers, practitioners, health plans and policy makers to preserve and build on the progress made through ATMC.

Like the ideas they contain, these categories move from the specific–fully sharing the ATMC work that has already been done–to the abstract–the creation of new methods of working together and communicating about strategies for preserving and enhancing the dramatic progress made in integrating tobacco-use screening and treatment into routine health care; and building on this progress to better address and treat other health behaviors critical to the prevention and management of chronic disease.

After hearing all the ideas presented, AHIP's Bocchino stressed the need for new methods of "rapid-cycle" research, to bring much-needed proven knowledge to a fast-changing marketplace. Orleans concluded by echoing Isham's comments about the value of the unique forum ATMC has created for addressing tobacco as part of the nation's ongoing health care quality improvement efforts.

Summary

The health insurance marketplace is moving to a model that expects cost savings and improved outcomes to result from greater consumer choice. However, these outcomes–especially those connected to tobacco–use cessation treatments–will require better methods of informing consumers about their choices than currently exist, and better understanding of how to use incentives to promote tobacco-use cessation, and the application of effective treatments and services, than the health care system currently possesses.

While good models exist for calculating the return on investment (ROI) of health plan tobacco-cessation interventions, and while these models demonstrate a clear financial benefit, they exist in a crowded environment and will need additional support–political story-telling, provider and consumer involvement, concerted information sharing–to drive further adoption of effective, evidence-based tobacco use cessation strategies.

Efforts to apply the lessons learned about successfully preventing and treating tobacco dependence to the prevention and treatment of obesity must begin with

developing evidence of what works for obesity prevention and intervention. Work also must be done to build support among the public for environmental changes that may control obesity. Ultimately, the lessons from tobacco control must inform an effort to address the combinations of often-related health behaviors exhibited by complex human beings.

Potential next steps are varied and range from the specific to the abstract. Underlying all these possible actions are several needs.

1. The health care delivery system needs to build new knowledge through effective and expeditious research to answer the questions of policy makers, health plan decision-makers, providers and consumers.

2. The system needs to communicate these findings more effectively and creatively.

3. Achieving these aims will require creating and sustaining active collaboration among practitioners, researchers, policy-makers and funders throughout the health care delivery system.

Attachment 1

Addressing Tobacco in Managed Care: The Path Ahead
September 23, 2005 Meeting Participants

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Attachment 2

Suggestions for Next Steps, from *Addressing Tobacco In Managed Care: The Path Ahead*, September 23, 2005[2]

Disseminate and Fully Institutionalize ATMC Results

1. Need to go from ATMC research findings to institutionalization of the lessons learned (best practices) across Health Care/Insurer systems
2. Close the loop and promote the successes made so that everyone sees/understands that the desired/new state-of-being excludes tobacco.
3. Keep on truckin' on tobacco.
4. Include stepped care treatments so that smokers who can't quit with brief or self-help treatments can get to more intensive, specialized treatment with experts in addiction and comorbidity.
5. Get every ATMC member health plan to support California's cessation model.
6. Link, through shared efforts and costs-benefits, comprehensive community, clinical, and individual efforts to normalize access, prevention and utilization of cessation services.
7. Post Tab 3 talking points on pertinent Web sites immediately.

Place Tobacco in a Broader Context: Expand Practice-Based Tobacco Research into Health Behavior Change

8. Provide research opportunities that will explore ways that physicians, health care systems, health care plans and employers can, individually and collectively, motivate patients to actively pursue multiple-behavior modification interventions.
9. Research–focus on rapid-cycle using time-series etc. that only get funded if RE-AIM model considered [drive to Ask, Advise, Refer][3].
10. Engage practice-based research networks to do the effectiveness research needed.

2 This attachment contains the verbatim text of the hand-written suggestions submitted by participants during the September 23 meeting. Minimal editing changes have been made to these suggestions.

3 **RE-AIM**: **R**each the target population, **E**fficacy or effectiveness, **A**doption by target settings or institutions, **I**mplementation–consistency of delivery of intervention, and **M**aintenance of intervention effects in individuals and populations over time

Create a Broader Behavior Change Model and Approach (Focus on Integration of Services and Systems and Health Plan-Community Linkages)

11. Convene brokers/employers/payers as a consortium to understand what they need to pay for behavior change interventions and what they now pay for ineffective services.

12. Creating a behavior change model.

13. Mobilization of Health Care/Insurance sectors to support community and policy interventions (both tobacco and obesity) that support individual behavior change.

14. Convene a working group to map out a comprehensive, integrated community. approach to promoting behavior change and create a business presentation on how its potential impact on health care costs, business productivity and the economy would be worthy of investment by health plans and employers.

15. Create forum for linking efforts that are forging collaborations between primary care delivery and community efforts–behavioral change.

16. Work with downstream and upstream stakeholders to change social norms around valuing prevention, promoting and providing evidence-based services and protecting individuals from engaging in risk behaviors–specifically in the 16–24 year old populations–and addressing cross-sections of multiple risk behaviors.

17. Form a trans-disciplinary team of scientists, stakeholders, and members of the public to redesign, transform and integrate delivery of health care that aligns policy, systems of care, providers and patients around primary prevention through changing multiple risk behaviors (smoking, obesity, alcohol, physical activity, stress-coping management) responsible for 50 percent of chronic disease combining information technology, total quality management, behavioral science and business-biomedical.

18. Increased demand for pharmacological and behavioral therapies among consumers/providers/researchers and policymakers.

19. Creating an integrative theme that ties together multiple behavioral risks and focuses on well-being.

20. Person-oriented health behavior measures for children and adolescents.

21. Further support research integration model (Quitline).

22. ROI for integration.

23. Weekend retreat/think tank to do what Larry suggested: brainstorm on redesign of health care system to better treat the whole person instead of one aspect at a time.

24. Figure out how to better integrate all levels of systems to improve cessation, obesity and chronic disease management/prevention ("Health IT to the rescue")–explore ways to leverage the National Health Information Network (NHIN). Develop a plan to use the NHIN to encourage (monitor, goal setting, reward and feedback–i.e. rapid cycle research) at all levels of the system.

25. Transform health care delivery and primary care to make collaborative care and doctor patient relationship.

26. Fuel redesign of primary care with linkage to public health and mental health.

27. Invent sufficient blended payments for primary care that encourage teamwork and asynchronous care.

28. Endorse/support Request for Applications: systems/information technology/ total quality management to multi electronic medical record under provider reimbursement.

Work to Increase the Demand for Tobacco-Use Cessation and Other Health Behavior Change Services Among Policymakers and Consumers

29. Next steps for progressing the discussion: Better market the solution. Find compelling spokesperson for the success of tobacco cessation (and obesity control/health behavior change) to highlight the importance, desire and success of behavior change interventions vs. magic bullet (i.e., Rx drugs = a fix). Ideas: successful quitters, Weight Losers, healthier kids, engaged docs. Give the public, academics, medical community and policymakers a "before" and "after" understanding of health behavior changes, societal norm changes.

30. Create political force and movement to realize success and change norms.

31. Developing a better understanding of how to influence decision-making and creating demand for wellness and prevention.

32. Work on public/consumer to further dialogue on all issues discussed. Identify/ generate national public opinion data on smoking and obesity and partner with media to implement multi-year, multi-component messaging that educates and taps into our "People Magazine"/"Celebrity Worship" culture in ways that are effective and more efficient than current practices–important to remember that the majority of people are non-smokers.

33. Policy–If there is a soda tax, money should go to help prevent and treat obesity, not general fund.

Change the Structure and/or Role of the Insurance System

34. Premium costs based on individual profiles, e.g., life insurance–my behavior determines my premium cost. Why not health insurance premiums?

35. If life insurance and car insurance is different than the health insurance industry, why does my state mandate car insurance and not health insurance (46.5 million Americans w/o insurance).

36. Work to make public policy advocacy for a healthy society a standard part of the responsibility of health plans, making the next step to a comprehensive approach to prevention. Background: Health plans naturally focus on working with their immediate constituents (employers, clinicians, their employees) on individual risk behaviors. In the policy arena, health plans have been largely defensive (e.g., guarding against mandates) and have been largely silent on tobacco control policy such as smoke-free public places and raising taxes on cigarettes.

Explore Further the Application to Obesity of What Has Been Learned About Tobacco

37. Obesity: collaborated effort to ID differences more thoroughly (obesity vs. tobacco) and analyze before moving to solutions.

38. Summarize what's known from tobacco control that can help obesity (Beverly's points) engaging individuals, physicians, health plans, employers, policymakers—what each actor needs to do.

39. Gather key leaders in tobacco control (research, policy, practice) to thoroughly assess the history and path of tobacco control progress and success, to generate in-depth insights into the theories behind, and the processes/ mechanisms involved in this success. Using this intro as a blueprint, derive implications and ideas for obesity (and other public health and healthcare improvement goals) by comparing the contextual factors, foundations, resources, problem attributes, etc., to devise a portfolio of strategies to succeed. And devise and launch a comprehensive collaborative campaign to implement those strategies.

40. AHIP, RWJ, CDC, NIH—all combine efforts and funding. Similar process to ATMC. Best practice promotion through awards; funding for evaluation; focus on health systems.

41. Summarize research on tobacco "lessons learned" for obesity.

42. Consolidate AGREE as the third A.

Take Specific Actions to Address Obesity

43. "Addressing Obesity in Managed Care"

44. Develop caloric balance tools and technologies to show progress in daily activities to initiate small successes (e.g., calorimeter vs. glucometer).

45. Develop SLOTH (Sleep, Leisure, Occupation, Transportation and Home-based activities) CDC model for obesity and exercise.

46. Tools/training for brief and appropriate physician interaction for behavior change as we did for tobacco.

47. Define and build consensus on the problem and goal through appropriate terminology (e.g. ? dependence), "obesity & sedentary lifestyle" and 10–15 percent weight loss.

48. Study link between addition/substitution of high fructose corn syrup and the obesity epidemic. ??? policy changes/legislation.

49. Obesity—not the problem. Energy balance: what we eat, physical activity.

Raise the Visibility of the Health Impact of Obesity

50. Find an effective way to use evidence about the health risks associated with obesity *and* stories to change the "phenomenon of the local" and perceptions of
    - individuals
    - health care providers
    - health plans
    - others

    about what is possible in terms of intervening to change obesity.

51. Go to the American Medical Association and get a Current Procedural Terminology (CPT) code for weight-reduction counseling.

52. Popularize 30 minute-exercise breaks with all major corporations.

53. Develop a national capacity (organized) to assess, evaluate and communicate major policy issues, advocacy and consumer education related to obesity–using the experiences of tobacco control to inform and guide the creation and startup of that task.

54. Soap opera: demonstrate success and failure with challenges of healthy lifestyle (Like "Desperate Housewives").

55. In healthcare–focus on normalizing addressing nutrition, physical activity and addressing obesity–create AAR (Ask, Advise and Refer).

Create New Consortia Linking Researchers, Practitioners, Health Plans and Policy Makers to Preserve and Build on Progress Made Through ATMC

56. Build a multidisciplinary group to create the next steps.

57. Build a viable bridge (in communication, decision-making and creative problem solving) between health care providers, patients and payers for a multiple risk strategy that can span the individual to group to community. (Research and Application) policy.

58. Conduct half-day forums (such as today) to discuss 1–2 specific issues that resulted from this conversation.

59. Healthy Lifestyles Network similar to Cancer Prevention Network (policy, community, healthcare, research).

60. Forge non-traditional partnerships with entertainment/media industry.

61. Convene a group of "Governor Huckabee" and "Al Roker" success stories to understand options and means to sustained weight loss.

Attachment 3

Relationship Among the "Next Step" Suggestions,
***Addressing Tobacco In Managed Care: The Path Ahead*,**
September 23, 2005