Tobacco Cessation Toolkit for Taft-Hartley Funds

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Since 2002, *WorkSHIFTS*, a collaborative labor outreach program of the Public Health Law Center, has partnered with union leaders and public health researchers to explore creative solutions for improving the health of unionized, blue-collar workers and their families. We are pleased to provide you with this *Tobacco Cessation Toolkit for Taft-Hartley Funds*, which we created in collaboration with the Minnesota Laborers, Unite Here, UFCW Local 1189, and the School of Public Health at the University of Minnesota, in response to requests from fund administrators, consultants and attorneys for reliable, user-friendly information about best practices for providing and promoting cessation benefits.

Despite considerable preventive efforts made during the last two decades, tobacco use remains the leading cause of preventable death in the United States. Among all U.S. adults, approximately 19.6% smoke. The burden of tobacco use on blue-collar workers and families, in particular, is unacceptably high. At present, those who work in the building trades and in food service and accommodations have the highest prevalence rates of smoking among *all* occupations—about 30%.

Between 2008 and 2011, we conducted educational outreach to Taft-Hartley Health and Welfare Fund administrators, consultants and attorneys, highlighting the need for funds to provide comprehensive tobacco cessation services and promote the use of the benefit by fund participants. In doing so, we emphasized the disproportionate impact that tobacco use has on blue-collar workers and demonstrated ways that funds could improve cessation services offered under health plans and promote the use of the benefit. Under the Patient Protection and Affordable Care Act, funds are now required to provide tobacco cessation services as part of standard health plans; however, the scope of cessation services offered varies considerably among funds and fund participants' use of the benefit is very low.

The *Toolkit* provides a succinct set of fact sheets on the health and economic effects of tobacco use, key elements of a comprehensive tobacco cessation benefit, and proven strategies for promoting use of cessation services. Each fact sheet can be tailored to meet the needs of individual funds. You can download the entire toolkit or an individual fact sheet by going to www.workshifts.org. We hope you will find it useful, and we encourage you to share it with your fellow Taft Hartley colleagues. As always, we welcome your questions or feedback and are always happy to hear from you.

Partnering for workers' health and wellness,

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Tobacco Cessation Toolkit for Taft-Hartley Health and Welfare Funds

Frequently Asked Questions

What is the purpose of the toolkit?
The *Tobacco Cessation Toolkit for Taft-Hartley Health and Welfare Funds* was created by WorkSHIFTS, in partnership with the Minnesota Laborers, Unite Here, UFCW Local 1189, and the School of Public Health at the University of Minnesota, in response to requests from Fund professionals for user-friendly information about tobacco use and tobacco cessation that they could tailor for use when addressing these issues in the funds with which they work.

Some of the fact sheets in the toolkit were included in *WorkSHIFTS'* newsletter series, *Cessation Benefits Focus,* and others have been updated from the *Union Guide to Tobacco,* published by *WorkSHIFTS* in 2004. The toolkit also includes several new fact sheets.

How can I use the toolkit?
The toolkit's accessible format allows you to quickly access pertinent facts related to tobacco use. You can use the fact sheets as stand-alone documents or in combination with some, or all, of the other fact sheets, depending on your needs. We encourage you to draw upon the facts and resources contained in the toolkit and to collaborate with your colleagues to seek ways to promote use of existing tobacco cessation benefits to support fund participants' success in quitting.

You can use the information in this toolkit to:

- Inform others about the health and economic harms of tobacco use and secondhand smoke
- Engage fund stakeholders in discussions about tobacco cessation and related wellness benefits
- Develop and implement cost-savings measures to improve the health of fund participants and preserve the financial well-being of funds
- Identify and implement tobacco cessation promotional opportunities
- Work with a fund's health plan provider to develop a tobacco cessation program that meets the needs of fund participants

How is the toolkit organized?
The toolkit is divided into eight sections. Each section contains fact sheets that capture key facts about tobacco use and cessation as they pertain to blue-collar workers and Taft-Hartley Funds.

Section 1. When it comes to smoking, are there disparities among occupational groups or industries?

- Smoking prevalence by industry and occupation group
- Blue-collar workers and tobacco

Section 2. How harmful is smoking to health?

- Smoking and health
- Diseases and conditions related to smoking
- Reproductive health, pregnancy and smoking
- Secondhand smoke

Section 3. Are smokeless and other tobacco products harmful?

- Smokeless tobacco and other tobacco products
- Electronic cigarettes

Section 4. What is the value of prevention and quitting?

- Costs related to tobacco use and tobacco cessation benefits

Section 5. What strategies are effective for quitting smoking?

- Nicotine dependence, relapse and quitting smoking
- An overview of tobacco cessation medications
- An overview of tobacco cessation counseling

Section 6. What can Taft-Hartley Health and Welfare Funds do to improve the ability of workers, retirees and dependents to quit successfully?

- Cessation benefit analysis
- Benefit promotion tool #1: Creating effective health messages
- Benefit promotion tool #2: Behavioral principles underlying effective cessation messages
- Benefit promotion tool #3: Example of a 6- or 12-month promotional campaign
- Benefit promotion tool #4: Checklist for monitoring a plan for a promotional campaign
- Best practices for wellness programs
- Evaluating a fund's wellness program

Section 7. What is the role of health reform in tobacco cessation, disease prevention and health promotion?

- Selected Provisions of the Patient Protection and Affordable Care Act

Section 8. How can I learn more?

- Selected resources

We hope you will find the materials presented in this *Tobacco Cessation Toolkit for Taft-Hartley Health and Welfare Funds* useful. Please check our website periodically—www.workshifts.org—for updates to the toolkit and links to additional information and resources on tobacco use and cessation. We look forward to continuing to work with you to improve worker's health and welcome your inquiries.

To learn more about smoking cessation, visit www.workshifts.org.

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Section 1

When it comes to smoking, are there disparities among occupational groups or industries?

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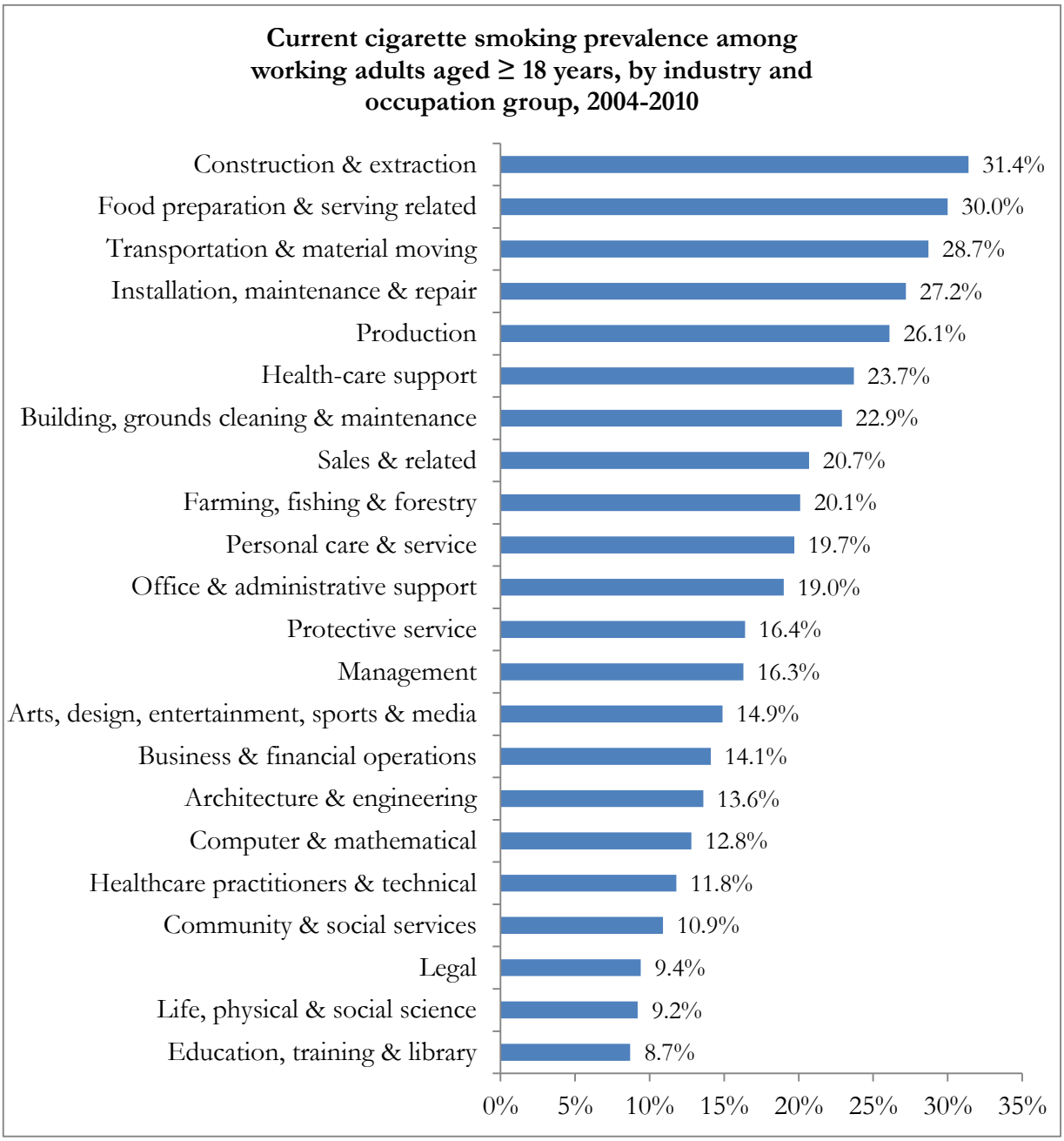
Smoking Prevalence by Industry and Occupation Group



Notes: (1) To increase reliability of measures, data was combined from surveys taken from 2004 - 2010.
(2) Data is age-adjusted to the 2000 U.S. standard population.

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Blue-Collar Workers and Tobacco

Smoking Prevalence

- Sixty percent of workers in Minnesota are blue-collar workers, according to 2008-2009 data.[1]
- In 2010, 16.1% of workers in Minnesota (about 397,000 persons) were represented by a union.[2]
- The rate of smoking is higher among blue-collar workers than white-collar workers.[3] One-third of blue-collar and service workers are smokers, whereas one-fifth of white-collar workers are smokers.[4]
- Compared to an overall rate of 19.6% for working adults 18 years of age or older, smoking rates in some occupational categories are significantly higher:
    - 31.4% of workers in construction and extraction
    - 30% of hospitality workers in food preparation and service
    - 28.7% of workers in transportation and material moving
    - 26.1% of workers in the production industry[3]
- Blue-collar workers are less likely to have smoke-free workplace policies compared to white-collar workers.[5]
- There is no safe level of exposure to secondhand smoke, and despite increased clean indoor air laws, blue-collar and service workers continue to have higher levels of cotinine, a component of tobacco smoke found in blood plasma, than workers in other occupations.[6]

Tobacco Marketing

- Historically, the tobacco industry has identified the working class as a critical market, using advertisements that depict a rugged, self-reliant, independent man with blue-collar/working class ethos.[7]

Tobacco-Related Health Risks

- Blue-collar workers are not only more likely to smoke, they are also more likely to be exposed to occupational hazards that interact with tobacco, multiplying negative health effects.[4]
- The interaction between tobacco smoke and occupational toxins can increase the risk of lung cancer for blue-collar workers by up to 53 times compared to individuals who do not smoke and are not exposed to occupational toxins.[8]
- The interaction between tobacco smoke and occupational exposures increases the risk for chronic obstructive pulmonary disease among blue-collar workers.[9]

Quit Smoking

- Although blue-collar and white-collar workers attempt to quit smoking at the same rate, blue-collar and service workers are less likely to quit successfully.[4, 10]
- White-collar workers are more likely than other workers to have quitting assistance available to them through their employers.[11]

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Section 2

How harmful is smoking to health?

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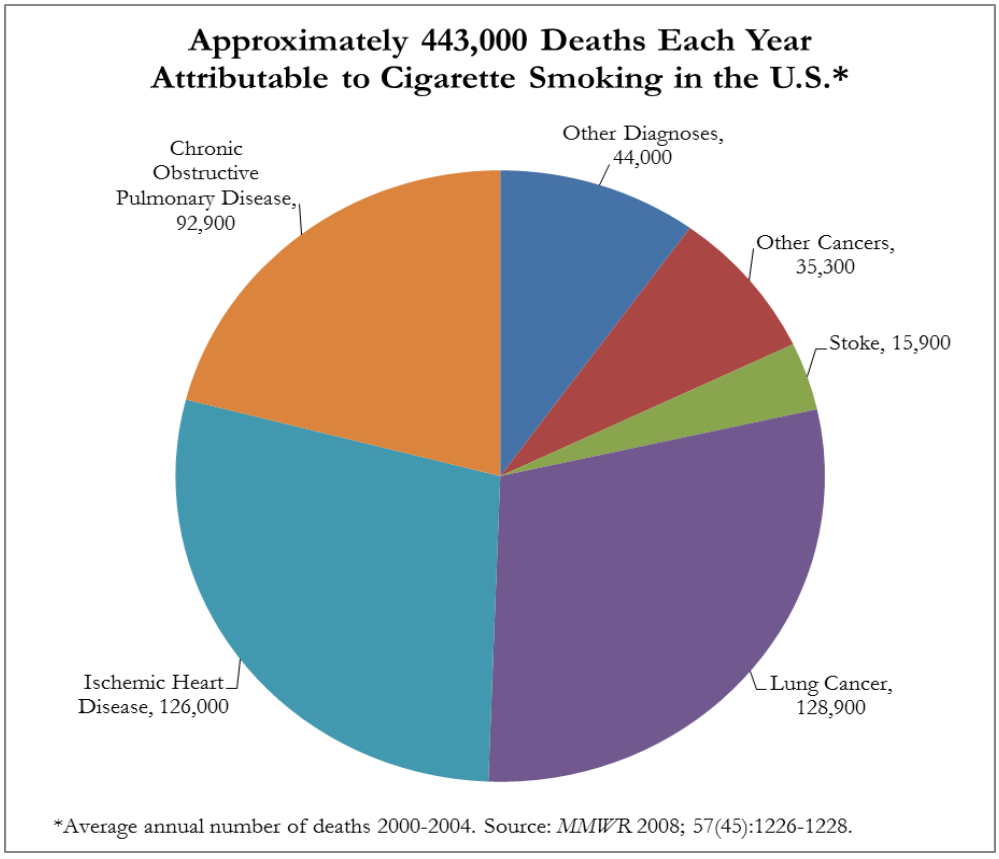
Smoking and Health

When it comes to health, tobacco use matters. Despite declining rates over time, smoking continues to be the leading cause of preventable death, disability, and disease in the United States. More specifically:

- Smoking causes one-fifth of all deaths—approximately 443,000 deaths each year.[1]
- Smoking kills more people every year than deaths from poor diet and physical inactivity, alcohol consumption, car crashes, gun-related violence, and illicit drug use combined.[2]
- Smoking shortens the lifespan—adults who smoke die approximately 13-14 years earlier than nonsmokers.[3]
- Smoking decreases quality of life by increasing the risk of chronic disease.Just three chronic diseases—heart disease, cancer and stroke—account for more than 50% of annual deaths, and all three are closely associated with tobacco use.[4] Chronic diseases afflict nearly half of all U.S. adults and account for 70 percent of deaths and more than 75 percent of the nation's health care expenditures. [4, 5, 6]
- Tobacco use also has a significant a financial burden. It is estimated that smoking incurs $193 billion each year in health care costs and lost productivity.[1]



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Diseases and Conditions Related to Smoking

Cancer

- In 2007, cancer was the 2nd leading cause of death in the U.S., after coronary heart disease.[1]
- Smoking causes: bladder cancer; bone marrow and blood cancer; cervical cancer; esophageal cancer; kidney cancer; laryngeal cancer; lung cancer; oral cancers; pancreatic cancer; stomach cancer; and throat cancers.[2]
- In the U.S., one-third of deaths from cancer could be prevented if no one smoked.[2]
- The greater the number of cigarettes and the greater the number of years a person smokes, the greater the risk for cancers caused by smoking. In most cases, the risk for cancer decreases after quitting completely.[3]
- Cigarette smoking causes most cases of lung cancer. Approximately 90% of all lung cancer deaths among men and almost 80% among women are caused by smoking.[3]
- Compared to nonsmokers, men who smoke are about 23 times more likely to develop lung cancer and women who smoke are about 13 times more likely to develop lung cancer.[3]

Respiratory Diseases

- Smoking causes chronic obstructive pulmonary disease (COPD), including emphysema and bronchitis.[4] COPD inflicts about 10 million people in the U.S.[3]
- COPD is one of the ten most common chronic health conditions in the U.S. and one of the ten most common conditions that limit daily activities.[3]
- Upper and lower respiratory tract infections are more common among smokers than non-smokers.[3]
- Approximately 90% of deaths from COPD are related to smoking.[3]
- Female smokers are nearly 13 times as likely and male smokers are nearly 12 times as likely to die from COPD as their nonsmoking counterparts.[3]

Cardiovascular Diseases

- Smoking causes coronary heart disease (a narrowing of the blood vessels that supply the heart with blood and oxygen), which is the leading cause of death in the U.S. among both men and women.[3] More than 1 in 4 deaths is from heart disease.[5]
- Smoking can cause aneurysms, or bulging blood vessels that burst, which can lead to death.[4]
- Compared to non-smokers, smokers have an increased risk of developing peripheral vascular disease (a narrowing and hardening of the arteries that provide blood to the legs and feet).[6]
- Exposure to secondhand smoke can cause cardiovascular disease in non-smokers.[4, 6]
- Smoking cigarettes doubles a person's risk for stroke. A person's risk for stroke decreases steadily after quitting smoking.[4]
- Strokes are the third leading cause of death in the U.S., causing about 1 in 17 deaths, about 800,000 cases per year.[7]

Oral Diseases

- Smoking is a cause of periodontitis, a serious gum disease that can lead to the loss of teeth and bones.[3]

Impaired Vision

- Compared to nonsmokers, smokers in the U.S. have 2-3 times the risk for developing cataracts, the leading cause of blindness.[8]

Bone Mass and Fractures

- Smoking decreases bone mass among postmenopausal women.[8]
- Smoking increases the risk for hip fractures among men and women.[8]
- Every year in the U.S., over 300,000 seniors over the age of 65 suffer hip fractures. The estimated costs associated with hip fractures range is $7 billion to $10 billion per year.[3]

Diabetes

- Smoking increases the risk of having type 2 diabetes.[4]
- Smokers with diabetes have a more difficult time controlling their blood sugar levels than nonsmokers with diabetes.[4]
- Diabetic smokers increase their risk of complications, such as: kidney and heart disease, amputation, retinopathy (eye disease that causes blindness) and peripheral neuropathy (nerve damage).[4]

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Reproductive Health, Pregnancy and Smoking

Smoking Before Pregnancy

Smoking has a negative impact on both women's and men's reproductive health:

- Women who smoke before pregnancy have a 30% higher chance of being infertile.[1]
- The risk for delayed conception is twice as high among women who smoke compared to women who don't smoke.[1]
- Smoking may be associated with erectile dysfunction among men.[2]
- Smoking may harm men's sperm, leading to birth defects, decreased fertility or miscarriage.[3]

Smoking During Pregnancy

- Smoking during pregnancy increases the risk of pregnancy complications, miscarriage, stillbirth, Sudden Infant Death Syndrome (SIDS), low birth weight babies and premature delivery.[3, 4]
    - The risk of dying from SIDS is 1.4 to 3 times greater among babies born to women who smoked during pregnancy.[1]
    - Babies born to women who smoked during pregnancy weigh an average of 200 grams less than babies born to women who did not smoke.[1]
    - The risk of being born prematurely is increased by 30% among babies born to women who smoked during pregnancy.[1]
- Smoking during pregnancy negatively affects infants' lung development.[5]
- Women who smoke during pregnancy are more likely to experience placenta previa (when the placenta grows too close to the womb's opening) and placental abruption (when the placenta separates from the wall of the womb too early). Both conditions cause pregnancy complications and can negatively affect the baby's health.[5]
- The risk of giving birth to an infant with congenital heart defects is greater among women who smoked during the month before pregnancy to the end of the first trimester compared to women who did not smoke during this period.[6]

Secondhand Smoke & Pregnancy

- The odds of giving birth to a low birth weight baby are 20% higher among pregnant women who are exposed to secondhand smoke compared to pregnant women who are not exposed to secondhand smoke.[1]
- Babies who are exposed to secondhand smoke have a higher risk of dying from SIDS.[7]
- Babies and children exposed to secondhand smoke suffer higher rates of ear infections, bronchitis and pneumonia. [3]

Health Care Costs Related to Smoking & Pregnancy

- In the United States, neontal health care costs attributable to maternal smoking are approximately $366 million per year, or $704 per maternal smoker.[8]
- In Minnesota in 2007, smoking-attributable neonatal health care costs were $4 million.[9]
- Helping pregnant women quit smoking is one of the best cost-saving preventive services available:
    - Up to $6 saved per $1 invested in a prenatal tobacco cessation program[10]
    - $4,000 saved per low birth weight baby prevented[11]
    - $63,000 per perinatal death prevented [11]
    - $210,000 per Sudden Infant Death Syndrome (SIDS) case prevented[12]

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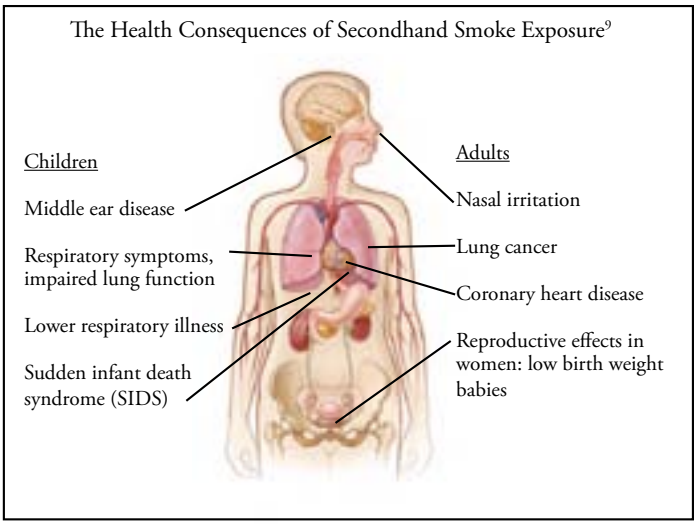
Secondhand Smoke

Who is Exposed to Secondhand Smoke?

- Despite progress that is eliminating tobacco use in public spaces, millions of people remain exposed to secondhand smoke.[1]
- Blue-collar and service workers are less likely to be covered by workplace smoking restrictions than white collar workers.[2]
- Exposure to secondhand smoke is more prevalent among children.[1] Ninety percent of children's secondhand smoke exposure is attributed to parents.[3]



What is Secondhand Smoke?

- Secondhand smoke consists of the smoke that is released from the burning end of a cigarette (sidestream smoke) and the smoke that is exhaled by a smoker (mainstream smoke).[4]
- Secondhand smoke is a human lung carcinogen.[4, 5] It contains at least 250 cancer-causing chemicals, including: benzene, arsenic, beryllium, chromium, cadmium, ethylene oxide and nickel compounds.[4, 6]
- Secondhand smoke contains various toxic chemicals and gases, including hydrogen cyanide (used in chemical weapons), carbon monoxide (found in car exhaust), butane (used in lighter fluid), ammonia (used in household cleaners) and toluene (found in paint thinners).[4]

Health Risks

- Secondhand smoke causes premature death and disease in nonsmokers.[4]
- Exposure to secondhand smoke even for a short period of time has immediate consequences for the cardiovascular system and can trigger a heart attack.[4]
- Nonsmokers' risk of heart disease increases 25-30% when exposed to secondhand smoke at work or home.[4]
- In the U.S., exposure to secondhand smoke causes approximately 3,400 lung cancer deaths among adult nonsmokers each year.[7]
- Nonsmokers' risk of lung cancer increases 20-30% when exposed to secondhand smoke at work or home.[4]

Health Risks Among Children

- Secondhand smoke is associated with Sudden Infant Death Syndrome (SIDS) and low birth weight babies.[8]
- Because their lungs are not fully developed, young children are particularly susceptible to the damaging effects of secondhand smoke.[8]
- In children, secondhand smoke causes respiratory symptoms and infections, including wheeze, breathlessness, cough and phlegm.[8]
- Children with asthma who are exposed to secondhand smoke are more likely to suffer from more severe and frequent asthma attacks.[4]
- Children who are routinely exposed to secondhand smoke are more likely to suffer from middle ear infections and require ear tubes for drainage.[4]

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Section 3

Are smokeless and other tobacco products harmful?

Smokeless Tobacco and Other Tobacco Products

What is Smokeless Tobacco?

Long cut snuff[5]

- Smokeless tobacco is a term used to describe tobacco that is not burned.[1]
- Smokeless tobacco comes in various forms, but the two basic forms are snuff and chewing tobacco:[2, 3, 4]
  - Snuff is a finely cut or powdered tobacco. It is available in moist or dry forms. Moist snuff is placed between the gums and cheek or behind the upper or lower lip and does not need to be spit. Moist snuff is often packaged as a sachet or teabag-like pouch. Dried snuff is available as a powdered form and can be inhaled through the nose.
  - Chewing tobacco is usually packaged as loose leaves, plugs, or twists. It is placed between the cheek and gum/teeth and is meant to be spit.
- Other forms of smokeless tobacco products include lozenges (i.e. Ariva, Stonewall), pellets (Camel Orbs), sticks (Camel Sticks), and film strips (Camel Strips).
- Smokeless tobacco products contain nicotine and are addictive.[6]
- There is no scientific evidence that supports the use of smokeless tobacco as a strategy to help smokers quit.[7]

Dissolvable smokeless tobacco products

Smokeless Tobacco Users

- There are more than 1 million new smokeless tobacco users every year.[8]
- Men, young adults between the ages of 18-24, and individuals without a high school education are most at risk for using smokeless tobacco products. [9]
- The percentage of adults in Minnesota using smokeless tobacco products increased from 3.1% to 4.3% between 2007 and 2010.[10]
- Compared to all adults in Minnesota, current smokers are more likely to use smokeless tobacco products. The prevalence of individuals who use both cigarettes and smokeless tobacco products, also known as dual use, was 9.6% in 2010.[9]

Health Effects

- Smokeless tobacco is not safer than smoking cigarettes.[1, 11]
- The nicotine absorbed from smokeless tobacco stays in the user's bloodstream longer than the nicotine absorbed from a cigarette.[1]
- There are 28-cancer causing agents found in chewing tobacco and snuff.[1]
- Smokeless tobacco users have an 80% increased risk for oral cancer and a 60% increased risk for pancreatic and esophageal cancer.[13]
- Smokeless tobacco and other tobacco products are associated with negative health outcomes, including: cancer of the mouth, tongue, throat, esophagus, stomach and pancreas; Leukoplakia (oral lesions that can become cancer); tooth loss; receding gums and gum disease; abrasion of teeth, bone loss around the roots of the teeth; and increased risk of heart disease, heart attacks and stroke.[1, 11]

A Market for Smokeless Tobacco[11, 12]

Tobacco companies have responded to smoke-free laws by marketing and selling smokeless tobacco products. In 2006, approximately $354 billion was spent on advertising and marketing.

Use of smokeless tobacco enables smokers to get their nicotine fix in places where they are not able to smoke.

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Electronic Cigarettes

What is an Electronic Cigarette?

- Electronic cigarettes are battery-powered devices made of stainless steel that vaporize liquid nicotine or other contents in varying concentrations.[1]
- They are often designed to resemble a cigarette, cigar, or pipe.[2]
- Electronic cigarettes do not contain tobacco or emit smoke.[1, 3]
- Electronic cigarettes usually contain anywhere between 0 - 18 milligrams of nicotine.[4]
- An FDA analysis found that many of the electronic cigarette cartridges labeled nicotine-free contained small amounts of nicotine.[5]
- The cartridges in electronic cigarettes are available in an assortment of flavors, including bubblegum, mint and chocolate.[2]
- Electronic cigarettes have both carcinogens and toxic chemicals, such as diethylene glycol (ingredient in antifreeze).[5]

*American Legacy Foundation. Electronic Cigarettes ("E-Cigarettes").2009.

Who Uses Electronic Cigarettes?

- In 2010, current smokers in Minnesota were approximately 5 times more likely than non-smokers to use electronic cigarettes. Approximately 3.6% of current smokers compared to 0.7% of the general population use electronic cigarettes.[6]
- Use of electronic cigarettes decreases with age, with the highest prevalence rate among 18-24 year olds.[6]
- Among current smokers, females are more likely than males to use electronic cigarettes.[6]

Marketing & Regulation of Electronic Cigarettes

- Electronic cigarettes are marketed by manufacturers as a device to help smokers quit smoking.[1]
- Smoke-free laws have helped electronic cigarette manufactures to market the device as an alternative for smokers to get their nicotine fix in places where smoking is banned.[2]
- Importing electronic cigarettes into the U.S. is currently banned due to safety concerns and the regulatory status.[2]
- Electronic cigarettes are not regulated by the Food and Drug Administration as a smoking cessation aid.[3]
- There is no evidence that electronic cigarettes are a safe and effective strategy to help smokers quit.[1]

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Section 4

What is the value of prevention and quitting?

Costs Related to Tobacco Use and Tobacco Cessation Benefits

Cost of Tobacco in Minnesota

- In Minnesota, smoking-attributable health care expenditures cost $2.87 billion in 2007.[1]
- Smoking-attributable productivity losses related to cancer, cardiovascular disease and respiratory diseases cost $1.3 billion in Minnesota in 2004.[2]

The Cost of Prevention

- Tobacco use screening and intervention has consistently received the highest ranking for improved health outcomes and is more cost-effective than commonly offered preventive services including colonoscopies, screening for hypertension, mammograms, pap smears, and cholesterol screening and treatment.[3]
- Tobacco use screening and intervention is one of three clinical preventive services that is a proven cost-saving measure.[3]
- Tobacco cessation treatment for pregnant women is one of the most cost-effective preventive services available.[4]

Why Quitting is Important to Cost Savings

- Cost analyses demonstrate that cessation benefits are cost-saving for employers and highly cost-effective for health plans.[5, 6]
- For every former smoker who does not relapse, the lifetime savings of tobacco-related health expenses is approximately $22,434.[7]
- Comparing the cost of offering a cessation program with the business savings gained from each smoker who successfully quits, there is a net savings of $542 per smoker.[7]

Calculating Return on Investment

- To estimate a business' return on investment for various tobacco cessation benefits, visit the online ROI calculator at www.businesscaseroi.org.

Cost of a Tobacco Cessation Benefit

- The average cost in dollars per-member-per-month (PMPM) of a cessation benefit depends on several factors: the types of treatments covered, cost sharing provisions, and benefit use rates.[8]
- The estimated cost of a cessation benefit can range from $.02 PMPM for minimal benefits, which only cover telephone-based counseling, to $.45 PMPM for benefits, which cover prescription and over-the-counter medications, as well as individual counseling sessions.[9]
- A comprehensive, effective cessation benefit generally cost less than $.50 PMPM.[9, 10, 11]
- Full coverage of tobacco cessation benefits is associated with increased quit attempts and utilization of pharmacotherapy treatments.[12]

Savings to the Health Plan During the First Year Per Smoker Who Quits*

Health Consequences of Smoking	Estimated Savings
Coronary Heart Disease & Stroke	$153
Adult Pneumonia	$3
Low Birth Weight Babies	$9
Childhood Asthma	$14
Other Childhood Respiratory Conditions	$8
Childhood Ear Infections	$5
Total Savings	$192

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Section 5

What strategies are effective for quitting smoking?

A Fact Sheet by WorkSHIFTS
October 2011

Nicotine Dependence, Relapse and Quitting Smoking

Nicotine Dependence

- Nicotine is highly addictive, similar to heroin, cocaine, and alcohol.[1]
- The most common form of chemical dependence in the U.S. is nicotine dependence.[2]
- 20.6% of adults in the United States are smokers—46.6 million people.[3]
- Over half of all living adults who have a history of smoking have successfully quit.[4]
- Smokers with anxiety diagnoses have higher levels of nicotine dependence and increased withdrawal symptoms after quitting.[5]
- People who are highly nicotine dependent smoke more than 20 cigarettes daily and smoke within the first half hour of waking up in the morning.[6]
- Research suggests that various factors may contribute to nicotine dependence, including psychosocial, biologic and genetic factors.[7]
- When smokers try to quit, they can experience withdrawal symptoms, including irritability, frustration, anger, anxiety, increased appetite, and difficulty concentrating.[8]
- Withdrawal symptoms peak within the first 1-2 days after quitting and gradually decline over time.[8]
- Many things trigger the need to smoke, including places, feelings, moods, or activities.[9]

Relapse

- Nicotine dependence is a chronic condition that usually requires repeated interventions.[6]
- On average, smokers make between 8-11 quit attempts before successfully quitting.[10]
- Most untreated smokers relapse within eight days after trying to quit:[11]
  - 24-51% are abstinent at one week
  - 15-28% are abstinent at one month
  - 10-20% are abstinent at 3 months
- Smokers, especially women, relapse because of a fear of weight gain.[6]

Quitting Smoking

- Most adult smokers, about 70%, want to quit smoking.[12]
- In 2010, 55% of smokers tried to quit for more than one day.[13]
- The chance of successfully quitting smoking increases with every attempt.[14]
- If a smoker's spouse or partner quits, they are five times more likely to quit.[15]
- At any given time, about 10% of smokers plan to quit within the next month, 30% think about quitting within the next six months, 30% think about quitting at some point, and 30% are not planning to quit.[16]
- One-third of all smokers who succeed in quitting use treatment to do so.[17]
- Combining smoking cessation medications and counseling significantly increases abstinence rates.[6]

Factors that make quitting smoking challenging:[6]

- High stress levels
- Living with other smokers
- Lack of knowledge regarding effective cessation treatments
- Lack of access to cessation treatments
- High nicotine dependence
- Having a diagnosed mental health condition

Key elements to successfully quitting smoking:[6]

- Motivation to quit
- Confidence in ability
- Readiness to quit
- Social support
- Support from healthcare providers1
- Supportive environment, including smoke-free homes and workplaces
- Access to and use of cessation treatments, including medications and counseling

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An Overview of Tobacco Cessation Medications

Medications are important and effective tools for increasing cessation success by relieving nicotine craving and withdrawal symptoms. Medical providers should encourage all tobacco users who are planning a quit attempt to use one or a combination of cessation medications, except when medically contraindicated. There are currently seven FDA-approved tobacco cessation medications available that increase long-term tobacco use quit rates. These treatments are listed in the chart below and are available either by prescription or over-the-counter (OTC).[1]

Name	Forms	Availability	Duration	Dosage	Cost[a]
Bupropion SR	Generic Zyban® Wellbutrin SR®	Prescription only	Start 1–2 weeks before the quit date. May be used for 2–6 months	150 mg tablet twice daily	1 box of 60 tablets, 150 mg = $97/mo (generic); $197–$210/mo (brand name)
Varenicline	Chantix®	Prescription only	Start 1 week before the quit date; use 3–6 months	1 mg twice daily after patient has stopped smoking	1 mg, box of 56 = $131 (about 30-day supply)
Nicotine gum	Nicorette Nicorette DS	OTC only	Up to 12 weeks or as needed	One piece every 1–2 hours; not to exceed 24 pieces daily	2 mg, 100–170 pieces = $48; 4 mg, 100–110 pieces = $63
Nicotine inhaler	Nicotrol inhaler	Prescription only	Up to 6 months; taper at the end	6–16 cartridges per day, tapering at end of treatment	1 box of 168, 10 mg cartridges = $196
Nicotine lozenges	Generic Commit	OTC only	3–6 months	At least 9 lozenges per day in first 6 weeks; not to exceed 20 lozenges daily	2 mg, 72 lozenges per box = $34; 4 mg, 72 lozenges per box = $39
Nicotine nasal spray	Nicotrol NS	Prescription only	3–6 months; taper at the end	Minimum dose = 8 doses daily; Maximum dose = 40 doses daily	$49 per bottle, approximately 100 doses
Nicotine patch	Nicoderm CQ Nicotrol	OTC or prescription	8–12 weeks	21 mg daily, first four weeks; 14 mg daily, next two weeks; 7 mg daily, next two weeks	Two-week supply: 7 mg box = $37 14 mg box = $47 21 mg box = $48

[a] Cost data excerpted from *Treating tobacco use and dependence: 2008 update*. Cost was estimated by averaging the retail price of medications at national chain pharmacies in several U.S. cities and online price listings in January 2008. **For nicotine replacement therapy products, the quantity used will determine how long the supply lasts and will vary by individual.**

Combination Medications

A number of combinations of medications are also effective in improving quitting success, and using two types of tobacco cessation medications simultaneously can improve quit rates when compared with one medication.[4, 5, 6, 7] Combination therapy or high-dose nicotine replacement therapy (NRT) may be suitable for those who are highly nicotine dependent or have a history of severe withdrawal symptoms.[1, 9] The following combination therapies are effective in increasing quit rates.[1, 2, 9, 10]

- Long-term nicotine patch + other NRT product (gum or spray)
- Nicotine patch + nicotine inhaler
- Nicotine patch + Bupropion SR

Treatment Options

It is important to provide plan participants with a wide range of treatment options, as success with particular methods varies among individuals. Smokers who are ready to quit should talk with their doctors to learn about possible treatment approaches so they can select the options most appropriate for them. Because the process of quitting usually involves several attempts, smokers may need to try several different types of cessation medications before achieving success. The combination of medications and counseling is more effective than the use of either method alone.[1]

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An Overview of Tobacco Cessation Counseling

An Overview of Tobacco Cessation Counseling

Individual and group counseling is a key strategy for providing support to individuals during their attempts to quit smoking. Counseling has been shown to improve the likelihood of achieving success, particularly when used in conjunction with cessation medications.[1] Counseling programs provide information and resources to help tobacco users develop a quit plan, address specific barriers to quitting, seek support for their efforts, and manage withdrawal symptoms and stress to prevent relapse. The most effective counseling is tailored to meet individual needs and preferences. Methods and intensity will vary based on the type and amount of support needed. [2]

The following counseling methods have been shown to be effective in improving quit rates.[1]

Telephone-based counseling (quit lines, call-back counseling)[1, 2]

- Connects individuals trying to quit with tobacco cessation counselors over the phone
- Offers flexibility and privacy
- Provides a convenient resource and is readily accessible at moments when smokers feel the need for support
- Provides personal support to keep individuals on track

Individual counseling[1, 2]

- Provides a series of in-person, individual counseling sessions with a trained tobacco cessation counselor
- Allows counseling to be tailored to address unique individual issues
- Offers reinforcement and continuing support

Group counseling[1, 2]

- Provides a series of in-person group counseling sessions among smokers trying to quit, led by a trained tobacco cessation counselor
- Has the advantage of involving interaction between participants that provides peer support, guidance and reinforcement

Key Elements of Counseling Treatment[1]

- Problem solving skills in the following areas: achieving total abstinence, reviewing previous quit attempt successes and failures, identifying and avoiding triggers, limiting/abstaining from alcohol, and encouraging housemates to quit
- Support and encouragement as part of treatment
- Professional guidance from trained, experienced counselors and clinicians

Additional Information

- The delivery of smoking cessation programs using more than one method of counseling is beneficial.[1, 3]
- Clinicians should provide multiple counseling sessions because there is a strong relationship between greater numbers of counseling sessions and improved cessation outcomes.[1, 3]
- Cessation rates improve as the length of counseling sessions increases. High intensity (more than 10 minutes) sessions result in higher quit rates than minimal intensity (less than 3 minutes) sessions.[4]
- Counseling can be provided by a variety of clinicians including, but not limited to, health educators, tobacco treatment specialists, physicians, nurse practitioners, and pharmacists.[1]
- The combination of counseling and medications has been found to be more effective for smoking cessation than the use of either method alone.[1]

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Section 6

What can Taft-Hartley Health and Welfare Funds do to improve the ability of workers, retirees and dependents to quit successfully?

Cessation Benefits Analysis

The Rationale for Building a Comprehensive Tobacco Cessation Benefit

Given the high costs of health care, why should Taft-Hartley funds provide a comprehensive tobacco cessation benefit? The answer is clear - evidence shows that tobacco use is associated with increased health care costs and decreased workplace productivity. Providing a comprehensive tobacco cessation benefit increases access to proven cessation treatment methods, thereby assisting smokers in their efforts to quit successfully. Because the process of quitting usually involves several attempts, smokers may need to try different types of cessation medications before achieving success. A comprehensive tobacco cessation benefit enables smokers to find the most appropriate treatment method to quit successfully, and is cost-effective for insurers and employers.

How to Build a Comprehensive Tobacco Cessation Benefit: Key Components

A comprehensive tobacco cessation benefit meets the following criteria:

1. Covers multiple evidence-based treatment options, including all FDA-approved tobacco cessation medications and counseling:

- Medications: Covers both prescription and over-the-counter medications. These products should be covered individually and in combinations as recommended by the U.S. Public Health Service's "Treating Tobacco Use and Dependence: A Clinical Practice Guideline." Currently, there are seven FDA-approved medications:
  - Nicotine gum
  - Nicotine patch[2]
  - Nicotine inhaler
  - Nicotine nasal pray
  - Nicotine lozenges
  - Bupropion SR
  - Varenicline
- Counseling: Covers at least four counseling sessions, approximately 15-30 minutes per session. Counseling sessions can include telephone, individual, and group counseling.

2. Eliminates or minimizes co-pays or deductibles associated with counseling sessions and tobacco cessation medications.
3. Provides both medication and counseling coverage for at least two courses of medication and counseling per year.
4. Does not put a lifetime or cost limit for tobacco cessation counseling and medication.
5. Does not require fund participants to participate in a formal counseling program as a precondition to accessing medication benefits, or vice versa.
6. Provides coverage for dependents.

The key components of a model benefit are consistent with the recommendations and conclusions of the following evidence-based reviews for tobacco use treatment: Treating Tobacco Use and Dependence: A Clinical Practice Guideline, U.S. Department of Health and Human Services. Public Health Service. June 2008; The U.S. Preventive Services Task Force; The World Health Organization/Society for Research on Nicotine and Tobacco Use Treatment; The Cochrane Collaboration; The U.S. Center for Disease Control and Prevention's Community Preventive Services Task Force; National Action Plan for Tobacco Cessation.

[1] Evidence-based refers to recommendations which are consistent with the 2008 U.S. Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence.

[2] Nicotine patch is available in over-the-counter or prescription form.

Tobacco Cessation Benefit Components	Fund Health Plan	Model Benefit
Over-the-counter medications	The plan covers all over-the-counter tobacco cessation medications at no cost to the fund participant. Participation in the Blue Cross Blue Shield quit smoking program is required to access over-the medications.	The plan covers all over-the-counter medications, including: • Nicotine gum (Nicorette®, generic) • Nicotine patch (Nicoderm®, Habitrol®, Prostep®, Nicotrol®, & generic) • Nicotine lozenge (Commit® & generic)
Prescription medications	The plan covers all prescription tobacco cessation medications at 20% cost to the fund participant. Participation in Blue Cross Blue Shield quit smoking program is required to access prescription medications.	The plan covers all prescription medications, including: • Nicotine inhaler (Nicotrol®) • Nasal spray (Nicotrol®) • Bupropion SR (Zyban®, Wellbutrin® & generic)Nicotine patch (Nicoderm®, Habitrol®, Prostep®, • Nicotrol®, & generic) • Varenicline (Chantix®)
Counseling	The plan provides phone-based coaching at no cost to the participant. Participation in Blue Cross Blue Shield quit smoking program is required to access phone-based coaching. Participants can access other forms of counseling via the employee assistance program, T.E.A.M. Inc.	The plan covers at least four counseling sessions, approximately 15-30 minutes per session. Covered evidence-based counseling sessions include telephone, individual, and/or group counseling. The plan recognizes that a variety of trained professionals, and not just physicians, can provide evidence-based counseling for tobacco cessation (and makes these eligible for reimbursement).
Annual limits	The plan does not have annual limits.	The plan provides coverage for at least two courses of medication and counseling per year.
Lifetime limits	Quit smoking attempts are limited to three attempts per lifetime.	The plan does not have a lifetime or cost limit for tobacco cessation counseling and medications.
Out-of-pocket costs	Fund participants have to pay a co-pay for prescription medications.	The plan eliminates or minimizes co-pays or deductibles associated with counseling sessions and tobacco cessation medications.
Dependents	The plan provides coverage for spouse and dependent children.	The plan provides coverage for spouse, domestic partner, and dependent children.

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Benefit promotion tool #1
Creating effective health messages

This tool can be used for guidance in creating health messages that are most likely to lead to cessation.

Perceptions that facilitate quit attempts	Illustrations of messages that can be used to positively influence participants' perceptions of risk and barriers to quitting
Goal: People believe tobacco use puts them personally at risk for disease and other harmful health consequences.	Participants are part of an occupational group which has smoking rates that are twice the national average of 20 percent of all U.S. adults. The highest rates of smoking among full-time workers aged 18-64 are in food preparation and serving-related occupations (44.7 percent) and in the construction and extraction trades (42.9 percent), compared with a national average of 28.4 percent of all full-time employees aged 18 to 64. (See Resources, Page 4, for resources on smoking rates by occupation.)
Goal: People believe the harmful consequences of tobacco use are severe.	Messages: Smoking causes 80-90 percent of lung cancer deaths and 90 percent of chronic obstructive lung disease. It increases the risk of coronary heart disease by 2-4 times, stroke by 2-4 times, development of lung cancer by 13 times for women and 23 times for men. (See Resources, Page 4, for health statistic resources.)
Goal: People believe the benefits of cessation are meaningful to them.	Messages: Stopping tobacco use is associated with positive consequences, such as improved health and physical fitness and financial gain. For example, a pack-a-day smoker can save approximately $1,500 a year by quitting. (That could pay for a nice vacation with your family.)
Goal: People believe it is possible for them to overcome the barriers to quitting.	Messages: The importance of social support from families, coworkers, funds, unions and employers. The importance of addressing participants' underlying concerns, such as financial stress, that can derail their quit attempts. (See Sidebar, Page 2.)

Sources: National Survey on Drug Use and Health, "The NSDUH Report." Retrieved February 1, 2010, from the U.S. Health and Human Services' Office of Applied Sciences website: http://oas.samhsa.gov/2k9/170/170OccupationHTML.pdf

For additional references, see "References," in Cessation Benefits Focus, Issue 4, March 2010, available at www.workshifts.org.

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Benefit promotion tool #2
Behavioral principles underlying effective cessation messages

This tool summarizes principles that, when used in designing health messages, have been found to be most likely to lead to cessation. We have included several examples of ways to build on these underlying principles.

Underlying Principles	Definitions	Example of incorporating principles into development of promotional messages and strategies
Self confidence	Building confidence among participants in their ability to quit smoking or use other forms of tobacco.	Produce written materials, videotapes or other media that profile other union members who have been successful in quitting tobacco use. Design hard hat stickers for workers who have succeeded in quitting with relevant messages, such as: "If I can quit, so can you! Ask me how." or "Quitting Makes Cents." Sponsor a health promotion event where participants who have quit using tobacco give testimonials about their experiences or are available to answer questions.
Observational/ experiential learning	Learning to perform new behaviors by observing demonstrations or by trying skills needed to change.	In captive audience settings, such as at toolbox meetings, union meetings or health fairs, show a videotape of a union member making a call to a telephone counseling cessation hot line or stage live demonstrations of counseling calls. Feature an online video, which demonstrates an in-person tobacco cessation counseling session/group and advertise its availability.
Facilitation	Providing tools and resources that make new behaviors easier to adopt.	Make comprehensive health insurance coverage for tobacco cessation available and provide free samples of medications such as over-the-counter nicotine gum or lozenges. Print tobacco cessation information on the outside of fund mailings (members may be more likely to see it on the outside of the envelope).
Social support	Providing positive support for quitting from persons influential in members' lives.	Encourage families, co-workers and union leaders to support members' efforts to quit.
Self-regulation	Learning to modify one's own behavior through self-monitoring, goal-setting, feedback and getting social support.	Provide health insurance coverage for tobacco cessation counseling that routinely employs these techniques with persons counseled.
Incentives	Using material (money, gift items) or non-material (privileges) rewards to reward positive behavior.	Research is limited and mixed on the value of incentives for achieving quitting. However, incentives can be used to attract people to participate and this might lead to larger absolute numbers of quitters.

For additional references, see "References," in Cessation Benefits Focus, Issue 4, March 2010, available at www.workshifts.org.

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Benefit promotion tool #3
Example of a 6- or 12-month promotional campaign

A promotional campaign could be implemented over a 6- or 12-month period.

Month	Message	Delivery Method
January (6-month campaign) **January (12-month campaign)**	"Did you know that smoking rates among workers in the building trades and in hospitality settings are twice as high as the national average? Your fund cares about your health so it provides members with insurance coverage for counseling and medication to aid in quitting tobacco use. This benefit covers the following: (insert details of what is covered by their benefit together with contact information)." "Return this postcard to receive hard hat stickers saying, '(insert tobacco cessation messages).'"	General mailing from fund to all participants.
February (6-month campaign) **March (12-month campaign)**	"I quit and this is how I did it" testimonial from a participant.	Booth at a health fair or presentation at union meeting or workplace. Provide free samples of cessation medications.
March (6-month campaign) **May (12-month campaign)**	Engage a representative from a company that produces cessation medications to answer questions and provide samples.	Booth at health fair or presentation at union meeting or workplace.
April (6-month campaign) **July (12-month campaign)**	Play a video demonstrating a quitline-type counseling call.	Booth at health fair or presentation at union meeting or workplace.
May (6-month campaign) **September (12-month campaign)**	"Your union supports your efforts to lead healthier, more active lives by stopping smoking."	Celebrate "World No Tobacco Day" (May 31st) by having union leaders communicate messages of support to those who decide to quit.
June (6-month campaign) **November (12-month campaign)**	"Return this postcard for a free sample of nicotine gum."	Postcard mailing to all fund participants.

For additional references, see "References," in Cessation Benefits Focus, Issue 4, March 2010, available at www.workshifts.org.

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Benefit promotion tool #4
Checklist for monitoring a plan for a promotional campaign

This checklist is designed to help monitor promotional efforts. It is based on materials developed by the National Tobacco Cessation Collaborative and can help you strategize on how to build demand for use of the benefit and ensure the inclusion of the tested principles of behavior change described in Benefit Promotion Tools #1-3.

Strategic Questions	Considerations/Action Steps
Does your Taft-Hartley Health and Welfare Fund:	
Have a comprehensive cessation benefit in place that includes coverage for counseling and cessation medications?	• Evaluate and identify ways to improve existing benefits.
View smokers as consumers and take a fresh look at quitting from their perspective? Make efforts to develop a better understanding of quitters' preferences and needs?	• Understand the quitting journey and nicotine addiction and engage smokers in new ways and in new places along the way? • Promote tobacco cessation products and services in ways that reach smokers, especially those who are underserved? • Correct misconceptions about what works and what doesn't regarding nicotine replacement therapies (NRTs) and counseling?
Combine and integrate evidence-based strategies into a promotion plan for a campaign to achieve maximum impact?	Has the fund used health messages that: • Address ways in which fund participants are particularly vulnerable to the consequences of smoking and using tobacco? • Address the serious health and financial costs of tobacco use? • Convey the health and financial benefits conferred by tobacco cessation? • Build fund participants' confidence that they can quit smoking? • Allow members to observe and/or learn by experience ways in which they can seek counseling and medications? • Encourage families, co-workers and union leaders to support participants' quit efforts; • Facilitate participants' use of the benefit provided? • Provide participants with financial or non-financial incentives for engaging in the tobacco cessation process?
Establish a system for documenting and measuring the success of your benefit promotion?	Has the fund: • Documented the promotional strategies put into action? • Recorded the number of participants who use the benefit, union/participant satisfaction with the process, and other key factors involved in implementation? • Surveyed participants about their quit attempts, including measuring the number who successfully quit?

Sources: Innovations in Building Consumer Demand for Tobacco Cessation Products and Services." Retrieved February 1, 2010, from the National Tobacco Cessation Collaborative's website: http://www.tobacco-cessation.org/PDFs/CD%20Conference%205-3-07%20Final%20Report.pdf

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Best Practices for Wellness Programs

Planning and Design

- *Know your audience*: Assess knowledge, attitudes, behaviors and health status using claims data, demographic data, biometric on-site testing, surveys, and/or focus groups.[1]
- *Maximize program relevancy*: Engage fund participants to ensure that the program design is relevant to them and their families.[2]
- *Facilitate and demonstrate respect*: Engage unions, management, workers, and families by working together toward the achievement of common goals.[2]
- *Establish clear operating principles*: Set clear operating principles to help define priorities, direct program design, and facilitate the allocation of resources.[2]
- *Start with achievable targets*: Build the program incrementally, using ongoing evaluation of employee participation, behavior change and organizational support.[2]
- *Adopt consistent policies to support program aims*: Align program activities with the physical and organizational environment, e.g., if you provide tobacco cessation services, support tobacco use prohibitions on worksite premises.[1]
- *Integrate related systems*: Make connections between current programs and policies and integrate them under the umbrella of total health.[2, 3]
- *Adopt and maintain a long-term outlook*: A long-term outlook increases the chance of sustainability and brings more value to an initiative.[2]

Implememntation

- *Recruit leadership to champion the program*: Leaders should visibly demonstrate commitment and be active participants.[1]
- *Engage mid-level management*: Mid-level management can respond to the needs/preferences of both workers and upper management, and can promote wellness programs and connect workers to appropriate resources.[2]
- *Communicate*: Deliver clear and consistent messages to all stakeholders. Identify the most feasible and effective methods of communication for each stakeholder group.[1, 2]
- *Develop creative ways to stimulate participation*: Use testimonials from successful participants. Use incentives. Recognize members who achieve goals. Account for the work environment—location, type of work, employer policies—when creating ways to engage participants.[1, 2]
- *Ensure confidentiality*: Communicate your plans to fund participants to ensure confidentiality and adhere to standards meant to protect confidentiality.[2]

Track & Evaluate Results

- *Track process/implementation data:* To improve upon the program and present a snapshot of the program to relevant stakeholders, collect data such as: number of fund participants involved; time; costs; company policies that impact health; and employee/management satisfaction.[1, 2]
- *Measure and analyze outcome data*: Gather data prior to implementation and at various times, post-implementation, to determine whether there were changes in participants' health status and whether planned objectives were met.[1, 2]
- *Learn from experience*: Make adjustments to the program based on results and feedback from stakeholders.[2]

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Evaluating a Fund's Wellness Initiative

Including evaluation components in the design of a wellness initiative is necessary to determine what aspects of the initiative have been successful and to identify areas for improvement.[1, 2, 3] Evaluating the initiative will help guide a fund's future efforts, facilitate decision-making, and provide guidance for other funds who may be interested in undertaking a similar initiative.

An evaluation includes the systematic collection, analysis, and reporting of information about an initiative.[1, 3] The evaluation findings help trustees and administrators understand the relative strengths and weaknesses of the initiative and how it can be improved to maximize intended outcomes. Although it can be difficult to allocate financial resources for this purpose, the knowledge gained makes investing in evaluation money well spent.[4]

Types of Evaluation

Three types of evaluation are important for accurately assessing a wellness initiative—process, intermediate, and outcome evaluations.

Process evaluation. A process evaluation provides insights about the relative merits of the initiative—what did and didn't work, who was reached, and what areas might have benefitted from improvement.[1, 3] A process evaluation can occur during or after implementing an initiative. Conducting a process evaluation during implementation may identify opportunities for mid-course adjustments. Examples of questions that probe process evaluation are:

- Was the initiative implemented as planned?
- How did the initiative achieve its objectives?
  - What strategies were used to reduce the number of tobacco users?
  - What activities were conducted?
    - How many fund members were screened for tobacco use?
    - What materials did fund members receive about tobacco cessation services? For example, a fund can keep a record of messages related to prevention or environmental change, such as preventive messages that discourage tobacco use or encourage participation in the fund's initiative
- Which stakeholders were involved?
- What were the experiences of individuals who participated in the initiative?

Intermediate evaluation. An intermediate evaluation examines the short-term outcomes of an initiative.[1, 3] The short-term outcomes are connected to long-term outcomes.[4] Examples of questions that probe intermediate outcomes include:

- What immediate effects did the initiative have?
  - Were there changes in the number of claims that indicate whether fund participants used the tobacco cessation services?
  - How many fund participants made a quit attempt?
- Can the fund clearly attribute changes in the rate of participation in the initiative to the campaign?
- Did the fund's initiative directly affect participants' behavior or knowledge?
  - For example, a fund can keep a record of participants' knowledge about tobacco cessation medications before and after an initiative.

Outcome evaluation. Also known as long-term evaluation, this kind of evaluation examines the long-term effects of a fund's initiative on its participants' health status and whether planned objectives were met.[1, 3] Examples of questions that examine outcomes include:

- What changes in prevalence of tobacco use occurred as a result of the initiative?
- What health effects were associated with the initiative? For example, insurance claims can be used to measure health effects relative to the following questions:
  - Was there a change in the number of tobacco-related deaths? Tobacco-related diseases? Tobacco-related disabilities? Number of sick days used?

A Sample Initiative to Reduce the Prevalence of Tobacco Use Within a Fund

In conjunction with setting a goal to reduce the prevalence of tobacco use among fund participants, a fund can design an initiative to implement and promote a comprehensive tobacco cessation benefit, including the following evaluation components:

Program objective: Reduce the prevalence of tobacco use among fund participants.
Intervention strategies:
(1) Implement and promote coverage of comprehensive tobacco cessation services;
(2) Create educational messages about the value and availability of tobacco cessation benefit; and
(3) Launch a campaign, setting a firm goal to reduce the prevalence of tobacco users by a specified percentage or numberby a certain date, e.g., by December 2012, the fund will reduce the prevalence of tobacco users by 20%.
Evaluation question: Will the provision of a comprehensive tobacco cessation benefit, coupled with a campaign to reduce the percentage of tobacco users by a target date, increase the number of fund members who attempt to quit and succeed in quitting tobacco use?
Process measures: List events that occurred as part of the initiative, stakeholders involved, and strategies used.
Short-term outcomes: An increased use of tobacco cessation services by fund participants.
Long-term outcomes: Reduction in prevalence of tobacco use among fund participants, decrease in tobacco-related deaths, disease, and disability.

References

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Section 7

What is the role of health reform in tobacco cessation, disease prevention and health promotion?

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Selected Prevention Provisions of the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) ushers in a new era of health care in the United States, placing a greater emphasis on health promotion and prevention initiatives. Embedded within the PPACA are evidence-based provisions that address prevention, health promotion, and wellness. This factsheet provides a partial listing, and is intended to highlight some of the prevention provisions that may be of great interest to Taft-Hartley Funds.

For individuals

- *Coverage of tobacco-cessation services for pregnant women in Medicaid (§4107)*: Requires states to provide tobacco cessation services, including counseling and pharmacotherapy, without cost-sharing, to pregnant women receiving Medicaid.[1, 2]
- *Preventive health services (§2713):* Requires new group health plans and private health insurance plans to cover preventive services which have been graded 'A' or 'B' by the U.S. Preventive Services Task Force, without cost-sharing.[1]

For workplaces

- *Employer-based wellness programs (§4303)*: Mandates the Centers for Disease Control and Prevention (CDC) to provide employers with programmatic support, including technical assistance, consultation and other tools for evaluating wellness programs.[1, 2]
- *Grants for small businesses to provide comprehensive workplace wellness programs(§10408):* Commits $200 million in grant monies from 2011 to 2015 for establishing worksite-based wellness programs for small businesses. To be eligible, employers: (1) Must have less than 100 employees who work at least 25 hours per week; (2) Must not have a wellness program in place at the time of their application; and (3) Must use the funds to provide a comprehensive wellness program.[3, 4]
- *Reasonable break time for nursing mothers (§4207):* Amends the Fair Labor Standards Act of 1938 by requiring employers with at least 50 employees to provide nursing mothers with reasonable break time and suitable facilities (not including bathrooms).[1, 5] This provision also applies to employers with fewer than 50 employees unless compliance would impose an undue hardship.

National

- *National diabetes prevention program (§10501):* Establishes a national program to reduce preventable diabetes among at-risk adult populations.[1]
- *Nutrition labeling of standard menu items at chain restaurants (§4205):* Establishes nutrition labeling requirements for standard menu items served in chains of 20 or more restaurants, similar retail food establishments (e.g., grocery store delis) and vending machines, including disclosures of total calories, calories from fat, and other nutrient information.[1]
- *Oral health (§4102):* Creates a 5-year national educational campaign on oral healthcare education and prevention.[4] Establishes demonstration grants on dental caries disease management, education and surveillance.[1]

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Section 8

How can I learn more?

Selected Resources

Blue-Collar Workers & Tobacco Use

Publications

- Centers for Disease Control and Prevention. Current cigarette smoking prevalence among working adults—United States, 2004-2010. *Morbidity and Mortality Weekly Report* 2011, 60(38):1301-1336.
- Mitchell RJ, Weisman SR, Jones RM, Erickson D. The role of labor organizations in tobacco control: What do unionized workers think? *American Journal of Health Promotion* 2009;23(3):182-186.
- Substance Abuse and Mental Health Services Administration, Office of Applied Studies—The NSDUH report: Cigarette use among adults employed full time, by occupational category
- WorkSHIFTS, Public Health Law Center—An employer guide tobacco
- WorkSHIFTS, Public Health Law Center—A union guide to tobacco: Tobacco and labor unions

Tobacco Use & Health

Publications

- Centers for Disease Control and Prevention— Health effects of cigarette smoking
- Centers for Disease Control and Prevention—Successful business strategies to prevent heart disease and stroke
- Centers for Disease Control and Prevention—The power of prevention: Chronic disease…the public health challenge of the 21st century

Costs

Publications

- America's Health Insurance Plans—Making the business case for smoking cessation programs – Executive summary
- American Legacy Foundation—Covering smoking cessation as a health benefit: A case for employers
- C-Change—Making the business case: How engaging employees in preventive care can reduce health care costs
- Centers for Disease Control and Prevention—Save lives, save money: Make your business smoke-free
- Partnership for Prevention—Priorities for America's health: Capitalizing on life-saving, cost effective preventive services. Executive summary
- Partnership for Prevention—Serious gains: Reducing tobacco use improves productivity and profit
- University of Wisconsin Center for Tobacco Research and Intervention—Report: The business case for coverage of tobacco cessation

Cessation

Publications

- Clinical Practice Guideline—Treating tobacco use and dependence: 2008 update

Websites

- American Lung Association—State tobacco cessation coverage
- Smoking Cessation Central—Resources for businesses on cessation coverage
- Tobacco Cessation Leadership Network—Cessation topics and resources

Tobacco Cessation Benefits

Publications

- American Lung Association—Helping smokers quit: State cessation coverage 2009
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To learn more about smoking cessation, visit www.workshifts.org.

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