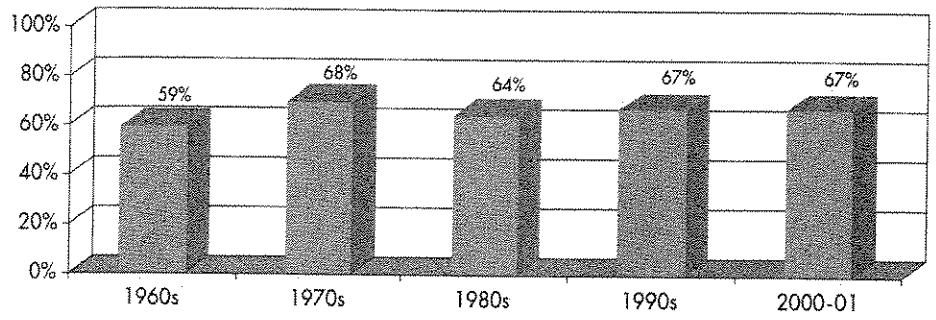
SMOKING BEFORE AND DURING PREGNANCY

Compared to nonsmoking women, women of childbearing age who smoke have more difficulty getting pregnant. The WTS asked respondents who ever smoked to indicate whether or not they smoked during the 30 days before they became pregnant. Since 1960, approximately two-thirds of WTS respondents reported smoking during the month before pregnancy (Figure 3). There was only small variation in the percentages from 1960 through 2001 and no trend towards a decreased smoking rate was observed.

FIGURE 3

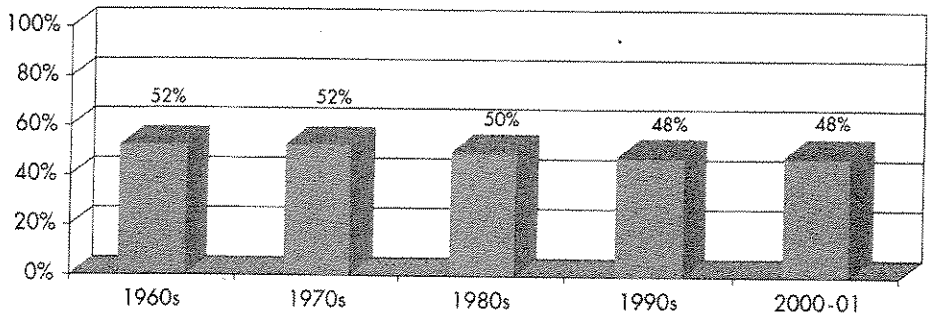
Percentage of current or former smokers who smoked in the 30 days before becoming pregnant



The WTS also asked respondents if they smoked after they found out that they were pregnant. A slight decreasing trend was observed from the 1960s to 2000-2001 but approximately half of all ever smokers (current or former) smoked at some point during their pregnancy (Figure 4). This finding is surprising given the increase since the 1960s in information about the harmful effects of smoking that has been made available to smokers through the media and from health care providers.

FIGURE 4

Percentage of current or former smokers who smoked after learning about being pregnant

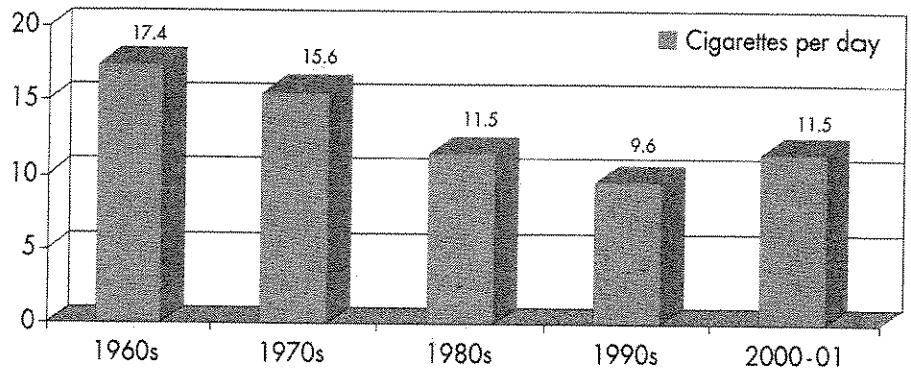


THE DATA CONTINUED

Respondents who smoked during their last pregnancy were asked to indicate how many cigarettes they smoked during pregnancy. Health data indicate that the more a woman smokes, the greater the risk to the unborn baby. WTS data reveal a decreasing number of cigarettes smoked per day since the 1960s with a small increase among recently-pregnant (2000-2001) smokers (Figure 5). The overall decrease in the average number of cigarettes smoked per day is encouraging but further efforts are warranted to reverse the recent upward trend.

FIGURE 5

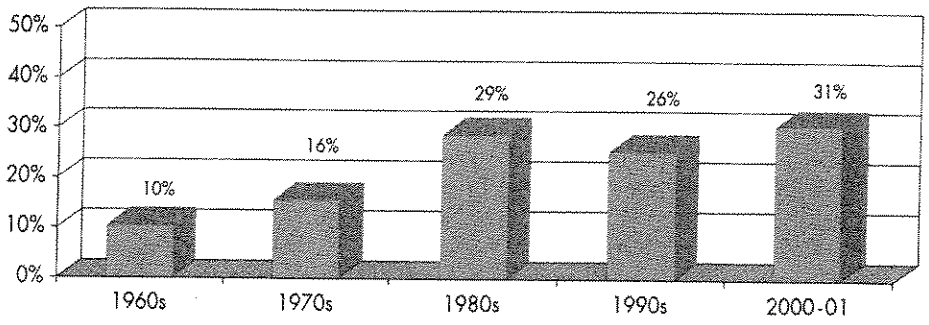
Mean number of cigarettes smoked per day by respondents who smoked during their pregnancy



An important indicator of progress in reducing smoking during pregnancy is the presence of a sustained quit attempt lasting 7 days or longer. The WTS asked respondents who smoked during their last pregnancy if they had quit for 7 days or longer. The results showed that three times as many recently-pregnant smokers made a 7-day or longer quit attempt compared to smokers who were pregnant during the 1960s (Figure 6).

FIGURE 6

Percentage of pregnant smokers who made a quit attempt lasting 7 days or longer



Another encouraging trend concerns the percentage of respondents who were able to maintain abstinence after a quit attempt. Because of small sample sizes, data for the years 1960-1989 were combined into one group as were the data for the years 1990-2001. **Since 1990, approximately 61% of pregnant smokers who made a quit attempt of 7 days or longer were able to maintain abstinence compared to approximately 44% of respondents who made a similar quit attempt during 1960-1989.**

Taken together, these results suggest that a larger percentage of pregnant smokers are trying to quit and are successfully staying quit. However, a majority of pregnant smokers are not making sustained quit attempts and about 40% of those who do make such an attempt return to smoking.

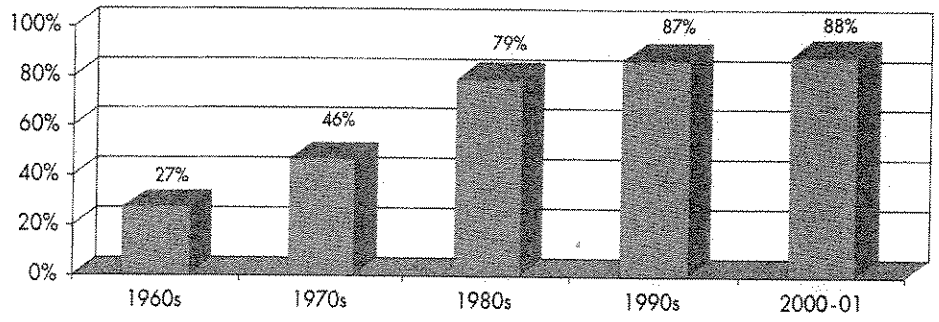
HEALTHCARE PROVIDER BEHAVIOR

A key factor in reducing smoking during pregnancy is the role of healthcare providers in identifying and treating pregnant smokers. Virtually all pregnant women seek medical care during their pregnancy. As such, healthcare providers who care for pregnant patients are in a unique position to identify and intervene with pregnant smokers. The recent U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence* (Fiore et al., 2000), recommends that all patients should be asked about tobacco use and should have their tobacco-use status documented on a regular basis.

The WTS asked respondents whether or not their doctor or other healthcare professionals asked them about using tobacco after respondents learned they were pregnant. The results showed a dramatic increase since the 1970s in the percentage of healthcare providers who asked pregnant respondents about tobacco use (Figure 7). Although this percentage for respondents who were last pregnant during 2000-2001 was high, 12% of pregnant patients reported that they were not asked about smoking and other tobacco use.

FIGURE 7

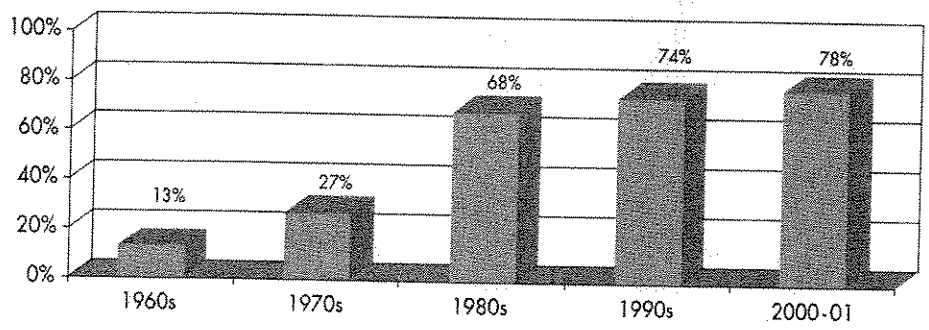
Percentage of pregnant smokers who reported that healthcare providers asked them about tobacco use



The U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence* (Fiore et al., 2000), also recommends that all physicians and clinicians strongly advise their patients who smoke to quit. The WTS asked respondents who smoked during their last pregnancy whether or not their doctor or other healthcare provider advised them to stop. The results showed that great improvements have been made since the 1960s when only about 1 in 10 pregnant smokers were advised to quit (Figure 8). For respondents who were last pregnant during 2000-2001, about 3 out of 4 (78%) reported that their doctor or other health professional advised them to quit.

FIGURE 8

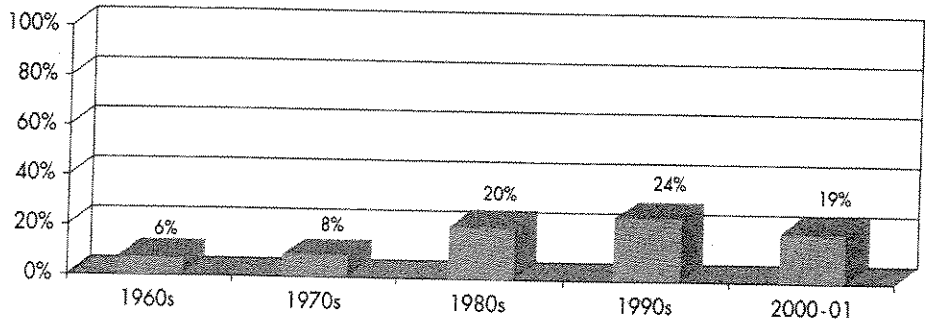
Percentage of pregnant smokers who reported that healthcare providers advised them to quit using tobacco



All healthcare providers should not only encourage pregnant smokers to quit, but they should also provide pregnant smokers with assistance in quitting. The WTS asked respondents to indicate whether or not their doctor or other healthcare provider encouraged them to set a quit date or offered other cessation assistance. The results showed that few pregnant smokers reported being encouraged to set a quit date although there is an increasing trend over time (Figure 9) with a slight decrease during 2000-2001.

FIGURE 9

Percentage of pregnant smokers who reported that healthcare providers encouraged them to set a quit date



The WTS also asked respondents to indicate whether or not their doctor or other health professional gave them information about smoking cessation or referred them to a smoking cessation program. Given the rarity of specialized smoking cessation programs before 1990, results were compiled for respondents who were last pregnant since 1990. **These results showed that fewer than 1 in 10 respondents reported that their doctor or other heath professional provided information or referrals for smoking cessation.**

Clearly, healthcare providers should offer a variety of cessation assistance to all pregnant smokers given the potential harm to child and mother. Thus, this is an area of intervention that needs considerable improvement.

FACTORS THAT ARE ASSOCIATED WITH SMOKING DURING PREGNANCY

There are several factors that are associated with smoking during pregnancy as well as having difficulty quitting during pregnancy. Major factors include starting to smoke at a young age, heavy smoking, young age at pregnancy, having a spouse/partner who smokes, lower education, and lower income (Lu, Tong, & Oldenburg, 2001). The WTS included questions about these risk factors, which are examined in a series of analyses presented below.

To examine these issues, data for respondents (those reporting they were ever smokers) who were last pregnant since 1990 were analyzed to allow for a sufficiently large sample size of 265 respondents who were pregnant within approximately the last 10 years. These analyses compared 126 respondents who reported smoking during their last pregnancy with 139 respondents who reported not smoking during their last pregnancy.

Table 2 shows that respondents who smoked during their last pregnancy started smoking at a younger age, were less likely to have at least a high school education, and had lower annual incomes compared to respondents who did not smoke during their last pregnancy. The individual effects of these demographic factors were modest but the presence of more than one of these risk factors may incrementally increase the risk for smoking during pregnancy.

Smoking during pregnancy was even more highly related to having smokers among family or friends. Over half of the respondents who smoked during their last pregnancy had a spouse or partner who smoked compared with only one-third of the respondents who did not smoke during pregnancy. The most influential factor differentiating the two groups is having a majority of family members or friends who smoke. Almost two-thirds of respondents with a majority of their family members or friends as smokers reported smoking during pregnancy compared to only one-fourth of respondents who did not smoke during their last pregnancy.

Table 2- Factors Influencing Ever Smokers to Smoke During Pregnancy

Risk Factor	Respondents Who Did Not Smoke During Last Pregnancy (n=140)	Respondents Who smoked During Last Pregnancy (n=126)
Half or more of friends/family members smoke (%Yes)	25.7	65.6
Annual household income < $35,000 (%)	43.2	57.1
Less than a high school education (%)	43.5	56.5
Spouse or partner who smokes (% Yes)	33.1	52.4
Age at last pregnancy (in years)	27.0	26.4
Age when first started smoking (in years)	15.3	14.3

Of additional interest, **almost 84% of the respondents who reported smoking during their last pregnancy were smoking at the time of the survey. Only about half of the respondents who did not smoke during their last pregnancy were smoking at the time of the survey.** This finding is important because of the harmful effects of postpartum smoke exposure on infants and children of mothers who continued to smoke.

FACTORS ASSOCIATED WITH MAKING A QUIT ATTEMPT DURING PREGNANCY

These analyses focus on respondents who reported smoking during their last pregnancy. A total of 122 of 126 respondents answered a survey question about making a quit attempt during their last pregnancy. Analyses compared those who quit smoking for 7 days or longer during their pregnancy with those who did not quit for at least 7 days.

Results of the analyses showed that only a few risk factors were associated with making a quit attempt (Table 3). The most important finding in these analyses concerns educational level. Nearly 40% of respondents who did not make a quit attempt had less than a high school education compared with only about 3% of respondents who reported making a quit attempt. Also, respondents who smoked fewer cigarettes and who had fewer family members or friends who smoked were more likely to have made a quit attempt but the associations were more modest. Income, age at first cigarette, age at last pregnancy, and spouse/partner smoking were not associated with making a quit attempt.

Table 3- Factors Associated with Making a Quit Attempt for 7 Days or Longer Among Respondents Who Smoked During Pregnancy

Risk Factor	Respondents Who Did Not Make A Quit Attempt (n=88)	Respondents Who Made A Quit Attempt (n=34)
Annual household income < $35,000 (%)	58.0	58.8
Spouse or partner who smokes (% Yes)	52.3	54.5
Half or more of friends/family members smoke (%Yes)	71.6	50.0
Age at last pregnancy (in years)	26.5	25.7
Age when first started smoking (in years)	14.0	14.4
Number of cigarettes per day during pregnancy	11.2	8.6
Less than a high school education (%)	38.8	2.9

Among the respondents who made a serious quit attempt (abstinent 7 days or longer) during their last pregnancy, 61.8% were able to remain abstinent for the rest of their pregnancy. On a less positive note, only 27.3% of these respondents were abstinent at the time of the survey. Furthermore, only 11.4% of those women who did not make a quit attempt during their last pregnancy were abstinent at the time of the survey.

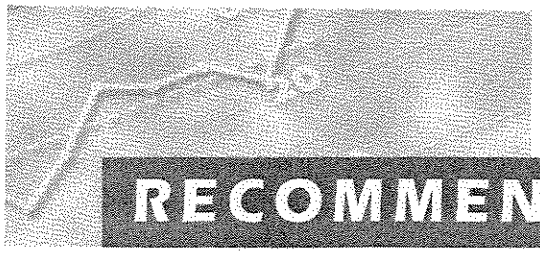
CONCLUSIONS

Smoking during and after pregnancy is a major public health concern given the potential for a wide range of harmful effects on both the mother and child. The findings in this report suggest that progress is being made in lowering the prevalence of smoking during pregnancy in Wisconsin but continued effort is needed to sustain that progress and to address areas that need improvement. The modest 2-3 percentage point reduction in the percentage of Wisconsin women who smoked during pregnancy from 1995 (18.9%) to 2000 (16.5%) and the higher rates among 18-24 year-olds (>25%) in 2000 attest to the continuing importance of prevention and treatment programs for women of childbearing age.

The results of this survey showed that a high percentage of Wisconsin smokers continued to smoke after learning that they were pregnant (48% in 2000-01). However, the average number of cigarettes smoked per day by these pregnant women appears to have decreased in recent decades. Another promising trend was the increasing percentage over time of pregnant smokers who made a quit attempt lasting 7 days or longer. Only 10% of pregnant smokers achieved 7 days of abstinence in the 1960s compared to 31% in 2000-01. Also, an increasing percentage of smokers achieving initial abstinence were able to stay abstinent for the duration of pregnancy (44% before 1990; 61% after 1990).

Doctors and other health providers who care for pregnant smokers are doing well in some areas but much improvement is needed in other important areas. Clinicians are doing a relatively good job of asking pregnant smokers about tobacco use (88% in 2000-01) and advising them to quit (78% in 2000-01). However, during the past 10 years, only about 1 in 5 pregnant smokers were encouraged to set a quit date and only 1 in 10 were offered information or referral for specialized smoking cessation treatments. All pregnant women should be asked about tobacco use at every clinic visit and all tobacco-using pregnant women should be encouraged to quit and assisted with quitting. The important role of perinatal and other healthcare providers treating tobacco use and dependence in pregnant women cannot be overstated.

Consistent with other surveys, several factors appear to be associated with smoking and quitting smoking during pregnancy. The most important factors associated with smoking during pregnancy include having a spouse/partner who smokes, having many friends and family members who smoke, less education, and lower income. Major factors associated with making a quit attempt during pregnancy include having fewer friends and family members who smoke and having at least a high school education. Knowledge of these factors may help clinicians and policymakers to reduce further the likelihood that pregnant women will smoke.



RECOMMENDATIONS

Both Healthy People 2010 (a health promotion and disease prevention agenda from the U.S. Department of Health and Human Services) and the Wisconsin Tobacco Control Board (WTCB) have established ambitious goals for reducing smoking prevalence in all groups of Wisconsin citizens. Reducing smoking prevalence in pregnant women should be a top priority given the harmful effects of smoking on both mother and child.

In 2000, the prevalence rate of smoking during pregnancy in Wisconsin was 16.5%. The Healthy People 2010 goal is a 50% reduction in overall smoking prevalence while the WTCB has set a shorter-term goal of reducing overall smoking prevalence by 20% by 2005. Thus, the short-term (2005) goal for reducing smoking during pregnancy is a prevalence rate no higher than 13.2% and the long-term goal is a rate no higher than 8.3%. To reach the goals of the WTCB and Healthy People 2010, certain immediate actions must be taken. Based on the Wisconsin Tobacco Survey and other research, the following action steps are recommended:

- **Train Healthcare Providers.** Because virtually all women seek medical care after becoming pregnant, perinatal clinicians and others in the health care system play a vital role in identifying pregnant smokers and providing motivation and assistance to quit. Perinatal clinicians and other health professionals should be trained to provide effective, evidence-based treatment and relapse prevention with all pregnant smokers. Support of training and technical assistance for healthcare providers and tobacco cessation specialists should be enhanced.

- **Promote the Wisconsin Tobacco Quit Line to Pregnant Smokers.** The Wisconsin Tobacco Quit Line offers special cessation assistance to pregnant smokers and new mothers at no cost and provides referral information to local programs for additional help. Effective strategies to increase the use of the Quit Line by pregnant smokers should be implemented. These strategies include paid advertising, media coverage, and referrals through healthcare providers and others.

- **Support First Breath.** The Wisconsin First Breath smoking cessation program for pregnant smokers, sponsored by the Wisconsin Women's Health Foundation, has shown promise in pilot studies and should remain a priority for continued funding and support.

- **Assist At-Risk Populations.** Special efforts should be made to identify and assist smokers in specific at-risk populations such as younger women of childbearing age and racial/ethnic minorities. In addition, treatments should be tailored to optimally assist smokers from diverse backgrounds.

- **Increase Utilization by BadgerCare and Medicaid Recipients.** Smoking cessation is a covered benefit available to individuals eligible for BadgerCare and Wisconsin Medicaid recipients. Public health clinics, WIC providers, community clinics, and HMOs serving Medicaid recipients are well-positioned to assist women with cessation. Special efforts should be made to increase the availability of tobacco cessation treatment to these recipients as well as utilization of this covered benefit by recipients.

➢ **Support Prevention of Smoking in Women of Childbearing Age.** Prevention of smoking initiation in teenage girls and young women of childbearing age is an important part of reducing smoking during pregnancy. Continued funding of effective prevention programs as well as funding of additional research on prevention programs will contribute to the overall reduction in smoking rates in pregnant women.

➢ **Support a Comprehensive Tobacco Control Program.** A comprehensive tobacco control program should be a funding priority for Wisconsin. This comprehensive program should include programs designed to change social norms about smoking, to reduce exposure to second-hand smoke, and to address the treatment needs of smokers within the context of their families, friends, and communities. Support for research to identify the most effective approaches to tobacco control should also be a funding priority.

RESOURCES

STATE OF WISCONSIN RESOURCES:

Tobacco Control Resource Center for Wisconsin
http://www.wtcb.state.wi.us/

Wisconsin First Breath Smoking Cessation Program for Pregnant Smokers
http://www.wwhf.org/firstbreath.htm
1-800-448-5148 (Lisette Jehn at the Wisconsin Women's Health Foundation)

Wisconsin Tobacco Quit Line:
1-877-270-STOP (7867)

University of Wisconsin Medical School Center for Tobacco Research and Intervention:
http://www.ctri.wisc.edu
608-262-8673

FEDERAL RESOURCES:

U. S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence
http://www.surgeongeneral.gov/tobacco/

Women and Smoking: A Report of the Surgeon General
http://www.cdc.gov/tobacco/sgr_forwomen.htm

CDC Tobacco Information and Prevention Source (TIPS)
http://www.cdc.gov/tobacco/index.htm
1-800-CDC-1311

TECHNICAL NOTES

The Wisconsin Tobacco Survey (WTS) was conducted in 2001 by the University of Wisconsin Center for Tobacco Research and Intervention (UW-CTRI). The survey garnered information from 6135 Wisconsin residents using extensive interviews. The purpose of the survey was to provide important information about: 1) current tobacco use patterns among Wisconsin adults, 2) attitudes towards efforts to regulate tobacco, 3) patterns of smoking cessation attempts, and 4) a number of other tobacco research issues. The survey included 162 questions on general health, tobacco use, smoking cessation, smokers' use of health care services, smoking during pregnancy, and demographics.

The survey consisted of three primary tracks – current cigarette smoker, former cigarette smoker, and never cigarette smoker. Current smoker was defined as someone who smoked 100 cigarettes in a lifetime and now smokes every day or some days. A former smoker was defined as someone who smoked 100 cigarettes in a lifetime and now does not smoke at all. A never smoker was defined as someone who has never smoked a cigarette or has never smoked 100 cigarettes in a lifetime. Questions about tobacco use of any kind (e.g., cigar smokers, pipe smokers, or snuff/chewing tobacco users) were also included. A major goal of the project was to contrast trends in behaviors and attitudes across these different groups defined on the basis of tobacco use status.

UW-CTRI retained Opinion Dynamics Corporation (ODC) to conduct the 2001 Wisconsin Tobacco Survey (WTS). The WTS used a scientifically-selected random sample which gave all households with telephones a chance of inclusion in the study. Within a selected household, the respondent was chosen by a procedure that randomly selects the oldest adult male, the youngest adult male, the oldest adult female or the youngest adult female. Household members eligible for inclusion in the survey included all related adults (aged 18 or older), unrelated adults, roomers, and domestic workers who consider the household their home.

The survey was designed to over sample the two most disproportionately African American counties in Wisconsin, Milwaukee and Racine. Out of 6,135 people surveyed, people living in Milwaukee and Racine counties completed 2,226 surveys. African American residents completed four percent or 268 surveys. Neither Native Americans nor Hispanics could be over sampled meaningfully without compromising the rest of the project.

The survey was programmed into a Computer Assisted Telephone Interviewing (CATI) software program to perform the basic data collection tasks of telephone interviewing. As questions were displayed, the interviewer read them to the respondent and keyed in the responses. The survey automatically skipped inappropriate questions and checked for the acceptability of responses. All attempts to contact potential respondents were tracked and coded by sample disposition. This enabled the CATI system to properly designate sample points for calling, schedule callbacks, and administer non-responsive contact attempts.

Before eliminating a respondent from the sample and randomly selecting a replacement, at least five telephone calls were made to reach the household. Efforts were made to ensure a highly representative sample by varying calls at different times of day and on different days of the week. Callbacks were scheduled as requested by respondents. Completed interview status was only assigned once all data was collected for a given interview.

TECHNICAL NOTES CONTINUED

For the purpose of this study, the Council of American Survey Research Organizations (CASRO) methodology was used to calculate response rate. The methodology apportioned dispositions with unknown eligibility status (e.g., no answer, answering machine, busy, etc.) to dispositions representing eligible respondents in the same proportion as exists among all calls of known status. The starting sample (N) for the entire survey was 33,636. Thirty-six percent of this group was invalidated (e.g., disconnected phone, busy phone), leaving a N of 21,387. The application of the CASRO response rate formula to this sample resulted in an adjusted N of 19,036. A total of 6,155 respondents completed the interview, resulting in a CASRO-adjusted response rate of 32.3%.

Data from 20 respondents were deleted from the final dataset due to inconsistencies in their responses to the tobacco use questions. A total of 6,135 valid surveys were included in the final dataset. Among those people, 4,106 never smoked, 1,071 were former smokers and 958 were current cigarette smokers. To ensure confidentiality, no respondent identifiers were retained in the interview records, and reports cite only aggregate figures.

The Wisconsin Tobacco Survey data were weighted to more accurately represent the population of Wisconsin. WTS data were weighted based on five demographic, geographic, and SES characteristics of respondents – age, gender, race, education attainment, and geographic location. Known population information was based on the 2000 Census data for Wisconsin, except for education attainment, which was based on the 1990 Wisconsin Census data. In addition to demographic and SES characteristics, the WTS data were weighted based on two locations – Milwaukee County/Racine County and all other Wisconsin Counties. This was done to adjust the data based on these two locations because the WTS includes an over sample of Milwaukee and Racine Counties, resulting in an over representation of these populations.

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KEY INDIVIDUALS INVOLVED IN THE PREPARATION OF THESE PAPERS ARE:

Timothy B. Baker, Ph.D.; Stevens S. Smith, Ph.D.; Michael Fiore, M.D., M.P.H.; Gloria Meyer, M.A.; Lezli Redmond, M.P.H.; Timothy W. Bosworth, Ph.D.; Patrick Remington, M.D., M.P.H.; David Ahrens, M.S.; and Ann Christiansen, M.P.H.

Lead author of this paper was Stevens S. Smith, Ph.D.

Graphic design: Department of Medical Illustration, UW-Medical School

ADDITIONAL COPIES ARE AVAILABLE FROM:

Sandy Keller
UW Center for Tobacco Research and Intervention
1930 Monroe Street, Suite 200
Madison, WI 53711
608-262-8673
slk@ctri.medicine.wisc.edu

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QUICK REFERENCE GUIDE FOR CLINICIANS

Treating Tobacco Use And Dependence

U.S. Department of Health and Human Services
Public Health Service

To All Clinicians

The Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, on which this Quick Reference Guide for Clinicians is based was developed by a multidisciplinary, non-Federal panel of experts, in collaboration with a consortium of tobacco cessation representatives, consultants, and staff. Panel members and guideline staff were:

Guideline Panel

Michael C. Fiore, MD, MPH
(Panel Chair)
William C. Bailey, MD
Stuart J. Cohen, EdD
Sally Faith Dorfman, MD, MSHSA
Michael G. Goldstein, MD
Ellen R. Gritz, PhD
Richard B. Heyman, MD
Carlos Roberto Jaen, MD, PhD
Thomas E. Kottke, MD, MSPH
Harry A. Lando, PhD
Robert E. Mecklenburg, DDS, MPH
Patricia Dolan Mullen, DrPH
Louise M. Nett, RN, RRT
Lawrence Robinson, MD, MPH
Maxine L. Stitzer, PhD
Anthony C. Tommasello, MS
Louise Villejo, MPH, CHES
Mary Ellen Wewers, PhD, RN

Guideline Staff

Timothy Baker, PhD
Victor Hasselblad, PhD
Brion J. Fox, JD

An explicit, science-based methodology was employed along with expert clinical judgment to develop recommendations on treating tobacco use and dependence. Extensive literature searches were conducted and critical reviews and syntheses were used to evaluate empirical evidence and significant outcomes. Peer review was undertaken to evaluate the validity, reliability, and utility of the guideline in clinical practice.

This Quick Reference Guide for Clinicians presents summary points from the Clinical Practice Guideline. The guideline provides a description of the development process, thorough analysis and discussion of the available research, critical evaluation of the assumptions and knowledge of the field, more complete information for health care decisionmaking, and references. Decisions to adopt particular recommendations from either publication must be made by practitioners in light of available resources and circumstances presented by the individual patient.

As clinicians, you are in a frontline position to help your patients by asking two key questions: "Do you smoke?" and "Do you want to quit?" followed by use of the recommendations in this Quick Reference Guide for Clinicians.

QUICK REFERENCE GUIDE FOR CLINICIANS

Treating Tobacco Use and Dependence

U.S. Department of Health and Human Services
Public Health Service

October 2000

Abstract

This Quick Reference Guide for Clinicians contains strategies and recommendations from the Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence*. The guideline was designed to assist clinicians; smoking cessation specialists; and health care administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions. It was based on an exhaustive systematic review and analysis of the extant scientific literature from 1975-1999, and uses the results of more than 50 meta-analyses.

This Quick Reference Guide summarizes the guideline strategies for providing appropriate treatments for every patient. Effective treatments for tobacco dependence now exist, and every patient should receive at least minimal treatment every time he or she visits a clinician. The first step in this process—identification and assessment of tobacco use status—separates patients into three treatment categories: (1) patients who use tobacco and are willing to quit should be treated using the "5 A's" (*Ask, Advise, Assess, Assist, and Arrange*); (2) patients who use tobacco but are unwilling to quit at this time should be treated with the "5 R's" motivational intervention *(Relevance, Risks, Rewards, Roadblocks, and Repetition)*; and (3) patients who have recently quit using tobacco should be provided relapse prevention treatment.

Suggested Citation

Fiore MC, Bailey WC, Cohen SJ, et. al. *Treating Tobacco Use and Dependence.* Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. October 2000.

Purpose

Tobacco is the single greatest cause of disease and premature death in America today, and is responsible for more than 430,000 deaths each year. Nearly 25 percent of adult Americans currently smoke, and 3,000 children and adolescents become regular users of tobacco every day. The societal costs of tobacco-related death and disease approach $100 billion each year. However, more than 70 percent of all current smokers have expressed a desire to stop smoking; if they successfully quit, the result will be both immediate and long-term health improvements. Clinicians have a vital role to play in helping smokers quit.

The analyses contained within the Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, demonstrate that efficacious treatments for tobacco users exist and should become a part of standard caregiving. Research also shows that delivering such treatments is cost-effective. In summary, the treatment of tobacco use and dependence presents the best opportunity for clinicians to improve the lives of millions of Americans nationwide in a cost-effective manner.

Key Findings

The guideline identified a number of key findings that clinicians should utilize:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.
2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
   - Patients *willing* to try to quit tobacco use should be provided with treatments that are identified as effective in the guideline.
   - Patients *unwilling* to try to quit tobacco use should be provided with a brief intervention that is designed to increase their motivation to quit.

3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user who is seen in a health care setting.

4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.

5. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).

6. Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients who are attempting tobacco cessation:

   - Provision of practical counseling (problemsolving/skills training);
   - Provision of social support as part of treatment (intra-treatment social support); and
   - Help in securing social support outside of treatment (extra-treatment social support).

7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients who are attempting to quit smoking.

   - Five *first-line* pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
     - Bupropion SR
     - Nicotine gum
     - Nicotine inhaler
     - Nicotine nasal spray
     - Nicotine patch
   - Two *second-line* pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:
     - Clonidine
     - Nortriptyline
   - Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:

   - All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments that are identified as effective in this guideline; and
   - Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

Identification and Assessment of Tobacco Use

The single most important step in addressing tobacco use and dependence is screening for tobacco use. After the clinician has asked about tobacco use and has assessed the willingness to quit, he or she can then provide the appropriate intervention, either by assisting the patient in quitting (the "5As") or by providing a motivational intervention, the ("5 R's"). Figure 1 can be used as a guide to identify both current and former tobacco users and to provide the appropriate treatment of all patients. The following three sections address the main three groups of patients: (1) smokers who are *willing* to make a quit attempt, (2) smokers who are unwilling to make a quit attempt at this time, and (3) former smokers.

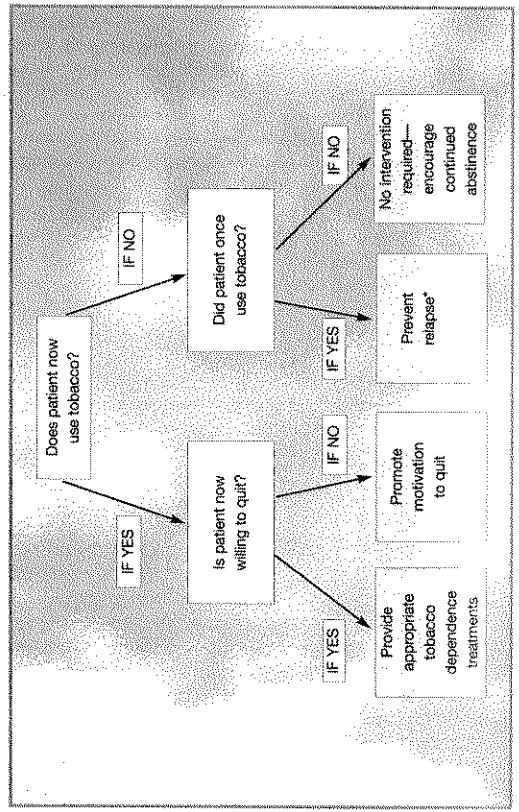

Figure 1. Screen for tobacco use status

*Ongoing assessment recommended, as the case of the adult who has not used tobacco for many years.

TOBACCO USERS WILLING TO QUIT

The "5 A's," *Ask, Advise, Assess, Assist,* and *Arrange*, are designed to be used with the smoker who is willing to quit.

Table 1. Ask—systematically identify all tobacco users at every visit

Action	Strategies for implementation
Implement an officewide system that ensures that, for EVERY patient at EVERY clinic visit, tobacco-use status is queried and documented.[a]	Expand the vital signs to include tobacco use or use an alternative universal identification system.[b]

VITAL SIGNS

Blood Pressure: _____

Pulse: _____ Weight: _____

Temperature: _____

Respiratory Rate: _____

Tobacco Use: Current Former Never

(circle one)

[a]Repeated assessment is *not* necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record.

[b]Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.

Table 2. Advise—strongly urge all tobacco users to quit

Action	Strategies for implementation
In a clear, *strong,* and *personalized* manner, urge every tobacco user to quit.	Advice should be: ■ *Clear*—"I think it is important for you to quit smoking now and I can help you." "Cutting down while you are ill is not enough." ■ *Strong*—"As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you." ■ *Personalized*—Tie tobacco use to current health/illness, and/or its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use on children and others in the household.

Table 3. Assess—determine willingness to make a quit attempt

Action	Strategies for implementation
Ask every tobacco user if he or she is willing to make a quit attempt at this time (e.g., within the next 30 days).	Assess patient's willingness to quit: ■ If the patient is willing to make a quit attempt at this time, provide assistance. ■ If the patient will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention. ■ If the patient clearly states he or she is unwilling to make a quit attempt at this time, provide a motivational intervention. ■ If the patient is a member of a special population (e.g., adolescent, pregnant smoker, racial/ethnic minority), consider providing additional information.

Table 4. Assist—aid the patient in quitting

Action	Strategies for implementation
Help the patient with a quit plan.	A patient's preparations for quitting: ■ *Set a quit date*—ideally, the quit date should be within 2 weeks. ■ *Tell* family, friends, and coworkers about quitting and request understanding and support. ■ *Anticipate* challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. ■ *Remove* tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car).

Table 4. Assist—aid the patient in quitting (continued)

Action	Strategies for implementation
Provide practical counseling (problemsolving/training).	■ *Abstinence*—Total abstinence is essential. "Not even a single puff after the quit date." ■ *Past quit experience*—Review past quit attempts including identification of what helped during the quit attempt and what factors contributed to relapse. ■ *Anticipate triggers or challenges in upcoming attempt*—Discuss challenges/triggers and how patient will successfully overcome them. ■ *Alcohol*—Because alcohol can cause relapse, the patient should consider limiting/abstaining from alcohol while quitting. ■ *Other smokers in the household*—Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or not smoke in their presence.
Provide intra-treatment social support.	■ Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. "My office staff and I are available to assist you."
Help patient obtain extra-treatment social support.	■ Help patient develop social support for his or her quit attempt in his or her environments outside of treatment. "Ask your spouse/partner, friends, and coworkers to support you in your quit attempt."

Table 4. Assist—aid the patient in quitting (continued)

Action	Strategies for implementation
Recommend the use of approved pharmacotherapy, except in special circumstances.	■ Recommend the use of pharmacotherapies found to be effective. Explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.
Provide supplementary materials.	■ *Sources*—Federal agencies, nonprofit agencies, or local/state health departments. *Type*—Culturally/racially/educationally/age appropriate for the patient. *Location*—Readily available at every clinician's workstation.

Assist Component—Three Types of Counseling

Assisting patients in quitting smoking can be done as part of a brief treatment or as part of an intensive treatment program. Evidence from the guideline demonstrates that the more intense and longer lasting the intervention, the more likely the patient is to stay smoke-free; even an intervention lasting fewer than 3 minutes is effective. The following three tables provide further detail and examples of the three forms of counseling that were found to be effective in treating tobacco use and dependence: (1) practical counseling (problemsolving/skills training), (2) intra-treatment social support, and (3) extra-treatment social support.

Table 5. Common elements of practical counseling

Practical counseling (problemsolving/skills training) treatment component	Examples
Recognize danger situations—Identify events, internal states, or activities that increase the risk of smoking or relapse.	■ Negative affect. ■ Being around other smokers. ■ Drinking alcohol. ■ Experiencing urges. ■ Being under time pressure.
Develop coping skills—Identify and practice coping or problemsolving skills. Typically, these skills are intended to cope with danger situations.	■ Learning to anticipate and avoid temptation. ■ Learning cognitive strategies that will reduce negative moods. ■ Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure. ■ Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention).
Provide basic information—Provide basic information about smoking and successful quitting.	■ Any smoking (even a single puff) increases the likelihood of full relapse. ■ Withdrawal typically peaks within 1-3 weeks after quitting. ■ Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating. ■ The addictive nature of smoking.

Table 6. Common elements of intra-treatment supportive

Supportive treatment component	Examples
Encourage the patient in the quit attempt.	■ Note that effective tobacco dependence treatments are now available. ■ Note that one-half of all people who have ever smoked have now quit. ■ Communicate belief in patient's ability to quit.
Communicate caring and concern.	■ Ask how patient feels about quitting. ■ Directly express concern and willingness to help. ■ Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
Encourage the patient to talk about the quitting process.	Ask about: ■ Reasons the patient wants to quit. ■ Concerns or worries about quitting. ■ Success the patient has achieved. ■ Difficulties encountered while quitting.

Table 7. Common elements of extra-treatment supportive

Supportive treatment component	Examples
Train patient in support solicitation skills.	■ Show videotapes that model support skills. ■ Practice requesting social support from family, friends, and coworkers. ■ Aid patient in establishing a smoke-free home.
Prompt support seeking.	■ Help patient identify supportive others. ■ Call the patient to remind him or her to seek support. ■ Inform patients of community resources such as hotlines and helplines.
Clinician arranges outside support.	■ Mail letters to supportive others. ■ Call supportive others. ■ Invite others to cessation sessions. ■ Assign patients to be "buddies" for one another.

The use of pharmacotherapy is a key part of a multicomponent approach to assisting patients with their tobacco dependence. The following tables address the clinical use of pharmacotherapies for tobacco dependence and some of the more common questions and concerns regarding pharmacotherapy.

Table 8. Clinical guidelines for prescribing pharmacotherapy for smoking cessation

Who should receive pharmacotherapy for smoking cessation?	All smokers trying to quit, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations: those with medical contraindications, those smoking fewer than 10 cigarettes/day, pregnant/breastfeeding women, and adolescent smokers.
What are the first-line pharmacotherapies recommended?	All five of the FDA-approved pharmacotherapies for smoking cessation are recommended, including bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and the nicotine patch.
What factors should a clinician consider when choosing among the five first-line pharmacotherapies?	Because of the lack of sufficient data to rank-order these five medications, choice of a specific first-line pharmacotherapy must be guided by factors such as clinician familiarity with the medications, contraindications for selected patients, patient preference, previous patient experience with a specific pharmacotherapy (positive or negative), and patient characteristics (e.g., history of depression, concerns about weight gain).
Are pharmacotherapeutic treatments appropriate for light smokers (e.g., 10-15 cigarettes/day)?	If pharmacotherapy is used with lighter smokers, clinicians should consider reducing the dose of first-line NRT* pharmacotherapies. No adjustments are necessary when using bupropion SR.

*NRT = Nicotine replacement therapy

Table 8. Clinical guidelines for prescribing pharmacotherapy for smoking cessation (continued)

	Clonidine and nortriptyline
What second-line pharmacotherapies are recommended?	
When should second-line agents be used for treating tobacco dependence?	Consider prescribing second-line agents for patients unable to use first-line medications because of contraindications or for patients for whom first-line medications are not helpful. Monitor patients for the known side effects of second-line agents.
Which pharmacotherapies should be considered with patients particularly concerned about weight gain?	Bupropion SR and nicotine replacement therapies, in particular nicotine gum, have been shown to delay, but not prevent, weight gain.
Are there pharmacotherapies that should be especially considered in patients with a history of depression?	Bupropion SR and nortriptyline appear to be effective with this population.
Should nicotine replacement therapies be avoided in patients with a history of cardiovascular disease?	No. The nicotine patch in particular is safe and has been shown not to cause adverse cardiovascular effects.
May tobacco dependence pharmacotherapies be used long-term (e.g., 6 months or more)?	Yes. This approach may be helpful with smokers who report persistent withdrawal symptoms during the course of pharmacotherapy or who desire long-term therapy. A minority of individuals who successfully quit smoking use *ad libitum* NRT medications (gum, nasal spray, inhaler) long term. The use of these medications long term does not present a known health risk. Additionally, the FDA has approved the use of bupropion SR for a long-term maintenance indication.
May pharmacotherapies ever be combined?	Yes. There is evidence that combining the nicotine patch with either nicotine gum or nicotine nasal spray increases long-term abstinence rates over those produced by a single form of NRT.

Table 9. Suggestions for the clinical use of pharmacotherapies for smoking cessation[a]

Pharmacotherapy	Precautions/ Contraindications	Side Effects	Dosage	Duration	Availability	Cost/day[b]
First-line Pharmacotherapies		(Approved for use for smoking cessation by the FDA)				
Bupropion SR	History of seizure History of eating disorder	Insomnia Dry mouth	150 mg every morning for 3 days, then 150 mg twice daily (Begin treatment 1-2 weeks pre-quit)	7-12 weeks maintenance up to 6 months	Zyban (prescription only)	$3.33
Nicotine Gum		Mouth soreness Dyspepsia	1-24 cigs/day- 2 mg gum (up to 24 pcs/day) 25+ cigs/day- 4 mg gum (up to 24 pcs/day)	Up to 12 weeks	Nicorette, Nicorette Mint (OTC only)	$6.25 for 10, 2-mg pieces $6.87 for 10, 4-mg pieces
Nicotine Inhaler		Local irritation of mouth and throat	6-16 cartridges/day	Up to 6 months	Nicotrol Inhaler (prescription only)	$10.94 for 10 cartridges
Nicotine Nasal Spray		Nasal irritation	8-40 doses/day	3-6 months	Nicotrol NS (prescription only)	$5.40 for 12 doses

Table 9. Suggestions for the clinical use of pharmacotherapies for smoking cessation[a] (continued)

Pharmacotherapy	Precautions/ Contraindications	Side Effects	Dosage	Duration	Availability	Cost/day[b]
Nicotine Patch		Local skin reaction	21 mg/24 hours	4 weeks	Nicoderm CQ, (OTC only),	Brand name patches
		Insomnia	14 mg/24 hours then 7 mg/24 hours	then 2 weeks then 2 weeks	Generic patches (prescription and OTC)	$4.00-$4.50[c]
			15 mg/16 hours	8 weeks	Nicotrol (OTC only)	
Second-line Pharmacotherapies		(Not approved for use for smoking cessation by the FDA)				
Clonidine	Rebound hypertension	Dry mouth Drowsiness Dizziness Sedation	0.15-0.75 mg/day	3-10 weeks	Oral Clonidine-generic, Catapres (prescription only)	Clonidine-$0.24 for 0.2 mg
Catapres	(transdermal)				Transdermal (prescription only)	Catapres $3.50
Nortriptyline	Risk of arrythmias	Sedation Dry mouth	75-100 mg/day	12 weeks	Nortriptyline HCl-generic (prescription only)	$0.74 for 75 mg

[a]The information contained within this table is not comprehensive. Please see package insert for additional information.
[b]Prices based on retail prices of medication purchased at a national chain pharmacy, located in Madison, WI, April 2000.
[c]Generic brands of the patch recently became available and may be less expensive.

Intensive interventions are appropriate for any tobacco user who is willing to use them. Evidence shows that intensive interventions are more effective than brief interventions and should be used whenever possible (e.g., available resources, patient is willing). The following table presents the results of guideline analyses that examined different components of intensive treatment programs.

Table 10. Components of an intensive intervention

Assessment	Assessments should ensure that tobacco users are willing to make a quit attempt using an intensive treatment program. Other assessments can provide information useful in counseling (e.g., stress level, presence of comorbidity).
Program clinicians	Multiple types of clinicians are effective and should be used. One counseling strategy would be to have a medical/health care clinician deliver messages about health risks and benefits and deliver pharmacotherapy, and nonmedical clinicians deliver additional psychosocial or behavioral interventions.
Program intensity	Because of evidence of a strong dose-response relationship, the intensity of the program should be: *Session length*—longer than 10 minutes. *Number of sessions*—4 or more sessions. *Total contact time*—longer than 30 minutes.
Program format	Either individual or group counseling may be used. Proactive telephone counseling also is effective. Use of adjuvant self-help material is optional. Followup assessment intervention procedures should be used.
Type of counseling and behavioral therapies	Counseling and behavioral therapies should involve practical counseling (problemsolving/skills training) (see Table 5) and intra-treatment (see Table 6) and extra-treatment social support (see Table 7).

Table 10. Components of an intensive intervention (continued)

Pharmacotherapy	Every smoker should be encouraged to use pharmacotherapies endorsed in the guideline, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations (e.g., pregnancy, adolescents). The clinician should explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy agents include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and the nicotine patch. (see Tables 8 and 9).
Population	Intensive intervention programs may be used with all tobacco users willing to participate in such efforts.

Assist Component—Special Populations

Interventions should be culturally, language, and educationally appropriate. In general, the treatments that were found to be effective in the guideline can be used with members of special populations, including hospitalized smokers, members of racial and ethnic minorities, older smokers, and others.

Table 11. Arrange—schedule followup contact

Action	Strategies for implementation
Schedule followup contact, either in person or via telephone.	*Timing*—Followup contact should occur soon after the quit date, preferably during the first week. A second followup contact is recommended within the first month. Schedule further followup contacts as indicated. *Actions during followup contact*—Congratulate success. If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Remind patient that a lapse can be used as a learning experience. Identify problems already encountered and anticipate challenges in the immediate future. Assess pharmacotherapy use and problems. Consider use or referral to more intensive treatment.

TOBACCO USERS UNWILLING TO QUIT

The "5 R's," *Relevance*, *Risk*, *Rewards*, *Roadblocks*, and *Repetition*, are designed to motivate smokers who are unwilling to quit at this time. Smokers may be unwilling to quit due to misinformation, concern about the effects of quitting, or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising the smoker to quit, and assessing the willingness of the smoker to quit, it is important to provide the "5 R's" motivational intervention.

Relevance

Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of risks are:

- Acute risks: Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, and increased serum carbon monoxide.
- Long-term risks: Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.
- Environmental risks: Increased risk of lung cancer and heart disease in spouses; higher rates of smoking in children of tobacco users; increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.

Rewards

The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of rewards follow:

- Improved health.
- Food will taste better.
- Improved sense of smell.
- Save money.
- Feel better about yourself.
- Home, car, clothing, breath will smell better.
- Can stop worrying about quitting.
- Set a good example for children.
- Have healthier babies and children.
- Not worry about exposing others to smoke.
- Feel better physically.
- Perform better in physical activities.
- Reduced wrinkling/aging of skin.

Roadblocks

The clinician should ask the patient to identify barriers or impediments to quitting and note elements of treatment (problemsolving, pharmacotherapy) that could address barriers. Typical barriers might include:

- Withdrawal symptoms.
- Fear of failure.
- Weight gain.
- Lack of support.
- Depression.
- Enjoyment of tobacco.

Repetition

The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

FORMER SMOKERS—PREVENTING RELAPSE

Most relapses occur soon after a person quits smoking, yet some people relapse months or even years after the quit date. All clinicians should work to prevent relapse. Relapse prevention programs can take the form of either minimal (brief) or prescription (more intensive) programs.

Components of Minimal Practice Relapse Prevention

These interventions should be part of every encounter with a patient who has quit recently. Every ex-tobacco user undergoing relapse prevention should receive congratulations on any success and strong encouragement to remain abstinent. When encountering a recent quitter, use open-ended questions designed to initiate patient problemsolving (e.g., How has stopping tobacco use helped you?). The clinician should encourage the patient's *active* discussion of the topics below:

- The benefits, including potential health benefits, that the patient may derive from cessation.
- Any success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc.).
- The problems encountered or anticipated threats to maintaining abstinence (e.g., depression, weight gain, alcohol, other tobacco users in the household)

Components of Prescriptive Relapse Prevention

During prescriptive relapse prevention, a patient might identify a problem that threatens his or her abstinence. Specific problems likely to be reported by patients and potential responses follow:

Lack of support for cessation

- Schedule followup visits or telephone calls with the patient.
- Help the patient identify sources of support within his or her environment. (Table 7.)
- Refer the patient to an appropriate organization that offers cessation counseling or support.

Negative mood or depression

- If significant, provide counseling, prescribe appropriate medications, or refer the patient to a specialist.

Strong or prolonged withdrawal symptoms

- If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacotherapy or adding/combining pharmacologic medication to reduce strong withdrawal symptoms.

Weight gain

- Recommend starting or increasing physical activity; discourage strict dieting.
- Reassure the patient that some weight gain after quitting is common and appears to be self-limiting.
- Emphasize the importance of a healthy diet.
- Maintain the patient on pharmacotherapy known to delay weight gain (e.g., bupropion SR, nicotine-replacement pharmacotheripies, particularly nicotine gum).
- Refer the patient to a specialist or program.

Flagging motivation/feeling deprived

- Reassure the patient that these feelings are common.
- Recommend rewarding activities.
- Probe to ensure that the patient is not engaged in periodic tobacco use.
- Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.

Conclusion

Tobacco dependence is a chronic disease that deserves treatment. Effective treatments have now been identified and should be used with every current and former smoker. This Quick Reference Guide for Clinicians provides clinicians with the tools necessary to effectively identify and assess tobacco use, treat tobacco users *willing* to quit, treat tobacco users who are *unwilling* to quit at this time, and treat former tobacco users. There is no clinical intervention available today that can reduce illness, prevent death, and increase quality of life more than effective tobacco treatment interventions.

Guideline Availability

This guideline is available in several formats suitable for health care practitioners, the scientific community, educators, and consumers.

The *Clinical Practice Guideline* presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references.

The *Quick Reference Guide* is a distilled version of the clinical practice guideline, with summary points for ready reference on a day-to-day basis.

The *Consumer Version* is an information booklet for the general public to increase consumer knowledge and involvement in health care decisionmaking.

The full text of the guideline documents and the meta-analyses references for online retrieval are available by visiting the Surgeon General's Web site: **www.surgeongeneral.gov/tobacco/default.htm**

Single copies of these guideline products and further information on the availability of other derivative products can be obtained by calling any of the following Public Health Service clearinghouse's toll-free numbers:

Agency for Healthcare Research and Quality (AHRQ)
800-358-9295

Centers for Disease Control and Prevention (CDC)
800-CDC-1311

National Cancer Institute (NCI)
800-4-CANCER

Posted Mar. 02, 2003

Editorial: Doyle right to fund efforts to stop smoking

One of the most frequently mentioned targets for cutting to help overcome the state's $3.2 billion deficit has been the Tobacco Control Board, the organization set up to use proceeds from the tobacco settlement for anti-smoking efforts.

After all, the state squandered the settlement money to bail out the last budget.

Gov. Jim Doyle struck the right note in his 2004-05 budget proposal by calling for the elimination of the board, but allocating $15 million for anti-smoking programs in the Department of Health and Family Services.

This continues, albeit at a lower than optimum level, funding for the board's programs, which have been producing results. Studies have found that tobacco prevention programs have helped reduce smoking by high-schoolers by 18 percent in the last three years. Anti-smoking groups are concerned about losing that momentum.

Reducing smoking among teens is key to effective anti-smoking efforts. Typically, people start smoking in their teens or early 20s and become addicted to nicotine. That addiction makes it harder and harder to quit in later years.

Smoking among Wisconsin teens had been rising steadily in the 1990s. The concern is that could lead to increases in premature deaths and illnesses in future years. Smoking already is related to more than 8,000 deaths a year in this state. It's a cause of heart disease, stroke, cancer and other lung ailments. The annual cost of dealing with smoking-related illnesses has been estimated at $1.4 billion. Public health officials say that smoking is by far the leading preventable cause of death and disease in this country.

David Gunderson, the executive director of the Tobacco Control Board, who stands to lose his job if the budget proposal is OK'd by the Legislature, was upbeat about Doyle's proposal. He was quoted by a Milwaukee newspaper as saying, "The governor's proposal maintains funding for tobacco prevention, and that helps our goal of stopping kids

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from smoking and helping smokers quit."

Including funding for anti-smoking efforts should bring better health and lower health-care cost long after the state's fiscal crisis has been solved.

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WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

March 3, 2003

Ms. Sandra Terranova
Medical College of Wisconsin
Office of Planning and Government Affairs
8701 Watertown Plank Road
Milwaukee, Wisconsin 53226-0509

Dear Ms. Terranova:

The Joint Legislative Audit Committee will hold a public hearing on Legislative Audit Bureau report 03-3, *Use of Tobacco Control Board Funds*, on Tuesday, April 1, 2003 at 10:00 a.m. in Room 411 South of the State Capitol. A copy of the hearing notice is enclosed for your reference.

As this audit report relates to the activities of the Medical College of Wisconsin, we ask you to be present at the hearing to offer testimony in response to the audit findings and to respond to questions from committee members. Please plan to provide each committee member with a written copy of your testimony at the hearing.

Should you have any questions about the hearing, please contact us.

Sincerely,

Senator Carol A. Roessler
Co-chairperson
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz
Co-chairperson
Joint Legislative Audit Committee

Enclosure

cc: Janice Mueller
State Auditor

SENATOR ROESSLER
P.O. Box 7882 • Madison, WI 53707-7882
(608) 266-5300 • Fax (608) 266-0423

REPRESENTATIVE JESKEWITZ
P.O. Box 8952 • Madison, WI 53708-8952
(608) 266-3796 • Fax (608) 282-3624

WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

March 3, 2003

Dr. Michael Fiore, Director
Center for Tobacco Research and Intervention
1930 Monroe Street, Suite 200
Madison, Wisconsin 53711-2027

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Should you have any questions about the hearing, please contact us.

Sincerely,

Senator Carol A. Roessler
Co-chairperson
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz
Co-chairperson
Joint Legislative Audit Committee

Enclosure

cc: Janice Mueller
State Auditor

SENATOR ROESSLER
P.O. Box 7882 • Madison, WI 53707-7882
(608) 266-5300 • Fax (608) 266-0423

REPRESENTATIVE JESKEWITZ
P.O. Box 8952 • Madison, WI 53708-8952
(608) 266-3796 • Fax (608) 282-3624

WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

March 3, 2003

Mr. David Gundersen, Executive Director
Wisconsin Tobacco Control Board
1 West Wilson Street, Room B-158
Madison, Wisconsin 53701-1190

Dear Mr. Gunderson:

The Joint Legislative Audit Committee will hold a public hearing on Legislative Audit Bureau report 03-3, *Use of Tobacco Control Board Funds*, on Tuesday, April 1, 2003 at 10:00 a.m. in Room 411 South of the State Capitol. A copy of the hearing notice is enclosed for your reference.

As this audit report relates to the activities of the Tobacco Control Board, we ask you to be present at the hearing to offer testimony in response to the audit findings and to respond to questions from committee members. Please plan to provide each committee member with a written copy of your testimony at the hearing.

Should you have questions about the hearing, please contact us.

Sincerely,

Senator Carol A. Roessler
Co-chairperson
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz
Co-chairperson
Joint Legislative Audit Committee

Enclosure

cc: Janice Mueller
State Auditor

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WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

March 3, 2003

Ms. Helene Nelson, Secretary
Department of Health and Family Services
1 West Wilson Street
Madison, Wisconsin 53703

Dear Secretary Nelson:

The Joint Legislative Audit Committee will hold a public hearing on Legislative Audit Bureau report 03-3, *Use of Tobacco Control Board Funds*, on Tuesday, April 1, 2003 at 10:00 a.m. in Room 411 South of the State Capitol. A copy of the hearing notice is enclosed for your reference.

This audit relates to the activities of the Tobacco Control Board. Although the audit does not specifically address the funds received by the Thomas T. Melvin Youth Tobacco Prevention and Education Program, this program does receive a significant amount of money from the Tobacco Control Board. We ask that someone familiar with the program be available to answer questions that may arise concerning this program. This person is welcome to testify if so desired. If so, please plan to provide each committee member with a written copy of the testimony at the hearing.

In addition, we invite comment on the Governor's proposal to eliminate the Tobacco Control Board, specifically how the Department would absorb the administrative duties formerly assumed by the board with the addition of only one full time employee.

Should you have questions about the hearing, please contact us.

Sincerely,

Senator Carol A. Roessler
Co-chairperson
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz
Co-chairperson
Joint Legislative Audit Committee

Enclosure

cc: Janice Mueller, State Auditor
Gary Radloff, Department of Health and Family Services

SENATOR ROESSLER
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REPRESENTATIVE JESKEWITZ
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(608) 266-3796 • Fax (608) 282-3624

STEVENS POINT, WISCONSIN
STEVENS POINT Journal
www.stevenspointjournal.com

Stevens Point Weather
Temp: 9 °F
Hi: 20 °F
Lo: 17 °F

OPINION

Tue, Mar 4, 2003

State must stay vigilant against tobacco

The battle against tobacco use is a worthy one, and it is only beginning. Issues tobacco use will not go away - unlike the $5.9 billion the state was to receive ov its share of tobacco lawsuit settlement money.
Gov. Jim Doyle plans to keep anti-tobacco efforts active with $15 million in fund his proposed budget. The governor said his budget commitment will continue to tobacco use even though his plan eliminates the Wisconsin Tobacco Control Boa of June, the board's allocated funding from the state budget will be gone, as wil Doyle's plan would give the state Department of Health and Family Services res overseeing anti-tobacco programs.

The impact on local anti-tobacco efforts is unclear at this time. The Portage Cou Free Coalition receives about $50,000 from the state Tobacco Control Board, an distributed through Portage County Health and Human Services, said Cathy Mac community tobacco prevention specialist. It's not known whether the coalition w to operate through the state Department of Health, or if the department would structure for anti-tobacco programs.

What is clear is that anti-tobacco efforts must be continued and recent gains sh allowed to go up in smoke. We must make a priority to support the education of about dangers of tobacco use through programs such as N-O-T (Not On Tobacc persist with cessation programs such as the Wisconsin Tobacco Quit Line, (877) help people quit and stay away.

We must make sure our governor and our legislators know we support continue against tobacco use. Only with education and activism against tobacco use can inroads against tobacco addiction. Unless measures continue now to prevent yo starting to smoke and to support people trying to quit, health-care related costs productivity costs will continue to climb higher each succeeding year.

Coalition coordinated programs have proved effective in areas from cessation to MacKay said. Among high school students, 33 percent smoked in 2001; in 2002 were smoking. The number of adults in Wisconsin who smoke decreased by 5 p the past year, MacKay said.

More restaurants and other employers have gone smoke-free because of educat clean air concerns. Other businesses are training employees about laws against tobacco products to underage people. Physicians are encouraged to intervene w

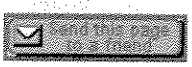
patients, and scientists are studying ways to prevent relapse.

The Tobacco Control Board was created in 2001 to oversee distribution of the se money and coordinate efforts in the state to combat tobacco use especially amc life span was only a little longer than that of the settlement money. Tobacco set payments summarily were sold by the state, and proceeds went to patch up def state budget.

The state has seen huge health-care costs from tobacco-related illnesses. Futur expected to be even more costly. There will be no settlement money to lessen t burden as people without health insurance call on the state for help.
Young people need help to make the right decisions about tobacco use, said Kat school nurse coordinator with Portage County Health and Human Services. Very available for educational programs, but health professionals and volunteers are they can. It takes money for reliable programs and for people to lead them.

Doyle's $15 million seems a small amount compared with that original settleme it will help.

Back to Top



Front Page | News | Packers | Sports | Entertainment | Homes | Autos | Jobs | Classifieds | Contact Us

Asbjornson, Karen

From: Seaquist, Sara
Sent: Monday, March 10, 2003 10:03 AM
To: Jermstad, Sara; Asbjornson, Karen
Subject: FW: Information on the Failure of the Wisconsin Tobacco Control Bureaucracy
CR email...audit and tobacco...

-----Original Message-----
From: Ira Sharenow [mailto:irasharenow100@yahoo.com]
Sent: Friday, March 07, 2003 9:52 PM
To: rep.jeskewitz@legis.state.wi.us; rep.kerkman@legis.state.wi.us; rep.kaufert@legis.state.wi.us; rep.cullen@legis.state.wi.us; rep.pocan@legis.state.wi.us; sen.risser@legis.state.wi.us; sen.roessler@legis.state.wi.us; sen.cowles@legis.state.wi.us; sen.darling@legis.state.wi.us; sen.george@legis.state.wi.us; sen.hansen@legis.state.wi.us
Cc: Bonnie Sumner; Taku Ronsman; Ira Yahoo Sharenow; Bill Lueders; Melanie Conklin; Daniel Bice
Subject: Information on the Failure of the Wisconsin Tobacco Control Bureaucracy

http://www.legis.state.wi.us/lab/reports/03-3highlights.pdf
http://www.legis.state.wi.us/lab/reports/03-3full.pdf

March 7, 2003

Dear Legislators,

I am writing to you in order to comment on the report of the Legislative Audit Bureau on WTCB and related organizations.

I am generally considered the leading tobacco control activist in the state, yet I was not consulted in fact it seems as though the Audit Bureau chose to not contact any of the top activists in Wisconsin. As a result, the report appears to be incomplete with respect to describing the woeful failure of Wisconsin tobacco control. However, I did not read the report thoroughly.

First of all it is clear that the WTCB has no meaningful performance standards. From my point of view the taxpayers are funding power trips and a lot of travel and vacations. I also get the sense that funding is based on cronyism, and past successes can be used as a reason for not funding people.

In fact, the WTCB funded Tobacco Free Dane County worked against my recent Madison smokefree restaurant ordinance efforts. When the final vote came up, Madison resident David Gundersen was in California while his alder sabotaged the ordinance.

In November 2001, I got the Madison smokefree workplace ordinance passed, the first in Wisconsin, yet Tobacco Free Dane County brought ZERO Madison residents to the final vote. However a few weeks before, they did have an expensive meeting on how to do grassroots. They talk about community involvement, yet they never act.

The Madison smokefree ordinance passed in 1992, and I also got ordinances passed in Shorewood Hills and Middleton. In all of their ten years TFDC has never even attempted a smokefree restaurant effort. But that apparently has not impacted their funding.

I consider the WTCB funded TFDC and their allies to be my primary adversaries whenever I attempt a smokefree effort. They worked to sabotage my smokefree workplace efforts; and they participated in secret and possibly ILLEGAL meetings in order to work with the tobacco industry allies to sabotage my most recent efforts.

There is a lot more to say, but I hope that just these few comments and the attachments will encourage you to ask the Audit Bureau to take a closer look at the harm caused by WTCB funded organizations.

The following statement from the introductory comments of the Legislative Audit Bureau is not really correct. Wisconsin used to have below average smoking rates compared to other states. It is only with the advent of the tobacco control bureaucracy and Project ASSIST that Wisconsin began losing ground on virtually all measurements.

"Nevertheless, Wisconsin's rates remain above national averages." [Emphasis added.]

P. 5 Did you realize that $1.5 million for 24,000 calls comes to $62.50 per call? Of course one should really be taking a look at CTRI. They soak up many millions of taxpayer dollars and the priorities of their people can really make someone wonder.

P.6 $357,400 for an unused survey!

P. 13 Gives the impression that WTCB successfully reduced smoking rates among youth to 33%. Interestingly the 1993 youth smoking rate was 25%. Also did the Audit Bureau examine the vast increase in young adult smoking?

It is also worth pointing out that WTCB began operation in 2000. From 1998-2000, cigarette sales fell 7.5%, according to the Wisconsin Department of Revenue. Now in the next two years, sales have only gone down 7.3%. More money spent but we are losing ground.

My recommendation is to clean house and then raise funding to $30 million. Perhaps you can hire some of the successful people who are working in other states. How to fund this? Well, Philip Morris just lowed prices by 50 cents on Marlboros. Why not raise the cig tax by 50 cents? Wisconsin is losing ground compared to other states with respect to increasing the health tax.

Finally, I realize that some politicians may be afraid to criticize the bureaucrats because they will then be accused of being in the pocket of

Philip Morris. Now it is true that since Tommy Thompson first took office, many Wisconsin politicians have fallen under the influence of Philip Morris campaign contributions; however, it is also important to recognize that many people who work in tobacco control have had or currently have close associations with the tobacco industry.

For those not familiar with my activity, in 1990 I initiated the smokefree UW-Madison policy, the first in the Big 10 and one of the first in the country; in 1991 I initiated the Madison smokefree restaurant ordinance, the first in the Midwest. More recently I got Madison to pass the first smokefree workplace law in Wisconsin. I was also the one who asked Fred Risser to sponsor legislation to ban smoking in the capitol. [Aside: When is DOA going to ban smoking in its building? If it had to obey city law, it would be violating the Madison smokefree restaurant ordinance, MGO 23.05.]

Ira

Wisconsin State Journal

December 6, 2002 Friday, ALL Editions

SECTION: FRONT; Pg. A1

LENGTH: 266 words

HEADLINE: WISCONSIN RANKS EIGHTH FOR HEALTH AND WELL-BEING

BYLINE: Brenda Ingersoll Wisconsin State Journal

BODY:
Wisconsin ranks eighth nationally in overall health and well-being, according to a report released Thursday.

It is the third year for The "United Way State of Caring Index," which analyzes 35 social and economic indicators. The report for 2000, the most current data available, shows "that this is still a desirable state in which to live," said Sandy Erickson, director of community building for United Way of Dane County. "The index is a report card that allows us to watch trends."

"One of the most interesting things is the 10-year trend of adults who reported smoking. In spite of all we know, there has been almost no change," Erickson said. In 1990, 24.7 percent of Wisconsinites reported smoking, compared to 24.1 percent in 2000.

"On the good side, a lower percentage of children and adults are medically uninsured, which in part is due to Badgercare," Erickson said, "and while we do have people living in poverty, it's still lower than what we've been seeing at the national level."

In 1999, 11 percent of Wisconsin children and adults were uninsured. That dropped to 7.1 percent in 2000. People living below the federal poverty level were 9.6 percent, compared to 11.3 percent nationally.

Other good news is that Wisconsin's infant mortality rate dropped from 8.2 deaths per 1,000 live births in 1990 to 6.7 in 1999, and its proportion of young children immunized rose from about 39 percent in 1990 to 74.2 percent in 2000.

Median household income dropped from 1999's $47,365 to $45,383 in 2000. Nationally, median household income for 2000 was $42,151.

From: Rick Orton [mailto:rorton@ci.madison.wi.us]
Sent: Wednesday, June 26, 2002 11:23 AM
To: DanIcenogle@icenogle.net; gadow@mailbag.com
Subject: Smoke Free Madison

Peter Munoz called me a little bit ago. He wanted to know how the Board meeting went, specifically the ordinance discussion. I shared with him my concerns and frustrations re: process before I told him of the TFDCC decision, that being support the concept of raising the exemption threshold to 50% or more of liquor sales (basically exempting some bars and taverns), neutral on the separately ventilated issue.

He was interested and sensitive to our decision and some of the rationale I shared w/ him.

Something that concerns me though is that when I asked about what the Mayor's position was, he said she hasn't decided until she sees something in writing. I said that we were feeling the same way. Also, Paulson is evidently part of the scheme but PM was not aware of his (paulson's) views. So, it seems that it is a Jean and Ira promotion. Peter complimented us on our position (albeit on something that doesn't exist). He suggested that it would be useful for him to have something

in writing from me re: ta,TFDCC statement of support/it's position. **I feel that somehow or other we're all of a sudden going to be out front on this, if we don't watch out.** At this point, I'm not sure that's what we were headed for. What do you think., open records and all though I haven't done the minutes yet? I said I'd have to check with higher ups before I felt comfortable sending somethin in writing.

Advice please.

Thanks.

Rick Orton, Coordinator
Tobacco Free Dane County Coalition, Inc.
Madison Department of Public Health
210 Martin Luther King, Jr. Blvd, Rm 507
Madison, WI 53703
608 294 5302
608 266 4858 Fax
rorton@ci.madison.wi.us

MINUTES (Corrected 7-25-02)
BOARD OF DIRECTORS MEETING
TOBACCO-FREE DANE COUNTY COALITION, Inc.
JUNE 25, 2002
WEA TRUST, 45 NOB HILL RD.
12:00 PM - 1:30 PM

Present: Pat Gadow, chair; Renae Sieling, WEA Trust; Susan Haag, RN, MDPH; Michelle Mangan, ACS; Gary Johnson, DCDPH; Michelle Mercure, ALA; Dan Icenogle, MD, JD; Cephus Childs, TCRCW; Rachelle Bartnick, ACS.

Staff present: Ryan Sheahan; Teresa Zais; Leah Tanke, AASPIRE Intern; Rick Orton, recorder.

Discussion/Action:

* **TCB Plan of Work** - Policy Objective Issue: the state's counter - proposal for County/TFDCC policy development objective is to achieve policy changes in 15 governmental units, businesses, etc., in 2002. The Board directed Johnson to:

o **negotiating number down to a lower number, five was mentioned;**
o advocate that those five can either be new policy initiatives or enhancements of current ones;
o seek to negotiate a multi-year approach whereby intermediate process objectives might be established toward achieving the five, or whatever the number, and that those intermediate process objectives can be counted for 2002, with completion of objective by 12/31/03
o we talked about this, but I do not have in my notes, and am not sure we settled on this, but the idea of negotiating a small or no penalty should we not achieve agreed upon objective;
o include accomplishments for all Dane County, Madison included;
o pursuing the concept that if the state wants policy change by 15 distinct entities w/ 10 employees or more, how about 1 entity w/ 150 employees or more.

Arguments for these positions may include:

o objectives as proposed by the state are just plain unrealistic on the face of it; achievement of these sorts of objectives do not happen over night, i.e. 6 months;
o the TCB 5 year goal is all government units and 100 businesses smoke free; proportionately, Dane County asked to ante up more than it's share, and in a six month period of time, to boot;
o best practices suggest that for long term success, a long term approach is indicated;
o the thought that all those entities out there who have achieved some sort of smoke-free environment are the easily picked fruit, there is no longer any "low hanging fruit" to pick; the thought that those yet to make smoke free policy changes are the ones less inclined to do so argues for a longer term process and commitment;
o **finally, all smoke-free policy efforts in Dane County involving TFDCC over the past 10 years, together, have not yielded 15 changes.**

Asbjornson, Karen

From: Muziksr@aol.com
Sent: Wednesday, March 12, 2003 10:30 PM
To: Karen.Asbjornson@legis.state.wi.us
Subject: Re: audit of UW

Hi Karen.

Please keep me informed about the progress of the audit of the UW System.

The audit of MATC was of great interest to me particularly in three areas: health insurance and the 2007 date; MATC salaries are much better than the UW which explains some of the shift of lower paid faculty and instructional academic staff from the University to the tech colleges; and the treatment of the Board. UW Regents, though manipulated at times, are much more aggressive in asserting their powers. Perhaps the difference is in the statutes.

Thanks,

Ed

Asbjornson, Karen

From: Asbjornson, Karen
Sent: Monday, March 17, 2003 8:38 AM
To: Asbjornson, Karen
Subject: FW: AB 126

audit stuff MPS

Karen Asbjornson
Office of Senator Carol Roessler
(608) 266-5300/1-888-736-8720
Karen.Asbjornson@legis.state.wi.us

-----Original Message-----
From: AERF [mailto:aerf@parentchoice.org]
Sent: Friday, March 14, 2003 4:10 PM
To: eberle@parentchoice.org
Subject: AB 126

To all legislators and staff:
For your information,
Wednesday night the Assembly Education Reform Committee voted 12-1 to send an amended AB 126 which directs the Legislative Audit Bureau to study the Milwaukee Parental Choice Program, to the full Assembly for a vote.

The bill has been scheduled for Tuesday's (3/18) floor calendar.

The Milwaukee choice coalition fully supports the bill and has been pushing for it since the 1999 biennium.
If you have technical questions before then please feel free to contact Steve Knudson in Rep. Jensen's office. Or, for a background history on the bill contact Ed Eberle, Director of Legislative Affairs at American Education Reform Foundation (414) 319-9160.

http://www.schoolchoicewi.org./pages/home/stgov/articleSTUDY
Thank you.

--

WISCONSIN TOBACCO CONTROL BOARD

2002 Annual Report
2002 Annual Report Executive Summary
2003 Strategic Planning

Since the inception of the Wisconsin Tobacco Control Board in April of 2000, the Board has launched a comprehensive spectrum of initiatives that have facilitated Wisconsin's fight against tobacco use, the state's number one preventable cause of death and disease. In this short time it has achieved many successes, some of which include:

- **High school smoking rates have decreased from 33% in 2001 to 27% in 2002.**
- **The Wisconsin Tobacco Quit Line has received over 30,000 calls since its inception. Callers to the Quit Line who set a quit-date have success rates three times higher than individuals trying to quit on their own.**
- **The cities of Onalaska, Holmen and Janesville became the most recent communities to ensure smoke-free environment; the City of Madison enacted Wisconsin's first policy to guarantee a smoke-free environment in workplaces.**
- **Over 5,000 youth have signed up to join the FACT movement against tobacco.**
- **45% of the pregnant smokers participating in the First Breath pilot study have quit or reduced their smoking.**
- **The rate of smoking among university of Oshkosh students has dropped 29% since the University began its campus campaign to market tobacco-free living.**

The Board represents a diverse array of sectors including industry, government, retailers, health care and education. This group is committed to achieving the long-term goal of reducing the $1.6 billion in health care costs and 7,300 deaths each year in Wisconsin from tobacco related diseases.

This web site provides information about the Board's members, legislative charge, and funded programs. It also provides information about past and upcoming meetings.

Additional Tobacco Control Resources are Available At:

Had Enough? Are you ready to stop smoking? Call the Quit Line at 1-877-270-STOP

For the latest tobacco news visit the TOBACCO CONTROL RESOURCE CENTER FOR WISCONSIN **at www.tobwis.org**

Wisconsin Youth Can Fight With Fact And Reverse the Trend

Asbjornson, Karen

From: Laurie Draheim [lad@ctri.medicine.wisc.edu]
Sent: Friday, March 21, 2003 12:42 PM
To: sen.roessler@legis.state.wi.us
Subject: Wisconsin Tobacco Quit Line - Fourth Quarter 2002 Summary and Full Report


Quit Line Summary - 4th quarte...


Quit Line 4th Quarter 2002 rep...

Dear Senator Roessler:

We are pleased to share with you the achievements of the Wisconsin Tobacco Quit Line for the fourth quarter of 2002.

Please see the attached summary for information about how statewide television advertising has boosted calls to the Quit Line and who is utilizing the services of the Quit Line. The full report for the fourth quarter of 2002 is also attached for your information.

The Wisconsin Tobacco Quit Line is coordinated by the UW - Center for Tobacco Research and Intervention, under the direction of Dr. Michael Fiore.

Please contact Lezli Redmond, MPH, UW-CTRI, Assistant Director for Intervention Programs, at 608-265-4143 or lr3@ctri.medicine.wisc.edu with any questions.

Thank you.

Laurie A. Draheim, MSPH
WI Tobacco Quit Line Coordinator
Center For Tobacco Research & Intervention
1930 Monroe St., Ste. 200
Madison, WI 53711
608-265-5617
608-265-3102 (fax)
1-877-270-STOP (7867) Quit Line
lad@ctri.medicine.wisc.edu
website: www.ctri.wisc.edu

MEDICAL COLLEGE OF WISCONSIN

Office of Planning and
Government Affairs

TO: **Honorable Members of the Joint Audit Committee**

FROM: **Kathryn A. Kuhn, Director**
Government Relations

DATE: **March 25, 2003**

RE: **Medical College of Wisconsin's Fight Against Tobacco Use**

The funds from the tobacco settlement allow the Medical College of Wisconsin to establish a unique presence in tobacco use prevention and cessation, research and educational programs to improve the health of Wisconsin's citizens and the state's economy.

The Impact of Tobacco Use in Wisconsin

Lung cancer continues to be the leading cause of cancer mortality for both women and men in Wisconsin. In 2002, 7,300 deaths in Wisconsin were due to smoking-related illnesses. In addition, an estimated 2,800 people died of lung or bronchus cancer and an estimated 3,000 new cases of lung cancer were diagnosed in Wisconsin in 2002.

The 2001 Wisconsin Behavioral Risk Factor Survey documented that 24% of Wisconsin adults currently smoke cigarettes. The percent of adults who smoke has remained virtually unchanged since 1992.

Medical College's Three-Front Attack on Nicotine Addiction

The Medical College has focused its battle against nicotine addiction on three fronts:

- *Community Outreach*
  Cessation programs specifically target the medically underserved population of Milwaukee's inner city youth and adults.

- *Clinical Research*
  The College's clinical research is developing innovative and effective strategies in smoking cessation.

- *Educational Programs*
  Educational programs for middle and high school students show the biological impact smoking has on the body as a preventive measure. Coordinated educational programs medical students, and residents in smoking cessation techniques using various methods and technologies to educate.

8701 Watertown Plank Road
Post Office Box 26509
Milwaukee, Wisconsin 53226-0509
(414) 456-8217
FAX (414) 257-0449

College's Research Compliments State's Tobacco Goals

The College's research and programs compliment the strategic plan developed by the State Tobacco Control Board in the following areas:

- *Adult Prevention and Cessation Efforts*
  - campus smoking cessation clinic
  - outreach cessation programs
  - clinical research programs on various smoking cessation methods
  - fMRI studies to determine nicotine's impact on the brain
  - education of medical students, residents, faculty and allied health professionals in smoking cessation interventions
  - development of math model to predict success of smoking cessation methods
- *Smoke-free Workplaces*
  - development of workplace programs to reduce employee tobacco use
- *Smoke-free Homes*
  - Interventions in households with asthmatic children and adults who smoke
- *Middle and High School Youth Prevention programs*
  - Community outreach cessation and education programs
  - Education of medical students, residents, faculty and allied health professionals in smoking cessation interventions
  - Anti-tobacco high school science curriculum

Program Refinements Resulting from the Legislative Audit

As a result of the State Legislative Audit Bureau's report on tobacco programs, the College modified its program to require:

- proposals include a realistic timetable for meeting patient accrual rates
- award notices be distributed by May 15th to allow researchers to obtain protocol approval prior to July 1st
- a part-time Tobacco Liaison position be created to coordinate the College's smoking cessation and prevention programs with community programs and coalitions and serve as a resource for information on the College's programs

Additionally, the College will work with the state to develop a longer funding period for clinical research.

Black Health Coalition of Wisconsin
2801 West Wisconsin Avenue • Milwaukee, Wisconsin 53208
Phone: (414) 933-0064 • Fax: (414) 933-0084

FACSIMILE TRANSMITTAL

TO: Carol Roessler **FAX:** 608 266-0423

FROM: Patricia McManus

DATE: 3-28-03

SUBJECT: Legislative Audit Bureau Report

NUMBER OF PAGES: 6

COMMENTS:

IF THERE ARE DIFFICULTIES WITH THIS TRANSMISSION, PLEASE CONTACT:

THANK YOU!!

Wisconsin Ethnic Network Collaborative

2801 West Wisconsin Avenue · Milwaukee, Wisconsin 53208
Phone: (414) 933-0064 · Fax: (414) 933-0084

Black Health Coalition of Wisconsin · Great Lakes Intertribal Council
United Migrant Opportunities Services · Wisconsin United Council of Mutual Assistance Associations

March 28, 2003

Senator Carol A. Roessler and

Representative Suzanne Jeskewitz, Co-Chairpersons

Joint Legislative Audit Committee

State Capitol

Madison, Wisconsin 53702

RE: Legislative Audit Bureau Report: Use of Tobacco Control Board Funds, February 2003

Dear Senator Roessler and Representative Jeskewitz:

The Wisconsin Ethnic Network Collaborative (WENC) would like to state its concerns regarding the statements made in the above referenced report regarding the activities of WENC during the first year. It is clear that whomever wrote the report did not understand the nature of the work of the network, because they based their assumptions regarding meeting goals by number of participants. The establishment and functioning of this network is not based on number of participants. It is a community empowerment strategy. The report also stated that WENC did not implement any of its local strategies which was not accurate. Members of WENC talked to staff from the bureau and sent them information, so we were quite surprised about the final statements that were placed in the report. To make things clearer, WENC would like to state the following:

1. Getting the whole network to function as a unit was difficult the first year and therefore we did not get the strategic plan completed. There was a change in the lead agency as a result. WENC also started three months late because of the need to appeal a funding decision regarding the network. WENC was structured to operate at three levels: the four ethnic groups working together, statewide ethnic networks, and then local strategies. Even in the best circumstances, it was understood that it would take time to get this whole infrastructure in place.

2. Various members of WENC were able to implement some of their local strategies, even in the first year. The report gave the impression that WENC conducted unauthorized activities other than what it was funded to do. However, those activities were the statewide and local strategies identified in our plan that was approved by the tobacco board.

a. The development of local coalitions by the African American Tobacco Free Task for in both Beloit and Madison were local strategies were started the first year. The South East Asian Tobacco Free Network implemented tobacco control related strategies in 12 different areas in the state.

b. Three of the four networks focused on obtaining data regarding tobacco use in their respective communities. This was also part of the work plan. Black Health Coalition – 150 African Americans participated in focus groups. UMOS conducted a survey of over 600 Hispanic/Latino persons, and WUCMAA conducted a survey of over 2,700 Hmong persons regarding tobacco control issues.

c. There was a three-day training in which individuals from California and Minnesota presented their experience in working with ethnic networks. This was done to build the infrastructure and capacity of the network. This was also part of the approved workplan.

Since the first year, WENC has moved ahead with the establishment of all four ethnic networks and the implementation of local strategies in each community. A WENC Strategic Plan has been developed and each ethnic network is in the process of developing or has developed its own.

It is important to WENC that the Joint Legislative Audit Committee has a clear picture of the activities. As with other projects, WENC certainly had some problems during program implementation. It is the first time in the history of the state that the four primary ethnic groups have worked jointly on a project such as this. While the establishments of ethnic networks have been proven to be best practices in other states, WENC is unique in that it uses a grassroots approach of community based organizations rather than being implemented by the State.

It is hoped that this information provides important information to the committee on the work that has been conducted by this very important project. The need for the state to address disparities in health, including tobacco-related morbidity and mortality require the work of entities such as WENC. WENC will be glad to provide a more updated report at your request. Thank you for your consideration. Please feel free to contact Patricia McManus, Project Coordinator, with any questions.

Sincerely,

Thai Vue, Chair
WENC