# Guide to evidence-based prevention
# Evidence summary

## Tobacco use and secondhand smoke exposure

### Health outcomes

- Ohio has higher tobacco use rates than most other states, ranking **39** for adult cigarette smoking[1] and **49** for secondhand smoke exposure for children.[2]
- Tobacco use and secondhand smoke exposure contribute to infant mortality, heart disease, cancer, diabetes and many other health problems.

### Healthcare costs

- **42 percent** of working-age Ohio Medicaid enrollees were current smokers in 2015.[3]
- Researchers estimate that **15 percent** of U.S. Medicaid costs are attributable to cigarette smoking.[4]
- It costs employers an estimated **$5,816** more per year to employ a smoker than a non-smoker, including healthcare and other costs.[5]

## Evidence-based prevention strategies relevant to state policy

### Increase unit price for tobacco products ★

**Ohio status**

*Excise tax rate on traditional cigarettes*

- Ohio's cigarette tax was increased by $0.35 in 2015 and is now $1.60 per pack, similar to the national average of $1.61 per pack.[6]

*Excise tax rates for other tobacco products and e-cigarettes*

- Little cigars: 37 percent of wholesale price[7]
- Other tobacco products: 17 percent of wholesale price (unchanged since 1993)[8]
- Electronic smoking devices and nicotine liquid: None

**Policy options**

- Increase excise taxes on any or all of the above products and/or allow local municipalities to do so. Impacts on tobacco use are proportional to the size of the price increase.
- Revise Ohio's minimum price law to prohibit the use of price discounting tactics.

### Media campaigns (mass-reach health communication interventions)

**Ohio status**

- The Ohio Department of Health (ODH) manages mass media campaigns delivered via TV, radio, social media, etc. The Centers for Disease Control and Prevention (CDC) funds and implements the national "Tips for Former Smokers" campaign in Ohio.
- Ohio spent approximately $1.9 million on media campaigns in SFY 2016;[9] the CDC-recommended level of investment for Ohio is $14.4 million.[10]

**Policy options**

Increase investment in mass media campaigns aimed at adults and/or youth. Evidence suggests that adult-focused cessation campaigns have the greatest impact on smoking prevalence and medical costs.[11]

## Evidence-based prevention strategies relevant to state policy (cont.)

### Quitline interventions (including mobile phone and internet-based interventions) ★

**Ohio status**

- The Ohio Tobacco Quit Line, which provides quit coaching and nicotine replacement therapy, is highly effective for those who can access it, but utilization is much lower than in most other states.[12]
- Access to Ohio's Quit Line is not universal. Many privately-insured Ohioans do not have access to the Ohio Quit Line. Medicaid managed care plan coverage of the Quit Line varies by plan.

**Policy options**

- Remove all barriers to use of the Quit Line.
- Invest state dollars to expand awareness, use and capacity of the Quit Line.

### Access to cessation counseling and medication (including reduction in out-of-pocket costs) ★

**Ohio status**

- While most adult smokers enrolled in Medicaid report that they want to quit,[13] a national study estimated that only 14% of Ohio adult smokers who received Medicaid had used tobacco cessation medications in 2013.[14]
- It is unclear what proportion of privately-insured smokers have received cessation services, but evidence suggests uneven coverage by commercial insurance plans.[15]

**Policy options**

Launch a high-intensity effort to increase cessation services by healthcare providers, with particular emphasis on Medicaid enrollees and state employees:

- Require reporting of performance on tobacco cessation metrics in Medicaid managed care and provider contracts
- Remove barriers such as co-pays, prior authorizations and quit attempt limits
- Offer quit incentives
- Raise awareness of cessation coverage among providers and tobacco users
- Monitor compliance of private health insurance plans with cessation coverage requirements

### Smoke-free policies

**Ohio status**

- Ohio has a comprehensive smoke-free workplace law in place.
- In 2014, 81 percent of Ohioans reported that they approved or strongly approved of this law.[16]

**Policy options**

- Maintain and enforce Ohio's smoke-free workplace law, including prompt collection of fines for violations.
- Support 100 percent tobacco-free school and college campuses and smoke-free multi-unit housing.

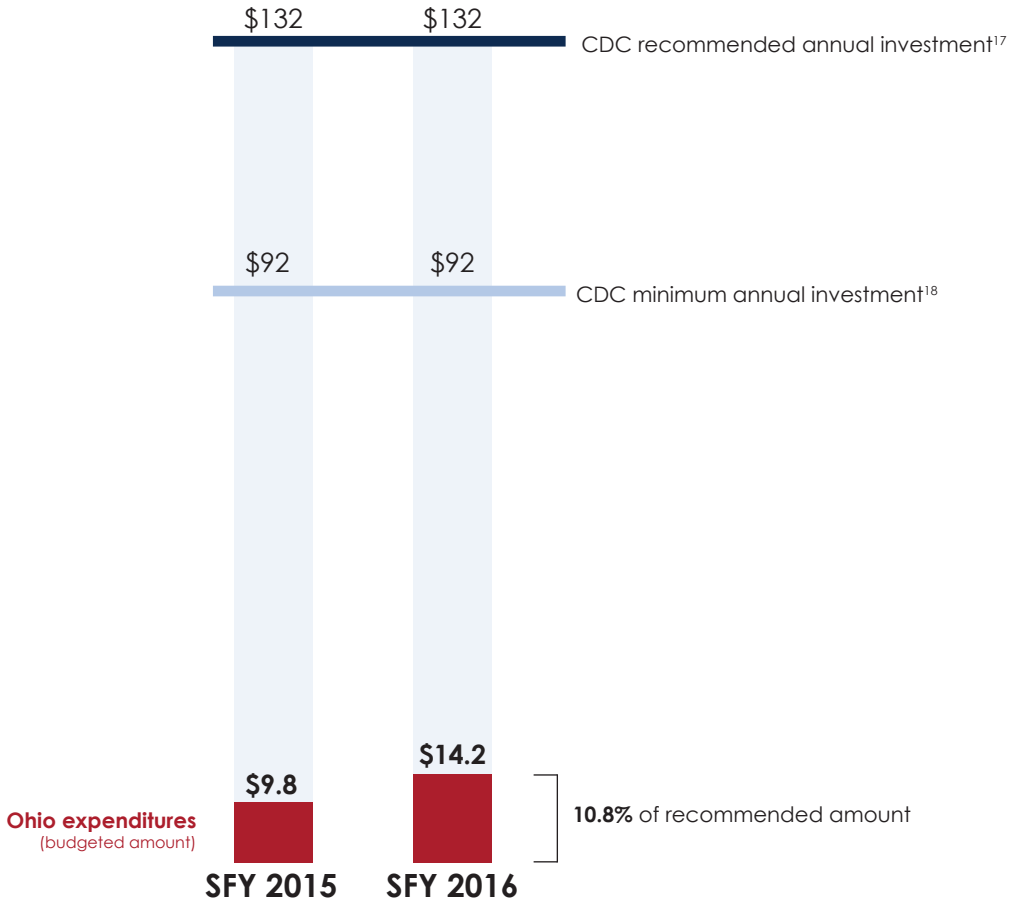
★=Likely to reduce health disparities (The Community Guide and/or What Works for Health have indicated that the strategy is likely to decrease disparities, including racial/ethnic, socioeconomic, geographic or other disparities, based upon the best available evidence.)

See **Evidence Inventory** publication for details and additional strategies

## Comprehensive tobacco control program

The CDC recommends that states have a comprehensive tobacco control program that includes the activities listed on pages 1 and 2, along with surveillance, evaluation and support for local coalitions. Ohio has these components in place, although the state's investment is far below the amount recommended by CDC to support an effective program (see chart).

### Ohio's investment in comprehensive tobacco control (in millions)




**Note:** Ohio expenditures include state and federal tobacco prevention and control expenditures. Does not include Medicaid spending.
**Sources:** American Lung Association[19]

## Our approach

To identify the strategies in this publication, HPIO developed an **Evidence Inventory** summarizing the following research reviews:

- The Guide to Community Preventive Services (CDC)
- U.S. Preventive Services Task Force Recommendations (Agency for Healthcare Research and Quality)
- What Works for Health (County Health Rankings and Roadmaps)

HPIO selected strategies from the Evidence Inventory to include in this fact sheet that met the following criteria:

- Strong evidence for reducing tobacco use and secondhand smoke exposure
- Relevant to state policy and actionable by state legislators and/or state agency leaders
- Timely opportunity for our state given Ohio's current status

To learn more about what works to prevent tobacco use, see the HPIO **Evidence Inventory** and policy brief, **The State of Tobacco Use Prevention and Cessation in Ohio**.

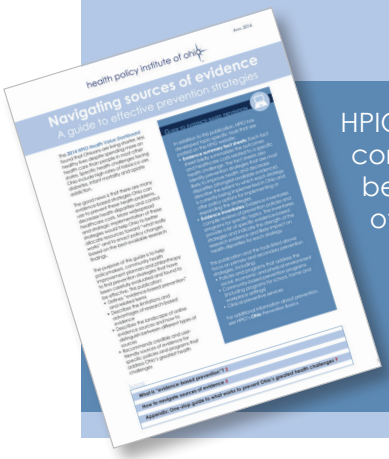
## Notes


1. Data from 2014 Behavioral Risk Factor Surveillance System, as compiled by America's Health Rankings, 2015 edition. "Smoking: Ohio." Accessed March 28, 2016. http://www.americashealthrankings.org/Measures/Measure/OH/Smoking
2. Data from 2011 National Survey of Children's Health, as compiled by the Health Policy Institute of Ohio. 2014 Health Value Dashboard. Columbus, OH: Health Policy Institute of Ohio, December 2014.
3. Data from the 2015 Ohio Medicaid Assessment Survey (OMAS) Adult Dashboard, stratified results. Current smokers among non-senior adults (ages 19-64). Accessed February 9, 2016. http://grcapps.osu.edu/dashboards/OMAS/adult/.
4. Xu, X., et al. "Annual Healthcare Spending Attributable to Cigarette Smoking: An Update." American Journal of Preventive Medicine 48, no.3 (2015): 326- 333. doi: 10.1016/j.amepre.2014.10.012.
5. Berman, Micah, et al. "Estimating the cost of a smoking employee." Tobacco Control 23, no.5 (2014): 428-433. doi: 10.1136/tobaccocontrol.2012.05.0888. This estimate considers absenteeism, presenteeism, smoking breaks, healthcare costs and pension benefits; it is based on private employers who self insure and use defined benefit pension systems.
6. Campaign for Tobacco-Free Kids. "State cigarette excise tax rates and rankings." 2016. Accessed March 25, 2016. https://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf.
7. Am. Sub. H.B. 59 of the 130th General Assembly. Ohio Revised Code section 5743.51.
8. Ohio Revised Code section 5743.51.
9. Information provided by the Ohio Department of Health. Provided March 23, 2016.
10. U.S. Centers of Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs. 2014. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
11. Microsimulation model analysis of smoking interventions for Ohio. Community Health Advisor. Accessed February 1, 2016. http://www.communityhealthadvisor.org/.
12. Health Policy Institute of Ohio. The state of tobacco use prevention and cessation in Ohio: Environmental scan and policy implications. Columbus, OH: Health Policy Institute of Ohio, June 2015.
13. Malarcher, Ann, et. al. "Quitting smoking among adults—United States, 2001-2010." Morbidity and Mortality Weekly 60, no. 44 (2011): 1513-1519. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6044a2.htm.
14. Ku, Leighton, et al. "Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit." Health Affairs 35, no.1 (2016): 62-70.
15. American Lung Association. "State Health Insurance Marketplace Plans: New Opportunities to Help Smokers Quit." Chicago: American Lung Association, 2015. And, "The 6/18 Initiative Evidence Summary: Reduce Tobacco Use," U.S. Centers for Disease Control and Prevention. Accessed March 25, 2016. http://www.cdc.gov/sixeighteen/tobacco/index.htm.
16. Survey data provided by the Ohio Department of Health, April 2016.
17. U.S. Centers of Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs. 2014. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
18. Ibid.
19. American Lung Association (ALA). SFY2016 data are from "The State of Tobacco Control 2016." 2016. Accessed March 28, 2016. http://www.lung.org/our-initiatives/tobacco/reports-resources/sotc/. SFY2014 data provided by ALA, 2015.


## How can we improve health value in Ohio?

The **2014 HPIO Health Value Dashboard** identifies areas in which Ohio's performance is worse than most other states, including:

- Adult smoking
- Secondhand smoke exposure for children
- Adult diabetes
- Food insecurity
- Drug abuse (unmet need for illicit drug use treatment)
- Infant mortality


HPIO's **Guide to Evidence-Based Prevention** provides policymakers, community health improvement planners and philanthropy with the best-available sources of evidence for what works to address many of these challenges.

This fact sheet is part of a series of tools that comprise the Guide to Evidence-Based Prevention. HPIO will continue to add tools on specific health challenges throughout 2016. All publications can be found at: **http://bit.ly/1VVBPkH**