

BACKGROUND AND PURPOSE OF THE SUMMIT

The Charge: Cessation 2.0

Two related concepts served as guideposts for “Creating Positive Turbulence: A Tobacco Quit Plan for California.” Created by Stanley Gryskiewicz, the term “positive turbulence” describes a climate in which leaders promote beneficial changes in their organizations or in society by fostering creativity, recombination, and reinvention and by stimulating individual contributions toward a shared goal (Gryskiewicz, 1999). Web 2.0 refers to the second generation of Web development that has revolutionized the Internet, leading to the creation of Web based communities, social networking sites, video-sharing sites, wikis, blogs, and more.

The California Department of Public Health (CDPH) asked summit participants to apply these concepts to tobacco cessation and make similarly transformative recommendations representing “Cessation 2.0.” We asked them to think creatively about what could be done in California, beyond simply doing a better job implementing current best practices or adopting good ideas from other states. We asked them to take what is known about cessation, the political and economic environment, the health care delivery system, partnerships, and marketing and to recombine this knowledge in new ways, or with strategies and technologies from other fields to raise California to a new level with respect to cessation. We challenged participants to develop strategies that would be relevant in the new economy and to look for ways

to develop new connections focusing more on cooperation than on coercion to create sustained change. Just as the power of Web 2.0 derives from the decentralized, voluntary participation of thousands of individuals, the power of Cessation 2.0 should derive from its potential to engage active, new partners.

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Considerations Guiding the Discussion

Current funding for CTCP is approximately \$55 million annually, with budget reductions anticipated. Funding available to the CTCP Media Campaign continues to decline while the cost of advertisement (ad) placement keeps rising. Local health departments also have shrinking budgets for tobacco control. For these reasons, the Quit Plan for California favors low- or no-cost strategies using partnerships and outside resources.

Despite the second-lowest rate of tobacco use in the nation, California still has nearly four million smokers, equivalent to the population of Oregon

(Al-Delaimy et al., 2008). CDPH charged summit participants with determining how to encourage and support these four million smokers to quit, in ways that are:

- fiscally responsible and realistic with respect to the state of the economy;
- population-based;
- marketable in a cost-effective manner;
- likely to be embraced by health care providers and insurers; and
- forward thinking and boundary-testing.

Four topics were not discussed at the summit:

1. Increasing the state's tobacco tax. CTCP requires a Quit Plan that is viable without additional resources.
2. Mandating health insurance coverage of cessation treatment. This issue was included in recent or current comprehensive health insurance proposals under consideration at the state and federal levels.¹
3. Expanding face-to-face cessation services or alternative treatments. These are costly to provide and, in the case of alternative treatments, lack clear evidence of effectiveness.
4. Adopting harm reduction strategies. CTCP does not support harm reduction as a cessation strategy as there is a lack of scientific evidence demonstrating its effectiveness and effect at both the individual and population levels.

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Other Important Considerations

Efforts to increase tobacco cessation should be viewed in the context of the larger discussion of health care reform. Several of the themes from that discussion are favorable to tobacco cessation. These include a focus on prevention and wellness rather than on simply treating disease, the importance of cost-efficiency in treatment selection, the benefits of coordinated chronic disease management and of integrated patient care systems such as electronic medical records, and the need to address disparities in access to treatment to improve overall health outcomes. From the broader discussion of health care reform, new systems and practices will emerge, presenting a golden opportunity to incorporate Cessation 2.0 strategies into health care in a systematic way.

Although tobacco use is receding in California, the prevalence is still high in certain groups. American Indians/Alaska Natives, African Americans, Asian men, Caucasian men, lesbian/gay/bisexual/transgender individuals, enlisted military personnel, and rural residents have higher rates of tobacco use than the general population (Al-Delaimy et al., 2008). Increasingly, tobacco use is associated with low socioeconomic status (SES), mental illness, and substance abuse (Centers for Disease Control and Prevention, 2008; Lasser et al., 2000). To continue lowering the overall prevalence of tobacco use in the state, California must increase cessation efforts within these subgroups.

¹The Patient Protection and Affordable Care Act (Pub.L. 111-148, 124 Stat. 119, to be codified as amended at scattered sections of 42 U.S.C.) was signed into law by President Barack Obama on March 23, 2010. Effective September 23, 2010, insurers are prohibited from charging co-payments or deductibles for preventive care and medical screenings on all *new* insurance plans and by 2018 all existing health insurance plans must cover checkups and other preventive care without co-pays. Medicaid would start covering stop-smoking services for pregnant women starting in October 2010.

California is fortunate to have many strong, local organizations that are engaged in tobacco control and can act as proponents and messengers of change. But resources are often scarce for these organizations, so it is important to give careful consideration to how they can incorporate low- or no-cost Cessation 2.0 strategies into their current activities, in particular by recruiting additional active partners.

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On a population level, the strategies that are most effective in reducing the prevalence of tobacco use are those that increase the frequency of quit attempts (Zhu, 2006). Current resources are insufficient to provide cessation assistance to all smokers for every quit attempt. Not all smokers want assistance, though the majority of them do want to quit. “Self quitting,” while it has a low efficacy rate, is still the most common route to successful quitting (Chapman and Mackenzie, 2010).