Healthcare Council

Tuesday, January 23, 2007
1:00 PM
Morris Hall

Action Packet

Marco Rubio
Speaker

Aaron Bean
Chair

COUNCIL MEETING REPORT

Healthcare Council

1/23/2007 1:00:00PM

Location: Morris Hall (17 HOB)

Attendance:

	Present	*Absent*	*Excused*
Aaron Bean (Chair)	X		
Thomas Anderson	X		
Loranne Ausley	X		
Bill Galvano	X		
Rene Garcia	X		
Hugh Gibson	X		
Gayle Harrell	X		
D. Alan Hays	X		
Ed Hooper	X		
Jimmy Patronis	X		
Ari Porth	X		
Elaine Schwartz	X		
Kelly Skidmore	X		
Priscilla Taylor			X
Juan Zapata	X		
Totals:	**14**	**0**	**1**

COUNCIL MEETING REPORT

Healthcare Council

1/23/2007 1:00:00PM

Location: Morris Hall (17 HOB)

Other Business Appearance:

AHCA Budget Recommendations
Tom Arnold (Lobbyist) (State Employee) (At Request Of Chair) - Information Only
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee FL 32308
Phone: 850/488-3560

DCF Budget Recommendations
Bob Butterworth (Lobbyist) (State Employee) (At Request Of Chair) - Information Only
Department of Children & Families
1317 Winewood Blvd.
Tallahassee FL 32399
Phone: 850/487-1111

DCF Budget Recommendations
Melissa Jaacks (Lobbyist) (State Employee) (At Request Of Chair) - Information Only
Department of Children & Families
1317 Winewood Blvd.
Tallahassee FL 32399
Phone: 850/487-1111

Idea #87 Marketplace of Affordable Health Care
Bob Wychulis (Lobbyist) (At Request Of Chair) - Information Only
FL Association of Health Plans, Inc.
P. O. Box 10748
Tallahassee FL 32301
Phone: 850/386-2904

Idea #87 Marketplace of Affordable Health Care
Gerald B. Sternstein (At Request Of Chair) - Information Only
Care Access Health Plan
801 E. Hallandale Beach Blvd., #200
Hallandale FL 33009
Phone: 305/614-5012

New Proposed CBC Allocation Method
Glen Casel (At Request Of Chair) - Information Only
Florida Coalition for Children
605 Crescent Exec. Court, Suite 428
Lake Mary FL 32746
Phone: 407/333-8256

Tobacco Amendment Implementation
Paul Hull (Lobbyist) - Information Only
American Cancer Society, FL Division
3709 W. Jetton Avenue
Tampa FL 33629
Phone: 813/382-9235

Committee meeting was reported out: Wednesday, January 24, 2007 8:42:15AM

COUNCIL MEETING REPORT

Healthcare Council

1/23/2007 1:00:00PM

Location: Morris Hall (17 HOB)

Summary: No Bills Considered

Committee meeting was reported out: Wednesday, January 24, 2007 8:42:15AM

Community Interventions

Community interventions at the local level influence societal organizations, systems, and networks to support tobacco free norms. Social norm change approaches are designed to affect tobacco use by "indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible." The social norm change model presumes that durable social norm change occurs through shifts in the social environment of local communities, at the grass roots level (California Department of Health Services, 1998).

Notes:

- The 2006 Community Intervention category combines three 1999 budget categories: Community programs to reduce tobacco use, Chronic disease programs to reduce the burden of tobacco-related diseases and Statewide programs.
- This intervention category also includes funding for targeted interventions to reduce tobacco-related disparities and to promote local policy change.

In 1999, Chronic disease programs to reduce the burden of tobacco-related diseases supported programs to implement interventions that link tobacco control efforts with other programs that address specific diseases caused by tobacco.

In 1999, Statewide programs supported state-level policy change, programs to support local programs (e.g. technical assistance, training), and organizations that have statewide access to specific communities.

Costing Parameters in 1999 Best Practices

- Community program costs were estimated based on per capita expenditures in California and Massachusetts, which both had strong local programs with significant program focus on serving disparate populations.
- Community program cost estimates included a range of funding for personnel and resources to provide training and technical assistance to community programs.
- Costing parameters for Chronic disease programs included specific cost recommendations for integrating tobacco prevention and control with state cardiovascular disease, asthma, cancer, and oral health programs.
- Costing parameters for Statewide programs were based on a per capita cost estimate derived from state experiences in California, Massachusetts, and Oregon. Statewide grants in these states provided a strong emphasis on community coalitions and efforts to reduce tobacco-related disparities.
- Quitline costs were included in the Statewide program intervention category.

Changes Since 1999 Best Practices

- We are not aware of any new state experiences or studies that indicate that funding levels greater than the 1999 "upper" bound estimate will achieve higher levels of program impact.

Media Interventions

Media interventions educate, inform, and change social norms around tobacco use. They support other program interventions by increasing visibility of an issue, promoting services, framing debates, and influencing attitudes and behaviors. The independent Task Force on Community Preventive Services strongly recommends use of mass media education campaigns in conjunction with other community interventions to decrease tobacco use initiation and increase cessation. Media campaigns to prevent initiation and promote cessation are intended to counter tobacco industry influences and increase pro-health messages throughout a state, region, or community. Media campaigns are also very effective in driving calls to telephone quitline services. Media can include media advocacy, earned media or donated and paid placement of messages and promotions.

Costing Parameters in 1999 Best Practices

- A per capita population cost was based on experience with multi-year sustained tobacco media campaigns in Massachusetts and California.
- State specific estimates were generalized using Massachusetts's per capita expenditures as an "upper" bound and California's per capita expenditures during sustained campaign periods as a "lower" bound.

Changes Since 1999 Best Practices

- New data on the efficacy of intensive youth-focused media campaigns (e.g. Florida, American Legacy Foundation)
- Ability to calculate the cost of media campaigns by designated market areas (DMA's) using standard media rate metrics. Commonly used metrics include Target Rating Points (TRP's) and Gross Rating Points (GRP's). TRP's and GRP's are measures of advertising intensity that combine frequency of broadcast with the number of people in a target audience who are reached. Cost estimates to reach target TRP's or GRP's can be made for each DMA.
- Evidence pointing to a possible "sweet spot" of media exposure based on evidence from youth campaigns (i.e. delivering 800, 1,200, and 1,600 rating points per quarter). Levels below this value may not have a sufficient impact to change population smoking prevalence. Given the funding constraints that states face, GRP's beyond 1,600 may not be realistic.

Cessation Programs

Cessation programs are programmatic interventions to provide population-based cessation services to the individual smoker. These may include quitlines, as well as system-based initiatives to ensure that all tobacco users seen in the healthcare system are screened, that they receive brief advice to quit, and that they are offered more intensive counseling services and FDA approved medication.

Note: The costs for other interventions known to increase cessation rates such as increasing the price of tobacco products, smokefree policies, insurance coverage for tobacco use treatments, and media campaigns are captured in State-level coordination and Media interventions categories in the 2006 Best Practice update.

Costing Parameters in 1999 Best Practices

"Lower" bound

- Identifying smokers during a clinical visit (screening)
- Providing brief counseling to smokers

"Upper" bound

- Minimum ("lower" bound) plus
- Cost of providing partial to full coverage for range of cessation services, including counseling and over the counter nicotine replacement therapy (NRT), to up to 10% of smokers (the percentage expected to use full cessation services each year).
- It was assumed that insurance would cover NRT costs for 50% of smokers receiving services.
- Costs were based largely on the experience of Group Health Cooperative of Puget Sound and the California quitline.

Changes Since 1999 Best Practices

- As recommended by The Task Force on Community Preventive Services and state experience, quitlines have become a minimum standard for providing cessation treatment. Thus, quitlines which were only included in the "upper" bound in the 1999 Best Practices estimates are now included in the "lower" bound estimate as standard practice in the 2006 Best Practice update.
- Evidence suggests that provision of free NRT dramatically increases quitline volume which substantially increases the total number of quitters. Thus, the 2006 Best Practice update proposes that the "lower" bound cost estimate include some level of provision of NRT.
- The Surgeon General's Interagency Report on Cessation suggests that more smokers (up to 15%) would access quitline services each year.
- Fewer population-based interventions, such as increasing the use of reminder systems to prompt clinicians to treat tobacco users, are now emphasized in the 2006 "upper" bound estimates.

Youth Programs

Youth programs prevent tobacco use initiation and encourage cessation among young people by shaping their environment to support smoke-free norms.

Notes:

- Funding to implement other interventions known to prevent tobacco use initiation and encourage cessation among young people, much as increasing the price of tobacco products and media education campaigns, are captured in the Community interventions and Media interventions categories in the 2006 Best Practice update.

- The 2006 Best Practices Youth program category combines two 1999 budget categories: School Programs and Enforcement.

- In the 2006 Best Practices update, inter-agency activities regarding the enforcement of smokefree policies is included in the State-level coordination intervention category. The effective interventions from the 1999 Enforcement category are now addressed in the Community program category.

Costing Parameters in 1999 Best Practices

- In 1999, School Programs included technical assistance to school districts and per capita student funding for schools based on the experience in California and Oregon.
- In 1999, Enforcement included enforcement of minors' access restrictions and statewide coordination to enforce smoke-free policies. Minors' access cost estimates were based on state experiences enforcing the provisions of the Synar Amendment, on FDA contracts with states and on the experience in Florida.
- School program costs were estimated based on a per capita amount per student in grades K-12 to implement CDC School Guidelines.
- School program costs included an estimate for the provision of training and technical assistance to schools.
- Cost estimates for enforcement included a base cost plus a per capita cost.

Changes Since 1999 Best Practices

- The Task Force on Community Preventive Services found that there is insufficient evidence to demonstrate the effectiveness that school-based education and interventions to reduce minors' access to tobacco when that are implemented alone. When these activities are implemented in combination with media and community-based activities they are effective.
- State experience since 1999 (Oregon, Washington, New York, Kansas) suggest using three core cost parameters to estimate cost for Youth programs. These include:
  - State-wide infrastructure (The Department of Public Health working with the Department of Education)
  - Mini-grants to schools and/or districts to support school policy change
  - A per capita amount per student in grades K-12 for implementation of CDC School Guidelines.
- There is uncertainty about the appropriate range of funding for each of the identified cost parameters.

Infrastructure categories

Central Surveillance and Evaluation

Surveillance is the regular monitoring of measures over time to inform program and policy direction and interventions.

Evaluation includes point-in-time assessments to measure the effectiveness of specific programs, policies, and media efforts.

Costing Parameters in the 1999 Best Practices

- 10% of the total tobacco prevention and control budget

Changes Since 1999 Best Practices

- We are not aware of any new state experiences or studies suggesting a different way of calculating a cost estimate for this category.

State-level Coordination

State-level coordination includes coordinating program components and partnerships, supporting community coalitions, monitoring of grants and initiatives, strategic planning, training, and support for policy initiatives.

Costing Parameters in the 1999 Best Practices

- 5% of the total tobacco prevention and control budget

Changes Since 1999 Best Practices

- Additional state level experience on the costs to coordinate interventions to reduce tobacco-related disparities.
- Inter-agency coordination around policy and regulation were shifted from the 1999 Enforcement category to the State-level coordination in the 2006 Best Practices update.