TOBACCO USE PREVENTION AND CESSATION TASK FORCE FINAL REPORT

West Virginia Legislature
December 2021

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EXECUTIVE SUMMARY

The Tobacco Use Prevention and Cessation Task Force is pleased to provide its final report to the West Virginia Legislature. The Task Force was created in 2020 for "the purpose of recommending and monitoring the establishment and management of programs that are found to be effective in the reduction of tobacco, tobacco products, alternative nicotine products, and vapor products use by all state citizens, with a strong focus on the prevention of children and young adults use of tobacco, tobacco products, alternative nicotine products, and vapor products."

This report describes results from the Task Force's year-long study of how the West Virginia Department of Health and Human Resources Division of Tobacco Prevention (DTP) implements prevention and cessation programming, as well as existing science-based best practices and the potential for improving this important work. These and other directives are detailed in legislative HB 4494.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) data, West Virginia has the highest tobacco use rate and substance use disorder (SUD) in the United States. The World Health Organization concludes that smoking increases the progression of COVID-19, including death. This effect is increased among young people, which makes tobacco dependence treatment paramount. In addition, relapse of SUD is increased in those who continue or initiate cigarette use after stopping the use of illicit drugs. Therefore, incorporating tobacco cessation treatments and tobacco use prevention efforts into substance abuse treatment may be one way to improve long-term substance use outcomes.

The conclusions and recommendations provided in this document are the result of a year-long effort to study how tobacco control is funded, coordinated, and evaluated in West Virginia. Therefore, this list is extensive but not exhaustive. The Task Force submits these recommendations as a first step in a strategic, guided directional shift that will chart a new course in how our state addresses tobacco use.

Much of what is recommended in this document would create significant changes in scope, direction, and operations at the WVDHHR Division of Tobacco Prevention. The task force believes these actions are critical in addressing and reducing tobacco use: the single, most preventable cause of death and disease in our state. Its toll is further highlighted in this report.

If the legislature agrees to accept and fund these recommendations, we recommend an additional year of Task Force oversight in its current model to continue to serve in autonomous review of the recommendations in this document.

Key Recommendations

Cessation Interventions

- In light of West Virginia's high levels of nicotine addiction, DTP should continually adjust tobacco cessation treatment protocols to reflect the most up-to-date, evidence-based best practices, as needed.

- Tobacco cessation quitlines are the cornerstone of every state's tobacco control program. In a rural state like ours-- with a high prevalence rate for tobacco use--offering online and phone cessation services is critical. The Task Force recommends a realignment of goals/objectives in the next request for proposals to potential tobacco quitline managers that include a much more robust data collection and evaluation component. Additionally, the WV Tobacco Quitline funding needs to be increased to extend the time that patients are on NRT, provided adequate combinations of medications when necessary (not only dual therapy but triple therapy if indicated). The Quitline investment should be a minimum of $2.14 per tobacco user. Suggested funding for the WV Tobacco Quitline: $1,655,600

- DTP should fund Certified Tobacco Treatment Training Programs' training of 150 providers per year on evidence-based cessation strategies for the highly addicted tobacco user and promote awareness of both patients and providers for the potential need for combination medication treatment. Suggested funding for trainings per year for five years: $99,000

- The State of West Virginia should recognize and reimburse tobacco treatment services by Medicaid and other third-party payers to all providers whose licensing board permits tobacco cessation counseling/pharmacotherapy or are certified tobacco treatment specialists.

- The State of West Virginia should address its contract with the WV Tobacco Quitline Vendor that limits Nicotine Replacement Therapy (NRT) to every two weeks for a total of eight weeks, according to the WV Bureau of Public Health (BPH). It should revise this contract to allow a minimum of 16 weeks of NRT to our heavily addicted population.

- DTP should establish Tobacco Treatment Central Clinics that function as an arm of its programming. These clinics should partner with the WV Tobacco Quitline for counseling and evidence-based pharmacotherapy provision to decrease

barriers to patients and clients interested in cessation. Suggested funding for clinics: $964,000

- DTP should extend pharmacotherapy provision for heavily addicted tobacco users for a longer time period, in order to titrate an adequate level to match nicotine addiction level and allow enough time for gradual reduction of dosage to improve abstinence rates.

Community Interventions

- DTP should re-establish a community-based network with a minimum of ten positions across the state like its previous Regional Tobacco Prevention Coalition (RTPC) Network. These community efforts should focus on:
    - Education and prevention of tobacco use, with a focus on young adult usage,
    - Education on policies affecting environmental air and youth access to tobacco and vaping products,
    - Promotion of smoke-free workplaces, homes, worksites, and public places.

  Suggested funding for the community-based network: $5.7 million

- A youth-specific community intervention, coupled with a youth-specific media intervention, has incredible potential to ensure all children, regardless of where they live, are exposed to anti-tobacco messaging and education. Community youth-based outreach and intervention programs should continue to offer a cessation component and incorporate vaping cessation. These programs should be available in multiple settings, not just in public schools. Leaders should collaborate with the adult community-based network and media interventions to promote and disseminate shared messaging that markets to multiple populations. Suggested funding for the youth prevention and cessation program: $1.5 million

- DTP should continue to support community interventions targeted at populations disproportionately affected by tobacco use. These include: African Americans, the LGBTQIA+ population, pregnant tobacco users, and smokeless tobacco users. We emphasize the need for subcontractors to work with evaluators to ensure data collection is a key component of the grant work. Suggested funding for targeted interventions: $500,000

Media Interventions

- Mass-reach health communication interventions should be a cornerstone of DTP programming. These interventions are effective in countering pro-tobacco advertising and promotion, especially among youth and young adults.

- A comprehensive media intervention strategy should “brand” all education, prevention, and cessation messaging under the same umbrella, meaning that it should look to consumers as a cohesive communication intervention. Similarly, all DTP messaging and programming should be marketed as a unified strategy.

- DTP should invest in a media intervention strategy that prevents the onset of tobacco use by our youth and navigates those who want to quit to the WV Tobacco Quitline and local cessation services. The subcontractor of DTP’s media intervention data should work with evaluators to measure the efficacy of the campaign’s reach across the state, such as media impressions, social media followers, and connections between media messaging and referrals to the WV Tobacco Quitline and RAZE program. Other organizations contracted with DTP for prevention and cessation services should be educated on the media intervention strategy and ways to cross-promote. Suggested funding for media interventions: $3.7 million

Evaluation

- Data collection should be a critical component of the DTP program to determine the impact of interventions and how to effectively tailor the program to meet the needs of the state. There have been consistent gaps and lags in data collection, making it unclear if programming is effective or strategies modified.

- A request for proposal or quotation should be advertised nationally and promoted to encourage a variety of applications for funding to evaluate DTP's programming. Experience and expertise in evaluating the state tobacco program should be a priority. Evaluations should occur promptly, and results should be shared publicly.

- The State of West Virginia should require an independent evaluation of DTP to evaluate the efficacy of programming and ensure appropriate data is collected and used to inform the strategic planning of future programming and appropriately stored.

- An evaluation plan should include innovative strategies to improve data collection and utilization. Funding should include creating a “process evaluation” to quantify how campaigns/interventions were implemented (vs. goals) and what their costs were.
- Evaluation of the WV Tobacco Quitline is a critical component to understanding the efficacy of the Quitline and media and cessation interventions. Data collection should include specific data sets that are reported consistently, on at least an annual basis, but optimally every month. DTP should be required to consistently store years of data and use this information to form a baseline to evaluate future programming.

- DTP should create a process for storing evaluation data and a plan for utilizing it to inform strategic planning. Funding should be included in the state budget to ensure this process is in DTP's next strategic plan. Suggested funding for evaluation: 10% of total funding for DTP is recommended for the cost of a comprehensive evaluation plan.

Policy

- The West Virginia Legislature should increase the cigarette tax to $2.20 per pack and 43% for all other tobacco products to make access more difficult, reducing youth/adult tobacco use and smoking during pregnancy while providing substantial revenue to West Virginia.

- The Legislature should increase funding for Tobacco Control Programs to $16.5 million annually as current funding is well below the CDC-recommended level of $27.4 million.

- The State of West Virginia and DTP should support and defend comprehensive coverage for tobacco cessation services under Medicaid, Medicare, and both public and private insurance, and support health systems change to incorporate tobacco cessation.

- The State of West Virginia should support removing all flavored tobacco products (including menthol) from the market.

- Localities must maintain local control of smoke-free air laws in order to protect and strengthen current laws or implement new, comprehensive smoke-free indoor air laws to protect public health.

INTRODUCTION

Tobacco use is the single most preventable cause of death and disease in West Virginia. Prevalence by adults and youth is among the highest in the nation, costing the state millions in health care costs annually.

In West Virginia:

• 4,300 deaths are caused by smoking each year.

• 23.8 percent of adults use tobacco, well above the national average of 13.7%.

• 23.2 percent of pregnant women smoke.

• 40.6 percent of high school students use tobacco.

• More than 1 in 3 (35.7%) of high school students use e-cigarettes -- a 150% increase over two years.

• High school students who report frequent use of vaping products increased by almost 440%.

• Over 60% of youth report ever using e-cigarettes.

Tobacco costs every West Virginian. Smoking is estimated to cost over $1 billion annually in direct healthcare costs, including $277.3 million in Medicaid costs. The taxpayer burden for smoking-caused government expenditures is $1,212 per person. *(See sources in appendices.)*

In 2020, the West Virginia Legislature passed House Bill 4494, *Tobacco Use Cessation Initiative, to improve the way our state addresses the burden of tobacco use.* The bipartisan bill amended the Code of West Virginia by adding a new article relating to expanding tobacco use reduction and cessation initiatives by creating a Task Force to undertake studies and monitor and advise the Division of Tobacco Prevention (DTP) and recommend policies to the Legislature. The bill passed on March 7, 2021. It was signed on March 24 and became law on June 5, 2020.

HB 4494 outlined general directives for the Task Force. It was to “meet quarterly at the call of the chair to study, monitor, and recommend funding and initiation of programs that reduce tobacco, tobacco products, alternative nicotine products, and vapor products consumption in West Virginia, and to initiate studies and processes to provide the most efficient and effective use of the funds dedicated for this purpose.” The make-up of the Task Force was to include a variety of persons in the health care field, including individuals certified from one of the programs accredited by the Council for Tobacco Treatment Training Programs or who received a National Certificate in Tobacco Treatment Practice, advocates, and citizens, with the intention of the

Legislature to create a dynamic and innovative group to focus, monitor, and facilitate state resources towards this goal.

Members of this Tobacco Use Prevention and Cessation Taskforce were invited to participate in this work in the fall of 2020, and work officially began in February, 2021. Bylaws to govern the Task Force were drafted by WVDHHR staff and were adopted in March, 2021.

According to HB 4494, Dr. Ayne Amjad, Commissioner for the West Virginia Department of Health and Human Resources, Bureau for Public Health, and the West Virginia State Health Officer, was to serve as the Chair of the Tobacco Use Prevention and Cessation Task Force. Task Force Members elected Dr. Susan Morgan as Vice-Chair and Teresa Mills as Secretary.

The Task Force opted to meet monthly rather than quarterly. It divided responsibilities to complete the work by creating four subcommittees: Cessation Interventions, Communications/Media, Community Interventions, and Evaluation. These groups met on their own schedules and in addition to the Task Force's monthly meetings. While their processes differed, each group reviewed a wealth of historical documents, consulted experts in and outside of the state, and drafted respective recommendations in their scope of work. In the fall of 2021, the group began the work to synthesize the recommendations into this final document.

The Task Force would like to thank the West Virginia Department of Health and Human Resources (WVDHHR) Division of Tobacco Prevention (DTP) staff for serving in an administrative assisting capacity, including taking notes, scheduling meeting logistics, and responding to many requests for data and reports and other documents. Often, several staff members and consultants with the DTP would join Task Force meetings.

The Task Force would like to acknowledge the tremendous time and dedication of Kelli Caseman in guiding the layout, writing, and editing of this final report to the West Virginia Legislature. Kelli's involvement and commitment to this project has been exemplary.

We would like to thank our fellow Task Force members for volunteering their time and expertise to fulfill this important work in the hopes of fulfilling the mission of improving the health of West Virginians.

Finally, we would like to thank the West Virginia Legislature for their foresight and interest in initiating this effort and assembling a group to review, evaluate, and re-align the work to prevent and decrease tobacco use in our state.

TASK FORCE MEMBERS

Dr. Ayne Amjad - Chair
Bureau for Public Health/Commissioner & State Health Officer

Dr. Susan Morgan- Vice-Chair
West Virginia University School of Dentistry Faculty - Dental Profession Representative

Teresa Mills- Secretary
Cabell-Huntington Health Department/ American Lung Association Representative

Kelli Caseman
Executive Director, Think Kids - Youth Representative

Juliana Frederick Curry
American Cancer Society Representative

Melissa Gaydos
West Virginia University Certified Tobacco Treatment Training Program (CTTTP)

Cheryl Jackson
Citizen Member

Dr. Timothy Lefeber
Citizen Member

Dr. Kevin McLaughlin
Physician - Medical Profession Representative

Molly McMillion
Citizen Member

Greg Puckett
West Virginia Prevention First Network Representative

Tina Zuk
American Heart Association Representative

PROCESS OF EVALUATION

The Tobacco Use Prevention and Cessation Taskforce met monthly, between February and November, for ten sessions. Meetings were open to Task Force members' invited guests and WVDHHR and DTP staff and consultants. In May, Rhonda Williams and Tanya Wells with the Vermont Department of Health's Tobacco Control Program presented to the Task Force at the request of its members. Also in May, Laura Corbin with Tobacco Free Florida joined the Task Force at its request. Members had an opportunity to query speakers and used the presented information to help inform and guide their recommendations.

The Task Force met virtually with each meeting scheduled for 90-minutes:

February 9, 2021
March 9, 2021
April 13, 2021
May 11, 2021
June 8, 2021
July 13, 2021
August 10, 2021
September 28, 2021
October 19, 2021
November 9, 2021

Links to the minutes for each meeting are listed in Appendix D.

Due to the extensive work that the Task Force was charged to complete, members were divided into subcommittees:

- Cessation Interventions
- Community and Media
- Evaluation and Assessment
- Policy Recommendations

Each subcommittee created its own processes for researching, communicating, evaluating, and drafting recommendations for this final report.

The Cessation Intervention Committee pulled statistical data from a West Virginia University IRB-approved research project to show that healthcare providers who attended a certified treatment training program in West Virginia significantly increased their knowledge, skills, and tobacco treatment practice. The healthcare providers who

attended the program gained knowledge regarding combination pharmacotherapy and counseling for West Virginia's highly nicotine-dependent population.

Evidence-based studies and recommendations in the CHEST Tobacco Treatment Toolkit reveal that individuals with more severe addiction or less ability to tolerate withdrawal need higher medication levels for a longer period of time. Data from the West Virginia Tobacco Prevention Department's annual spending reports were evaluated to identify the WV Tobacco Quitline's annual financial contributions utilized for tobacco treatment counseling and nicotine replacement therapy.

The Communications and Media and Evaluation and Assessment subcommittees merged. It kept a standing meeting open every Thursday at 8:30 am. It requested numerous DTP documents to learn how previous data was aggregated, stored, and reported, and if this data could be used to inform steps moving forward. The committee also requested contracts, evaluation reports, and quitline data. It scheduled and facilitated meetings with Karla Sneegas and Lorraine Reed from the CDC's Office of Smoking and Health, and Kevin Davis with RTI International's Center for Health Analytics, Media, and Policy (CHAMP).

Members also researched and studied comparative state tobacco control and prevention programs in states with similar populations: Idaho, Maine, Montana, and Nebraska.

It assessed numerous DTP subcontracts with community partners. A table detailing how funding was allocated from 2013- 2020 is provided in Appendix C.

The Policy Committee used guidance from the American Lung Association's State of Tobacco Control report to identify the policy priorities, which evaluates states and federal government on the proven-effective tobacco control laws and policies necessary to save lives. The report provides recommendations for tobacco policy needed to eliminate the death and disease from tobacco use which was used as a blueprint to create our policy recommendations for West Virginia.

RECOMMENDATIONS

Cessation Interventions

Evidence-based treatment approaches to smoking cessation include several behavioral treatments such as individual, group, and telephone counseling, as well as pharmacotherapies approved by the U.S. Food and Drug Administration. These treatments have been shown to be effective when delivered across a wide variety of settings, via several platforms, and to a diversity of populations—including groups that have been disproportionately impacted by tobacco use.

The Task Force recommends the creation and promotion of a statewide campaign by funding Certified Tobacco Treatment Training of 150 providers per year, for the next five years. This training will provide availability of the specialists for Behavioral Mental Health Clinics, Federally Qualified Health Clinics, wellness centers, and tobacco treatment clinics. Funding is recommended per year at $99,000 for five years. Needs will be reassessed after five years as part of the evaluation process.

What a Certified Tobacco Treatment Training Program (CTTTP) is and why it is important:

Tobacco cessation pharmacotherapy needs to be based on the client's nicotine addiction level, utilizing evidence-based mono & combination pharmacotherapy.

WVU School of Dentistry's CTTTP outcome measures from the 2018 and 2019 programs show success and potential to further reduce smoking rates in our state with better utilization of NRTs with more provider education.

- Participants' ability to discuss the appropriate use of nicotine replacement therapies went from 33% (2018 pre-conference) to 84% (2018 (6-month) post-conference).
- Participants' ability to prescribe combination therapy in 2018 went from 33% pre-conference to 58% post-conference.
- Only 33.8% (n=26) of the seventy-seven participants before the 2019 conference could discuss the appropriate use of nicotine replacement therapies with patients.

The Task Force recommends recognizing and reimbursing tobacco treatment services to <u>all</u> providers whose licensing board permits tobacco cessation treatment and/or certified tobacco treatment specialists.

The contract between the West Virginia Tobacco Quitline Vendor and the State must be revised to allow a minimum of 16 weeks of NRT to our heavily addicted population. Those insured by Medicaid are limited to 90 days of NRT, one time per year. The one-time per year attempt and 90-day limit for those insured should be removed. Any of the seven FDA-approved medications should not require step therapy.

Approximately 70 percent of smokers nationally want to quit smoking (Babb S, et al., 2017). A 2019 survey of WV High School students found approximately 53 percent of these high school students who used tobacco tried to quit. (WV YRBS, 2019). Without assistance, only three to five percent of smokers quit successfully (Hughes J, et al., 2004). For the WV Tobacco Quitline to successfully assist clients with tobacco cessation, the medicine prescribed must be adequate to address the client's needs based on their addiction level, and the medication must be administered for an adequate length of time.

The overwhelming majority of those individuals who contact the Quitline are cigarette smokers. The following statistics obtained from the Quitline reveal cigarette packs smoked per day by WV residents contacting the service. The statistics reveal a highly addicted population based on the number of total participants each year enrolling in the Quitline and the percentage of those using two or more packs of cigarettes per day.

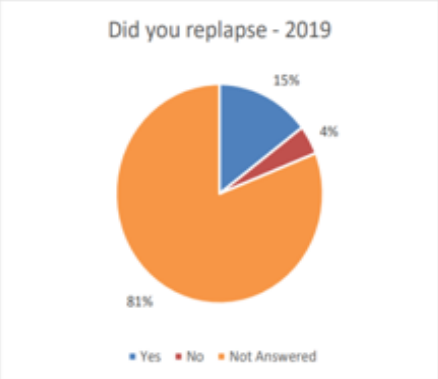
Year	2018	2019	2020
2 PACKS/DAY	1505	1334	923
3 PACKS/DAY	248	244	188
4 PACKS/DAY	35	30	17
5 PACKS/DAY	10	4	2
Total	1798	1612	1130
Total # completed enrollment in QL	8452	7673	Data not provided

Evaluation Question 5. What are the cessation outcomes for the Quitline?

The Quitline initiated follow-up calls to track cessation rates in 2019; therefore, no follow-up data on cessation rates were available for the 2018 evaluation period. The 2019 data is derived from the following four 7-month follow up questions for cessation tracking:

1. Did you relapse after initial enrollment?

Relapse	
Yes	1127
No	329
Not Answered	6219



Year 2020

LINE	CL DESCRIPTION	AMOUNT
1	Eligibility Verification	$ 110,209.00
2	Coaching Call #1	$ 59,708.00
3	Coaching Call #2	$ 49,287.00
4	Coaching Call #3	$ 33,453.00
5	Coaching Call #4	$ 12,390.00
6	Reactive Coaching Call	$ -
7	Nicotine Patch 21mg	$ 34,920.00
8	Nicotine Patch 7mg & 14mg	$ 22,248.00
9	Nicotine Gum 2mg & 4mg	$ 5,947.50
10	Nicotine Lozenge 2mg & 4mg	$ 10,710.00
11	Dual Therapy	$ -
12	Research	$ -
13	Nicotine Gum 4mg	$ -
		$ 338,872.50

The Quitline funding should be increased to extend the time that patients are on NRT, provided adequate combinations of medications when necessary (not only dual therapy but triple therapy if indicated). The Truth Initiative's 2020 report suggests that WV invests $0.97 per smoker, compared to the national average of $2.14. Given our highly addicted population, $0.97 is inadequate. The Quitline investment should be a minimum of $2.14 per tobacco user.

The following example illustrates the importance of this issue:

An individual who smokes two packs of cigarettes per day gets approximately 40 mg of nicotine each day. To adequately treat this individual using nicotine patches, two 21mg patches should be utilized for four weeks. The nicotine level should be reduced by 7 mg to 14 mg every two weeks thereafter.

If nicotine levels are reduced by 7mg every two weeks, the individual will typically need to be on NRT for 14-weeks, not 8-weeks. If nicotine levels are reduced by 14 mg every two weeks (using the 8-week model), the patient is left with a 14 mg addiction level at the end of treatment and will likely return to smoking.

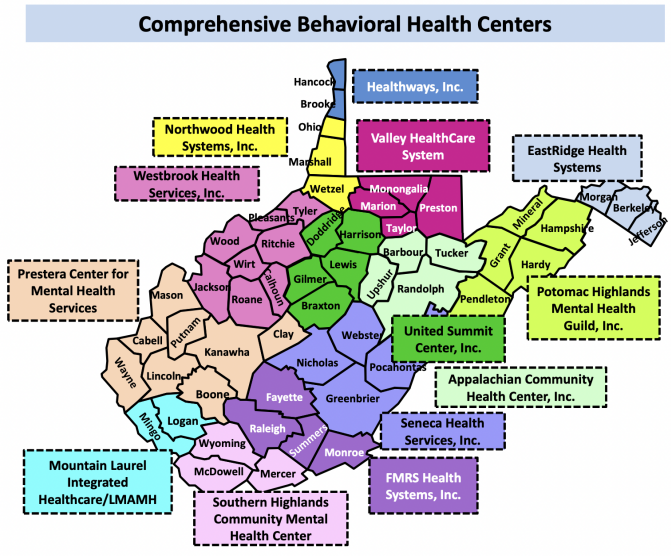
This example demonstrates the importance of extending the current contract between the WV Tobacco Quitline Vendor and the State of West Virginia.

Evidence-based information includes the following:

- Course of treatment longer than 12 weeks is more effective than shorter courses of treatment (currently, the Quitline, as funded by the Bureau of Public Health, outlines only 8-weeks of treatment).
- Individuals with more severe addiction and those with less ability to tolerate withdrawal will need more medication for a longer period. When withdrawal is well controlled and the patient is no longer using tobacco products, the medications can be gradually stepped down (i.e., NRT). If withdrawal is not well controlled and/or the patient is still using tobacco products, the medication should be stepped up, intensified, or additional medications added.
- Two (or sometimes even three) FDA-approved tobacco dependence treatment medications together can work better than just one.

Providers need to be knowledgeable in addressing the highly addicted tobacco-using patient. As noted above, two (or sometimes even three) FDA-approved tobacco dependence treatment medications may be indicated to increase cessation rates. The Cessation Task Force Subcommittee is requesting $99,000 per year for the next five years to provide tobacco cessation education for 150 providers each year.

DTP should establish Tobacco Treatment Central Clinics that function as an arm of the WV Tobacco Quitline for counseling and evidence-based pharmacotherapy provision to decrease barriers to patients and clients interested in cessation. Thirteen Comprehensive Behavioral Health Clinics (pilot programs) should be created and located throughout the state. Additionally, a Tobacco-Free Me Virtual Site should be created with Certified Tobacco Treatment Training personnel that provide counseling and place tobacco cessation medication in the patient's hands at the time of counseling, thus reducing barriers to treatment. These fourteen sites will work in concert with ten community tobacco prevention programs to expand tobacco treatment throughout the state.



Revised Oct 2021

A Director of "Tobacco Treatment Central" will work in cooperation with the Director of the ten Community Regional Programs and the Director of the WV Tobacco Quitline. Funding considerations include:

- Hiring 14 Tobacco Treatment Specialists
- Travel
- Data Collection and Outcome Measures

Cessation Intervention CommitteeFunding Request	
WV Quitline Funding	$1,655,600.00
Train 150 Certified Tobacco Treatment Specialists	$ 99,000.00
Tobacco Treatment Central	$ 964,000.00
Total Funding	**$ 2,718,600.00**

Community Interventions

Community interventions are critical and must be coordinated with other program elements of a comprehensive tobacco control program. For example, media interventions must be coordinated with community interventions to ensure consistency and to strategically amplify and disseminate key messaging. In the Task Force Community and Media Committee's meeting with the CDC Office of Smoking and Health experts, it was stressed that media can cause change, but for this change to be lasting, it needs to be combined with interventions at the community level.

In its conversation with the Task Force's Community and Media Committee, CDC staff mentioned several times, "*You have to have a community program.* If you don't have boots on the ground, your other work will only go so far. That is the heart and soul of being able to make lasting change. This is where attitudinal change happens."

The Task Force focused primarily on two specific types of community interventions in its strategic process: an adult outreach network, like the former West Virginia Tobacco Prevention Coalition Network, and youth school and community prevention and cessation programming, like the state's current RAZE program.

Community Programs for Outreach and Intervention with Adults: The CDC Office of Smoking and Health Program members reported to the Community and Media Subcommittee that West Virginia once had one of the strongest community-level programs in the nation when the tobacco control program was funded at higher levels. This previous network consisted of ten regional tobacco prevention coordinators serving ten different regions in the state. These regional specialists had service areas that were small enough to accomplish the recommended CDC goals effectively—things like developing partnerships with local organizations and stakeholders, mobilizing support for local policies, raising awareness, educating, and engaging the community.

The Task Force recommends establishing another community-based network, very similar to DTP's former network. Each designated community region would have a staff person focused on community outreach and network development.

The primary staff in these networks would:

- Support tobacco prevention and control best practices
- Promote and support targeted community interventions
- Plan and implement network development
- Locally support DTP's efforts to assess and collect data that aligns with its strategic planning.
- Increase community and local policymakers to increase knowledge regarding tobacco prevention and control policies.

The initial funding request for the community-based, regional network would be higher at first to re-establish the positions that were eliminated when the funding was cut in 2018. These costs include overhead office expenses, start-up equipment, and supplies. This funding level could potentially be reduced after the network is in place. The Task Force recommends startup funding for this network at $5.7 million.

Community Programs for Outreach and Intervention with Youth: Task Force committee members were aware as its work began that there had been historic concerns from Legislators over previous funding for a tobacco prevention youth movement in our state that had been more focused on marketing "gear" than substantive prevention messaging and quantitative results. House Bill 4494 specifically emphasized recommendations to improve prevention and cessation interventions for children, adolescents, and teens. Clearly, the Legislature realizes that decreasing initial tobacco use has the potential for the greatest impact in curbing our tobacco use prevalence rates.

RAZE has been a state-based, grassroots program for over 20 years now in West Virginia, and DTP has collaborated with the American Lung Association in West Virginia to do this work. It has become known as a leading health-focused youth movement in the state. The Task Force recommends that this important work continue, but that the youth prevention and cessation intervention program's reach and impact be redefined and developed.

Here, we will focus specifically on the community interventions; in the media section, we provide recommendations to ensure youth-specific targeted messaging permeates every region of our state. As every child and youth should be exposed to anti-tobacco education and messaging via a robust media campaign, every child must have opportunities to be exposed to tobacco education and potentially participate in evidence-based youth programming throughout their childhood in both their schools and communities.

The Task Force recommends a more robust program that isn't explicitly focused in the public school setting but expands into religious, private, homeschools, and charter schools and engages with community youth groups. There are currently around 70 RAZE "crews" in West Virginia's schools, but over 700 public schools. DTP's youth programming needs much more impact than this to reduce our tobacco use initiation

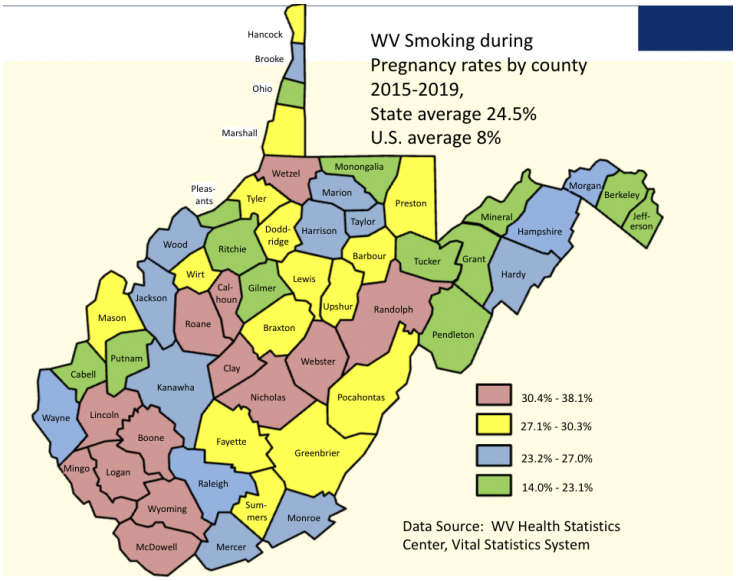
rates. The CDC recommends that school-based interventions be combined with other evidence-based, population-level interventions for engaging youth. And so, the Task Force recommends a more holistic approach to prevention and cessation programming for youth.

Also, subcontractors should be contractually obligated to collaborate with evaluators to collect data that does more than count participants, but rather prove the efficacy of the "movement." These pivotal changes might be challenging at first, but they are essential to broadening the program's service scope and evaluating the efficacy of programming. This data is key to adapting the program to engage more children and youth and to respond and improve the way these interventions are implemented.

This youth-based outreach and intervention program should continue to offer a cessation component. They should be provided in the community settings, not just in public schools. Leaders should collaborate with the adult community-based network and media interventions to promote and disseminate a shared dissemination strategy.

If the youth prevention and cessation program successfully broadens its scope, the program should expand to include colleges and universities. However, before this happens, mechanisms must be in place to ensure adequate data collection to establish a baseline in efficacy and a strategy to use this data to expand services. This has historically been a missing component and must be part of the program moving forward. To achieve this, the Task Force recommends initial funding at $1.5 million.

Targeted Community Interventions: The Task Force recommends that DTP continue to offer community interventions targeted at key populations. These include: African Americans, the LGBTQIA+ population, pregnant tobacco users, and smokeless tobacco users, as these populations are disproportionately affected by tobacco use. Women smoking during pregnancy are also an example of a key population which requires very specific intervention throughout prenatal and postpartum care. West Virginia has the highest rate of women who smoke while pregnant, with a rate that is nearly triple that of the rest of the nation. Despite statewide efforts, the number of women in West Virginia who use tobacco before, during, and after pregnancy has only recently seen small decreases (25.3% in 2015 to 23.7% in 2020). Pregnancy is a unique opportunity to intervene, and targeted interventions are a



strategic way to lower the risk of adverse birth outcomes, decrease infant mortality, and improve the long term health of our children.

There should be an internal process in place for widely disseminating requests for funding (RFPs) to ensure the targeted audiences— especially those representing marginalized communities— are aware and can apply for funding. Disparities in tobacco use remain across marginalized populations defined by race, educational level, and socioeconomic status. And so, we recommend an internal dissemination plan focused on equity and inclusion of these targeted population groups to ensure funding is distributed to organizations that represent these groups.

Again, the Task Force reiterates the need for subcontractors to work with evaluators to ensure meaningful data collection is a key component to the grant work. We suggest funding for targeted community interventions at $500,000.

Media Interventions

Mass-reach health communication interventions should be a cornerstone of DTP programming. These interventions are effective in countering pro-tobacco advertising and promotion, especially among youth and young adults. Funding should always be allocated for this intervention, and a portion of current funding for youth programming should be re-allocated for this intervention. This funding is needed to ensure all of West Virginia's children receive prevention messaging via print media, radio advertising, digital advertising, and social media platforms. This media needs to include targeted media based on populations/communities with high tobacco prevalence. A request for proposals should include a competitive process to ensure the contractor is experienced in statewide strategic media interventions.

Based on the state's high tobacco usage rates, the committee recommends adopting the CDC's higher spending recommendation for this category of $3.7 million. This is because the CDC media spending recommendation is based on achieving gross rating points (GRPs), which in layman's terms are how one measures how many times an ad is seen by the intended audience. There has not been a robust media campaign for some time in West Virginia. Without frequent media campaign messaging tailored to changing social norms, motivating smokers to quit, and protecting West Virginians from secondhand smoke, the culture of tobacco use will remain unchanged.

This funding would be used to create a comprehensive media campaign that would include all of DTP's programs. Importantly, this contract will include a working relationship with the program evaluators to ensure DTP captures meaningful data on this campaign and its influence in promoting and educating the public and key demographics.

In its meeting with the Media and Communications Committee, the CDC noted that when a state introduces a new media campaign, it takes more GRPs to change a culture. Once progress has been made, a state can back off a little in its media spending in future years. And so, as the campaign progresses, the cost of the campaign could decrease.

Branding of DTP's WV Tobacco Quitline, community-based network, youth campaign, and targeted interventions should be aligned under the same umbrella. Data should be collected to evaluate the campaign's reach across the state, such as media impressions, social media followers, and connections between media messaging and referrals to the Quitline and the RAZE program.

It is important to note that CDC program staff emphasized to the committee that West Virginia "isn't like other states" when it comes to media. DTP should contract with an evaluator that can design measurement tools that will provide effective media evaluation.

Beneficial Activities for Effective Media and Mass-Reach Health Communication Intervention Efforts

- Audience insight research to determine the current knowledge, attitudes, and behaviors of target audiences, as well as the motivations and behavioral theory that can best influence change among specific audiences.
- Formative research to identify promising messages and concepts.
- Formative evaluation to pretest campaign materials to ensure that they are clear, credible, and persuasive and that they motivate the audience to change their attitudes and behaviors.
- Surveillance to understand pro-tobacco messaging, media placements, and marketing tactics.
- Local media promotion, event sponsorships, and other community collaboration tie-ins to support and reinforce the statewide campaign, increase awareness about policies that protect and promote health, and shift social norms related to tobacco use.
- Digital technologies, such as text/SMS messaging, social media, Web sites, and blogs to generate messages that can be further disseminated by the target audience.
- Process and outcome evaluation of a comprehensive communication effort, as well as specific evaluations of new and innovative approaches, including the use of digital media.
- Promotion of available services, including the state's telephone cessation quitline number or the quitline portal numbers (1-800-QUIT-NOW, 1-855-DÉJELO-YA), as well as quitting Web sites and social media pages.

Evaluation and Assessment

Funding should be included in the DTP budget to create a strategic plan to guide program initiatives and evaluation. This plan should consist of a logic model that details goals, data measures, and outputs. It should also include the input of other stakeholders around the state.

Effective evaluation requires planning and strategy. The data and information gathered should be used to evaluate subcontractors, priorities for action, and future programming and policies. **DTP should create a process for storing evaluation data and a plan for utilizing it to inform strategic planning.** Funding should be included in the state budget to ensure this process is in DTP's next strategic plan, and evaluation of DTP should include its method for storing and utilizing this data. DTP should not rely on subcontractors to keep this data on its behalf.

Funding should be allocated for a "process evaluation" to quantify how campaigns and interventions were implemented (vs. goals) and what their costs were. This will help determine the efficacy of programming and if current programs are worth their return on investment.

A percentage of any DTP budget should be dedicated to rigorous evaluation of programming, regardless of budget size. **A request for proposal or quotation should be widely advertised and promoted nationally to encourage a variety of applications for funding to evaluate DTP's programming.** Experience and expertise in evaluating a state tobacco program should be a priority. Evaluations of DTP programs should occur promptly, not years later, and results should be shared publicly.

An independent program evaluation by evaluators experienced in working with multiple state programs with varying territories and budgets would be beneficial. Benefits include the following:

- **Avoids Perceived Conflicts of Interest**: Independent, external evaluators analyze data, interpret results, draw conclusions, and make recommendations about the program so that the program is not evaluating itself. When results, findings, and recommendations from independent evaluations are made to state legislatures, the independent nature often gives them additional credence or validity since the agency or program is not evaluating its own performance and advocating for funding based on an internal evaluation. The committee's goal includes greater funding for the program that would be coordinated across multiple state agencies/departments. Tobacco control programs are typically comprehensive, with multiple state agencies carrying out tobacco control interventions and activities. Comprehensive program evaluations often interpret data, draw conclusions, and make recommendations about how program activities are carried out across the program and how program funding is allocated or distributed with respect to CDC Best Practices recommendations.

- **Expertise / Experience**: **The Task Force recommends contracting with independent external evaluators that have experience conducting state tobacco control program evaluations.** They can "hit the ground running," already knowing how to conduct the evaluation, what data is needed, how to obtain the data, and how to best analyze the data, present results, draw conclusions, and make recommendations. External evaluators with experience

are also familiar with what other state programs have done or are doing. They have a sense of the "pulse" in the field or what is happening elsewhere. States, and particularly policymakers, tend to be interested in knowing what other states are dealing with, how other states have addressed the issue, and how their state compares to other states. Independent external evaluators are also familiar with evidence-based research and emerging issues, bringing that knowledge to the evaluation.

- **Efficiency**: **Independent evaluators can work efficiently.** In addition to working efficiently, external evaluators can take the burden off state staff. Individuals who would typically have the technical skills to conduct analyses and evaluation activities tend to be quite busy already and are often not able to take on the extra workload that such an evaluation would require.

Every subgrantee should be expected to report data that inform efforts to meet strategic goals. This data is more than just information to assure work was completed; instead, it should show the efficacy of the programs to prevent and reduce tobacco use. Failure to report clear, concise data should be grounds for not renewing a subcontractor's contract.

As a cornerstone of DTP's programming, evaluation of the WV Tobacco Quitline should include specific data sets that are reported consistently, on at least an annual basis, but optimally on a monthly basis. DTP should evaluate what data is most important to collect, such as: the number of calls received per quarter, the number of those who successfully received NRT, the number who completed the program, the number who remained tobacco-free six months after the program, and how consumers were referred to the Quitline— via media campaign, health care provider, community program, etc.

An evaluation component should include innovative strategies to improve data collection and utilization**.** For example, can DTP, the Quitline, providers, and healthcare systems collaborate to create a referral plan within electronic health records (EHRs)? Such strategies are happening in other states; it's time to make these improvements in West Virginia.

Members of the Task Force's Cessation Intervention Committee consulted with previous external evaluators of the WV Tobacco Quitline. The Task Force supports the conclusions and recommendations made by the WVU Program Evaluation Research Center in the 2017 and 2018 timeframe that are attached in Appendix A, and the External Evaluation for Quitline in 2019 by the University of Charleston in Appendix B.

Policy

Tobacco Prevention and Control Program Funding: West Virginia remains well below the CDC-recommended level of $27.4 million.

The Task Force recommends increased and sustained funding for Tobacco Cessation and Prevention starting with an increase to **$16.5 million** annually to fund these evidence-based components as follows:

Recommended 2022 DTP Budget

West Virginia Tobacco Quitline	$1,655,600
Certified Tobacco Treatment Training Program	$99,000
Tobacco Treatment Clinics	$964,000
Mass Reach Health Communication Interventions:	
Community Programs/ Outreach	$5.7 million
Youth Community Programs	$1.5 million
Targeted Community Interventions	$881,400
Media	$3.7 million
Surveillance/Evaluation:	$1.5 million
Administration/Staffing:	$500,000
Total recommended funding	**$16.5 million**

Why Fully Funding Tobacco Prevention and Cessation Programs Is Important:

WEST VIRGINIA TOBACCO PREVENTION & CONTROL PROGRAMS REDUCE HEALTHCARE COSTS

Tobacco prevention and control activities are a public health "best buy." Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce the number of people who smoke, as well as tobacco-related diseases and deaths. For every dollar spent on tobacco prevention, states can reduce tobacco-related health care expenditures and hospitalizations by up to $55. The longer and more states invest, the larger the reductions in youth and adult smoking. A comprehensive statewide tobacco control program includes efforts to:

For more information on tobacco prevention and control, visit cdc.gov/tobacco.

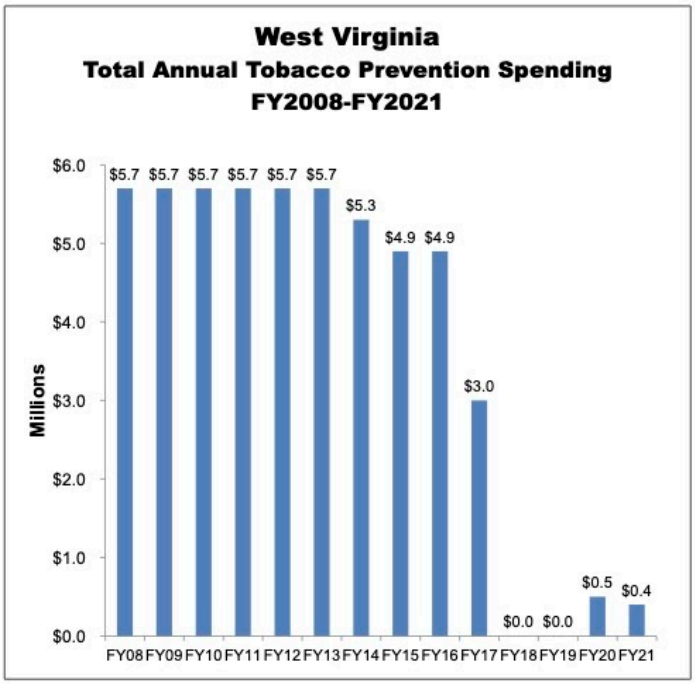
- Comprehensive tobacco prevention and cessation programs prevent kids from initiating tobacco use, help adult users quit, educate the public, the media, and policymakers about policies that reduce tobacco use, address disparities, and serve as a counter to the ever-present tobacco industry.

- Tobacco prevention and cessation programs are very cost-effective. For example, a 2013 study found that California's tobacco control program saved over $55 in health care cost savings for every $1 invested from 1989 to 2008. A 2011 study showed that Washington's program saved the state $5 in just tobacco-related hospitalization costs for every $1 spent from 2000 to 2009.

- According to a study published in JAMA in 2019, states can see a significant savings in Medicaid spending from just a 1 percent reduction in tobacco prevalence. The study found estimated Medicaid savings in the year following a 1 percent reduction of smoking prevalence would total $2.6 billion, with median state savings of $25 million. (*Glantz, S. JAMA Network Open.2019: 2(4):e192307. doi:10.10001/jamanetwrokopen.2019.2307)*

- Fewer young people would smoke. One study concluded that if states spent just the minimum amount recommended by the CDC, youth smoking rates would be 3 percent to 14 percent lower nationwide.

- Fewer adults would smoke. A study concluded that if states had spent just the minimum amount recommended by the CDC between 1995 and 2003, there would have been between 2.2 million and 7.1 million fewer smokers.



CDC Recommended Spending: $27.4 million

The West Virginia Division of Tobacco Prevention current funding levels are as follows:

- FY2021 State Funding for Tobacco Control Programs: $445,000

- FY2021 Federal Funding for State Tobacco Control Programs: $1,204,734*

- FY2021 Total Funding for State Tobacco Control Programs: $1,649,734

- CDC Best Practices State Spending Recommendation: $27,400,000

- Percentage of CDC Recommended Level: 6.0%
- State Tobacco-Related Revenue: $234,400,000

**Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention.*

Tobacco Taxes: The single most effective strategy in reducing tobacco use, particularly among children, is to increase tobacco taxes across all tobacco products.

- WV's cigarette tax rate is below the average state cigarette excise tax ($1.91 per pack), and increasing taxes is a proven policy to prevent and reduce tobacco use.
- The current WV tax on tobacco is $1.20; other tobacco products are taxed at seven percent of the wholesale price, and vaping products are taxed at $.075 per milliliter.
- Every 10 percent increase in the price of cigarettes reduces consumption by about four percent among adults and about seven percent among youth.
- It is important that tax increases apply to all tobacco products at an equivalent rate to encourage people to quit rather than switch to a cheaper product as well as to prevent youth from starting to use any tobacco product.
- In many states, including West Virginia, other tobacco products are taxed at a lower rate than cigarettes, making them an appealing alternative for price-sensitive consumers, including youth.
- Other tobacco products include, but are not limited to: moist snuff, nasal snuff, loose-leaf and plug chewing tobacco, snus, dissolvable tobacco products, cigars, pipe tobacco, roll-your-own tobacco, hookah, and electronic cigarettes.
- Recent research shows cigarette taxes must increase by a minimum of $1.00 per pack to have a meaningful public health impact.
- To maximize revenue, WV should establish tax parity between cigarettes and other tobacco products to ensure that states do not lose revenues from people switching from cigarettes to lower-taxed tobacco products, a type of switching which has been common in recent years.
- Small tax increase amounts do not produce significant public health benefits or cost savings because the cigarette companies can easily offset the beneficial impact of such small increases with temporary price cuts, coupons, and other promotional discounting. Splitting a tax rate increase into separate, smaller

increases in successive years will similarly diminish or eliminate the public health benefits and related cost savings (as well as reduce the amount of new revenue).

- To parallel the new $2.20 per pack cigarette tax, the state's new tax rate for other tobacco products should be 43 percent of the wholesale price with minimum tax rates for each major category linked to the state cigarette tax rate on a per-package or per-dose basis.
- The excise tax on cigarettes and other tobacco products will provide not only one of the best mechanisms for reducing youth tobacco use and smoking during pregnancy, along with a host of other benefits, but also has the potential to bring in substantial revenue to the State of West Virginia.
- **The projected new annual revenue from increasing the cigarette tax by $1.00 per pack is $75.85 million.**
- The additional revenue from raising other tobacco product tax rates to parallel new levels is $26.80 million.

Projected Public Health Benefits for West Virginia from the Cigarette Tax Rate Increase	
Percent decrease in youth (under age 18) smoking:	**9.6%**
Youth under age 18 kept from becoming adult smokers:	**4,600**
Reduction in young adult (18-24 years old) smokers:	**1,000**
Current adult smokers who would quit:	**9,600**
Premature smoking-caused deaths prevented:	**3,700**
5-Year reduction in the number of smoking-affected pregnancies and births:	**1,600**
5-Year health care cost savings from fewer smoking-caused lung cancer cases:	**$1.93 million**
5-Year health care cost savings from fewer smoking-affected pregnancies and births:	**$4.52 million**
5-Year health care cost savings from fewer smoking-caused heart attacks & strokes:	**$4.59 million**
5-Year Medicaid program savings for the state:	**$2.15 million**
Long-term health care cost savings from adult & youth smoking declines:	**$297.50 million**

*The projections were generated using an economic model developed jointly by the Campaign for Tobacco-Free Kids and the American Cancer Society Cancer Action Network and are updated annually. The projections are based on economic modeling by researchers with Tobacconomics: Frank Chaloupka, Ph.D., and John Tauras, Ph.D., at the Institute for Health Research and Policy at the University of Illinois at Chicago, and Jidong Huang, Ph.D., and Michael Pesko, Ph.D., at Georgia State University. The state Medicaid cost savings projections, when available, are based on enrollment and cost estimates by Matt Broaddus at the Center on Budget and Policy Priorities using data from the Centers for Medicare and Medicaid Services.

Link to full report/projections provided here.

Access to Cessation Services: The Task Force recommends that all forms of cessation counseling be covered (individual, group, phone), and there should be no barriers to care such as insurance surcharges. **All** West Virginians need access to tobacco cessation coverage.

The Task Force supports comprehensive coverage for tobacco cessation services under Medicaid, Medicare, and both public and private insurance. The Task Force also supports health systems change to incorporate tobacco cessation.

Cigarette smoking is one of the greatest drivers of adverse health outcomes and costs for the state's Medicaid program and other state and private insurers. Tobacco treatment is one of the most cost-effective preventive services, with as much as a $4 return on every dollar invested.

The Task Force recommends that the State of West Virginia cover all forms of cessation counseling— individual, group, and phone. There should be no barriers to care, such as insurance surcharges. Currently, cessation services and medications vary, depending on the insurer.

This is a current overview of cessation coverage provided by West Virginia's Medicaid Program:

Medications: All seven standard cessation medications are covered.

These are:

- NPR patch
- Lozenges
- Gum
- Inhalers
- Nasal spray
- Chantix (Varenicline)
- Zyban (Bupropion)

Counseling: Individual, Group, Telephone counseling is covered. It offers additional options of text, Apps, and expanded telehealth in its cadre of counseling services.

Barriers to Coverage: Some barriers exist to access care.

Medicaid Expansion: Those enrolled under Medicaid expansion qualify for coverage.

This is a current overview of cessation coverage provided by state employee health plan(s):

Medications: All seven medications are covered.

Counseling: Some counseling is covered

Barriers to Coverage: Some barriers exist to access care.

The WV Tobacco Quitline currently invests $0.64 per smoker, while the national median of Quitline investment is $2.28 per smoker.

Remove barriers to cessation treatment: All cessation medications are covered by insurers for 12 weeks, with daily maximum limits. There are barriers to accessing some therapies. For example, nicotine nasal spray is reserved for those who have failed other forms of nicotine replacement therapy. NRT and bupropion (dual therapy) are not covered concurrently, and prior authorization is required for coverage of tobacco cessation drugs and is coordinated through the Quitline.

Flavored Tobacco Products: Research has shown that children and youth who use e-cigarettes and vaping products are much more likely to smoke cigarettes and become addicted to nicotine. Flavored vaping products lead to initiation of tobacco use in children and should be targeted for removal to prevent youth from becoming addicted to nicotine and becoming future smokers. With 35 percent of our high school students in West Virginia becoming addicted to nicotine by vaping, we must act to ensure that another generation of West Virginians does not become addicted to nicotine.

The Task Force recommends that menthol and flavored tobacco products need to be removed from the market.

- Nationally and locally, there are growing efforts by policymakers at all levels to prohibit the sale of all flavored tobacco products.

- Flavored tobacco products are fueling the e-cigarette epidemic. According to the 2019 National Youth Tobacco Survey, nearly 97% of youth e-cigarette users reported using a flavored tobacco product in the last month and 70% cited flavors as the reason for their use. The 2021 National Youth Tobacco Survey reported almost 85 percent of youths using e-cigarettes used flavored products.

- Menthol is attractive to youth because it creates a cooling effect, reduces the harshness of cigarette smoke and suppresses coughing. Those effects make menthol cigarettes more appealing to young, inexperienced smokers, and research shows that they are more likely to addict youth.

- Ending the sale of all flavored tobacco products – including flavored e-cigarettes, menthol cigarettes, and flavored cigars – is critical to stopping the youth e-cigarette epidemic and creating the first tobacco-free generation. Youth between the ages of 12-17 are the group most likely to use menthol cigarettes.

- Eliminating menthol tobacco is also critical in ensuring health equity. Menthol cigarettes disproportionately affect African Americans. 85% of African American adult smokers and 7 out of 10 black youth who smoke, use menthol. Tobacco industry documents show a concerted effort to target African-Americans through specific advertising efforts.

- State policy measures would go further than the proposed FDA rule by banning other flavors and other tobacco products, not just menthol cigarettes and flavored cigars. State policy measures would close a loophole in federal legislation that has allowed for escalating use of disposable flavored e-cigarettes by youth.

- The FDA rule could be delayed by court challenges, while new state laws would be more immediate.

Smoke-Free Air: The Task Force recommends that localities maintain local control of smoke-free air laws in order to protect and strengthen current laws or implement new, comprehensive smoke-free indoor air laws to protect public health. Everyone should be able to breathe smoke-free air in restaurants, workplaces, and other public places. For this to happen in West Virginia, 23 counties would need to strengthen their current regulations and pass fully comprehensive smoke-free ordinances. To make informed, strategic decisions about preemptive legislative proposals, Legislators should consider all of a preemption's bills' short-term and long-term consequences, including its impact on clean indoor air quality.

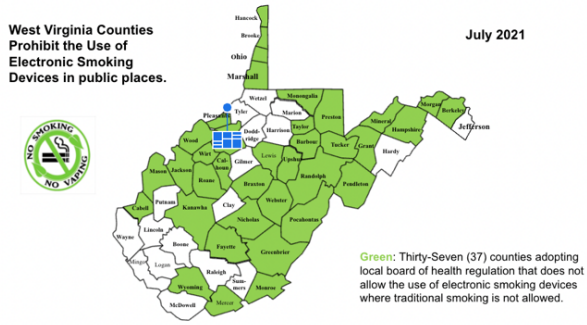
The American Lung Association evaluated regulations that restrict public smoking in all 55 West Virginia counties and assigned them letter grades from A to F based on the strength of the regulation.

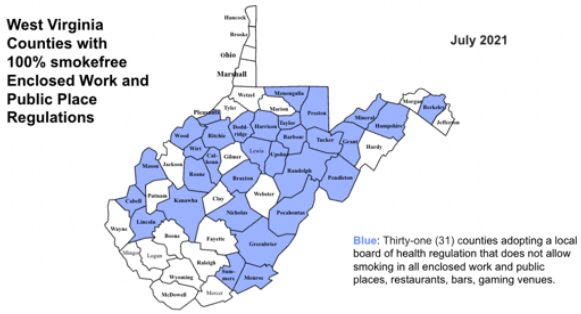
American Lung Association's "State of Tobacco Control" 2021 report:
West Virginia Highlights on smoke-free laws

County	Grade	County	Grade	County	Grade
Barbour	A	Kanawha/Charleston	A	Preston	A
Berkeley	A	Lewis	A	Putnam	F
Boone	B	Lincoln	A	Raleigh/Beckley	B
Braxton	A	Logan	D	Randolph	A
Brooke	B	Marion	C	Ritchie	A
Cabell/Huntington	A	Marshall	B	Roane	A
Calhoun	A	Mason	A	Summers	A
Clay	C	McDowell	C	Taylor	A
Doddridge	B	Mercer	C	Tucker	A
Fayette	B	Mineral	A	Tyler	D
Gilmer	F	Mingo	C	Upshur	A
Grant	A	Monongalia	A	Wayne	B
Greenbrier	A	Monroe	A	Webster	B
Hampshire	A	Morgan	B	Wetzel	D
Hancock	B	Nicholas	A	Wirt	A
Hardy	C	Ohio/Wheeling	B	Wood	A
Harrison	A	Pendleton	A	Wyoming	B
Jackson	B	Pleasants	A		
Jefferson	C	Pocahontas	A		

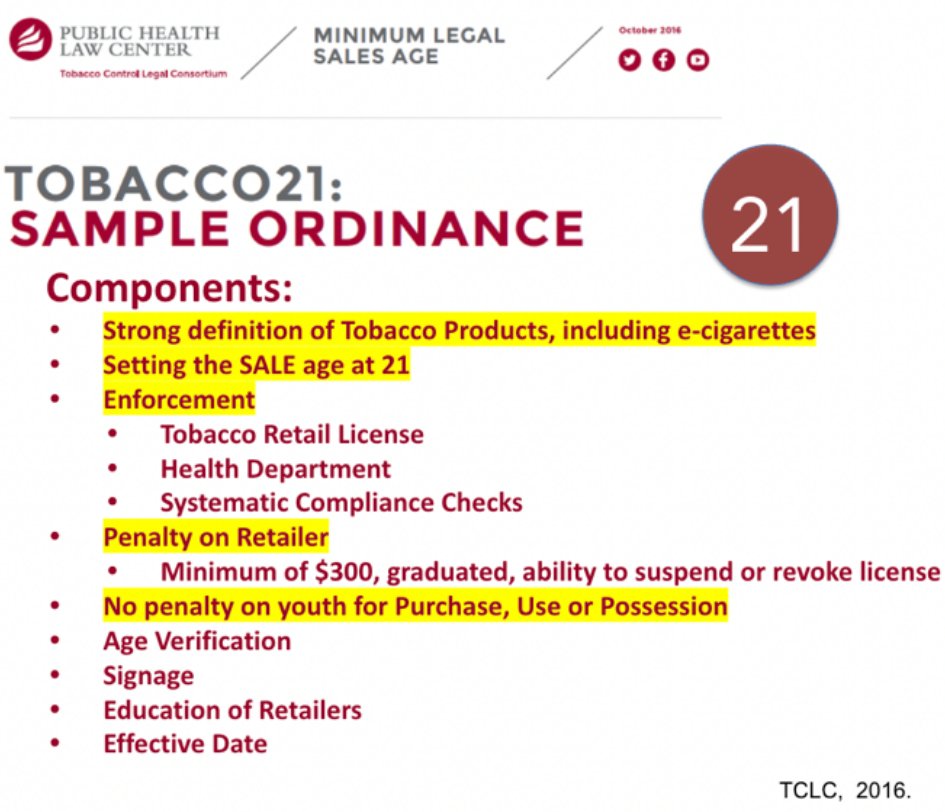
- Thirty counties earned A grades, 13 earned B grades, seven earned C grades, three earned D grades, and two counties earned F grades.

- WV received a better grade than previous years for Smoke-free Air with a “D.”
- The county authorities should continue to have the power to implement their own comprehensive smoke-free air laws, but more counties should do so. Two counties added e-cigarettes to their smoke-free laws (Raleigh and Cabell).





Tobacco 21: The Task Force recommends for the West Virginia Legislature to pass state legislation to further enforce the federal legislation. While a federal Tobacco 21 law passed in 2019, state and local jurisdictions should limit sales of all tobacco products, including e-cigarettes and their components, to those 21 and older, with the onus on the retailer to comply.



CONCLUSION

The Tobacco Use Prevention and Cessation Task Force appreciates Governor Jim Justice and his administrative team in selecting us to serve. Members volunteered their time and expertise for this work, and we appreciate our colleagues whose dedication produces this document.

To reiterate, a fundamental directive the Task Force recommends is to make data collection a cornerstone of DTP's responsibilities. We had expected to find years of data compiled, aggregated, and stored to peruse when we initiated this task. This was not the case. Our state should have what other state tobacco control programs have—years of data that can be used to establish baselines in which the efficacy of programs can be based. Funders, policymakers, and taxpayers expect to see quantifiable results from their investments.

Because the Task Force has laid out a robust, strategic direction for DTP to undertake, we recommend that the Task Force remain active into the second year of this redirection to ensure this is established. From this, we can help determine the additional and expansive needs of the administrative office, moving forward.

We also recommend $500,000 allocated for DTP's staffing to ensure adequate oversight of programming.

We appreciate the West Virginia Legislature and its work to pass HB 4494 in 2020. We hope the Task Force completed its work to the Legislature's satisfaction and look forward to working together to build a comprehensive tobacco control program in West Virginia.

APPENDIX A

Conclusions and Recommendations provided by the West Virginia University Program Evaluation Research Center

Relative to the data gathered about Quitline participants, the following recommendations were made by the WVU Program Evaluation Research Center:

1. Utilize a unique identifier for each participant that persists across years so person-centered analyses of the Quitline's impact can be completed. For example, the current system does not seem to allow the analysis of what proportion of participants in 2017 receiving various amounts of NRT continued to utilize tobacco or NRT in subsequent years. The proportion of Quitline participants who subsequently stop utilizing tobacco products or NRT may be a relevant indicator of program impact.

2. Collect referral information from all first-time callers via a dropdown list with answer options to the question "How did you hear about the Quitline?"

3. Collect discrete age data on each caller instead of an age range or a mixture of methods.

4. Utilize a discrete list instead of an open data field to collect residence by county.

5. Using a discrete list, expand gender options in demographic questions beyond the binary male/female currently asked to include "transmale," "transfemale," "something else", and "prefer not to answer." It is critical to track the number of trans* people using the Quitline because trans* people as a group have one of the highest rates of smoking, estimated at over 35% (Truth Initiative, 2018).

6. Add a demographic question via a discrete list about participant sexual orientation. Recommended selections are "straight/heterosexual," "lesbian," "gay," "bisexual," "queer," "something else," and "prefer not to answer." It is critical to track the number of LGBTQ people using the Quitline because this group smokes at 2.5 times the rate of straight adults, with bisexual people having the highest smoking rates of any sexual orientation (SAMHSA, 2012). 19

7. Utilize discrete lists to collect shipment numbers and types of NRT.

8. Improve the content on the https://wvtobaccoquitline.com/ website to offer more robust information, including detailed explanations of services and steps in the process, information on medications, and links to national resources (e.g. American Cancer Society, American Lung Association, CDC, NAQC, etc.). 9. Increase marketing activities in the fall months (September through December) to encourage enrollment.

10. Pursue opportunities to increase outreach and marketing to groups that appear to be underutilizing the Quitline, including males and residents of Regions 1, 2, and 3.

11. Institute 7-month follow-up calls to participants utilizing NAQC's recommended protocols.

12. Data were not provided on metrics related to response to incoming calls, such as the number of calls answered by a live person, the number of calls that rolled to voice mail, the number of hang-ups upon roll over to voice mail, and the rate of successful contact when a return call from a voice message is made. If such data exist, we suggest it be provided for future evaluations. If the data are not available, we recommend that the Quitline begin collecting these data as such information is relevant to assessing staffing levels. According to the CDC (2005), "Reaching a voice mail service rather than a live person can pose a serious barrier for first-time quitline users" (p. 40). Furthermore, the CDC considers "very good coverage" to be answering at least 90% of calls live during normal hours of operation (ibid). Data are essential to evaluate the WV Quitline's performance in this domain to inform staffing levels.

Other recommendations regarding future evaluations are to:

1. Develop a regular schedule for planning and executing evaluations to assure ongoing, timely monitoring of the Quitline service, and to assure enough time for data acquisition and analysis in support of thorough and timely evaluation report delivery.

2. Conduct key informant interviews as part of future evaluations to assess the implementation of policies, Quitline protocols, and the extent of training.

3. Include a site visit by the evaluation team to the Quitline as part of future evaluations.

4. Consider engaging an evaluation of the life of the Quitline service at its twentieth anniversary in 2021.

The Program Evaluation and Research Center stands ready to collaborate and support the implementation of the recommendations that follow, as well as to consider additional fruitful collaborations.

APPENDIX B

WV Tobacco Quitline Recommendations Provided by the University of Charleston

Relative to the overall process of evaluation and outcomes monitoring, it is recommended to re-conceptualize the data collection and evaluation structure and processes explicitly based on funder and program information needs, including a detailed data dictionary with clear operational definitions for every data element. Ensure that each data element clearly relates to specific evaluation or other program information needs and is collected in such a way as to facilitate efficient analyses to demonstrate program efficacy and drive continuous program improvement.

Relative to the data gathered about Quitline enrollees, the following recommendations are offered:

1. Previous recommendation was “Collect referral information from all first-time callers via a dropdown list with answer options to the question “How did you hear about the Quitline?”. Referral questions are now implemented, but the majority of the callers did not answer this question; ensure that operators are asking the question of the callers.

2. Using a discrete list, expand gender options in demographic questions beyond the binary male/female currently asked to include “transmale,” “transfemale,” “something else”, and “prefer not to answer.” It is critical to track the number of trans* people using the Quitline because trans* people as a group have one of the highest rates of smoking, estimated at over 35% (Truth Initiative, 2018).

3. Add a demographic question via a discrete list about enrollee sexual orientation. Recommended selections are “straight/heterosexual,” “lesbian,” “gay,” “bisexual,” “queer,” “something else,” and “prefer not to answer.” It is critical to track the number of LGBTQ people using the Quitline because this group smokes at 2.5 times the rate of straight adults, with bisexual people having the highest smoking rates of any sexual orientation (SAMHSA, 2012).

4. Utilize discrete lists to collect shipment numbers and types of NRT.

5. Increase marketing activities in the fall months (September through December) to encourage enrollment.

6. Pursue opportunities to increase outreach and marketing to groups that appear to be underutilizing the Quitline, including males and residents of Regions 1, 2, and 3.

7. Data were not provided on metrics related to response to incoming calls, such as the number of calls answered by a live person, the number of calls that rolled to voicemail,

the number of hang-ups upon roll over to voicemail, and the rate of successful contact when a return call from a voice message is made. If such data exist, we suggest it be provided for future evaluations. If the data are not available, we recommend that the Quitline begin collecting these data as such information is relevant to assessing staffing levels. According to the CDC (2005), “Reaching a voice mail service rather than a live person can pose a serious barrier for first-time quitline users'' (p. 40). Furthermore, the CDC considers “very good coverage” to be answering at least 90% of calls live during normal hours of operation (ibid). Data are essential to evaluate the WV Quitline’s performance in this domain to inform staffing levels.

Other recommendations regarding future evaluations are to:

1. Develop a regular schedule for planning and executing evaluations to assure ongoing, timely monitoring of the Quitline service, and to assure enough time for data acquisition and analysis in support of thorough and timely evaluation report delivery.

APPENDIX C

Review of Prior Years of WV DTP Community Programming

Year	Organization	Programs	Objectives	Budget	Outcomes
2013	Multiple agencies	Regional Tobacco Prevention Network (10 people statewide)		31% of the budget	15 college programs, 49 counties w/ regulation, ACS and WCWV focus on Smoke-free work-places, SF Initiative assistance to health depts
2015	Multiple agencies	Regional Tobacco Prevention Network (10 people statewide)		26% of the budget	13 college programs, 55 county coalitions, 55 counties w/ regulations, 28 entities w/ parks and recreation coverage
2016	Multiple agencies	Regional Tobacco Prevention Network (6 people statewide)		29% of the budget	12 college programs, 55 county coalitions, 55 county CIA regulations, 37 parks and recreation regs, Tech Asst to HDs
2020	American Lung Association Covenant House McDowell Commission on Aging WV Health Right	Raze LGBT Initiative Healthcare education African American Initiative	Cessation, youth empowerment Reduce disparities, increase cultural competence Online cessation ed for pharmacists and techs Provide outreach, identify faith and social groups, provide educational materials, and implement flag in EHR.	$720,000 $40,000 $30,000 $45,300	67 Raze crews, Taking Down Tobacco at three schools, 6 NOT classes completed Reached 500+ via the website, conducted outreach at two events, other objectives not met (covid) Curriculum taping and CEU availability pending due to covid Provided outreach to 1,000 individuals via pharmacy bags, provided cessation to 132, implemented flag in EHR, and trained staff.

APPENDIX D

Task Force Meeting Minutes

February 9, 2021 Meeting Minutes

March 9, 2021 Meeting Minutes

April 13, 2021 Meeting Minutes

May 11, 2021 Meeting Minutes

June 8, 2021 Meeting Minutes

July 13, 2021 Meeting Minutes

August 10, 2021 Meeting Minutes

September 28, 2021 Meeting Minutes

October 19, 2021 Meeting Minutes

November 9, 2021 Meeting Minutes

APPENDIX E

Sources for Statistical Information and Centers for Disease Control Recommendations

West Virginia Tobacco Use Reduction State Plan

Campaign Tobacco-Free Kids - The Toll of Tobacco West Virginia

Centers for Disease Control Best Practices for Comprehensive Tobacco Control Programs

CDC Recommended Annual Investment in Tobacco Control - West Virginia

TOBACCO USE PREVENTION AND CESSATION TASK FORCE

To contact Task Force members, email the coalition for a Tobacco-Free West Virginia at tobaccofreewv@gmail.com.