Impact of Tobacco Use in Rural Northern California

- Cigarette smoking is the leading cause of preventable disease and death in the United States, accounting for more than 480,000 deaths every year, or 1 of every 5 deaths.[30]
- At the state level, each year Californians spend over $13 billion on health care and other costs associated with smoking and suffer an average of 40,000 smoking attributed deaths.[31]
- Rural communities across California have higher rates of smoking than urban communities. For example, in the state's largely rural northern counties the current smoker rate is 20.4%, much higher than the state's average of 12.5%.[32,33,34]
- Low-income adults in the area are twice as likely to be current smokers (31%) compared to the state low-income population (15%); that means roughly one in three adults living below the poverty level in northern California smoke.[35]
- Rural Northern California communities also have higher rates of smokeless tobacco use. [36]
- In the recent years, there has been an explosion of e-cigarette/vaporizer tobacco products often marketed as harmless or less harmful, less addictive, and with flavors that can be attractive to youth.[37]

How Health Centers Provide the Necessary Care

Clinical Interventions

- Utilize the U.S. Public Health Service recommended"5 A's":
  - Ask every patient about tobacco use.
  - Advise all smokers to quit.
  - Assess smokers' willingness to quit.
  - Assist smokers with treatment and referrals.
  - Arrange follow-up contacts.
- Make tobacco assessment part of the patient intake process and use automated provider reminders to assess tobacco users' willingness to quit.
- Provide patients with quit packet (gum, toothpicks, etc.), educational materials, and information about the California Smokers' Helpline at time of visit if patient is open to quitting.
- Follow-up with patients making a quit attempt. Contact patient within 1 week and 1 month to monitor progress.

Community Interventions

- Participate in American Cancer Smoke Out campaign and conduct educational outreach during health fairs and other community events.

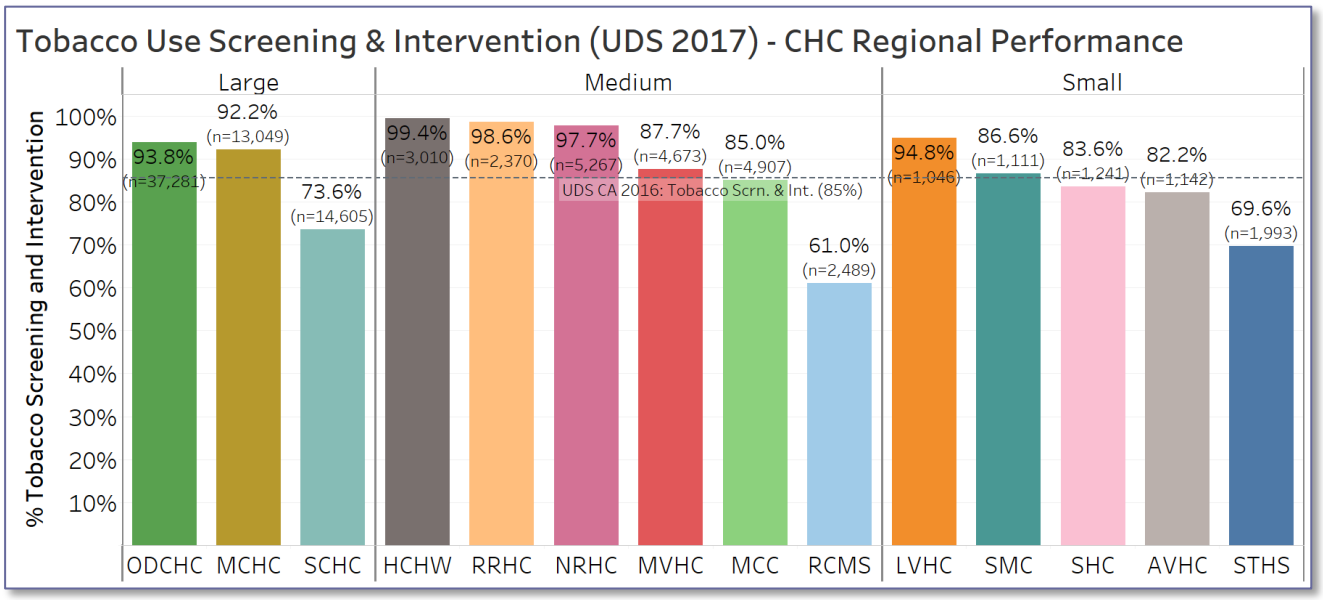
[30] U.S. Department of Health and Human Services (2014). The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2016 Mar 14].
[31] SAMMEC Smoking Attribute Expenditures 2009. CDC State Highlights: California
[32] "Far Northern California" = all counties in the Northwest and Northeast HEDIS reporting regions for Partnership HealthPlan of California: Del Norte, Humboldt, Siskiyou, Trinity, Shasta, Modoc, and Lassen.
[33] The California Department of Public Health, California Tobacco Control Program. (2015). California Tobacco Facts and Figures 2015.
[34] California Health Interview Survey (2012-2014). CHIS Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.
[35] Ibid. [Note: Low-Income was defined as <200% FPL for these calculations].
[36] Ibid.
[37] Olson, S. (2014). E-Cigarettes Anger Candy and Cookie Makers with Infringing Flavor Names. Medical Daily. May 27, 2014. ; see also Dennis, B (2014). Booming e-cigarette market in need of greater oversight, studies say. The Washington Post. June 27, 2014.

Tobacco Use Screening and Cessation Intervention

Rural Northern California Health Center Data

Key Points

- These indicators were added to the UDS dataset in 2011. Measuring performance may have supported increased assessment of tobacco use across member clinics.
- Identifying tobacco users and tracking cessation counseling and interventions can be a challenge due to limitations in EHR configuration. EHR updates are helping to improve documentation.
- Definitions for cessation counseling and interventions may differ between providers, which may lead to variation in the data across health centers.



Quality Measure Definitions (UDS)

- The percentage of patients 18 and over who were screened for any and all forms of tobacco use one or more times within the past 2 years; ***and***
- The percentage of patients who were identified as users of any and all forms of tobacco who received tobacco use intervention (cessation counseling, medication or a smoking cessation agent).
    - Current research shows that provider participation and advice lead to a greater likelihood of successfully quitting smoking by as much 66 percent.[38]
    - As few as three minutes of counseling or other primary care interventions can increase the success rate of smoking cessation.[39]

National Quality Goals and Benchmarks

California UDS Average (CA UDS Average 2016): The average performance among health centers in California for 2016 was 85.5%.

[38] USPSTF.2010. What to tell your patients about smoking: A report of the surgeon general: How tobacco smoke causes disease. Available at: http://www.cdc.gov/tobacco/data_statistics/sgr/2010/clinician_sheet/pdfs/clinician.pdf

[39] Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women, Topic Page. April 2009. U.S. Preventive Services Task force. http://www.uspreventiveservicestaskforce.org/uspstf/uspstbac2.htm

AVHC – Anderson Valley Health Center; HCHWC – Hill Country Health and Wellness Center; LVHC – Long Valley Health Center; MCC – Mendocino Coast Clinics; MCHC – MCHC Health Centers; MVHC – Mountain Valley Health Center; NRHC – Northeastern Rural Health Center; ODCHC – Open Door Community Health Centers; RCMS – Redwood Coast Medical Services; RRHC – Redwoods Rural Health Center; SCHC – Shasta Community Health Center; SHC – Shasta Cascade Health Centers; SMC – Shingletown Medical Center; STHS – Southern Trinity Health Services.