

Post-webinar Q&A

SCLC's live webinar on 3/12/19, **Advancing Smoking Cessation in California's Medicaid Population: The Medi-Cal Incentives to Quit Smoking (MIQS) Project**

Answered by Dr. Elisa Tong:

1. Prior to offering the \$20 incentive gift and patches, were Medi-Cal participants eligible to receive the patches from the quitline or were they deemed "ineligible" because of their benefit and referred to their physician for a prescription?

The California Smoker's Helpline did have some other special offers for free nicotine patches prior to the MIQS project. LA County had a limited time special offer for Medi-Cal members funded through LA Care, one of the large Medi-Cal programs. Also they have concurrent grant-funded projects, for example: CDC-funded Asian Smokers Quitline free nicotine patches, and state-funded patches for people living with a child 5 or under. Usual care is that the caller would contact their provider for prescriptions.

2. Why \$20 was chosen for the incentive amount? Is there any research to help determine an appropriate amount for the incentive? *Shu-Hong answered but do you have additional thoughts on this?*

Shu-Hong had mentioned the Helpline had offered a pedometer (\$10?) before as an incentive which was well-received. Plans may also use incentives, for example to encourage post-partum visits. Good area for future research.

3. Why is it that men aren't the majority for calling the No Butts helpline during this project period?

It was 59% for women callers. This is consistent with Helpline data trends for women to call more frequently.

4. Why does Varenicline react so differently from one person to another? Some people report nightmares, negative thoughts, some report good results?

As with any medication, side effects vary for each individual. Of note, there are 7 FDA-approved medications for tobacco cessation, and combination nicotine replacement therapy (eg patch plus lozenge) is considered to be equivocal to varenicline.

5. Are there any medical centers or clinics that utilize the two way referral service from CA Smokers Helpline? What have they experienced? I understand that most medical center use the one way referral system. We were wondering if a webinar can be conducted on these referrals systems and how the data is used to care for patients.

The Helpline did have a webinar with LA Department of Health Services and Alameda Health System about a bidirectional and unidirectional eReferral. The 5 UC health systems implement a bidirectional eReferral, but unidirectional is low cost ...pros and cons that each system must decide what works for them.

6. During the webinar mentioned above, someone said that half of the smokers in California are Medi-Cal recipients. I've been trying to find confirmation of this "fact" and haven't been able to. Are you able to shed any light on the source of this data?

Shu-Hong wrote another paper in our supplement that analyzed the California Health Interview Survey. About 40% of California's smokers are now covered by Medi-Cal.

"From 2011–2012 to 2016, the estimated number of California smokers in Medicaid nearly doubled from 738,113 to 1,447,945, and the proportion of smokers covered by Medicaid increased from 19.3% to 41.5%."

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Answered by Hai-Yen Sung, PhD:

7. The cost-benefit analysis is based on the complete case analysis or intention to treat?

The 180-day continuous abstinence rates used in the cost-benefit analysis were based on the complete-case measure.

8. On the discussion slide, third bullet, wouldn't the fact that the UC (no FI, no NP) have high quit rates mean that the cost saving estimates for using FI and NP would be overestimated, not underestimated?

The UC group in this study has a relatively high quit rate (14.1%) compared to the control groups examined in the previous similar studies. Our cost saving estimates of comparing the UC+FI+NP cessation treatment with the UC treatment were based on an effect size of 5.2 percentage points as reflected in the incremental quit rate (=19.3% – 14.1%). If the usual care is less effective such that the quit rate is lower than 14.1%, the effect size of treatment would be larger than of 5.2 percentage points, which would result in larger cost savings. In this case, our cost saving estimates would be underestimated.