Innovations in Building Consumer Demand for **Tobacco-Cessation Products and Services**

National Conference, May 3–4, 2007

Robert Wood Johnson Foundation

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Background

On May 3 and 4, 2007 more than 100 of the nation's experts in tobacco-cessation research, practice and policy gathered in Washington for the national conference *Innovations in Building Consumer Demand for Tobacco-Cessation Products and Services*.

The purpose of this conference was to disseminate, to a wider audience, the work of the Consumer Demand Roundtable, a program of the National Tobacco Cessation Collaborative, which since 2005 has been working to identify innovative strategies to increase the demand for, and use of, evidence-based tobacco-cessation products and services, especially among low-income and racial or ethnic minority populations where tobacco use is highest and evidence-based treatment use is lowest.

The Consumer Demand Roundtable[1] held three meetings in 2005 and 2006, working to generate new ways of thinking about how to increase demand for evidence-based tobacco-cessation products and services, especially through innovations in product design, research funding, practice and policy. **Appendix 1** lists the roundtable's members. Through its work, the roundtable developed six core strategies for building demand among smokers for proven tobacco-cessation products and services:

- Viewing smokers as consumers and taking a fresh look at quitting from their perspective.
- Redesigning evidence-based products and services to better meet consumers' needs and wants.
- Marketing and promoting cessation products and services in ways that reach smokers–especially underserved smokers–where they are.
- Seizing policy changes as opportunities for "breakthrough" increases in treatment use and quit rates.
- Systematically measuring, tracking, reporting and studying quitting and treatment use–and their drivers and benefits–to identify opportunities and successes.
- Combining and integrating as many of these strategies as possible for maximum impact.

The aim of the national conference was to explore each of these strategies in detail and to examine how they could be combined to achieve national breakthroughs in tobacco cessation and tobacco-use prevalence.

Participants discussed how best to move the field of tobacco cessation forward–given what is known about each of these strategies–and laying the groundwork for an action plan that could be developed and implemented by the National Tobacco Cessation Collaborative.

1 The work of the Consumer Demand Roundtable has been supported by the American Cancer Society, the American Legacy Foundation, the Centers for Disease Control and Prevention, the National Cancer Institute, the National Institute on Drug Abuse, and the Robert Wood Johnson Foundation, with additional support from the Office of Behavioral and Social Science Research of the National Institutes of Health, Pfizer, GlaxoSmithKline and Pinney Associates.

Introduction to the Meeting

Consumer Demand Roundtable co-chairs Carlo DiClemente, Ph.D., of the University of Maryland, and C. Tracy Orleans, Ph.D., of the Robert Wood Johnson Foundation (RWJF), opened the national conference by setting the stage for the roundtable's work:

- DiClemente highlighted how, over the course of its work, the roundtable had increasingly become aware of, and focused on, the consumer. "What if we took seriously the idea of smokers as consumers?" DiClemente asked, in describing the roundtable's thinking. "Consumers," he continued, "are a *valued* commodity. It's not just an alternative term for client, patient or smoker.… A consumer perspective shifts the emphasis." For the roundtable, shifting this emphasis meant concentrating on those who want or need cessation products and services, rather on the products and services solely in and of themselves.
- Orleans then led participants on what she termed a "tour of the positive changes that have occurred since the first Consumer Demand Roundtable meeting 18 months earlier." First, an increased "push" from the science of tobacco-use cessation by means of:
  - "Strong science-based clinical practice guidelines" (currently being made even stronger).
  - The 2006 National Institutes of Health State of the Science Tobacco Conference recommendations that identified boosting consumer demand for guideline-based treatments as a top priority for research, practice and policy.
  - Emergence of another effective cessation medication (i.e., varenicline or CHANTIX™).
- Second, greater tobacco-dependence treatment capacity, especially through:
  - Expansions of free quitlines to cover all 50 states and the District of Columbia.
  - Expansions in the services available through quitlines (e.g., non-English language counseling, free medications and Internet chat room connections).

  These were matched by policies that have the effect of increasing market and consumer demand for cessation treatments and services, including:
  - Two new national media cessation campaigns: the National Cancer Institute's "Calling It Quits" and the American Legacy Foundation's "Become an Ex-."
  - The sweep of new clean indoor air laws in states and communities across the country.
  - The continued rise in state tobacco excise taxes.

  Change is taking place. Orleans cautioned, however, that the changes up to now have been incremental. "We need breakthroughs," she challenged, "we are looking for inspiration on how to achieve the kinds of breakthroughs we have seen, for example, in New York City."

Keynote: Peter Diamandis, Chairman and CEO of the X PRIZE Foundation

To begin the discussion of breakthrough change, Orleans introduced Peter H. Diamandis, chairman and CEO of the X PRIZE Foundation.

The X PRIZE Foundation, working with other foundations and donors, identifies a specific goal "with the potential to benefit humanity," as the foundation puts it, and develops a program to award a multimillion-dollar prize to the first team to achieve that goal.

The first such prize, the Ansari X PRIZE, conceived of by Diamandis with sponsorship from the Ansari family, sought to bring breakthrough innovation to space travel. In the wake of its success, current X PRIZE competitions are seeking innovation in human genome sequencing and in the creation of super-fuel-efficient automobiles.

In his presentation to the national conference, Diamandis stressed that "breakthroughs are something that the day before was a crazy idea." Prizes can help create breakthroughs, because prizes can serve to change the conventional way of thinking about an issue.

For the Ansari X PRIZE, the conventional way of thinking held that space travel could only be run by governments. The Ansari X PRIZE removed this conventional way of thinking as an option; the prize called for private space flight. Breaking the rules, Diamandis explained, "created change in its wake."

Diamandis challenged conference participants to bring the idea of an X PRIZE-like approach to tobacco control. As he had commented at a pre-conference dinner, "It's time to kill the beast." To have a successful prize competition, Diamandis stressed the importance of:

- Defining a goal that is both audacious and achievable: something that can be done in three to eight years.
  - The goal needs to be succinct (able to be explained in an elevator).
  - The goal should define a problem, not a solution.
  - The goal needs to be able to be measured objectively.
- Allowing for the risk-taking that true breakthroughs require. Prizes are uniquely capable of "driving unconstrained thinking," and such thinking–and risk-taking–is what is sought.
- Ensuring that the prize "involves the human spirit. Any prize," Diamandis continued, "has to wrap the heroic element around it."

In questions and discussion, conference participants asked specifically about whether prizes would be as effective in the behavioral arena as they seem to be in engineering and genetics. Diamandis answered that, while not every issue can be solved by a prize, "heroic stories are the carrier vehicle for the technology." The prize is useful, Diamandis continued, because it "creates the end point, the target."

As for other actions to support tobacco cessation, Diamandis agreed that the "challenge is to make quitting cool by association." Legislative change, such as FDA regulation of tobacco (see below) is also needed; Diamandis felt that young entrepreneurs could be a source of funding for the legislative advocacy that could drive such regulatory change.

What Will It Take to Reach the National Cessation Goal?

How big a breakthrough is, in fact, required? Is the United States close to meeting the national goals for tobacco-use cessation with the approaches being taken now, or is a different cessation strategy needed?

To answer this question, David Levy, Ph.D., of the Pacific Institute of Research and Evaluation–supported by David Abrams, Ph.D., and Patricia Mabry, Ph.D., from the National Institutes of Health, Office of Behavioral and Social Sciences Research–presented Levy's modeling of the impact of various tobacco-cessation actions on smoking prevalence rates in the United States.

Healthy People 2010 includes a goal that only 12 percent of the adult population will smoke. Levy explained the different approaches to cessation, and the different smoking prevalence rates that his predictive modeling shows will result.

- It will be possible to achieve the *Healthy People 2010* goal by 2010 if the United States:
  - Doubles the number of people making a quit attempt.
  - Doubles the number of these people who use the evidence-based treatments (pharmacotherapy, counseling, or both pharmacotherapy and counseling).
  - And then doubles the percentage of these who do not relapse from their current rates for all three treatments.
- Focusing on three "traditional" policy changes (tax increases, clean indoor air acts and the promotion of cessation) will have a smaller effect: a predicted smoking prevalence in 2020 of 15 percent vs. 17.9 percent under the status quo.
- Smoking prevalence in 2020 will be 15.8 percent if five more aggressive cessation policies are enacted:
  - Full access to evidence-based treatment.
  - Free proactive quitlines.
  - Free nicotine-replacement therapy.
  - Free Web-based treatment.
  - Brief intervention at every health care visit.
- Making all three traditional policy changes, enacting all five cessation policies and doubling long-term abstinence rates (what Levy referred to as the "Full Throttle" model) results in a smoking prevalence in 2020 of 7.5 percent of the adult population, and the *Healthy People 2010* goal would be met in 2012.

In discussion, conference participants identified the potential FDA regulation of tobacco and the growth of the use of other forms of tobacco as additional elements, with both positive and negative consequences, to consider adding to the predictive model.

Viewing Smokers as Consumers and Taking a Fresh Look at Quitting From Their Perspective

Understanding the consumer's perspective is the first of the Consumer Demand Roundtable's six core strategies for increasing the use of evidence-based tobacco-cessation treatments.

To help meeting participants to do so, Kay Kahler Vose, M.A., roundtable planning-committee member and marketing expert, presented a summary of what the marketing firm, Porter-Novelli, showed to be key characteristics of smokers in its 2006 Styles Database:

- Smokers are high sensation seekers.
- They are more interested in living now than in living longer.
- Only 32 percent of smokers say that they do everything they can to stay healthy, vs. 52 percent of nonsmokers.
- Health is not as important to smokers as it is to nonsmokers, but appearance is. Kahler Vose relates this finding to smokers' perception of themselves as more adventurous and youthful than nonsmokers, and more trendsetting.
- Smokers are less likely to attend church, and more likely to follow alternative music, read edgy magazines, go to bars and nightclubs, gamble, play cards and buy lottery tickets.
- They often go to the Internet for health information. Kahler Vose noted the difficulty of finding accurate information about smoking cessation on the Internet.

The key message Kahler Vose finds in these data is that smoking is intimately tied up with smokers' self-perception. Any marketing or outreach around cessation needs to help smokers understand that giving up smoking does not mean giving up who they are.

Kahler Vose then led a discussion about the pre-conference consumer research assignment, in which participants were asked to try to find information about cessation from common sources: a Google™ search, other Web sites or a local pharmacy. Participants commented that:

- A Google search for effective products and services proved confusing; it was difficult, even impossible, to discriminate between effective and ineffective quitting aids.
- Philip Morris's highly publicized Web site on smoking cessation is boring, especially when compared to the jazzy magazine Philip Morris publishes for smokers.
- Other sites, e.g., Wikipedia, Trusted Source™ and the Web site of one physician, contain blatant misinformation on the risks of using nicotine-replacement therapy (NRT).
- The Web site for the nicotine replacement drug Nicotrol® "treats me as a patient when I don't see myself as a patient."
- At the local CVS drugstore, all the nicotine-replacement products are behind the counter. "You have to know what you want before you get to the counter, and there's a long line behind you. You won't know what it will cost. The way we're handling the NRTs is worse than [the way] we're handling cigarettes."

Matt Barry, M.P.A., of the Campaign for Tobacco-Free Kids® then provided an overview of just why consumers are so confused. After showing ads for a number of new products of uncertain lineage and composition:

- Aeros® smokeless cigarettes
- NicStic©
- Electronic cigarettes

- NicoGel®
- Nicodip™

Barry highlighted two issues:

- Consumers do not know the facts about smoking and cessation. Fifty-three percent of smokers report that nicotine is a cause of cancer, and as a result see nicotine-replacement therapy as potentially dangerous, lacking information on how it works. Most cannot differentiate effective treatments from unproven treatment aids and over-the-counter herbal remedies.
- Well aware of this, tobacco companies are competing for consumers with products that they are positioning as being less harmful–new brands of "light" cigarettes, for example. Smokeless tobacco products such as Revel and Snus are also being heavily marketed as ways to get around the restrictions of clean indoor air laws.

To build an even stronger understanding among conference participants about consumers' perspectives on smoking and quitting, this session of the conference concluded with a focus group of current women smokers (led by the New York City-based market research firm Just Ask a Woman).[2] The focus group members were brutally honest in their comments on smoking and quitting, which included:

- I smoke because… "I like it." "It's my only outlet for stress."
- When I think about quitting… "I get nervous." "I think about weight gain." "I'd get stress, I don't know what else I'd do."
- What do you do when you can't smoke? "As soon as I finish my meal and the check is paid, I'm out there digging in my purse for a cigarette." "I try not to visit places that won't allow me to smoke, so I stay home a lot."
- Tried to quit last year using Wellbutrin®. "I couldn't keep at it, I felt like a failure."
- "I quit for seven years and started up again two-and-a-half months ago when my mother got lung cancer. I've quit now for two days and I'm ready to slap someone."
- Does your doctor know you smoke? "I lie."
- "Cigarettes are $5 and [nicotine-replacement therapy] is $45. It's too expensive, and health insurance won't pay. They'll pay a thousand million dollars to suck out your lungs and give you chemo, but they won't give you what you need to stop."
- What about your children? "I keep it out of the house. I tell them, 'Don't do what Mommy does; have a healthy life.'"
- "They have nonalcoholic beer. Can they come up with a cigarette that gives you the same effect without harmful ingredients?"
- To quit, "You have to make up your mind and be ready to do it. Help for quitting is not effective enough."
- "I know how to deal with stress. It's just easier to pick up a cigarette."
- Does anybody use counseling? "No. Then you'd have to admit that you're an addict."

2 Audio clips of this session are available on the conference Web site, **www.consumer-demand.org**.

These stories and views painted a sordid picture of what it is like to try to quit smoking without help:

- Most focus group participants lacked knowledge of effective products and services that could help them quit.
- Some had used effective medications but often without counseling or guidance on how to use them correctly.
- Overall, there was a pervasive sense of demoralization. Most of the women on this panel had tried to quit and failed. They seemed to have given up not only on the value of treatment but also on their own capacity or ability to quit and, as a result, on their motivation to quit.

Redesigning Evidence-Based Products and Services to Better Meet Consumers' Wants and Needs

How exactly, then, can providers of cessation treatments integrate knowledge about consumers and their perspectives into the actual design of these products and services?

Peter Coughlan, Ph.D., of the design firm IDEO; Myra L. Muramoto, M.D., M.P.H., of the University of Arizona; and Caroline Cremo Renner, M.P.H., of the Alaska Native Tribal Health Consortium, described how they went about doing just that through work on increasing consumer demand for cessation services (funded by RWJF) in Alaska and Arizona.

Coughlan began by outlining the approach IDEO takes to design, highlighting the importance of beginning a design effort by observing how the product and service is currently used and asking the users about their experience.

The next step involves telling stories, reaching into how people personally resonate with their use of the product or service. With the customer focus strongly cemented through this early work, the designers then move on to synthesizing the information, brainstorming ideas, creating and refining prototypes, experimenting, and then spreading ideas.

Coughlan noted the value of beginning this process with what he called "extreme users," those who would "turn up the contrast" and clarify the key issues. With this in mind, Alaska and Arizona were chosen as the prototype sites.

The work in Alaska and Arizona followed eight design principles that the roundtable developed:

- Kick the tires.
- Lower the bar.
- Make it look and feel good.
- Facilitate transitions.
- Make progress tangible.
- Foster community.
- Connect the dots.
- Integrate it with my life.

Renner then described the design work at the Alaska Native Tribal Health Consortium. The goal of this work, she explained, was "to understand better the needs of Alaskan Natives around tobacco use, uncover new opportunities around the quitting journey and build upon successes of the existing Alaskan cessation program."

The key finding of the early design work was the value of coupling tobacco-cessation opportunities with medical procedures. These medical procedures take place in Anchorage, where services are organized and well-run. The question the design team explored was how quitting could be supported during all phases of the patient's treatment, even in villages where care is less well organized.

Renner presented the preliminary design of products that could support quitting at various points in the process–

- At the time of referral
- At diagnosis
- During preparations for the procedure
- At the time of the procedure
- During healing and recovery

–and ultimately provide an "integrated, culturally relevant offering for tobacco cessation."

The focus of the Arizona project, Muramoto explained, was an existing Helpers program, which trains family, friends and volunteers to speak with tobacco users about quitting in a helpful and productive way. The goal of the design work was to look at the Helpers training program through its consumers' eyes.

In its work, the design team identified the steps that a Helper goes through:

- Learning about the program.
- Getting trained.
- Trying the new skills.
- Seeking support.
- Spreading the word.

The design team began to think about consumer-focused design of products that would support each of these steps. The opportunity, Muramoto explained, lies "in providing an experience and the means to build a 'helper' community and not just a training program." In the long run, she emphasized, this can help to change the social norms for quitting.

Marketing and Promoting Cessation Products and Services in Ways That Reach Smokers—Especially Underserved Smokers—Where They Are

Several companies and organizations actively involved in reaching out to smokers about quitting then described what they do to reach these smokers "where they are."

Consumer Products

GlaxoSmithKline (GSK), the makers of Nicorette®, NicoDerm® CQ® and Commit® lozenges is one such consumer-products company, and GSK's Mike Wesnofske, M.B.A., provided an update on its marketing strategy.

GSK has both unbranded and branded marketing programs: The unbranded program addresses the importance of nicotine-replacement therapy with an educational advertising campaign for smokers titled "Tame the Beast." It uses the explanatory term "therapeutic nicotine" or TN, and highlights the slogan "TN gives your willpower a fighting chance."

The "Tame the Beast" campaign was supported by a promotional effort offering free samples of nicotine-replacement products at **www.way2quit.com**. The program had some success, giving away 6,000 samples and 3,000 sets of discount coupons.

About 15 percent of visitors to the site asked for the samples. GSK was disappointed, however, that the campaign did not draw more visitors to the site (given that such a large percentage of visitors to the site took action).

The marketers are theorizing that there may be some messenger bias at play, with consumers not trusting a major pharmaceutical company. GSK, Wesnofske promised, will try again.

GSK also is working to strengthen the power of the Nicorette, NicoDerm and Commit brands. He distributed samples of new flavors for Nicorette gum (fruit chill) and Commit lozenges (cherry).

Smokers have been trained by cigarette companies to identify with brands, Wesnofske explained. Branding is "vital to this public health cause."

Bringing Services to Smokers

Frank Vitale, M.S., national director of the Pharmacy Partnership for Tobacco Cessation, described the outreach of which he and his colleagues have been a part at NASCAR® races.

GSK became a lead sponsor of NASCAR when tobacco companies had to give up such sponsorships as part of the Master Settlement Agreement. More than 40 percent of NASCAR fans are smokers, making the races a good place to reach potential consumers of tobacco-cessation products and services.

At the NASCAR events, Vitale and his colleagues provide short behavioral interventions around two pieces of information:

- Medications will help you stop smoking.
- Medications will help more if you use them in combination with counseling.

These outreach efforts target:

- *Race attendees.* The raceways have tents with banners reading "Free Quit Smoking Coaching." These tents contain educational information and are staffed by specially trained counselors. The counselors offer pulmonary function tests, describe treatments and distribute coupons for nicotine-replacement therapy. These tents attracted 77,000 smokers in the 2005–2006 season and 67,000 so far this season.
- *Members of the pit crew "team,"* who are increasingly being recognized as essential to the success of any NASCAR driver. The counselors work with crew members and also with shop members and office staff, providing medications and counseling services that begin with a face-to-face meeting and continue with follow-up by phone and at the races. More than 180 NASCAR staff members have participated. The participants have achieved an impressive 55 percent quit rate.

Vitale emphasized the value of the approach and the potential for replicating it at other similar venues (e.g., arts festivals, concerts and air shows); he is actively exploring how to involve more pharmacists in this outreach.

Promoting Quitlines

The North American Quitline Consortium has also been working on promotion. The consortium's Randi Lachter, M.P.H, highlighted several recent developments, including:

- The North American Quitline Consortium's Promotion Task Force's development of a set of core principles for quitline promotion. These include the need for promotions to be evidence-based and to be conducted with a plan to provide adequate resources to meet the increased demand for services that the promotion will drive.
- Massachusetts' "Ready, Set, Quit" campaign. This campaign used a community-focused approach that involved partnering with city government and local community-based organizations in four target cities in the state (thereby keeping promotion costs low). The campaign used a multicultural approach and focused also on outreach to men. In two of the cities, Fall River and New Bedford, 6 percent of smokers completed an intake at the quitline during the promotion, with a marginal program cost of $878 per additional quitter.
- Some quitlines are purchasing banner and text ads on Web sites such as Yahoo!® and Google. These are proving highly cost-effective. Such ads also can be highly targeted and allow for detailed tracking and extensive reporting. Minnesota currently is conducting such a campaign with a cost per registrant of $59.
- In Arizona, the state quitline is conducting an advertising campaign to complement the implementation on May 7 of the state's smoke-free law. The campaign targets Hispanic men in their mid-20s and Hispanic women in their early 50s. Tracking data show that call volumes spike when the advertisements run. The quitline has a bilingual coaching staff; uses promotoras (local health promoters) and has arranged to fax referrals to health clinics that serve predominantly Hispanic populations.

Seizing Policy Changes as Opportunities for "Breakthrough" Increases in Treatment Use and Quit Rates

In introducing this strategy, Danny McGoldrick of the Campaign for Tobacco-Free Kids set up the goal of a "trifecta" of three concurrent policy changes:

- Clean indoor air laws.
- Tobacco tax increases.
- Increased funding for smoking-cessation programs.

New York City is the best-known example of McGoldrick's trifecta, where these three policy initiatives resulted in a 15 percent decrease in adult smoking within two years. Other examples of the trifecta are rare–Maine is the only state, for example, that has undertaken all three changes. In other states and communities:

- Tax increases are popular: 43 states have passed such laws since January 1, 2002. Eight states are considering new or additional tax increases in the current legislative session.

- Clean indoor air laws are also proliferating: 22 states (and many more cities) have some type of clean indoor air act in place or due to go into effect in the near future. Nine states are considering such laws in the current legislative session.
- The weak leg is the funding for tobacco-prevention and cessation programs. Only three states meet the current Centers for Disease Control and Prevention (CDC)-recommended funding level. That level is about to go up, so even fewer states will be compliant.

  Specifically, in fiscal year 2007, state tobacco revenues totaled $21.7 billion. The CDC recommends funding prevention and cessation programs at a total of $1.6 billion. States actually spend $597.5 million. There is some progress, however, as Iowa, Indiana, Florida, New Mexico and Washington State have increased funding for these programs for FY 2008.

McGoldrick concluded with a reminder that the Master Settlement Agreement payment increase will begin in FY 2008 and will last for 10 years. While these funds could support many prevention and cessation programs, such programs currently do not have a natural constituency. There is a clear need to "rally the troops," McGoldrick stated, and he urged using advertising, public relations, direct advocacy and grassroots activism to do so.

Marjorie Paloma, M.P.H., of RWJF then showed how Kentucky, with the highest rate of smoking in the United States, built an effective constituency for policies that support cessation through:

- A statewide coalition with broad representation from all sectors of the economy.
- Advocacy, including lobbying in the statehouse and through the media via op-ed articles, direct mail and "earned media" (e.g., news coverage).
- Links to statewide cessation services and early planning for the promotion of these services (so cessation was a focus of the effort at the start).

Kentucky succeeded in securing Medicaid coverage for tobacco-cessation services. Pregnant women were covered in 2005 and coverage was extended to all Medicaid beneficiaries in 2007 (although the details are not yet fully worked out and a new governor makes future support unclear).

The state of New Jersey (where a statewide smoke-free law went into effect April 15, 2006) and the city of Philadelphia (whose smoke-free law became effective in January 2007) also show ways that clean indoor air laws served to promote smoking cessation. Paloma and Jennifer Friedman of the Campaign for Tobacco-Free Kids presented examples of promotional programs and materials such as:

- "Smoke Free New Jersey: A Breath of Fresh Air," the promotional program about the new law that (with financial support from RWJF) included in all its publications information on how to quit.
- "Be Smoke Free in NJ: Quit2Win," a concomitant outreach program that saw a 142 percent increase in quitline enrollees from 2005 to 2006. Some 4,700 of these enrollees reported quitting smoking and remaining smoke-free for six months.
- **www.smokefreephilly.org**, the main coordinating vehicle for information on Philadelphia's clean indoor air law and on how to quit smoking.

Paloma and Friedman noted the importance of collaboration among state and local health departments to coordinate the planning for these new laws. They also stressed the importance of integrating cessation messages and strategies into all information provided about the new laws–whether that information is targeted to employers, smokers, the general public or the media.

The Campaign for Tobacco-Free Kids is working with the Robert Wood Johnson Foundation to disseminate an "implementation toolkit" (including information on promoting cessation services after the policy change goes into effect) for cities and states putting clean indoor air laws in place. This toolkit will help states and cities plan proactively to stimulate and meet the heightened demand for cessation products and services driven by clean indoor air laws and tobacco tax increases.

Combining and Integrating as Many of These Strategies as Possible for Maximum Impact

Such multi-component initiatives can happen at many levels: within a city, for example, or a health plan, or on a state or regional level.

A Multi-Component Initiative in a City

Sarah B. Perl, M.P.H., assistant commissioner for the Bureau of Tobacco Control at the New York City Department of Health and Mental Hygiene provided more information on the components of New York City's "perfect storm" of three policy actions: cigarette tax increases in 2002, city and state clean indoor air laws that became effective in 2003, and a concomitant focus on supporting smoking-cessation treatment.

New York City made it easier to quit by:

- Giving away nicotine-replacement therapy directly to the public, through a nicotine patch give-away program first held in 2003 and then revived from 2005 to 2007. Perl noted that there was great demand for free patches in 2003, but since then, "the stuff does not walk out the door on its own." The city is now actively promoting both cessation and the availability of free nicotine-replacement therapy (see below).
- Increasing enrollment in, and the use of medications at, cessation programs at the Health and Hospitals Corp., New York City's public hospital system.
- Using Public Health Detailing–in which public health workers deliver brief, targeted messages to physicians and other health care providers in their offices or clinics–to educate these providers about the importance of screening patients for tobacco use and about the delivery of cessation services.
- Providing medication, technical assistance and support to clinic– and community–based organizations that provide cessation services.
- Building acceptance for the use of medications and counseling in quit attempts.

New York City also ramped up its anti-smoking media campaign in 2006 in response to a leveling-off of smoking prevalence rates (after the initial decline). The campaign has been expensive and effective. Calls for help to quit smoking tripled in the first six months of 2006, compared to the first six months of 2005. Perl emphasized several issues to keep in mind in managing a comprehensive media campaign:

- Keep the campaign's message consistent, persuasive and salient to smokers.
- Run the campaign intensely: Show the messages frequently and for an adequate length of time.
- Show hard-hitting ads that provoke a negative emotional response.
- Spend the money; being visible will compound the effort by generating coverage in the press and on television and radio. If you can't spend enough to run a strong campaign, the effort may not be worthwhile at all.
- Be aware that while adult-focused ads may be effective with kids, the reverse may not be true.

Perl stressed the effort New York City has put into evaluating the impact of "the perfect storm." The most recent results show that:

- Teen smoking prevalence fell to 11 percent from 15 percent between 2003 and 2005.
- Adult smoking fell dramatically in the first year after the "perfect storm" but is now leveling off at just under 19 percent prevalence.

A Multi-Component Initiative in a Health Plan

Tim McAfee, M.D., M.P.H., chief medical officer of Free & Clear®, Group Health's tobacco-cessation corporation, presented the multi-component health plan-based smoking-cessation initiative undertaken beginning in the 1990s by the Group Health Cooperative of Puget Sound.

The goal of the initiative, McAfee explained, was to reduce prevalence of tobacco use at Group Health by 50 percent, from 25 percent of members in 1985 to 12.5 percent in 2000. To achieve this goal, Group Health worked to build a comprehensive, coordinated set of smoking-cessation interventions that would cover all stages of tobacco use. Through these interventions, Group Health was able to reduce the prevalence of tobacco use by 40 percent, from 25 percent of members to 15 percent, by the mid-1990s.

The components of the initiative were:

- Using evidence-based treatments and services.
- Identifying tobacco users in the primary care setting.
- Training practice teams in providing brief interventions and advice on quitting.
- Referring users of tobacco to phone counseling and group programs.
- Providing insurance coverage for counseling and for medications.
- Integrating this work with other initiatives in the organization (e.g., prevention, quality and chronic care initiatives).
- Supporting policy changes in the community that would support tobacco-use cessation.

For McAfee, the key lessons learned were:

- The science is a good starting place, especially as it helps to build clinician buy-in for the initiative.
- Developing the product, marketing plan and sales strategy is a real challenge; it draws on business skills unfamiliar to clinicians.
- Systems support is valuable. At Group Health, the existence of a telephone support system was hugely helpful.
- "Measurement matters": It is necessary to know what is happening and what is working.

In 2003 Group Health created a new corporation to market more broadly its Free & Clear quitline. The purpose of the incorporation was to increase the comprehensiveness and reach of its services through a dedicated focus on tobacco-use cessation and specific service improvements such as the integration of pharmacotherapy into these cessation-treatment services. Free & Clear now provides cessation quitline services to eight states and to many companies and health plans across the country.

A Multi-Component Initiative Linking State and Health Plan Efforts

Larry An, M.D., of the University of Minnesota and part of the Minnesota "Call it Quits" collaborative then described this public–private partnership to improve quitline services in Minnesota.

The partnership includes the state's health plans, ClearWay Minnesota (an independent nonprofit organization funded by the state's tobacco settlement money) and Blue Cross/Blue Shield of Minnesota. The health plans provide quitline services to their own members and ClearWay acts as gatekeeper, fielding initial calls, directing enrollees to their own plans and providing services to the uninsured.

An important part of this initiative has been the provision of free nicotine-replacement therapy to quitline enrollees. Initially, ClearWay provided the medications, but this became too expensive. Through the public–private partnership arrangement, health plans began to provide the nicotine-replacement therapy to their own members. Five Minnesota health plans now offer free medications to their members as part of their own quitline services. They are finding that this action is strengthening the link between smokers trying to quit and their health plans.

"Call it Quits" also sponsors a pay-for-performance program linked to quitline referrals. In comparing clinics participating in this program with those that did not, the collaborative found that the participants had many more referrals to quitlines. The collaborative has also developed a "superclinic outreach model" in which patients who are smokers are identified and contacted. Within two weeks of contact, 11 percent of these smokers had voluntarily reached out to a quitline.

Consumer Demand Research and Surveillance Needs

On its second day the national conference then moved to the question of what to do now (2007), specifically, how to advance the field of tobacco cessation. This discussion began with an overview of research and surveillance needs, with presenters from the National Institutes of Health (NIH), the CDC and academia.

State-of-the-Science Conference Statement

To establish the baseline of what is currently known, Pebbles Fagan, Ph.D., M.P.H., of the National Cancer Institute, presented the NIH's State-of-the-Science Conference Statement on Tobacco Use.

Developed in June 2006 and available on the **NIH's Web site**, the State-of-the-Science Conference Statement clarified the types of cessation-treatment products and services that are effective. Consistent with the U.S. Public Health Service guidelines and recommendations from other sources, the State-of-the-Science statement found value in:

- Mass media campaigns, especially when combined with counseling or other support services.
- Providers advising patients to quit.
- Increasing the unit price for tobacco products.
- Reducing the cost of cessation therapies.
- Culturally tailored, gender-specific and language-appropriate programs.
- Strategies that institutionalize cessation services in health settings.

Much more needs to be learned and documented, however, about the consumers' experience with tobacco-cessation products and services. Specifically, the conference statement mentions the need for more research on:

- Tailoring cessation services to specific populations.
- Making cessation treatment attractive and increasing demand for such treatment.
- Understanding the media's role in making treatment attractive.
- Reducing barriers in implementing strategies to increase consumer demand for cessation products and services.
- Understanding the reasons for the effectiveness of telephone-based counseling.
- Evaluating the impact of financial incentives and public performance reporting on increasing smoking cessation.
- Determining the effectiveness of incorporating context into interventions to prevent or stop tobacco use.
- Developing more effective pharmacotherapies and other treatment products.

Fagan clarified that no specific funding opportunities have arisen as yet from the State-of-the-Science Conference. She recommended exploring the NIH's existing small grant programs and other such funding opportunities.

Measuring, Tracking, Reporting and Studying Quitting and Treatment Use

Ann Malarcher, Ph.D., M.S.P.H., of the CDC's Office on Smoking and Health, spoke about the CDC's actions around the surveillance and tracking of tobacco cessation, highlighted by both the State-of-the-Science Conference Statement and by the Consumer Demand Roundtable, in the fifth of its six core strategies for building demand for tobacco-cessation products and services.

Malarcher explained that most current measurements of quitting and treatment use are driven by program evaluation needs. The CDC has developed logic models for the main components of tobacco control, including one logic model directly

related to cessation treatments and services. The short-term, intermediate and long-term outcomes defined in the logic model drive the metrics that are used.

These outcomes are, by necessity, quite general and include:

- Improved awareness of cessation services in the short term.
- Increased numbers of quit attempts in the intermediate term.
- Increased cessation in the long term.

Sources of data include the National Health Interview survey (used for measuring progress on Healthy People 2010 goals), the tobacco-use supplement of the Current Population Survey and, for youth, the National Youth Tobacco Survey.

Collecting data on these measures, Malarcher continued, poses a number of challenges:

- General health surveys are conducted more often and therefore provide more timely data, but these contain few questions about tobacco use, cessation and cessation-treatment use. For example, they usually only count quit attempts, as opposed to assessing quitting methods and experiences.
- Tobacco surveys are sporadic and provide only limited, "snapshot" information about cessation throughout the quitter's journey.
- It is hard to get timely data, although this situation is improving.
- The small numbers of smokers surveyed limits researchers' ability to look at one intervention, or at population subgroups, or at specific localities.

Malarcher concluded that interest and support for gathering tobacco-specific information is growing, however. Specifically, she sees a willingness to consider conducting tobacco-specific surveys more frequently as well as an increasing number of published research studies on cessation. Malarcher urged conference participants to take advantage of opportunities to build on these new sources of data.

The Value of Longitudinal Panel and Cohort Studies

Gary Giovino, Ph.D., M.S., of the State University of New York at Buffalo, then presented a comprehensive case for longitudinal panels or cohort studies that track one group of smokers over time–a need discussed often during the earlier roundtable meetings. Such cohort studies, Giovino explained, would provide "a videotape rather than a snapshot" of smoking and quitting behavior. Giovino argued that such studies "present the optimal methodology for assessing smoking," specifically:

- All stages of tobacco use (including cessation strategies and treatments used).
- The manifestations of tobacco dependence.
- Motivation, attitudes, perceptions, and intentions about smoking and about quitting.
- Co-morbidities experienced by smokers and by quitters.
- Efficacy, stress, support and coping skills among quitters.
- Actual tobacco use, through the testing of biomarkers in hair or saliva.

Giovino also provided some examples of attempts to assess tobacco use, quitting attempts and methods in the same population over time, including the:

- National Youth Smoking Cessation Survey
- Assessing Hard Core Smoking Survey
- International Tobacco Control Policy Evaluation Project
- Smoking Toolkit Study in the U.K.

Conference participants were highly engaged in discussing the concept and potential value of longitudinal panel and cohort studies:

- Roundtable member Saul Shiffman, Ph.D., of the University of Pittsburgh stressed the importance of having a method of consumer-focused surveillance that will give information about whether people choose to quit, what treatments they use and why they use them.
- Fagan and Malarcher both responded that the National Cancer Institute and the CDC would be responsive to such a possibility.
- Dianne Barker, M.H.S., of the Public Health Institute urged the creation of an advocacy group to promote these critical changes in surveillance and research funding.
- Roundtable member Frank Vocci of the National Institute on Drug Abuse suggested the National Cancer Institute Foundation as a funding vehicle.
- To support this, Giovino noted that there is a growing international consensus on the value of cohort research to understand the trajectories of tobacco use and cessation.

Michael Fiore With an Update on the National Action Plan for Tobacco Cessation: Six Recommendations for Federal Action and Current Status

The Consumer Demand Roundtable then welcomed Michael Fiore, M.D., M.P.H., professor of medicine at the University of Wisconsin and founder and director of the University of Wisconsin Center for Tobacco Research and Intervention.

Fiore is also the chair of the review panel for the *U.S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence.* Fiore provided an update on the status of the six recommendations of the National Action Plan for Tobacco Cessation.

- *A national quitline network.* The network exists, but its reach is not as great as intended–the network reaches 1 percent of current smokers while the projection was for 16 percent. The network needs more funding, and needs to conduct more outreach.
- *An ongoing paid media cessation campaign.* The United States now has two national programs, one funded by the National Cancer Institute and the second–the "Become an Ex-" campaign–sponsored by the American Legacy Foundation. Overall funding is low, however–promotion for state quitlines averages about $194,000. There is a need for better understanding of the media used by smokers, and how to harness these media for promotion of quitting.

- *Inclusion of evidence-based tobacco-cessation services and medications in benefits provided to all federal beneficiaries and in all federally-funded health programs by 2005.* Progress has occurred. There is now Medicare coverage for such services and Medicaid coverage in 42 states. The VA has eliminated the co-payment for cessation counseling, and there has been growth in private-sector insurance coverage.
- *A broad, balanced research agenda.* The NIH, the CDC and the Agency for Healthcare Research and Quality (AHRQ) have all released announcements of grants available for research related to tobacco-use cessation. These are occurring, however, in an overall climate of cuts in federal money for health research.
- *Training for clinicians.* There has been essentially no progress in federal funding in this area.
- *Establishment of a "Smokers Health Fund."* The National Action Plan had envisioned such a fund, to be financed by excise taxes on cigarettes and other tobacco products. At least 50 percent of these tax revenues were to be dedicated to implementing the National Action Plan. Fiore noted that this recommendation was "unlikely to happen at the federal level," but he was somewhat heartened by the increases at the state level in tobacco excise taxes.

In describing the value and importance of the National Action Plan for Tobacco Cessation, Fiore noted that its components became the basis of the U.S. Department of Justice's original request for a settlement of $130 billion in its lawsuit against tobacco companies. (Fiore then added that the settlement request was later reduced to $10 billion, presumably the result of political pressure.) Nevertheless, Fiore continued, the elements of the National Action Plan are critical to the health of the nation. "Every consumer," he emphasized, "deserves to know how to quit."

Designing Breakthrough Strategies and Innovations

To give conference participants the opportunity to develop and present their own ideas on increasing demand for cessation products and services, Peter Coughlan of IDEO led the conference through an interactive design exercise that included:

- Individual brainstorming about possible activities that would increase consumer demand for tobacco-cessation products and services.
- Discussion of these ideas with one colleague to refine the components.
- Presentation to the entire conference.
- Grouping of the ideas by the Consumer Design Roundtable strategy to which they applied.

After almost an hour of lively and engaged discussion–and some laughter–about 40 ideas were presented by conference participants. **Appendix 2** contains the full list of ideas. The ideas covered:

- Concepts such as large-scale policy changes (a national smoke-free law).
- Marketing (a TV show that would be like *The Biggest Loser*, but for smokers).
- Product redesign (repackaging nicotine-replacement therapy so it resembles New Age aromatherapy cleaning products).

Updates on Current Initiatives

Several interesting and hopeful developments in the field of tobacco-use cessation were presented at the three Consumer Demand Roundtable meetings. The national conference included updates on four of these:

- The new drug from Pfizer, CHANTIX™.
- Placing tobacco under Food and Drug Administration (FDA) regulation.
- Other new pharmacotherapy treatments.
- The American Legacy Foundation's "Become an Ex–" campaign.

CHANTIX™ (varenicline)

Roslyn F. Schneider of Pfizer discussed CHANTIX, a drug recently approved for tobacco cessation by the FDA that specifically targets the nicotine receptors in the brain to reduce the craving for nicotine and the possibility of a smoking relapse. Schneider reported that the launch of the drug in 2006 had gone well, with a high level of patient interest and continuing enthusiasm. Refill rates after the first month are not as high as they should be, however. The barriers to continued use cited by Schneider include:

- Insurers or employers not offering coverage for smoking cessation (including CHANTIX), and patients seeing the cost of CHANTIX as a barrier, especially if they have to pay cash. (Schneider added that a day's supply of CHANTIX costs less than a pack of cigarettes.)
- Many smokers feel that they've successfully quit after the first month, and therefore do not need any more treatment.

Pfizer has designed a free 52-week support plan called GetQuit to support patients and their physicians during quit attempts. There is a 60 percent to 70 percent enrollment in GetQuit among those who are aware of the program, and 95 percent of these report being satisfied or very satisfied.

Pfizer also launched an unbranded consumer campaign in the fall of 2006: "A Fresh Look at Quitting." Within three months, the campaign had garnered two million visitors to its Web site and more than 2,000 callers to its helpline. Pfizer is finding that the campaign's message "Willpower alone is not enough" is effective; it especially helps to remove the stigma consumers can feel that "I failed at quitting because I am weak."

FDA Regulation of Tobacco

Mitch Zeller, J.D., of Pinney Associates then discussed the prospect of FDA regulation of tobacco. The FDA had first asserted its jurisdiction over tobacco in 1996, but this was reversed by the Supreme Court in 2000. A return to FDA regulation for tobacco might have been codified as part of the state lawsuits settlement, but this change required new legislation that the Senate failed to pass when it was introduced in the 1997–1998 session.

The legislation was submitted again as part of a compromise in the Kennedy-DeWine bill in 2004–2005, but again, it did not pass. The legislation has now been reintroduced and faces a much stronger likelihood of passage as a result of the changed political environment.

The proposed legislation:

- Allows pre-market evaluation of any express or implied health claim for a tobacco product.
- Bans descriptors like "light" or "mild."
- Authorizes an increase in the size of the package warning to 50 percent of the label size.
- Supports the FDA taking a more flexible approach in reviewing nicotine-replacement therapy.

Zeller said that "conventional wisdom" gives the legislation a 50 percent likelihood of passage. Passage of the legislation is important, he added, because it will "level the regulatory playing field."

"The cleanest, safest method of nicotine delivery (i.e., nicotine-replacement therapy)," he continued, "is now the most highly regulated."

New Pharmacotherapies

A number of promising new drugs are in the development pipeline, reported Frank Vocci, Ph.D., of the National Institute on Drug Abuse (NIDA). These include:

- Rimonabant, which appears to inhibit weight gain on quitting.
- NicVAX™, a nicotine vaccine. Its Phase II clinical trial met its goal, so work will continue to test this promising new cessation aid which may also help to prevent relapse after quitting.
- Selegiline, a monoamine oxidase inhibitor currently used in the treatment of Parkinson's disease. This drug's effectiveness for tobacco-use cessation, when administered via a skin patch, will be tested in two trials started in May 2007. Selegiline appears to eliminate the risk of a hypertensive crisis that often comes with monoamine oxidase inhibitors.
- Dopamine D3 Receptor Antagonists. While these are still five or 10 years down the line, the hope is that they will serve also to reduce relapse after quitting.

The "Become an Ex–" Campaign

Donna Vallone, Ph.D., of the American Legacy Foundation provided information on the pilot phase of its "Become an Ex–" campaign, a multi-component smoking-cessation initiative that seeks to "develop a clear, authoritative voice of cessation to offer 'real know-how' from a trusted brand."

From September 2006 through June 2007 the campaign has been piloted in four U.S. cities, with Grand Rapids, Mich. serving as the key evaluation site. The first phase of this pilot was launched in Grand Rapids in November 2006 and ran through early January 2007.

Results of the first phase of the pilot included an increased call volume and also an increase in **Web site** traffic (although this may have been driven by earned media at the start of the campaign, as the Web site had not been highlighted in the early stages).

The evaluators used surveys to judge consumers' awareness of, and receptivity to, the advertisements that were run. About a third of respondents reported awareness of the ads, and these people showed comparatively high receptivity to the messages.

The Phase II pilot advertisements were airing at the time of the meeting. These are built around the concept of "re-learning" the process of quitting and breaking the process into manageable pieces.

Synthesizing What Attendees Heard and Moving Forward

The national conference ended with a panel discussion of several components of work necessary for continuing the effort towards building consumer demand for evidence-based tobacco-cessation products and services.

Saul Shiffman, Ph.D., of the University of Pittsburgh moderated the panel of representatives from the organizations that support the National Tobacco Cessation Collaborative, asking each panelist for one innovative idea that had come to them during the national conference:

- *A vehicle is needed for continuing this work,* observed C. Tracy Orleans of RWJF, who proposed creating a dedicated forum for continuing the work of the roundtable, perhaps under the umbrella of the National Tobacco Cessation Collaborative. She stressed the need to develop a workplan or blueprint for moving forward, as well as a toolkit that would support the dissemination of the creative ideas already developed through the roundtable's work.

  The NIH's Patricia Mabry, Ph.D., added that "the world of Wiki," that is, the use of Wiki software that allows large groups of people to revise Web pages online, could support the development of this toolkit.

- *What research questions should be the priority?* David Abrams, Ph.D., of the NIH cited the importance of further exploring:
  - Consumer motivation.
  - The feasibility of a longitudinal cohort study. (Conference participants, however, cautioned against having the perfect become the enemy of the good. The focus needs to be on the information a longitudinal cohort study would provide, and how this information can be obtained "well enough.")
  - Developing a registry of quitters, as the foundation of a "natural study" of successful quit attempts.

- *Think creatively about funding.* Cathy Backinger, Ph.D., M.P.H., of the National Cancer Institute called for innovations in the *process* of funding, especially in how program announcements are disseminated. Research into effective dissemination of funding announcements could help support this effort.

- *Improve the communication of information about cessation.* The CDC's Karen Seiner, Ph.D., called for more publicizing of the national quitline portal 1-800-QUIT-NOW. "Get Google to highlight it!" she suggested, and also called for more strategies to involve state governments. Many participants agreed:
  - Saul Shiffman, Ph.D., of the University of Pittsburgh stressed the value of innovation at the state level as "rapid prototyping can happen more easily on a smaller scale."
  - Pebbles Fagan, Ph.D., M.P.H., of the National Cancer Institute supported investigating new vehicles for communicating information, pointing to the "eat five servings of fruits or vegetables per day" stickers that appear on the bananas at her grocery store.

- *The field of neuroscience is expanding*, noted NIDA's Frank Vocci, Ph.D. This new science in brain development–social neuroscience for example–may give clues to why smoking is such a powerful lure.
- *Collaboration is essential*, the American Legacy Foundation's Donna Vallone, Ph.D., added. The range of effort required is large, and tools that could naturally affect an audience of this size (e.g., the Internet, or national media) are most effectively used on a large scale.

Saul Shiffman then summarized the consensus of the panel, and the common finding of the national conference:

- Innovation happens as a result of collaboration. "If we have a vision," he said, "it has to be a 360-degree vision. Beyond researchers, clinicians, funders, we need to look at private enterprise, marketers *and* the consumers, and their families, colleagues and loved ones."

In closing the conference, co-chair C. Tracy Orleans stressed that the work to build consumer demand for tobacco-cessation products and services will continue–as a first step, conference participants will be asked to complete a follow-up survey on preferences for cessation initiatives to be undertaken by the National Tobacco Cessation Collaborative.

To remind all participants that immediate, personal action is possible, co-chair Carlo DiClemente noted he had begun "incorporating consumer demand into all that I do," and urged them to do the same.

Appendix 1

Consumer Demand Roundtable Members

David Abrams, Ph.D.
National Institutes of Health

Linda Bailey, J.D., M.H.S.
North American Quitline Consortium

Matt Barry, M.P.A.
Campaign for Tobacco-Free Kids®

Tim McAfee, M.D., M.P.H.
Free & Clear®

Carlo DiClemente, Ph.D. (co-chair)
University of Maryland

Amanda Graham, Ph.D.
Brown Medical School

David Graham, M.P.A.
Pfizer®
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Karen Gutierrez
Global Dialogue for Effective Stop Smoking Campaigns

Pablo Izquierdo, M.A.
Elevacion Ltd.

Katie Kemper, M.B.A.
GlaxoSmithKline Consumer Healthcare
(now Campaign for Tobacco-Free Kids)

Myra Muramoto, M.D., M.P.H.
University of Arizona

C. Tracy Orleans, Ph.D. (co-chair)
Robert Wood Johnson Foundation®

Joachim Roski, Ph.D., M.P.H.
National Committee for Quality Assurance

Saul Shiffman, Ph.D.
University of Pittsburgh

Victor Strecher, Ph.D., M.P.H.
University of Michigan

Susan Swartz, M.D., M.P.H.
Center for Tobacco Independence
Maine Medical Center

Frank Vocci, Ph.D.
National Institute on Drug Abuse

Dianne Wilson
South Carolina African American Tobacco Control Network

Planning Committee

Elaine Arkin
Robert Wood Johnson Foundation

Kay Kahler Vose, M.A.
Porter Novelli
(now an independent consultant)

Todd Phillips, M.S.
Academy for Educational Development

Stephanie Smith-Simone, Ph.D., M.P.H.
Robert Wood Johnson Foundation and Princeton University

Rajni Sood Laurent, M.A.
Academy for Educational Development

The full list of participants in the meetings of the Consumer Demand Roundtable is available at **www.consumer-demand.org**.

Ideas Generated Through the "Breakthrough Strategies and Innovations Activity" Arranged by Consumer Demand Strategy*

Viewing smokers as consumers and taking a fresh look at quitting from their perspective.
■ Engage Legacy youth advocates.
■ Involve CTFK youth advocates.
■ Youth ventures to compete on projects to youth demand for cessation products and services. 12-24 year olds; they don't consider themselves smokers, design for their peers.
■ Mine the NAQC MDS for consumer type research—how/why people call—to reach others.
■ Building confidence to succeed in quitting.
■ Communicate these facts:
● Smokers usually make several attempts before successfully quitting.
● The more attempts you make at quitting the greater your chances at succeeding.
● More than half of smokers here successfully quit.
■ 1-800-QUIT-NOW.
■ Market analysis
Redesigning evidence-based products and services to better meet consumers' needs and wants.
■ Provide NRT in a new delivery system (as in aerosolized nicotine) that delivers nicotine in bolus fashion.
■ Sell NRT as singles and give away sample packs with multiple NRT types.
■ Put in 1-800-QUIT-NOW on all NRTs in BIG letters and on all cigarette packs.
■ Dark chocolate nicotine/beans, espresso.
■ Camera phone with tailored reinforcement messages and images.
■ Develop a generic "redesign kit" for the field with IDEO and others.
■ Change tobacco treatment to be a menu of options first—individual approach like cancer treatment here are the options (media for this approach).
■ Toolkits: use a wiki approach. Include guiding principles for designers.
Marketing and promoting cessation products and services in ways that reach smokers—especially underserved smokers—where they are.
■ More segmented marketing and product design for NRT products. Ex—how deodorant is market "pH balanced for women", or Rogaine for Men and Women.
■ Profiling successful quitters on the news "Life After Quitting" Similar to fallen soldiers profiles.
■ Coordination of care for quitters—between clinical systems and quitlines—through the sharing of basic data to ensure continuity regardless of chosen method(s).
■ Brick road across the nation and around the planet of engraved bricks with names of those who have quit—used for annual marathon route.
■ Obtain feedback from smokers and use to design media/marketing campaigns (salient messages).
■ Celebrate the ex-smoker.
■ Changes social norms among entire population regarding smoking as an addiction and that quitting is hard.
■ Explain treatments—e.g., concern that quitlines will yell at them, break confidentiality, fundamental lack of understanding about what treatments entail.
■ Engage food store chains to carry smoking-cessation and nutrition campaigns:
● coupon to pharmacy.
● stop selling tobacco.

* These ideas are shown here in the form of participants' rough notes.

- Messages in barber shops, beauty shops, laundromats.
- Partner with Starbucks® and put stories/messages on cups/napkins.
- Present treatments as a way to help smokers "quit on their own."
- Program 1-800-QUIT NOW into all new cell phones.
- 1-800 number on milk cartons.
- Develop effective media campaign to moderate smokers to quit. Ad council similar to what was done with blood pressure —Do it for the ones you love.
- Nigel Gray Made Me Do It —long-term recreational use of therapeutic nicotine coupled with a true pulmonary delivery device for nicotine.
- Steal from smokers—if they can market for temporary abstinence or situational substitution, why can't we?
- What motivates and demotivates smokers as potential cessation consumers? And what sustains positive motivation?
- Publicize, using really cool people, that failing during a quit attempt doesn't mean that you're a failure as a person.
- Quitting parties (*Southern Living* and appearance) Quitting bar nights; snuggling parties for smokers.
- Video game like Viva Pinata (taking care of smoking animals trying different treatments).
- Get deal-or-no-deal models to quit and follow them with media on their journey.
- Quitter selected to play deal or no deal and relates their story about quitting (often participants talk about story).
- Have hospitals on *Grey's Anatomy*, *ER* and *General Hospital* adopt smoke-free campus policies written into the scripts.

Seizing policy changes as opportunities for "breakthrough" increases in treatment use and quit rates.

- National smoke-free laws
- Pursue the development and dissemination of a proactive "cessation playbook" so states/municipalities that go smoke free or increase tobacco taxes are prepared to activate and supports respond to quitters.

Systematically measuring, tracking, reporting and studying quitting and treatment use—and their drivers and benefits—to identify opportunities and successes.

- National (or smaller) naturalistic study on tobacco use or quitting.
- Embed requirements to address consumer based processes and design principles of same type into all new NIH RFPs for treatments.
- Use surveillance to give feedback to states and counties.

Combining and integrating as many of these strategies as possible for maximum impact.

- Expand programs like those implemented by NY state/city and Group Health.
- Create contests for provider referrals to quitline.

"Big" Ideas—Those That Involved More Than One Strategy*

- Develop a (range of) clean nicotine product that is an acceptable substitute for 50 percent of smokers (a la Mike Russell from around 1985).*
- A = Ask; W = Write or recommend "which product would you be most comfortable using to treat your dependence?"; E = Encourage complete tobacco cessation.
- School programs (coaching) to train kids as coaches (like CPR training) because they are peers on the front lines.
- Ex-smokers and concerned nonsmokers HELPERS Strategies 1-2-3.
- Become a hero/ex: give ex-smokers a chance to be cessation counselors and allow them to be heroes in the process by helping to reduce the national cancer rate. Building upon the community kit and motivating smokers to become ex-smokers and stay quit.
- Tattoo painting contest, linked to quitlines. Winners get design and cash prizes.
- Design, build and market products, services and communities for "life after quitting."
- Focus on relapsing smokers to make 2010 guidelines. Consumer research with relapsers: understand them so can design programs to reach them. How are these different for those who don't relapse? Goal is to reduce relapse by 10 to 20 percent.
- "Learn how to quit even if you do not want to" quit message.
- March on Washington by Smokers, former smokers and loved ones for FDA legislation.
- Develop a national cessation public education campaign through a national alliance.
- Reality TV show–the longest quitter.
- Find a way to reactivate, resuscitate the national action plan for cessation.
- Smoking cessation navigation program similar to patient now programs. Would assist smokers with navigating through the world of smoking cessation, and help them find the right program, money to purchase cessation products, etc.
- Smoking cessation mentoring buddy program. Similar to the AA buddy program, this program would pair a smoker with a buddy of like lifestyle who could introduce them to non-smoker lifestyle changes.
- Nontraditional partners–identify select panels to translate cessation info to build demand in non-traditional audiences.
- Team-up with concert venues to make information available for quitting at concerts, promoted on cups, plates, etc., instead of Budweiser.
- Competition for communities to get all outlets to stop selling tobacco (we could do in eight years) and appropriate help for smokers.
- Competition between health care plans on getting all smokers to quit; 1st to achieve having all members quit gets prize.
- Convene reps from stakeholder groups to develop an Action Plan collaboration, reduce duplication.

* Again, ideas are shown here as participants' rough notes.

- Repackage NRTs–(e.g., method cleaning products).
- Young adults–research and design program aimed at 18-24 year olds.
- Internet–tracker competition between states "Healthiest State."
- USA smoke-free PAL #50 to political organization focused on election charges on tobacco control.
- Documentary a la Al Gore's "Inconvenient Truth" about the tobacco wars. To do this, we should be filming and taping our meetings.
- National campaign to promote altruism to create a smoke-free world. All ages and smoking statuses can participate.
- Actively engage former and current smokers in our work as advocates and voices to policy-makers. Not just for "research" purposes.
- A Day of Free Treatment: meds, counseling, system, etc., with tons of marketing to encourage everyone to "kick the tires."
- TV show like Discovery weight-loss challenge for smoking cessation.
- Systems design and alignment workshop.
- 1-800-QUIT-NOW on cig packs.
- "Systems change where patients receive care." Tobacco intervention incorporated into the largest clinical information systems. Federally funded and mandated.
- Weight Watchers-like smoking centers.

Ideas for X PRIZES

- Make the experience of quitting as rewarding in the short-run as the experience of smoking. This could be the goal of the X PRIZE. They have to figure out how to do this and make it feasible.
- X PRIZE competition among health places. Reduce smoking rates within health plan to given percentage. Several levels of prize such as $1 million for 12 percent, $2 million for 9 percent.
- The county be a "10" competition: each U.S. county must enroll a "team" of their smokers to compete for a $100 million X PRIZE. The first team to have 5,000 smokers quit in 12 months.
- Hold a national competition and award a $1 million prize to the clinician who can document helping the most smokers quit in one year.
- X PRIZE: $1 billion scholarship fund for universities/colleges that go smoke-free (building and grounds); or $10 per full-time student who quits; min total award $25,000; max $500,000.
- The Ex-prize (ex-smoker): states compete to reduce their smoking prevalence as much as possible by 2010. Highest percentage decrease wins.
- X PRIZE: 5 x 50. For entities with populations of 50,000 or more. 50 percent quit with E-B Rx; of these, 50 percent maintain their quitting for 50 weeks, prize $5 million.
- Replace cigarette sales in pharmacies with cessation clinics; $500,000 prize to first pharmacy to get 1,000 smokers to quit.