Oregon Coalition of Health Care Purchasers (OCHCP)
Tobacco Cessation Programs Survey

As the enclosed letter explains, this questionnaire is part of the OCHCP's effort with the Tobacco Free Coalition of Oregon to learn more about employment-based tobacco cessation programs. You represent one of 50-60 major employers and health care purchasers invited to participate in this study. We are asking only one person in each organization to take part. Altogether, you represent over 500,000 lives in Oregon and SW Washington. As a human resources professional, you know tobacco's toll on employee productivity and health. For these reasons, your contribution to this study is especially important.

This study's data collection comprises a telephone interview and a mail-back questionnaire, both administered by the University of Oregon Survey Research Laboratory (OSRL). OSRL prepared this self-administered questionnaire to shorten your telephone interview. You also may wish to consult documents about your organization's health benefits plans to answer some items. You will need just 10-15 minutes to complete this questionnaire. Please use the enclosed, stamped envelope to return it no later than September 30, 2002. You may also fax it to me at OSRL, if you wish: 541-346-0388.

As with the telephone interview, this questionnaire is completely confidential and, of course, voluntary. The code below is for OSRL to merge data from the two surveys. All study results will be presented solely in aggregate form; it will not be possible to identify your answers. As a thank-you, after the study is completed, OCHCP will share the study report, as well as strategies or tools developed as part of this study to reduce tobacco use.

We appreciate you taking the time to complete both this and the telephone interview. If you have any questions, please do not hesitate to contact D'Anne Gilmore, Executive Director, OCHCP: gilmored@ccwebster.net; 503-631-4844.

P. A. Gwartney, Ph.D., Director - OSRL, Professor - Sociology
University of Oregon, 541-346-5007, osrl2@oregon.uoregon.edu, http://osrl.uoregon.edu/

Organization Code:

A

THE FIRST QUESTION GROUP CONCERNS TOBACCO CESSATION ASSISTANCE PROVIDED BY YOUR BUSINESS OR ORGANIZATION, BUT NOT OFFERED THROUGH THE HEALTH PLANS YOU OFFER EMPLOYEES.

1. Does your business or organization offer tobacco counseling programs? (Please circle YES or NO.)

1 YES *2* NO ⇨ ***Please skip to question 2, page 2.***

⇩

1a. (IF YES) What kinds of tobacco counseling programs do you offer? Please describe them in detail. For example: How do employees hear about the programs? Are they offered individually or in group settings? How frequently do counselors meet with tobacco users? How many times do they typically meet altogether? Where do they meet? How long have you offered this service? How did it begin? Add any other information you believe could be important. Feel free to attach additional pages, including any promotional materials.

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2. Does your business or organization provide any tobacco cessation medications?

1 YES *2* NO ⇨ ***Please skip to question 3, page 3***.

⇩

2a. (IF YES) Which tobacco cessation medications do you provide? (Please answer YES or NO for each with a check mark ✓.)

(1) Over-the-counter nicotine patches *1* YES ☐ *2* NO ☐

(2) Over-the-counter nicotine gum *1* YES ☐ *2* NO ☐

(3) Prescription nicotine patches *1* YES ☐ *2* NO ☐

(4) Prescription nicotine gum *1* YES ☐ *2* NO ☐

(5) Nicotine inhaler *1* YES ☐ *2* NO ☐

(6) Nicotine nasal spray *1* YES ☐ *2* NO ☐

(7) Zyban or Wellbutrin *1* YES ☐ *2* NO ☐

(8) Other *(please specify)* _____ *1* YES ☐ *2* NO ☐

2b. Do you have any of the medication coverage limitations listed below?

(1) Number of courses of treatment *1* YES ☐ *2* NO ☐

(2) Medication co-pay *1* YES ☐ *2* NO ☐

(3) Medication only for those enrolled in a program *1* YES ☐ *2* NO ☐

(4) Coverage limited to a certain yearly amount *1* YES ☐ *2* NO ☐

(5) Program access limited to a certain yearly number *1* YES ☐ *2* NO ☐

(6) Employee pays for some treatment *1* YES ☐ *2* NO ☐

(7) Other *(please specify)* _____ *1* YES ☐ *2* NO ☐

B

FOR THE TWO QUESTIONS BELOW, YOU MAY NEED TO CONSULT BUSINESS/ORGANIZATION RECORDS. THESE QUESTIONS WILL AMPLIFY INFORMATION FROM THE TELEPHONE INTERVIEW.

B1. Out of all of your business' or organization's employees, how many opt out of health care coverage?
(Note: Please answer with the number of employees, not FTE.)

_____Number of employees who opt out

B2. For how many lives does your organization provide health care coverage, when you include dependents in the total?

_____Number of lives covered, including dependents

C

The more difficult part of the survey comes in the next few pages. In order to use your valuable time well, we have made it straightforward and attempted to minimize tediousness.

We need to know which of 15 named health plans your business/organization offers currently (in 2002) and which ones you will offer in 2003. *Be sure to include health plans you will offer new in 2003*. Extra space is provided for self-insured and "other" health plans.

For each health plan you offer, either 2002 or 2003, please continue across the question grid rightward, indicating whether this plan:

Offers any tobacco cessation services?

Offers any tobacco counseling programs?

If yes, the names of those counseling programs.

Covers any tobacco medications?

If yes, the names of those medications, and

The coverage limitations for those medications.

Remember, no organizational data have been collected on this topic before, and this study represents over 500,000 persons in Oregon and Southwest Washington. Moreover, the study results will be made available by OCHCP to enable you to compare your business/organization to others. For these reasons, your careful answers are very important, and we thank you in advance.

Health plan name.	C1. Did you offer this health plan in 2002?	C2. Will you offer this plan in 2003?)	C3. Does this plan include tobacco cessation services?	C4. Does this plan offer tobacco counseling programs?	C4a. (If YES) Please list below the names of the counseling programs that the health plan offers.	C5. Does this plan cover tobacco medica-tions?	C6. Which tobacco medications are covered? *(For YES check the applicable box. For NO leave the box blank.)*	C7. What are medication coverage limitations? (*For YES check the applicable box. For NO leave the box blank.)*
Health Net Health Plan of Oregon	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Kaiser Perma-nente Health Plans	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
LifeWise	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
ODS Health Plan	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Pacific Hospital Associ-ation	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)

Health plan name.	C1. Did you offer this health plan in 2002?	C2. Will you offer this plan in 2003?)	C3. Does this plan include tobacco cessation services?	C4. Does this plan offer tobacco counseling programs?	C4a. (If YES) Please list below the names of the counseling programs that the health plan offers.	C5. Does this plan cover tobacco medica-tions?	C6. Which tobacco medications are covered? *(For YES check the applicable box. For NO leave the box blank.)*	C7. What are medication coverage limitations? (*For YES check the applicable box. For NO leave the box blank.)*
Pacifi-Care	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Pacific Source	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Provi-dence Health Plan	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Provi-dence Health Plan - HMO	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Provi-dence Health Plan – Indemnity Plan	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)

Health plan name.	C1. Did you offer this health plan in 2002?	C2. Will you offer this plan in 2003?)	C3. Does this plan include tobacco cessation services?	C4. Does this plan offer tobacco counseling programs?	C4a. (If YES) Please list below the names of the counseling programs that the health plan offers.	C5. Does this plan cover tobacco medica-tions?	C6. Which tobacco medications are covered? *(For YES check the applicable box. For NO leave the box blank.)*	C7. What are medication coverage limitations? (*For YES check the applicable box. For NO leave the box blank.)*
Provi-dence Health Plan - PPO	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Regence Blue Cross & Blue Shield of Oregon	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Regence Blue Cross & Blue Shield of Oregon - HMO	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Regence Blue Cross & Blue Shield of Oregon - Indemnity Plan	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Regence Blue Cross & Blue Shield of Oregon - PPO	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)

Health plan name.	C1. Did you offer this health plan in 2002?	C2. Will you offer this plan in 2003?)	C3. Does this plan include tobacco cessation services?	C4. Does this plan offer tobacco counseling programs?	C4a. (If YES) Please list below the names of the counseling programs that the health plan offers.	C5. Does this plan cover tobacco medica-tions?	C6. Which tobacco medications are covered? *(For YES check the applicable box. For NO leave the box blank.)*	C7. What are medication coverage limitations? (*For YES check the applicable box. For NO leave the box blank.)*
Self-insured Plan – *(please specify)* _____ _____	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line*	*1* YES □→ *2* NO □ ↓ *If NO, please skip to C5.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, please go to next line.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)
Other *(please specify)* _____ _____	*1* YES □ *2* NO □	*1* YES □→ *2* NO □ ↓ *If NO, you're all done.*	*1* YES □→ *2* NO □ ↓ *If NO, you're all done.*	*1* YES □→ *2* NO □ ↓ *If NO, you're all done.*	*1.* _____ *2.* _____ *3.* _____ *4.* _____ *5.* _____	*1* YES □→ *2* NO □ ↓ *If NO, you're all done.*	□ Over-the-counter nicotine patches □ Prescription nicotine patches □ Nicotine inhaler □ Nicotine nasal spray □ Zyban or Wellbutrin □ Other (specify)	□ Number of treatment courses □ Medication co-pay □ Medication only for those enrolled in programs □ Program access limited to a certain yearly number □ Other (specify)

That is the end of this questionnaire! Thank you for your time and careful attention to these questions. Please feel free to add your comments or reflections about workplace tobacco cessation efforts, programs, and services on a separate sheet of paper for inclusion in the study results.

Remember to return your completed questionnaire in the stamped, addressed enveloped to OSRL no later than September 30th!

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