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Cover Letter

11000 Optum Circle
Eden Prairie, MN 55344

T: 888-445-8745
F: 952-917-7878
optum.com

January 24, 2020

Dianna Gilliland and Connie Heinrichs, Buyers
Nebraska State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

Re: Request for Proposal Number: 6204 Z1

Dear Mses. Gilliland and Heinrichs,

Consumer Wellness Solutions, Inc., an Optum company operating under the Optum brand (hereinafter referred to as "Optum") is pleased to submit our response to the State of Nebraska Request for Proposal Number 6204 Z1 for the provision of Statewide Tobacco Cessation Quitline Services.

Optum delivers innovative, forward-thinking Quitline solutions backed by our expertise in behavior change, three decades of experience providing tobacco cessation services, and twenty years of experience operating state Quitlines. In addition to serving Nebraskans, we operate 24 additional unique, customized Quitlines. We process over one million calls annually and help more than 2,000 tobacco users every day.

Optum is proud of our long-standing partnership with the State of Nebraska, where we leverage our extensive experience and research efforts to meet the State's needs. In our Technical Proposal response, we describe our program design and our experience in detail, both of which best position Optum as the partner of choice to continue assisting Nebraskans with quitting smoking and other products that contain tobacco. We welcome the opportunity to continue our work with the State of Nebraska.

If you would like any additional information or have questions regarding our proposal, please do not hesitate to contact me at 501-837-8198 or by email at john.m.selig@optum.com .

Sincerely,

John M. Selig, Vice President
Public Sector Business Development

Form A

Form A
Contractor Proposal
Point of Contact

Form A
Contractor Proposal Point of Contact
Request for Proposal Number 6204 Z1

Form A should be completed and submitted with each response to this solicitation. This is intended to provide the State with information on the contractor's name and address, and the specific person(s) who are responsible for preparation of the contractor's response.

Preparation of Response Contact Information	
Contractor Name:	**Consumer Wellness Solutions, Inc. (Optum)**
Contractor Address:	11000 Optum Circle Eden Prairie, MN, 55344-2503 USA
Contact Person & Title:	John Selig, Vice President
E-mail Address:	John.m.selig@optum.com
Telephone Number (Office):	501-837-8198
Telephone Number (Cellular):	501-837-8198
Fax Number:	877-331-6733

Each contractor should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the contractor's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Contractor Name:	**Consumer Wellness Solutions, Inc. (Optum)**
Contractor Address:	11000 Optum Circle Eden Prairie, MN, 55344-2503 USA
Contact Person & Title:	John Selig, Vice President
E-mail Address:	John.m.selig@optum.com
Telephone Number (Office):	501-837-8198
Telephone Number (Cellular):	501-837-8198
Fax Number:	877-331-6733

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

CONTRACTOR MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Solicitation, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that contractor maintains a drug free work place.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	**Consumer Wellness Solutions, Inc.**
COMPLETE ADDRESS:	**11000 Optum Circle, Eden Prairie, MN 55344**
TELEPHONE NUMBER:	**989-415-5458**
FAX NUMBER:	
DATE:	1/21/2020
SIGNATURE:	
TYPED NAME & TITLE OF SIGNER:	**Judd Schiltz, Director of Finance**

Proprietary
information Table

PROPRIETARY INFORMATION TABLE HAS BEEN REDACTED DUE TO PROPRIETARY INFORMATION.

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II. Terms and Conditions

Contractors should complete Sections II through VI as part of their proposal. Contractor is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The contractor should also provide an explanation of why the contractor rejected the clause or rejected the clause and provided alternate language. By signing the solicitation, contractor is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and contractor fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this solicitation. The State of Nebraska reserves the right to reject proposals that attempt to substitute the contractor's commercial contracts and/or documents for this solicitation.

The contractors should submit with their proposal any license, user agreement, service level agreement, or similar documents that the contractor wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the contractor's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;

2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;

3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

Response:

As noted in the following pages, Optum respectfully submits the following clarification and/or alternate contract language for consideration. In the event that Optum is awarded a contract pursuant to this RFP process, it is Optum's intention to negotiate final contract terms and conditions that are mutually acceptable to Optum and the State of Nebraska.

A. General

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JP			

The contract resulting from this solicitation shall incorporate the following documents:

1. *Request for Proposal and Addenda;*
2. *Amendments to the solicitation;*
3. *Questions and Answers;*
4. *Contractor's proposal (Solicitation and properly submitted documents);*
5. *The executed Contract and Addendum One to Contract, if applicable; and,*
6. *Amendments/Addendums to the Contract.*

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Response:

Agreed.

B. Notification

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JS			

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth below, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or five (5) calendar days following deposit in the mail.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

Response:

Agreed.

C. Notice (POC)

The State reserves the right to appoint a Buyer's Representative to manage [or assist the Buyer in managing] the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the Contractor will be provided a copy of the appointment document, and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

Response:

Agreed.

D. Governing Law (Statutory)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

Response:

Agreed.

E. Beginning of Work

The contractor shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Response:

Agreed.

F. Amendment

This Contract may be amended in writing, within scope, upon the agreement of both parties.

Response:

Agreed.

G. Change Orders or Substitutions

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JS			

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

In the event any product is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract or purchase order to include the alternate product at the same price.

******Contractor will not substitute any item that has been awarded without prior written approval of SPB******

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope are not permitted unless required to ensure compliance with any applicable law, or unless, in DHHS's sole determination, such changes or modifications are essential to ensure maximum use of other resources consistent with the purposes of this RFP.

Response:

Agreed.

H. Vendor Performance Report(s)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State may document any instance(s) of products or services delivered or performed which exceed or fail to meet the terms of the purchase order, contract, and/or solicitation specifications. The State Purchasing Bureau may contact the Vendor regarding any such report. Vendor performance report(s) will become a part of the permanent record of the Vendor.

Response:

Agreed.

I. Notice of Potential Contractor Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
			"If Contractor ~~breaches the contract or~~ anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the anticipated ~~breach~~ or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach."

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

Response:

Optum proposes alternate language.

J. Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
		JS	"Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby. OR In case of breach by the Contractor, the State may, without unreasonable delay, make a good faith effort to make a reasonable purchase or contract to purchased goods in substitution of those due from the contractor. The State may recover from the Contractor as damages the difference between the costs of covering the breach. Notwithstanding any clause to the contrary, the State may also recover ~~the contract price together with any~~incidental or consequential damages defined in UCC Section 2-715, but less expenses saved in consequence of Contractor's breach. ~~The State's failure to make payment shall not be a breach~~, Contractor may suspend or terminate services if the State breaches its obligation to make payment for services in accordance with the terms of the contract, and does not cure such breach within thirty (30) days from receiving written notice of the breach from Contractor and the Contractor shall retain all available statutory remedies and protections."

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby. OR In case of breach by the Contractor, the State may, without unreasonable delay, make a good faith effort to make a reasonable purchase or contract to purchased goods in substitution of those due from the contractor. The State may recover from the Contractor as damages the difference between the costs of covering the breach. Notwithstanding any clause to the contrary, the State may also recover the contract price together with any incidental or consequential damages defined in UCC Section 2-715, but less expenses saved in consequence of Contractor's breach.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

Response:

Optum proposes alternate language.

K. Non-waiver of Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

Response:

Agreed.

L. Severability

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

Response:

Agreed.

M. Indemnification

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY (Optional)

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this solicitation.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

Response:

Agreed.

N. Attorney's Fees

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

Response:

Agreed.

O. Assignment, Sale, or Merger

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

Response:

Agreed.

P. Contracting with other Nebraska Political Sub-divisions of the State or another State

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Contractor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Response:

Agreed.

Q. Force Majeure

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JP			

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

Response:

Agreed.

R. Confidentiality

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JP			

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

Response:

Agreed.

S. Office of Public Counsel (Statutory)

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract.

Response:

Agreed.

T. Long-Term Care Ombudsman (Statutory)

Contractor must comply with the Long-Term Care Ombudsman Act, per Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this contract.

Response:

Agreed.

U. Early Termination

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JP			

The contract may be terminated as follows:

1) *The State and the Contractor, by mutual written agreement, may terminate the contract at any time.*
2) *The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.*
3) *The State may terminate the contract immediately for the following reasons:*

a) *if directed to do so by statute;*
b) *Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;*
c) *a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;*
d) *fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;*
e) *an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;*
f) *a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;*
g) *Contractor intentionally discloses confidential information;*
h) *Contractor has or announces it will discontinue support of the deliverable; and,*
i) *In the event funding is no longer available.*

Response:

Agreed.

V. Contract Closeout

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
			"Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein: 1. Transfer all completed or partially completed deliverables created under this Contract to the State; 2. Transfer ownership and title to all completed or partially completed deliverables created under this Contract to the State; 3. Return to the State all information and data created under this Contract, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures; 4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract; 5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract; 6. Return or vacate any state owned real or personal property; and, 7. Return all data in a mutually acceptable format and manner. Nothin in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim."

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. *Transfer all completed or partially completed deliverables to the State;*
2. *Transfer ownership and title to all completed or partially completed deliverables to the State;*
3. *Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;*
4. *Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;*
5. *Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;*
6. *Return or vacate any state owned real or personal property; and,*
7. *Return all data in a mutually acceptable format and manner.*

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

Response:

Optum proposes alternate language.

III. Contractor Duties

A. Independent Contractor / Obligations

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
			"Optum hires and provides extensive training for all Quit Coaches® who provide services in accordance with this contract. During training, individuals are employed on a temporary basis and are not transitioned to full employee status until completion of training."

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. *Any and all pay, benefits, and employment taxes and/or other payroll withholding;*
2. *Any and all vehicles used by the Contractor's employees, including all insurance required by state law;*
3. *Damages incurred by Contractor's employees within the scope of their duties under the contract;*
4. *Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law;*
5. *Determining the hours to be worked and the duties to be performed by the Contractor's employees; and,*
6. *All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)*

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the contractor's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

Response:

Optum proposes clarifying language.

B. Employee Work Eligibility Status

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. *The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html*
2. *The completed United States Attestation Form should be submitted with the solicitation response.*
3. *If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.*
4. *The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.*

Response:

Agreed.

C. Compliance with Civil Rights Laws and Equal Opportunity Employment / Nondiscrimination (Statutory)

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this solicitation.

Response:

Agreed.

D. Cooperation with Other Contractors

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JS			

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the perfomance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

Response:

Agreed.

E. Permits, Regulations, Laws

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JS			

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

Response:

Agreed.

F. Ownership of Information and Data / Deliverables

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
		JS	"The State of Nebraska shall have the unlimited right to publish, duplicate, use and disclose all information and data developed exclusively for the State of Nebraska by the Contractor pursuant to this contract. Notwithstanding anything in the contract to the contrary, and as between Contractor and the State of Nebraska, all right, title and interest in and to the Optum Enterprise Application System and all written materials not exclusively produced for the State of Nebraska but provided by Contractor in connection with this Contract (collectively the "Program"), including but not limited to the System and training materials as well as clinical and training protocols, and all related copyrights, patents, trademarks and other intellectual property rights, are the sole and exclusive property of Contractor and/or its licensors. No license or other interest in any Contractor proprietary

			materials or rights is granted or conveyed to the State of Nebraska except as expressly provided herein. As between the parties, and subject to the rights of service participants to their own data, the State of Nebraska shall own the data generated in connection with the services, provided however that Contractor may use such data for purposes of evaluation, quality assurance, and HIPAA required or permitted uses including treatment, payment, operations and the administration and management of Contractor's business."

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

Response:

Optum proposes alternate language.

G. Insurance Requirements

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. *Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;*
2. *Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,*
3. *Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.*

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within five (5) years of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and five (5) years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

Required Insurance Coverage	
Commercial General Liability	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
XCU Liability (Explosion, Collapse, and Underground Damage)	Included
Independent Contractors	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
Worker's Compensation	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
Commercial Automobile Liability	
Bodily Injury/Property Damage	$1,000,000 combined single limit

Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
Umbrella/Excess Liability	
Over Primary Insurance	$5,000,000 per occurrence
Professional Liability	
Professional liability (Medical Malpractice)	Limits consistent with Nebraska Medical Malpractice Cap
Qualification Under Nebraska Excess Fund	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
Commercial Crime	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
Cyber Liability	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$10,000,000
Mandatory Coi Subrogation Waiver Language	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
Mandatory Coi Liability Waiver Language	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

3. EVIDENCE OF COVERAGE

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Health and Human Services

Attn: TFN Program Manager

Address P.O. Box 95026

Lincoln, NE, 68509-0526

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

Response:

Agreed.

H. Notice of Potential Contractor Breach

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
			"If Contractor ~~breaches the contract or~~ anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the anticipated ~~breach~~ or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach."

If Contractor breaches the contract or anticipates breaching the contract the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, and may include a request for a waiver of the breach if so desired. The State may, at its discretion, temporarily or permanently waive the breach. By granting a temporary waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

Response:

Optum proposes alternate language.

I. Antitrust

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

Response:

Agreed.

J. Conflict Of Interest

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that no relationship exists between the bidder and any person or entity which either is, or gives the appearance of, a conflict of interest related to this Request for Proposal or project.

Bidder further certifies that bidder will not employ any individual known by bidder to have a conflict of interest nor shall bidder take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, bidder shall provide with its proposal a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall bid evaluation.

Response:

Agreed.

K. Advertising

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

Response:

Agreed.

L. Nebraska Technology Access Standards (Statutory)

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

Response:

Agreed.

M. Disaster Recovery/Back Up Plan

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

Response:

Agreed.

N. Drug Policy

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

Response:

Agreed.

O. Warranty

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Despite any clause to the contrary, the Contractor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Contractor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to Customer, or if Contractor is unable to perform the services as warranted, Contractor shall reimburse Customer the fees paid to Contractor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

Response:

Agreed.

IV. Payment

A. Prohibition against Advance Payment (Statutory)

Neb. Rev. Stat. §§81-2403 states, "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency."

Response:

Acknowledged.

B. Taxes (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. The Contractor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor

Response:

Acknowledged.

C. Invoices

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Email invoice to DHHS.TFN@nebraska.gov. All required monthly reports (exhibit 5) or other deliverables must be submitted with adequate detail to support payment and must be approved by the State. The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

Response:

Agreed.

D. Inspection and Approval

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

Response:

Agreed.

E. Payment (Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2403). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

Response:

Agreed.

F. Late Payment (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

Response:

Acknowledged.

G. Subject to Funding / Funding Out Clause for Loss of Appropriations (Statutory)

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

Response:

Acknowledged.

H. Right to Audit (First Paragraph is Statutory)

The State shall have the right to audit the Contractor's performance of this contract upon a thirty (30) days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. §84-304 et seq.) The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

Response:

Agreed.

V. Project Description and Scope of Work

The bidder should provide the following information in response to this Request for Proposal.

A. Project Overview

The Nebraska Department of Health and Human Services (DHHS), Tobacco Free Nebraska (TFN) Program requests proposals to provide a proactive telephone-based tobacco cessation Quitline, Nicotine Replacement Therapy (NRT), and online training for providers. The primary target audience for the Nebraska Tobacco Quitline is all Nebraskans who smoke cigarettes or use other tobacco products (including e-cigarettes) and have shown a readiness to quit.

TFN will provide support and assistance to the Contractor leading to success of the Nebraska Tobacco Quitline and success for Nebraskans quitting tobacco.

1) PURPOSE

To establish one contract to implement a free and convenient statewide telephone-based tobacco cessation Quitline to assist tobacco users. Services will be based on the recommendations contained in the following resources:

a) Center for Disease Control and Prevention (CDC) Telephone Quitlines: A Resource for Development, Implementation, and Evaluation https://www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/index.htm

b) U.S. Public Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/correctadd.html

c) North American Quitline Consortium (NAQC) Minimal Data Set (MDS) offering a standard approach to evaluating tobacco cessation Quitlines (www.naquitline.org).

Depending on each individual's readiness to quit, the Quitline will provide assessment, proactive (counselor-initiated) follow-up counseling, screening and recommendations related to the use of support materials and /or referrals to community based cessation programs. For participants receiving counseling, the contractor may offer Nicotine Replacement Therapy (NRT) (patch, gum or lozenges) after screening the caller for medical contraindications.

Based on the CDC's "Best Practices for Comprehensive Tobacco Control Programs", the Nebraska State Plan for Tobacco use Prevention and Cessation indicates that simultaneous comprehensive approaches in prevention, cessation, and protection are necessary to effectively reduce the harm caused by tobacco use and achieve the following goals:

a) Prevent the initiation of tobacco use among youth

b) Promote quitting among youth and adults

c) Eliminate exposure to secondhand smoke

d) Identify, reduce or eliminate the disparities related tobacco use

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 1, 2, 17, 24, and 39.

2) The Quitline will provide support to other tobacco control initiatives in Nebraska in the following ways:

a) Provide a foundation of service at no charge to the user and available for all Nebraskans who wish to quit using tobacco products.

b) Encourage healthcare professionals to address tobacco use with patients by providing a comprehensive online training complete with continuing education units and resources that supports intervention.

c) Serve as an incentive for insurers and employers to make tobacco dependence treatment a fully covered benefit so more Nebraskans will have access to counseling and other effective treatments.

d) Serve as a resource for public or voluntary policies that may serve to encourage tobacco users to quit.

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 1, 3, 8, 11, 17, 18, 24, 25, 28, 29, and 42.

B. Project Environment

1) OVERVIEW

Tobacco use remains Nebraska's leading cause of preventable death, killing an estimated 2,500 Nebraskans each year – more than auto accidents, AIDS, suicides, murders, alcohol and illegal drugs combined. Tobacco costs the state a total of $795 million annually in medical costs including $162 million of Nebraska's annual Medicaid expenditures. Smoking related mortality also results in more than $605 million in lost productivity each year in the state.

Nebraska's adult smoking rate is 16.0% (2018 Behavioral Risk Factor Survey. The state adult smokeless tobacco use rate is 5.2%. (2018 Behavioral Risk Factor Survey). Over the last three years, the Nebraska Tobacco Quitline's annual call volume has increased from 2,940 in 2016 to more than 3,364 callers in 2019. This number includes tobacco users, proxy callers, health professionals and the general public. Approximately, 90%-96% of those callers are tobacco users.

Based on the 2018 Nebraska Behavioral Risk Factor Survey, 58.3% smokers, stopped smoking for one day or longer because they were trying to quit smoking in the past 12 months.

2) CEREMONIAL USE OF TOBACCO IN AMERICAN INDIAN CULTURE

TFN acknowledges the spiritual and ceremonial value that tobacco has in Native American culture. The phrases such as 'tobacco-free', 'tobacco user', 'tobacco prevention', and 'tobacco control' mentioned in this document refer to commercially-produced tobacco products and non-ceremonial use of tobacco.

3) QUITLINE MEDIA CAMPAIGNS

TFN or its media contractor will coordinate the development and implementation of the media campaign to promote the Quitline to the general public. TFN will attempt, whenever possible, to provide advance notice to the contractor about media campaigns, media events and earned media activities.

4) PROMOTION TO HEALTHCARE SYSTEMS

TFN will be responsible for promoting the Quitline throughout the healthcare delivery system.

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 1, 3, 18, 29, and 31.

C. Project Requirements

To ensure Nebraska is a participant in the National Network of Quitlines. TFN will promote the 1-800-QUIT-NOW (1-800-784-8669) and the 1-855-DÈJELO-YA (1-855-335-3569) numbers as the avenue to promote the Contractor's services. A pro-active Quitline responds to incoming calls with immediate "reactive" assistance and follows-up initial contact with more comprehensive services through outbound (proactive) calls. The Contractor's cessation services shall include intake, assessment, disposition, treatment and follow-up, and must follow evidence-based practices and principles of motivational interviewing.

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 10, 15, 17, and 39.

D. Business Requirements

Contractor must have experience in the delivery of tobacco cessation services, specifically with successful experience in the delivery of telephone cessation counseling services.

1) *Contractor must be a covered entity and in full compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, which includes entering into a Business Associate Agreement (BAA) with DHHS to facilitate transfer of data. See Exhibit 6, HIPAA Business Associate Agreement Provisions.*
2) *Contractor must provide reports that meet the requirements of the CDC Office of Smoking and Health and National Quitline Data Warehouse Quitline Services Survey and CDC TIPS Campaign. See Exhibit 4, Nebraska Tobacco Quitline Reporting Requirements and Exhibit 5, Nebraska Tobacco Quitline Reports.*
3) *No Contractor or any proposed subcontractors can have a current, or within the past five years, contract or affiliation with tobacco companies. In addition, the awarded Contractor or any proposed subcontractor may not accept tobacco industry business (contract or affiliation) for the duration of this contract.*
4) *Contractor should have experience working with State Health Departments and/or State Tobacco Control programs on tobacco cessation interventions.*
5) *Contractor must be a member of NAQC.*
6) *Contractor must have experience in tobacco cessation, experience in serving diverse clients, and awareness/participation in NAQC efforts.*
7) *Contractor must be readily available, for DHHS communications, 8:00 AM to 5:00 PM, Central Time, Monday through Friday, unless otherwise specified within the RFP. Contractor must be available by telephone and email throughout the course of the contract.*
8) *Contractor is prohibited from using any funds paid through this contract for any direct contact with state legislators or their staff for purposes of influencing any legislative policies or funding decisions.*
9) *Contractor will be responsible for all packaging and postage necessary to provide NRT distribution to qualified participants.*
10) *Contractor must obtain appropriate continuing education units (CEU's) for various online healthcare provider training. At minimum, the CEU's must be available for all licensed prescriber healthcare professionals.*
11) *Contractor must provide, within two weeks of contract start date, an affirmation that TFN is the sole owner of the client database and that client data from the Nebraska Tobacco Quitline will not be used by the Contractor for any purpose other than the provision of Quitline services, administrative and management analysis for operational improvement, benchmarking, or similar activities without prior written approval of TFN.*
12) *The Contractor will work in close collaboration with the TFN staff and the TFN media Contractor to coordinate/adjust cessation media campaign efforts to assure call volume and Contractor staffing capacity mesh to every degree possible.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 4, 7, 9, 11, 15, 17, 27, 28, 31, 34, 35, 41, and 44.

In compliance with paragraph D.3 above, Optum certifies that it will not accept any grants or anything of value from any tobacco manufacturer, distributor, or other tobacco-related entities, unless exempted as grant funds or items of value which are totally and completely for non-tobacco related purposes and do not present any danger of promotion of or use of tobacco products or otherwise conflict with policies and programs known to prevent and reduce tobacco use.

Additionally, Optum agrees that during the course of this contract we will not engage in any professional services, in Nebraska or elsewhere, considered pro-tobacco activities. Optum also warrants that neither we nor any subcontractor we may utilize knowingly represents or receives payment from any tobacco product manufacturer or wholesaler, or any parent, affiliate or subsidiary of a tobacco product manufacturer or wholesaler or any interest group or advocacy

organization, that represents the interests of the tobacco industry and that we will not do so during the term of this contract.

Also, in compliance with paragraph D.8 above, Optum affirms that it will not use any funds paid through this contract for any direct contact with state legislators or their staff for purposes of influencing any legislative policies or funding decisions.

E. Scope of Work

The Contractor will implement, at no-charge to the caller, a telephone-based tobacco use cessation quitline to assist Nebraskans with quitting smoking or the use of other tobacco products. As appropriate to each individual's readiness to quit, the Contractor will provide screening, assessment, proactive counseling, distribution of NRT, and support materials to individuals seeking assistance from the Quitline. The Contractor will also provide referrals to community based cessation programs when and if community programs are available. Additional services to be provided include web-based coaching services, mobile applications (apps), text messaging, and free comprehensive online training on brief tobacco intervention techniques and best practices to help healthcare providers work with patients quitting tobacco. The Quitline will provide services in the following areas:

1) INTAKE

a) Provide screening of all callers to determine the services desired. Screening of tobacco users must include, but is not limited to, the Minimal Data Set questions as recommended by NAQC, and obtaining permission of the tobacco user to be contacted for follow-up.

b) Provide information to callers, tobacco users and non-users, on tobacco dependence and its treatment, the dangers of secondhand smoke and other tobacco-related information. Information may include advice for family and friends on helping a tobacco user quit, and providing appropriate support through a quit attempt.

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 1, 17, 18, 29, 34, 36, and 38.

2) COUNSELING AND CONSULTATION

a) Provide a simple, no-cost point of access to services to assist tobacco users in quitting by providing screening and assessment of readiness to quit, counseling and advice, NRT including information on the U.S. Public Health Service recommendations on the use of pharmacological cessation aids, support materials, and referral to community-based services as appropriate.

b) For callers who are ready to quit, the Contractor will assist the caller to develop a personalized quit plan; provide comprehensive, proactive, phone-based behavioral counseling to interested clients; linkage with available health plan coverage for tobacco dependence treatment; and/or referral to community-based services, if desired and available. For healthcare professionals, the Contractor must provide technical assistance and consultation on a variety of effective tobacco dependence treatment issues. Topics may include but are not limited to: up-to-date information about NRT; referrals to the Quitline; fax referral programs (Medicaid fax referral program); implementation of in-office procedures following the Public Health Service Clinical Practice Guidelines on Treating Tobacco Use and Dependence; assistance on complicated patient case management issues; community-based tobacco cessation programs; provide free comprehensive online training (including free continuing education units) on brief tobacco intervention techniques; and best practices to help healthcare providers work with patients quitting tobacco.

c) Share participant information with the healthcare provider and/or upon request by the Managed Care Organization (MCO) to provide information about an individual, Contractor may inform the MCO whether the individual has contacted the Nebraska Tobacco Quitline regarding his or her interest in tobacco cessation treatment. Contractor shall only provide information to MCO currently under contract with DHHS. This would include working with Nebraska Medicaid and its process for participants to receive tobacco cessation services (See Exhibit 1, Nebraska Medicaid Provider Bulletin).

d) Provide information and support to the family and friends of tobacco users who may request assistance in motivating and helping loved ones quit tobacco.

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 1, 11, 17, 24, and 39.

3) EVALUATION AND QUALITY ASSURANCE

a) Provide services that are culturally and linguistically appropriate for the following specific populations:

i) Medicaid beneficiaries

ii) Uninsured/Low Socioeconomic Status

iii) Pregnant women

iv) Senior adults

v) Veterans

vi) Smokeless tobacco users

vii) Native Americans

viii) African Americans

ix) Hispanic/Latinos

x) Spanish speaking callers

xi) Deaf and hard of hearing

xii) Callers with mental health or substance abuse disorders

xiii) Teens

xiv) Other limited English speaking populations

b) Facilitate effective evaluation of the Quitline by working collaboratively with TFN. Quitline evaluation will be conducted by the Contractor to verify tobacco use status and measure client satisfaction. Follow-up evaluation and client satisfaction calls may be made to a random sample of callers meeting evaluation criteria after the receipt of services, at 7 and 13 months.

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 18 and 29.

F. Contractor Requirements

1) SYSTEM CAPABILITY

a) The Contractor must ensure core functionality to provide qualified personnel, facilities and equipment necessary to run a quitline with services that includes, at a minimum, a toll-free telephone line, fax referrals and web-based services.

b) The Contractor's system must be able to handle multiple, simultaneous incoming and outgoing calls with multi-lingual capability through a language assistance line, including TDD line. Systems must offer, at a minimum, a strong scalable communications server, automatic call distribution functionality, real-time monitoring of overall activity as well as individual calls, collection, analysis and reporting of data, telephonic integration allowing information exchange between voice and data systems. Systems must have the ability to track during and outside of hours of operation, "hits to the line", abandonment rates, wait times, and length of call. The systems must also be able to record all calls for quality assurance purposes. Describe technical system capacity, including personnel, facilities and equipment available to provide a toll-free telephone service capabilities.

c) *The call center must provide a live answer during the "live" response hours of operations, per Section V.F.2. Automated answering systems may only be used when quitline personnel are unavailable. If an automated answering is used, the caller must not be required to select more than two options prior to speaking with a registration specialist or other staff person.*

d) *It is preferred the Contractor have the ability to accept referrals through an online form.*

e) *It is preferred the Contractor have the ability to accept referrals through a secure email system.*

f) *The Contractor must be able to handle "live referrals" when a provider contacts the contractor with the client or patient in the room, and then once connected turn the interaction over to the client/patient to complete intake and set a date for the first coaching call.*

g) *The Contractor must have the ability to accept an electronic health record referral (e-Referral).*

i) *Preferred bi-directional e-Referral that meets NAQC standards.*

ii) *An electronic connection will be implemented by the Contractor to interface with health care provider systems electronic health records for purposes of electronic referral to Quitline with electronic feedback. Implementation of two-way electronic referral for one healthcare systems, as identified by DHHS, will be provided at no cost to DHHS.*

h) *It is preferred the Contractor have the ability to bill and receive reimbursement from all participating health plans and Medicaid for services provided.*

i) *Office space must accommodate administrative, counseling and support staff and confidential records as well as sufficient telephone lines, telephones and computer hardware. A TDD line must be available to provide services to the hearing impaired.*

j) *The Contractor must utilize the Nebraska Medicaid fax referral system, Exhibit 7, Example Quitline Fax Referral Form, which allows healthcare professionals to fax a referral to the Quitline toll-free, so the Quitline may proactively contact a tobacco user to initiate services. Information may be provided by the Quitline to the referring healthcare professional and/or upon request by the MCO to provide information about an individual, Contractor may inform the MCO whether the individual has contacted the Nebraska Tobacco Quitline regarding his or her interest in tobacco cessation treatment. Contractor shall only provide information to a MCO currently under contract with DHHS.*

k) *The Contractor must be capable of identifying callers who may be eligible for Quitline services through a health plan, employer, or other resource and if such eligibility is determined, the Contractor must facilitate a warm transfer of those callers to the Quitline service for which they are eligible, and no charge to TFN for the Quitline services received.*

l) *The Contractor must provide 24 hour web-based services as an enhancement to the telephone-based services provided and/or as a stand-alone web-based tobacco cessation program. TFN prefers a system in which participants will be able to register for telephone-based and web-based services through the Internet.*

m) *The Contractor must work with TFN to ensure transfer of the Quitline telephone number, the fax referral telephone number, and must be willing to transfer both telephone numbers back to TFN in the event that a subsequent Contractor is utilized in the future.*

n) *The Contractor must work with TFN to determine the best option for coordination with NAQC and any other Quitline or support resources that may be available to Nebraskans during this contract period.*

Response:

Optum addresses the requirements of the above subsection in Section VI.A.i. Summary of Bidder's Proposed Personnel/Management Approach and in Attachment 1, Questions 3, 4, 5, 6, 7, 8, 9, 11, 12, 21, 27, and 31.

2) QUITLINE HOURS OF OPERATION

a) *The Contractor must ensure a system infrastructure to provide live response for 24 hours a day, seven days a week.*

b) *Peak times for calls must be continuously monitored, and staffing shall be modified accordingly to meet peak volume times. Volume must be assessed during live hours of coverage, and as needed in collaboration with media events.*

c) *Operation is not required for Thanksgiving Day, and Christmas Day, however coverage is required for other holidays, especially New Year's Day. Early closure at 2:00 p.m. Central Time on Christmas Eve, and 5:00 p.m. Central Time on New Year's Eve, is acceptable. On the following day, hours of operation must begin no later than 8:00 a.m. Central Time. Holiday coverage may be revised by mutual agreement after the first year of the contract and completion of a call volume analysis.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 9, 11, 12, 13, and 34.

3) CALL STANDARDS

Contractor should strive to achieve the following performance measures to assess the incoming call center capability.

a) *90% of calls received during operation hours to the Quitline shall receive a live response.*

b) *The average live answer speed shall be within 30 seconds.*

c) *Less than 5% abandonment for calls waiting greater than 30 seconds following the initial client queue message.*

d) *100% of self-help materials shall be sent within one day of registration.*

e) *95% of voicemail messages shall be initiated for return within one day.*

f) *70-80% of callers interested in speaking with a Quitline Specialist shall be transferred directly after completing registration. The remaining 20 to 30% will be contacted within the time frame that the participant requests.*

g) *The Contractor must reach, or document an attempt to reach, 90% of multiple call participants during the established appointment time for all intervention calls.*

h) *Contractor must attempt to contact all fax referrals within 24 hours of receipt.*

i) *70% of multiple call participants will receive a time-sensitive quit date call within 48 hours of their quit date.*

j) *80% of calls during airing of federal campaigns are answered within 30 seconds.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 11, 12, 17, 24, 29, and 30.

Additionally, Optum respectfully submits the following clarification contract language for consideration for the above section:

3. **"Call Standards**

   Contractor should strive to achieve the following performance measures to assess the incoming call center capability.

   d) 100% of self-help materials shall be sent within one business day of registration."

4) MANAGEMENT AND STAFFING

a) *The Contractor must provide a single point of contact (account representative) for communications between the Contractor and TFN.*

b) *The Contractor must develop a staffing plan that will provide live call response and counseling 24 hours, seven days a week by trained behavioral health specialists. Staff must have a bachelor's or master's degree in social work, psychology, or other behavioral health fields with a minimum of two years' of counseling experience.*

c) *The Contractor must ensure a ratio of at least one supervisor to every 10 to 15 counselors, and provide adequate orientation and ongoing training for all staff. Training must include cultural competency in working with Native Americans, African Americans, Hispanics/Latinos, and pregnant women.*

d) The Contractor must have a clinical and/or medical director available to provide technical assistance and oversight as needed.

e) If any staff members are allowed to work from home, the Contractor must have a plan for ensuring adequate supervision and training of home-based workers.

f) The Contractor must work with TFN to manage the funds available under this contract, in the event that demand begins to exceed the available State budget.

Response:

Optum addresses the requirements of the above subsection in Form A - Contractor Proposal Point of Contact, and in Attachment 1, Questions 9, 11, 18, 20, and 26.

5) REPORTING REQUIREMENTS

a) The Contractor must be able to collect data that measures the performance of the Contractor in terms of waiting time for callers, volume of calls received during times when a live answer is not available, abandonment rates, and accuracy of counseling information given by the staff.

b) The Contractor must collect required data elements. Data collection requirements may change upon mutual agreement of TFN and the Contractor.

c) Contractor will follow the Nebraska Medicaid flow chart process (See Exhibit 3, Flowchart), which includes providing an outcome report to providers regarding the Quitline client participant status.

d) Contractor will send both identified and de-identified data to TFN.

e) Contractor's computerized tracking system must be able to document Quitline activity, including the ability to tabulate discrete individuals, services provided, call patterns, caller demographics, and the analysis and reporting of data on a monthly, quarterly, and annual basis.

f) Contractor must use precautions to ensure that files and programs can be re-created in the event of loss by any cause, including plan to safeguard data files (frequency of back-up copies, storage location, methodology for restoring from backup copies when activity has been processed in the interim.)

g) Contractor must ensure confidentiality of caller records

h) Contractor must have a process for issuing a Notice of Privacy Practices and obtaining permission from participants to be contacted for evaluation.

i) Contractor must provide quarterly reports (See Exhibit 4, Nebraska Tobacco Quitline Reporting Requirements and Exhibit 5, Nebraska Tobacco Quitline Reports) and data for the National Quitline Data Warehouse reporting guidelines in conjunction with TFN.

j) The term "quit" shall be fully defined by 7 and 13 month follow-ups, from the quit date, when the client is contacted to determine smoking/tobacco use status within the past week. This will be divided by the total of individuals who have received at least one counseling session to determine quit rates. The inability to follow-up or locate an individual is not considered a "quit" for the purpose of the reporting requirements. Any reference to "quit rates" must be calculated using an intent-to-treat analysis. Quit rates utilizing other types of analyses may be included in addition to the intent-to-treat analysis rates; however, the applicant must clearly articulate how the rates were calculated See Attachment 4, Reporting Quit Rates. Quit rates will be calculated by treatment type.

Response:

Optum addresses the requirements of the above subsection in Appendix A.1.37.b. Data Dictionary (Proprietary Information), and in Attachment 1, Questions 2, 9, 12, 24, 33, 34, 35, 36, 37, 38, 41, and 44.

Additionally, Optum has provided a proposed alternate Nebraska Medicaid Flow Chart Process indicating the process we currently follow in Nebraska as Appendix V.F.5.c. Alternate Nebraska Medicaid Flow Chart Process.

6) *Quality Assurance/Quality Improvement*

a) *The Contractor must develop, implement, and follow a comprehensive quality assurance plan. The quality assurance plan must describe the procedures, standards, and measures to be used to ensure quality. It must also discuss how the organization's performance in the various areas of quality assurance is to be reported, how the reported data should be interpreted, and how that information will be used not only to maintain the quality of services, but to improve them as well. Quality assurance plan must be submitted to TFN for review and approval no later than 60 days after contract start date.*

b) *Contractor must work with TFN or a third party to facilitate follow-up research evaluation to determine quit rates and customer satisfaction. This may involve data use agreements for the purpose of HIPPA compliance, and may involve the Contractor's seeking the client's permission to participate in a follow-up study. See Exhibit 6, HIPPA Business Associate Agreement Provisions.*

c) *TFN may routinely make "secret shopper" calls to verify service quality. Describe how the Quitline will address issues that are identified as a result of "secret shopper" calls and provide a least one example of a quality improvement measure taken as a result of "secret shopper" feedback or other situations in which problems were identified by a state or commercial client.*

d) *Contractor must have a database system to ensure reporting accuracy.*

e) *Contractor must have a quality assurance plan as it relates to both Quitline operations and clinical service delivery.*

f) *Contractor must have a mechanism to address complaints internally, as well as the types of complaints that will be expected to be addressed by TFN and the process by which such calls will be referred to TFN for follow-up, while maintaining participant privacy under HIPAA.*

g) *Contractor must maintain current, science based, high quality services. Examples include, but are not limited to, a Scientific Panel or Advisory Board.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 9, 24, 33, 39, 40, 41, 43, and 44.

7) *Surveillance and Evaluation*

a) *Contractor must collaborate with TFN and any applicable third party to facilitate evaluation of the quantity and effectiveness of services and referrals.*

b) *Contractor must maintain a client database that meets the measures determined by TFN and National Quitline Data Warehouse, to assure confidential, efficient means of transferring the database as needed in order to conduct evaluation.*

c) *The term "quit" shall be fully defined by 7 and 13 month follow-ups, from the quit date, when the client is contacted to determine smoking/tobacco use status within the past week. This will be divided by the total of individuals who have received at least one counseling session to determine quit rates. The inability to follow-up or locate an individual is not considered a "quit" for the purpose of the reporting requirements. Any reference to "quit rates" must be calculated using an intent-to-treat analysis. Quit rates utilizing other types of analyses may be included in addition to the intent-to-treat analysis rates; however, the applicant must clearly articulate how the rates were calculated See Exhibit 2, Reporting Quit Rates. Quit rates will be calculated by treatment type.*

d) *Provide opportunities for TFN to engage in Quitline – related research in conjunction with other states Quitlines.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 2, 43, 44, and 45.

8) *SERVICE DELIVERY PROTOCOL*

The Quitline must provide the following services using a consistent, systematic and research-based protocol:

a) *Provide services to all clients at a minimum of age 16 years and older;*

b) Screen all callers and provide general information to callers requesting it;

c) Provide information to non-tobacco callers calling on behalf of friends or relatives who use tobacco;

d) Assess caller's tobacco use history and readiness to quit using tobacco products.

e) As appropriate, review tobacco treatment benefits including Medicaid provided by caller's third-party payer and facilitate linking the caller to the benefit.

f) For callers ready to quit, at no cost:

i) Provide an immediate counseling intervention with a Quitline specialist, for effective quitting,

ii) Review U.S. Public Health Service recommendations on the use of pharmacological cessation aids, provide nicotine replacement therapy and refer callers to physicians or other healthcare professionals as needed,

iii) If applicable, mail the NRT directly to the caller's permanent address

iv) Mail self-help materials,

v) Offer an opportunity to receive up to five (5) proactive follow-up behavioral counseling sessions based on the caller's need for the service. TFN may approve up to ten (10) proactive follow-up calls for specific populations. Request for approval must be provided in writing.

(a) The Contractor must provide comprehensive proactive counseling support initiated by Quitline cessation specialists to callers who are ready to quit and agree to counseling. The counseling must be based on protocols that has demonstrated through research in randomized clinical trials to be effective in providing support and assistance in helping people successfully quit tobacco use and prevent relapse.

(b) The Contractor must have established processes that callers enrolled in the intensive program are assigned a counselor who will follow-up with the caller through each of the subsequent sessions. In the event of staff turnover, illness, client availability for the sessions, or other events that would prohibit the same counselor from following-up with a caller, the caller should be informed of the circumstances and offered an alternative.

(c) The Contractor must strive to schedule the proactive follow-up counseling sessions as appointments with the caller at a specific date and time, or a specific date and range of time within which the session might be scheduled.

(d) Collaborate with TFN to facilitate follow-up evaluation at 7 and 13 months, from quit date, to verify tobacco use status and client satisfaction.

(e) For tobacco users who are not interested in receiving follow-up proactive counseling, offer encouragement to call the Quitline again for assistance as needed.

(f) Provide tobacco users who are not ready to quit tobacco use:

1. Appropriate motivational messages to promote effective quitting,

2. Send self-help or other appropriate materials, and

3. Encourage them to call back when they are ready to quit

(g) Provide information to family or friends of tobacco users who may be calling for information on how to support someone through a quit attempt.

g) Protocols for all counseling interventions, both initial and follow-up, must be based on research showing effectiveness inducing behavior change utilizing motivational interviewing and a cognitive-behavioral approach to treating tobacco use. All protocols will require review and approval by TFN. Protocols must be revised as needed, to keep pace with research on effective telephone-based tobacco dependence treatment interventions.

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 1, 2, 4, 11, 12, 15, 17, 24, 29, 30, 37, 39, 40, 42, and 46.

9) TECHNICAL ASSISTANCE FOR HEALTHCARE PROFESSIONALS

a) *The Contractor must provide technical assistance and advice to healthcare professionals who call the Quitline.*

i) *Provide a free comprehensive online training on brief tobacco intervention techniques and best practices to help healthcare providers work with patients quitting tobacco.*

(a) *Ensure all trainings are developed, delivered and maintained in compliance with accreditation requirements for continuing education units (CEUs) of target audience. The target audience consists of, but is not limit to: physicians, nurses, substance abuse counselors, mental health counselors, psychologists, social workers, certified tobacco treatment specialists and other healthcare professionals. At minimum, CEU's must be available for all licensed prescriber healthcare professionals.*

(b) *Topics should include, but not be limited to: up-to-date information and recommendations based on the PHS Clinical Practice Guidelines on Treating Tobacco Use and Dependence with regard to the use of pharmacotherapies; implementation of in-office procedures to address tobacco use; recording of intervention on electronic health records; tobacco dependence treatment with special populations; how to utilize the Nebraska Medicaid fax referral process with the MCOs; information on how clients can utilize the Quitline and its services; and effective in-office or community-based tobacco cessation interventions including the 5A's: Ask, Advise, Assess, Assist & Arrange or 2A's and a R: Ask, Advise and Refer.*

(c) *Process and provide free continuing education units (CEUs) to providers upon completion of the course.*

(d) *The Contractor must provide tracked and reported analytics for the online training to TFN.*

ii) *The Contractor must provide participant information with the healthcare provider and/or MCOs that are under contract with the State of Nebraska to help ensure continuity of care and seamless delivery of services.*

iii) *Provide technical assistance and consultation to TFN staff working with healthcare professionals on a variety of effective tobacco dependence treatment issues.*

iv) *Quitline medical director role must work with the Quitline staff and healthcare professionals to resolve complex issues.*

v) *Provide participant information with to the healthcare provider and/or MCOs.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 3, 25, 26, 27, and 28.

10) REFERRAL DATABASE AND FEEDBACK

a) *The Contractor must utilize available TFN resources for tobacco cessation services in addition to the Quitline. For example, www.QuitNow.ne.gov*

b) *The resources must provide sufficient information to match callers by location, type of cessation service, the time services are available, costs associated with participation or materials, and specialized services for target populations.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 14 and 22.

11) SUPPORT MATERIALS

a) *The Contractor must develop or use existing cessation support materials that address self-help cessation techniques for tobacco users. Tailored materials must be made available for smokeless tobacco users, pregnant women, youth and Native American callers. All support materials must be approved by TFN prior to implementation.*

b) *Materials are required to meet low literacy level needs (4th grade), utilize pictures and graphics extensively, and be available in English and Spanish, at a minimum. Materials may be required in additional languages if call volume or other analysis by either the Contractor or TFN indicate the need. Information on secondhand smoke and other tobacco-related educational materials will also be appropriately mailed to callers.*

c) *TFN approval of all materials is required. Any revisions to materials must be approved prior to implementation. The Nebraska Tobacco Quitline logo must be on all of the Contractor's printed materials for distribution to quitline callers, unless otherwise approved by TFN.*

d) *Support materials must be available for and provided to, but not limited to:*

i) *Proxy callers*

ii) *Healthcare professionals*

iii) *Tobacco users, not ready to quit*

iv) *Tobacco users, ready to quit but not interested in ongoing counseling*

v) *Specific populations (e.g. racial and ethnic minority groups, mentally ill, and rural populations).*

e) *Support materials must be sent out within 48 hours of request.*

Response:

Optum addresses the requirements of the above subsection in Appendix A.1.30 Self-help and Support Materials and in Attachment 1, Questions 1, 18, 29, and 30.

12) QUITLINE MEDIA CAMPAIGNS

a) *The Contractor must provide sufficient staffing in order to meet increased demand. The Contractor must collaborate with TFN and its media Contractor for effective coordination of media promotion and Quitline services.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 12 and 31.

13) PROMOTION TO HEALTHCARE SYSTEMS

a) *The Contractor will collaborate with TFN in updating and utilizing promotional materials that will be disseminated by TFN to healthcare professionals and systems. The Contractor will collaborate with TFN to assure effective coordination of promotion to healthcare professionals and Quitline services.*

b) *Contractor will work with TFN to respond to calls generated as a result of paid media promotion, earned media promotion, and promotion through health systems.*

c) *Contractor may also be requested to participate in annual presentations (up to two) at state conference/training programs identified by TFN to educate and inform stakeholders, healthcare professionals, administrators, insurers, and purchasers about the Quitline and promote the systems change recommendations contained in the U.S. Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence.*

d) *The Contractor must provide technical assistance to TFN regarding the development and utilization of a fax referral system as a way to increase the number of healthcare providers who refer patients to the Quitline.*

e) *Contractor will assist TFN or media Contractor to assure effective coordination with media promotion, promotion to healthcare professionals, and other tobacco control activities in Nebraska.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 3, 12, 25, 29, 30, 31, and 32.

G. Counseling Technical Requirements

1) *Provide a **Counseling System** that has the **following:***

   a) *Protocols for the first contact during live hours.*

   b) *Protocols to triage the caller's need for services.*

   c) *Protocols to assess a tobacco user's readiness to quit. For the caller ready to quit, the Counseling System must track:*

      i) *Registration for services*

      ii) *Initial counseling for successful quitting*

      iii) *Provision of self-help materials or other resources*

      iv) *Assessment of caller's interest in proactive cessation counseling*

      v) *Assessment of caller's insurance status including Medicaid and Medicare and feedback to the caller about the availability of tobacco dependence treatment coverage through health insurance.*

      vi) *Provide comprehensive, proactive follow-up cessation counseling. Counseling must be based on protocols that research in randomized trials has demonstrated to be effective in supporting people as they cease the use of tobacco products and in preventing relapse.*

      vii) *Provide cessation counseling to educate on nicotine replacement therapy options, how the caller will be screened for medical eligibility and how the proper nicotine replacement therapy will be selected for the caller.*

2) *Contractor will work with the **following populations,** but is not limited to:*

   a) *Medicaid beneficiaries*

   b) *Uninsured/Low Socioeconomic Status*

   c) *Pregnant women*

   d) *Senior adults*

   e) *Veterans*

   f) *Smokeless tobacco users*

   g) *Electronic Nicotine Delivery Systems (ENDS) users*

   h) *Behavioral health tobacco users*

   i) *Diverse ethnic, racial and cultural minorities, particularly Native Americans.*

3) *Provide services to callers with limited English proficiency.*

4) *Contractor must describe, to insured callers, how insured callers will be linked to their healthcare system to access a tobacco dependence treatment benefit, if available, or to a healthcare professional for prescription cessation aids or other medical follow-up*

5) *Protocols for referrals to community-based services.*

6) *Provide coaching services available through technology (e.g. web-based coaching, app, text messaging) and made available to all Nebraska tobacco users.*

7) *Provide professional staff.*

   a) *It is important that Nebraska callers feel that they have found meaningful help when they reach the Nebraska Tobacco Quitline , and that the Quitline staff will go the extra mile to assure that needs are met—whether for information and referral, immediate counseling assistance, linkage to a healthcare professional or health plan for tobacco dependence treatment benefits, or just reassurance that this is a difficult and important step and the Quitline's professional staff are capable of facilitating them through a quit process that will lead to success.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 14, 15, 17, 18, 19, 22, 23, 24, and 25.

H. Nicotine Replacement Therapy (NRT)

1. *TFN will approve a period of time and budget for when NRT will be available through distribution, the supply length (example: 2 weeks, 4 weeks, 6 weeks), the NRT options (example: Nicotine Gum, Patch, Lozenges, Combination Therapy) and who eligible to receive*
2. *Contractor will provide a supply of NRT to medically qualified participants over the age of eighteen (18) enrolled in the Nebraska Tobacco Quitline.*
3. *Contractor will provide and follow the NRT screening protocols. Protocols must be submitted to TFN, for approval, a minimum of 30 days prior to implementation.*
4. *Upon TFN approval, Contractor will provide NRT options per eligible participant; nicotine patches, gum, lozenges, or combination therapy of the patch and the gum or lozenges. Dosage and type of NRT shall be determined by the Quitline counselor and the caller at the time of screening. Type and Dosage options are as follows:*

NRT – 2-week supply	NRT – 4-week supply	NRT – 6-week supply
• Nicotine Gum – 2 mg • Nicotine Gum – 4 mg • Patch – 7 mg • Patch – 14 mg • Patch – 21 mg • Lozenges – 2 mg • Lozenges – 4 mg • Combination Therapy – Patch and Nicotine Gum • Combination Therapy – Patch and Lozenge	• Nicotine Gum – 2 mg • Nicotine Gum – 4 mg • Patch – 7 mg • Patch – 14 mg • Patch – 21 mg • Lozenges – 2 mg • Lozenges – 4 mg • Combination Therapy – Patch and Nicotine Gum • Combination Therapy – Patch and Lozenge	• Nicotine Gum – 2 mg • Nicotine Gum – 4 mg • Patch – 7 mg • Patch – 14 mg • Patch – 21 mg • Lozenges – 2 mg • Lozenges – 4 mg • Combination Therapy – Patch and Nicotine Gum • Combination Therapy – Patch and Lozenge

5. *Contractor will assume full responsibility for screening participants receiving medical authorization when necessary, and ordering NRT.*
6. *Contractor will ensure that NRT will be available to eligible participants screened during distribution times determined by Tobacco Free Nebraska.*
7. *Contractor will mail NRT directly to the participant's permanent home mailing address.*
8. *Contractor will monitor the TFN approved budget and distribution timeline.*

Response:

Optum addresses the requirements of the above subsection in Attachment 1, Questions 12, 17, 18, 37, and 46.

I. Reporting

1. *The Contractor must submit monthly, quarterly and annual reports (Exhibit 4, Nebraska Tobacco Quitline Reporting Requirements and Exhibit 5, Nebraska Tobacco Quitline Reports) to TFN to track use of the Quitline, as well as caller participation levels and progress. A computerized tracking system to document Quitline activity must be able to accurately tabulate discrete individuals, services provided, caller demographics and other characteristics including all referrals into and out of the system. The system must be able to produce reports on the types and amounts of services provided per caller, call patterns by time of day, day of week and month, and estimates of costs by types of service provided.*
2. *The Contractor must submit quarterly reports (Exhibit 4, Nebraska Tobacco Quitline Reporting Requirements and Exhibit 5, Nebraska Tobacco Quitline Reports) to TFN to comply with the National Quitline Data Warehouse Survey.*
3. *The Contractor must submit an electronic copy of the monthly report to TFN in order to receive payment for the reporting period. Quarterly reports and an annual summary of standardized reports that provide aggregate data by county must also be submitted in the same manner.*
4. *Contractor must ensure that files and programs can be re-created in the event of loss by any cause, including plan to safeguard data files (frequency of back-up copies, storage location, methodology for restoring from backup copies when activity has been processed in the interim.)*
5. *Contractor must provide and keep updated definitions of each item contained in the report.*

Response:

Optum addresses the requirements of the above subsection in Appendix A.1.37.a. Samples of Monthly Reports, Appendix A.1.37.b. Data Dictionary (Confidential), and in Attachment 1, Questions 9, 33, 34, 37, 38, and 44.

J. Deliverables

1. *See Cost Proposal, Attachment 2,*

   a. *All prices, including but not limited to personnel, supervision, training, travel, administrative costs, materials, postage and handling, data collection and reporting, referral database, language and system capability, must be included in the cost per client interaction completed. Quitline services must include day-to-day tracking & surveillance of interactions.*

   b. *Tobacco Free Nebraska will not pay for non-registered callers such as inquiries from the general public, out-of-state calls, prank calls, wrong numbers, hang-ups, voicemail, spambots and robocalls. Tobacco Free Nebraska will not pay for letters or calls made in an attempt to reach participants. All prices listed in the Cost Sheet must be for received/completed interventions and must not include those callers who enroll or agree to a protocol but do not receive it. Reimbursement will only be provided for each call after it has actually been completed.*

Response:

Optum addresses the requirements of the above subsection in Attachment 2. State Cost Proposal.

K. Optional Services

1. *Innovative Projects*

Changes or additions to the contract beyond the scope are not permitted unless required to ensure compliance with any applicable law, or unless, in DHHS's sole determination, such changes or modifications are essential to ensure maximum use of other resources consistent with the purposes of this RFP

2. *Custom Evaluation*

Custom evaluation efforts, as requested by TFN, go beyond the 7 month and 13 month quit rate and satisfaction rate evaluation. Custom Evaluation could focus on a specific population using the Quitline, a specific Quitline service provided, and/or other TFN Quitline initiatives and could involve gathering information from Quitline participants through a survey or other means as developed in the custom evaluation plan.

3. *Website/Text Messaging*

Opportunities for Nebraskans to access the quitline through Web Registration, Web Counseling, and Text Counseling while still meeting all of the requirements of this RFP.

Response:

Optum acknowledges and agrees to paragraphs 1 and 2 above, and addresses the requirements of the above paragraph 3 in Attachment 1, Questions 1, 17, 23 , and 33.

In summary, Optum agrees with the entirety of Section V. Project Description and Scope of Work, with the proposed change in language for subsection V.F.3.d., as specified immediately below subsection V.F.3. Call Standards.

L. List of Exhibits

1. *Exhibit 1 – Nebraska Provider Bulletin Medicaid*
2. *Exhibit 2 – Reporting Quit Rates*
3. *Exhibit 3 – Flowchart of Organization*
4. *Exhibit 4 – Nebraska Tobacco Quitline Reporting Requirements*
5. *Exhibit 5 – Nebraska Tobacco Quitline Reports*
6. *Exhibit 6 – HIPAA Business Associate Agreement Provisions*

Response:

Optum respectfully submits the following alternate contract language for consideration for **Exhibit 6 - DHHS HIPAA Business Associate Agreement Provisions, Services Contracts, Request for Proposal Number 6204 Z1**:

1. "THE CONTRACTOR shall do the following:
   1.1. Not use or disclose Protected Health Information other than as permitted or required by this Contract or as required by law. Contractor may use and disclose Protected Health Information for the purposes of managing and administering its internal business processes or to carry out the legal responsibilities. ~~relating to its functions and performance under this Contract.~~ Use or disclosure must be consistent with DHHS' minimum necessary policies and procedures.

6. TERMINATION.
   6.1. DHHS may immediately terminate this Contract and any and all associated contracts if DHHS determines that the Contractor has violated a material term of this Contract, or, in the event of a breach, after giving Contractor a reasonable opportunity to cure the breach.

   6.2. Within sixty (60)~~thirty (30)~~ days of expiration or termination of this Contract, or as agreed, unless Contractor requests and DHHS authorizes a longer period of time, Contractor, as feasible, shall return or at the written direction of DHHS destroy all Protected Health Information received from DHHS (or created or received by Contractor on behalf of DHHS) that Contractor still maintains in any form and retain no

copies of such Protected Health Information. Contractor shall provide a written certification to DHHS that all such Protected Health Information has been returned or destroyed (if so instructed), whichever is deemed appropriate. If such return or destruction is determined to ~~by the DHHS~~ be infeasible, Contractor shall use such Protected Health Information only for purposes that makes such return or destruction infeasible and the provisions of this Contract shall survive with respect to such Protected Health Information."

VI. Proposal Instructions

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. Proposal Submission

1. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

Response:

The name of our organization is Consumer Wellness Solutions, Inc., a Delaware corporation which is an Optum company operating under the Optum brand, and is referred to herein as "Optum." Our principal place of business is located at:

Optum
11000 Optum Circle
Eden Prairie, MN 55344-2503
USA

The original entity formed in 2003 was called Free & Clear, Inc., purchased by Alere, Inc. in 2009 and renamed Alere Wellbeing, Inc. In 2013, Alere Wellbeing incorporated in the state of Delaware, changing the name of its Tobacco Quitline business to Consumer Wellness Solutions shortly thereafter. In 2015, Optum, a division of UnitedHealth Group, acquired Alere Wellbeing. In November 2017, Alere Wellbeing changed its legal entity name only to Consumer Wellness Solutions, Inc., the name under which it has provided services since then.

b. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded contractor(s) will require notification to the State.

Response:

Optum is a division of United Health Group Incorporated, a publicly traded, Fortune 5, Minnesota-based corporation whose shares are listed on the New York Stock Exchange (NYSE: UNH). Neither Consumer Wellness Solutions, Inc. nor Optum has its own, independent audited financial statements, as all financial information rolls up into UnitedHealth Group financial information.

Accordingly, we have included the UnitedHealth Group Incorporated audited financial statements and associated Independent Auditor's Report for 2018, the most recent audited financials available. The statement is included as Appendix VI.A.1.b. UnitedHealth Group Form 10-K 2018, which includes historical background, organizational structure, financial statements, information on subsidiaries, and other relevant information. We have also included below a graphic showing the Consumer Wellness Solutions, Inc. Director and Officers, indicating those with financial responsibility.

Name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization:

John Rimstad, Director of Finance
Optum Finance
11000 Optum Circle
Eden Prairie, MN 55344 USA
Telephone: (952) 205-6636

There are no pending judgements or litigation, or real or potential financial reversals that might materially affect the viability of Optum and/or its ability to perform services prescribed in RFP 6204 Z1.

There is no anticipated change in ownership or control of the company during the 12 months following the proposal due date.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

Response:

The office location responsible for performance of the deliverables pursuant to the award of a contract with the State of Nebraska is:

Optum
11000 Optum Circle
Eden Prairie, MN 55344-2503
USA

e. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any Party named in the contractor's proposal response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Response:

We have been the Nebraska Tobacco Quitline contractor for the State of Nebraska for the last five years under Contract 62299-04. Additionally, we had an 11-month contract for Nicotine Replacement Therapy provision and evaluation, Contract 78423-04, which terminated June 30, 2018.

Additionally, UnitedHealthcare, a UnitedHealth Group affiliate of Optum, currently holds a contract with the State of Nebraska as a Medicaid MCO under Heritage Health. This relationship originated in 1996. The current contract is 71163-04 and covers the period of January 1, 2017 through December 31, 2021.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's proposal response is or was an employee of the State within the past six (6) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

Response:

This is not applicable to Optum.

g. CONTRACT PERFORMANCE

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the contractor or litigated and such litigation determined the contractor to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

Response:

This is not applicable to Optum.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects similar to this solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the contractor during its evaluation of the proposal.

The bidder should address the following:

Provide narrative descriptions to highlight the similarities between the bidder's experience and this solicitation. These descriptions should include:

The time period of the project;

The scheduled and actual completion dates;

The Bidder's responsibilities;

For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and

Each project description should identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

Bidder and subcontractor(s) experience should be listed separately. Narrative descriptions submitted for subcontractors should be specifically identified as Subcontractor projects.

If the work was performed as a subcontractor, the narrative description should identify the same information as requested for the bidders above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

Response:

We are pleased to provide a summary matrix of three similar projects for reference in Appendix VI.A.1.h. Similar Projects Matrix, including:

- Project narrative descriptions
- Time periods covered
- Scheduled and actual completion dates
- Optum's responsibilities under each project
- Reference contact information
- Our status as prime contractor or subcontractor

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

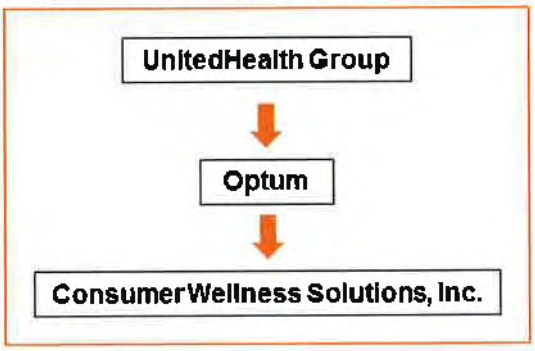
Response:

Organizational Structure

Our tobacco cessation services are delivered through Consumer Wellness Solutions, Inc., a wholly owned subsidiary of Optum. Optum is a Division of UnitedHealth Group (NYSE: UNH), as shown in **Figure VI.A.1.i – Corporate Structure** below.

Within Optum, our tobacco cessation services (commercially branded as Quit For Life®) are delivered out of our Prevention and Wellbeing division, where we are focused on engaging individuals to improve their health.

Figure VI.A.1.i – Corporate Structure



With Prevention & Wellbeing, we not only address tobacco cessation, but also deliver solutions around biometrics, employee assistance programs, onsite services, research, onsite and digital wellness coaching and a disease-management weight loss coaching solution. More information on these approaches can be found at the Prevention & Wellbeing website: https://www.optum.com/solutions/population-health/prevention.html

Due to the depth and breathe of the services we offer, we are able to leverage each areas capabilities, creating a unique environment to innovate and try new ways to help individuals improve their health.

Organizational Management

As stated above, our tobacco cessation services sit within Optum's Prevention and Well-being Coaching portfolio of products and services. These capabilities include our digital wellness product, our disease management, weight loss program, Real Appeal®, and our Quit For Life®/tobacco cessation services offered to employers, health plans, and state governments.

We work closely with another subsidiary of Optum, Rally®, which deploys extensive capabilities to drive consumer engagement through digital platforms. As a part of Rally, Vice President of Coaching Solutions **Scott Eising** oversees the entire coaching portfolio, with **Jeff Cross** leading our digital wellness and Quit For Life/tobacco cessation solutions.

Jeff Cross, Senior Director, Product Management. Mr. Cross has over ten years of experience in the medical/insurance industry with a focus on health behavior change and product launches. He has worked in his current role as a Senior Director with Optum for three years where he is responsible for the Quit For Life tobacco cessation product line. He manages a team of ten and leads product strategy analysis of Optum's State tobacco Quitline products. Prior to working with Optum, Mr. Cross was a Product Manager with the Mayo Clinic and the American Cancer Society.

Reporting to Jeff Cross, **Mary Kokstis, Director of Quit For Life/Tobacco Cessation**, has general management/GM responsibilities for our tobacco cessation solutions. In this role, Mary works across all of the business areas that support delivery and management of our services to deliver on outcomes, client and participation satisfaction and innovation.

Mary Kokstis, Director, Quit For Life/Tobacco Cessation. Ms. Kokstis has worked in tobacco cessation for close to 20 years and is currently Optum's tobacco cessation product General Manager. Over her 20 years, she has managed call center staff, implemented over 12 state tobacco Quitlines, and led the responses to state Quitline RFPs. She currently leads the retention plan for all markets and builds and mentors client services staff to assist them in meeting and exceeding client deliverables and expectations. She is the lead on building the sales readiness and

value story development for all of our markets, is the face of Optum's tobacco cessation services both externally and internally, and listens to our markets' needs to inform product development. Ms. Kokstis participates in national discussions and partnerships to support the growth, funding, and sustainment of publicly funded Quitlines. She was recently featured in an Optum webinar, The Evolving Landscape of Tobacco Cessation, and is an active blogger related to tobacco cessation. Ms. Kokstis currently holds a position on the North American Quitline Consortium Board of Directors. Ms. Kokstis earned two Bachelor of Science degrees in Community Health and Fitness and Exercise Science from Western Washington University in Bellingham, Washington.

The Nebraska Tobacco Quitline has benefited and will continue to benefit from the expertise of Optum staff with extensive experience working with Quitlines.

The following **Table VI.A.1.i – Key Personnel** provides information on the key personnel who will be supporting Nebraska's Quitline and their tenure with our organization. All of these professionals are currently, and will continue to be, involved with the Nebraska Quitline. In this section, we have provided biographies for the key personnel involved, as well as an organizational chart illustrating team leadership, interface and support functions, and reporting relationships, as Appendix VI.A.1.i.a. Organizational Chart. Resumes for key personnel who will be supporting the Nebraska Tobacco Quitline are attached as Appendix VI.A.1.i.b. Resumes of Key Personnel.

Table VI.A.1.i – Key Personnel

Optum Nebraska Tobacco Quitline Key Personnel	
Position	**Optum Designated Staff**
Senior Director, Product Management	Jeff Cross *(three-year tenure, bio above)*
Director, Quit For Life/Tobacco Cessation	Mary Kokstis *(20-year tenure, (bio above)*
Associate Director, Client Services	Omar Kordahi *(eight-year tenure, bio below)*
Account Services Manager	Jessica Benson *(nine-year tenure, bio below)*
Director, Product Management	Shweta Bhan *(ten-year tenure, bio below)*
Medical Director	Daniel Sullivan, MS, MD *(seven-year tenure, bio below)*
Clinical Director	Etta Short *(15-year tenure, bio below)*
Associate Director of Operations	Michelle Nygaard *(15-year tenure, bio below)*
Director of Clinical and Quality Support	Robert Vargas-Belcher, MSW *(15-year tenure, bio below)*
Manager of Training and Outreach Programs	Kara Kikuchi, N.D. *(nine-year tenure, bio below)*

Staff Assigned to the Nebraska Tobacco Quitline Program

Optum has one of the largest contact center operations and currently employs 85 Intake Specialists, 138 Quit Coaches, and 15 Supervisors. This team of professionals is trained and supported to provide tobacco cessation services to the approximately 140 million individuals covered for our services through our employer, health plan, and state government contracts. With an average tenure of eight years, our clients' shared agent staffing model allows Optum to provide scalable, on-demand services, tailored to the individual's needs.

Optum uses a blended operational and staffing model that includes highly trained and skilled staff, a focus on quality of services, and systems support that enables us to address caller needs at any time. By designating and training staff to address the needs of any Quitline caller, we are able to provide industry-leading services at reasonable costs to our clients while meeting the needs of our callers in a responsive manner. We have successfully provided tobacco cessation services to Nebraska residents since December 2009 and will continue to verify that our call center staff receive the training, support, resources, and supervision needed to provide exemplary services for the Nebraska Tobacco Quitline program.

At the helm of our cross-client operational leadership are key personnel who will be responsible for the day-to-day operations of our contact center:

Omar Kordahi, Associate Director, Client Services, is an innovative and results-oriented services leader with over 17 years of leadership experience, including client services, business management, and strategic planning in the health care industry. Mr. Kordahi is responsible for maintaining client relationships by ensuring overall satisfaction, including monitoring budgets and expenditures, providing strategic guidance, engagement recommendations, and overseeing the implementation of new services and products. Mr. Kordahi graduated from the University of Washington with a bachelor's degree in business administration and has over eight years of experience working with tobacco Quitlines.

Jessica Benson, Associate Account Manager. Ms. Benson will continue to serve as the Client Services Manager for the Nebraska Tobacco Quitline contract, and will be the primary advocate and support contact for the Department at Optum. Ms. Benson will continue to coordinate all aspects of the contract and monitor all activity closely to meet or exceed deliverables, including reporting, launch dates, billing, priority populations, scripting, referral methods, and participant materials. She also will work closely with the Department to integrate all project specifications, meet reporting requirements, and execute necessary database changes.

Ms. Benson will monitor activities and results according to our quality assurance plan. Should an issue arise that impacts services, she will promptly disseminate required information to internal and external audiences. She will also actively seek input from the Department to improve the participant and client experience. Ms. Benson graduated from the University of Washington with a bachelor's degree in sociology and has over nine years' experience working with Tobacco Quitlines within Optum.

Shweta Bhan, Director, Product Management. Ms. Bhan has served as Director of Product Management since 2013. In this role, she is responsible for directing product management for Optum programs, including our technology platforms. Ms. Bhan has demonstrated experience in new product development, marketing analysis, and vendor and client management. She brings 15 years of experience in product management and software development. Ms. Bhan earned a bachelor's degree in computer science from Bangalore University and a master's degree in marketing from the University of Memphis.

Daniel Sullivan, MS, MD, Clinical Medical Director. Dr. Sullivan has served as the Medical Director since 2006. In this role, he provides backup and additional oversight for our clinical team. Dr. Sullivan is a board-certified medical executive with over 20 years of experience in clinical medicine, research, and development and implementation of case and disease management programs. He has extensive experience in health systems leadership. He has successfully executed large scale, information-driven interventions for health management and medical resource management programs to change physician and patient behavior, resulting in improved health outcomes. Dr. Sullivan has in-depth knowledge and management experience in Clinical Informatics including data management, statistical analysis, study design, predictive modeling, and outcomes measurement. Skilled in the development of clinical care policies and guidelines, reporting tools and benchmarking, he has performed research and analysis in conjunction with major health care organizations as well as academic, governmental, and private service organizations. Dr. Sullivan has played key roles in the installation and configuration of enterprise-wide information management systems, including establishment of code set rules, user-specific configuration, and case management assessment and care plan configuration.

With expert knowledge in utilization management and quality improvement, Dr. Sullivan possesses a thorough knowledge of health care system management and business practices, products, and processes including Pharmacy Benefit Management and Managed Care organizations providing services under Medicare and Medicaid risk arrangements. He has achieved accreditation under NCQA, JCAHO, URAC, and CARF. He has performed HEDIS reporting and successfully completed HCFA and other regulatory audits, as well as instituted processes to meet HIPAA standards.

Dr. Sullivan earned a bachelor's and master's degree in mechanical engineering from Kansas State University. He received his Doctor of Medicine from the Medical College of Wisconsin and he earned a Certificate in Medical Management from the University of California, Irvine.

Etta Short, Clinical Development and Support. Ms. Short has been involved with Optum Quitline services since March 2005. She is responsible for providing program oversight, leadership, consultation, and resources to design, maintain, and improve the delivery of tobacco cessation services. In addition, she monitors our clinical outcomes, provider strategic insight and direction, supports our training programs, and partners with other corporate leaders to implement best practices for development and delivery of behavior change programs.

Ms. Short is currently on the Board of Directors of the accrediting body for counselor training programs, the CTTTP (Council for Tobacco Treatment Training Programs). Prior to joining Optum, she worked at a Health Educator for the University of Washington Medical Center. Ms. Short has an MS in public health education from the University of Washington.

Michelle Nygaard, Associate Director of Operations. Ms. Nygaard has more than 15 years of operational experience supporting telephonic and email/instant messaging coaching. She oversees and manages the day-to-day operations and staff of the cessation services program, weight management, and wellness programs. She focuses on building and sustaining a strong and professional team to deliver first-class phone and email-based customer service, as well as delivering effective and efficient work techniques, and excellent coaching and performance monitoring. Ms.

Nygaard oversees and manages the needs of managers and supervisors to verify that they meet operational and performance expectations consistently across all coaching programs.

Ms. Nygaard partners with stakeholders for client and program needs to drive effective and efficient improvements and feature enhancements that maximize resources, as well as positively impact participant, client, and employee experiences resulting in business growth due to decreased costs and client and employee retention. Her range of project experiences includes hiring and staff development; developing and implementing software program and database solutions; managing and implementing changes to support positive client and participant satisfaction results; and developing and executing opportunities for streamlining work processes.

Robert Vargas-Belcher, MSW, Director of Clinical and Quality Support. Mr. Vargas-Belcher has served as the Manager of Clinical and Quality Support since 2011 and is responsible for providing analytical and evaluation support to the Quit For Life program, supporting clinical recommendations for program improvements, areas for additional training, and other resources to develop staff, policies, protocols, or client customizations. He interfaces with departments to facilitate integration between contractual client needs and incorporation of best clinical practices into service delivery. Mr. Vargas-Belcher also has three years of experience providing psychosocial evaluation and clinical recommendations in a hospital setting.

Mr. Vargas-Belcher joined the Optum team in 2005. During his tenure, he has taken on several positions at Optum including Quit Coach, Quit Coach Trainer, Quit Coach Supervisor, and Quit Coach Manager. Mr. Vargas-Belcher earned a bachelor's degree in psychology from Seattle University. He also earned a master's degree in social work from the University of Washington and a master's degree in public health from San Diego State University.

Kara Kikuchi, N.D., Manager of Training and Outreach Programs. Dr. Kikuchi manages our Provider Training and Outreach unit. She is responsible for growing our training and technical assistance capacity, providing strategic guidance for programs, evaluating and assessing programs and program outcomes to determine appropriate resources and strategic adjustments, and leading new and developmental training and outreach projects. Dr. Kikuchi also leads a team of System Change Specialists to meet provider training and engagement contract requirements.

In addition to Optum's leadership team, the following individuals will continue to support the Nebraska Tobacco Quitline services:

Andrew Michalski, Director, Optum Customer Performance Management. Mr. Michalski has been Informatics Director at Optum since 2013. He manages all aspects of the Apollo Reporting systems. This includes data warehousing and replication, ETL development and processing, standard and ad hoc reporting on clinical, utilization, and operational metrics, and data presentation and visualization. Mr. Michalski works closely with both internal and external customers on reporting initiatives and to ensure accurate and timely reporting. Previously at Optum, he served as Director of Data Services, managing data ingest teams as well as the overall process to identify and stratify participants for disease management.

Mr. Michalski joined the Optum family in 2003. Previously, he supported business intelligence and data analysis for United Behavioral Health. In this role, he provided data support in the successful NCQA accreditation efforts for this national managed behavioral health organization. Mr. Michalski brings more than 19 years of leadership and health care data experience to Optum and works from the greater Chicago area. He earned his bachelor's degree in psychology from DePaul University in Chicago, Illinois.

Katrina Vickerman, Ph.D., Director, Optum Center for Wellbeing Research (OCWR). Dr. Vickerman is an active researcher in the area of health behavior change, with a focus on helping smokers quit via Quitlines. Dr. Vickerman earned her MA and Ph.D. in clinical psychology from the University of Southern California. She completed her pre-doctoral internship at the Department of Veterans' Affairs Puget Sound Healthcare System, American Lake Division. Prior to joining OCWR, she was the Lead Program Evaluator for Optum Quit For Life Quitlines.

Dr. Vickerman's recent research has focused primarily on vaping and e-cigarettes, as well as understanding Quitline program engagement, reengagement, and outcomes for priority populations. OCWR is composed of scientists and research staff who conduct studies that have been funded by the National Cancer Institute, National Institute of Drug Abuse, and the American Cancer Society. OCWR staff also contribute to evaluation work and have completed projects funded by the CDC Office of Smoking and Health and state departments of health. The team is particularly interested in questions regarding digital interventions, tobacco use comorbidities, new tobacco products, and ways to engage people in treatment.

Chelsea Nash, Senior Program Evaluator, has over nine years of experience in behavior change, including over a year of experience as a Quit Coach. She currently trains Program Evaluators in research design, statistics, and program evaluations. Ms. Nash is also responsible for managing Quitline evaluations, which includes planning, developing, and coordinating study design and follow-up surveys. Additionally, Ms. Nash received her Bachelor of Arts in psychology from Whitman College.

Jennifer Pech Cinnamon, Senior Clinical Program Manager. Ms. Pech Cinnamon is an instructional designer who specializes in creating scalable, engaging CME-accredited interactive online training programs to provide broad, unlimited, remote access to health care providers. She also offers graphic design services including brand development, logos, presentations, promotional materials, and webinars.

Jacqueline Hager, Senior Product Manager, Prevention. Ms. Hager has over ten years of health care and retail experience in product innovation. In her previous roles, Ms. Hager has launched many new products into the marketplace. From launching a mobile payment experience in Target stores, and bringing a home health care app to life for thousands of nurses to use, to bringing member-specific prescription price transparency to hundreds of thousands of doctors in the United States within their Electronic Health Record, creating products and bringing them to life is what she does best.

In 2019, Ms. Hager joined Optum to help develop and launch a Teen Vaping solution from both a campaign phase to delivering interventions that will work with parents and youth. She works closely with many of our Optum clinical experts who have 15+ years of smoking cessation experience, our engineering team, and our marketing group.

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

i.v. name, address, and telephone number of the subcontractor(s);

v. specific tasks for each subcontractor(s);

vi. percentage of performance hours intended for each Subcontract; and

vii. total percentage of subcontractor(s) performance hours.

Response:

This is not applicable to Optum.

2. TECHNICAL APPROACH

a. The technical approach is a written narrative response to the Corporate Overview and completion of Technical Response, Attachment 1.

Response:

Please see our responses to Attachment 1, which follows.

Attach. 1

Technical Response

Attachment 1

Request for Proposal Number 6204 Z1

Name: Consumer Wellness Solutions, Inc. (Optum)

Bidders should respond to the Bidder Responses using the format provided and must not change the order or number of the responses.

	Bidder Responses
	Description of Experience
1.	Bidder to describe experience in managing a telephone-based tobacco cessation Quitline, including the provision of screening, assessment, proactive counseling, support materials referrals to community-based cessation services, and web-based coaching.
	Bidder Response: (Where V. is Project Description and Scope of Work, this Question addresses elements from Subsections V.A.1., V.A.2., V.B., V.E.1, V.E.2., V.F.8., V.F.11, V.I., and V.K.) Optum has over 30 years managing and delivering tobacco Quitline services, the most experience of any vendor who operates multiple state tobacco Quitlines. Rooted in science, in 1985, our program evolved out of a National Institutes of Health randomized control trial, demonstrating the efficacy of telephonic Quitline services. Since that time, we have provided our services to over 4.5 million individuals. The landscape of tobacco cessation has evolved since our beginning, as has our program. We were the first service provider to incorporate web-based coaching as a part of the telephonic program in 2006, and we were the first to launch a stand-alone web-based coaching program in 2009. Since those launches, have served over one million partcipants through our portal. Continuing our innovation in delivering tobacco cessation services, we added text messaging to service package in 2012. In response to market changes, in 2013 we unbundled our solution and began providing stand-alone services to give people more choice in the services that work best for them. Maintaining the option of enrolling in our integrated telephonic program or stand-alone web based coaching, we also offered to participants the choice of enrolling in a standalone texting or email program, the option to receive materials only, or the option to order a 2-week NRT starter kit.

In 2020, we continue to address the digital age by adding expert-led online curriculum to our web-based program. In addition, we will be exploring group-based video coaching and launching a specific program for youth who vape and their parents. We remain active members of the North American Quitline Consortium to stay abreast on trends and contribute to the overall national movement to eliminate tobacco use.

Additionally, as we discuss later in this document, we are committed to supporting Nebraska's goals of:

- Preventing the initiation of tobacco use among youth
- Promoting quitting among both youth and adults
- Eliminating exposure to secondhand smoke
- Identifying, reducing, or eliminating the disparities related to tobacco use

Because of our public health roots, we recognize that different populations are disparately impacted by tobacco use. As a result, we have had the longest standing protocols for youth and pregnant women, and in 2016 we added tailored protocols for those with behavioral health concerns and American Indians.

Access to the program has equally evolved. Tobacco users can access our program through the national 1-800-QUIT NOW toll free number, but can also enroll online, be referred via fax, email, online, or electronically by their health care provider. In 2020, we are piloting expanding access options via text to enroll.

Advancing tobacco cessation is a core competency for us and since the 1985 study, we have authored or co-authored 175 industry publications, and participated in more than 30 research partnerships and more than 40 clinical trials. We are one of the only service providers who has an area dedicated to research.

We became Nebraska's service provider in 2009, and since that time, we have answered over 55,000 calls to the Nebraska Tobacco Quitline, enrolled more than 27,500 Nebraskans for services, and delivered more than 47,500 counseling sessions to these participants. Today, we operate Quitlines for 24 other state government agencies, over 1,000 employers and 35 health plans. Our Quit Coaches routinely help more than 2,000 participants a day on average, and we handle more than a million Quitline calls per year.

We are thrilled to submit our proposal to Tobacco Free Nebraska. Leveraging our Coach training curriculum, which has been accredited by the Council of Tobacco Treatment Training Programs (CTTTP) Association for the Treatment of Tobacco Use and Dependence (www.attud.org), we will continue to provide our evidence based, personalized, non-scripted, behavior change coaching to Nebraskans who access tobacco cessation services. Accreditation by CTTTP is an endorsement of the quality of our coaching services.

	We explain in detail our proactive coaching approach in our response to Question 17 in this document, and we describe our variety of printed materials, including those designed for priority populations, in our response to Question 29.
2.	Bidder to describe quit rates and satisfaction rates achieved for a state Quitline as similar in size and scope to Nebraska as possible. Include quit rates for multiple call participants receiving counseling only and those receiving counseling plus nicotine replacement therapy and other cessation medications through the Medicaid Program. Provide both responder rates and an intent-to-treat quit rates at 7 and 13 months follow-up, following quit date. See Exhibit 2, *Reporting Quit Rates*, for a more complete description of quit rates and related information requested, including definitions for responder and intent-to-treat rates.
	Bidder Response: (This Question addresses elements from Subsections V.A.1., V.F.5, V.F.7., and V.F.8.) For over 9 years, the State of Nebraska has contracted with us to evaluate services. For the past three years, surveys were conducted by an outside agency (MMS) in order to strengthen our commitment to unbiased results. Data collected by MMS was then provided to our internal evaluation team for analysis. The following Table A.1.2.a – Nebraska Quitline Rates depicts responder rates and intent-to-treat rates for callers receiving counseling calls only, as well as callers receiving counseling calls and NR. Please note that 13-month outcomes are not available, given our current contract deliverables with TFN, which only include collection at the North American Quitline Consortium (NAQC) Minimum Data Set (MDS)-recommended point of 7 months. Although we currently do not collect 13-month survey information in Nebraska, we do have limited 13-month survey data within our book of business. This data may not be for states similar to Nebraska, but we are happy to provide this information upon request. Outcomes Comparisons Outcomes data was combined across evaluations completed for the Nebraska Tobacco Quitline in 2018 and 2019. The table below illustrates outcomes for Medicaid-insured Nebraska Tobacco Quitline participants: a) who registered January 1, 2016 - May 31, 2019 and received counseling plus NRT, and b) who registered when NRT was not available through the Quitline and received counseling only (approximate registration dates when NRT was not available: January 1 - November 13, 2016; June 15 - November 30, 2017; July 1 - September 30, 2018).

Table A.1.2.a – Nebraska Quitline Rates

	NEQL PHONE PROGRAMS	
	Counseling plus NRT	**Counseling Only**
7-month survey response rate		
% (responded to survey/sampled)	33.9% (301 / 889)	36.7% (353 / 962)
30-day respondent tobacco quit rate[1,2]		
% (quit/responded to tobacco quit question)	34.3% (102 / 297)	27.3% (94 / 344)
30-day intent-to-treat tobacco quit rate[2]		
% (quit/sampled)	11.5% (102 / 889)	9.8% (94 / 962)
Satisfaction rate[1,3]		
% (satisfied/responded to satisfaction question)	91.5% (257 / 281)	86.2% (288 / 334)

[1] Responses of "refused" and "don't know" are excluded from respondent analyses.

[2] Tobacco abstinence percentages represent the percent abstinent from tobacco for 30 or more days at the time of the 7-month follow-up survey (30-day point prevalence quit rate).

[3] Percentages represent the percent satisfied (very, mostly, or somewhat) with services.

Outcomes for Medicaid members who received counseling and NRT exceed the NAQC recommendations.

For comparison purposes, we are also providing recent rates in **Table A.1.2.b – Similar State Quitline Rates** for another Optum Quitline state client similar to the Nebraska Tobacco Quitline. However, since NRT is a benefit provided to most participants through most of our Quitlines, we are unable to provide outcomes separately for those receiving counseling only versus those receiving counseling and NRT. Accordingly, these data points reflect callers who received counseling both with and without NRT.

Table A.1.2.b – Similar State Quitline Rates

	QUITLINE PHONE PROGRAM
	Counseling plus NRT
7-month survey response rate	
% (responded to survey/sampled)	34.7% (529/1525)
30-day respondent tobacco quit rate[1,2]	
% (quit/responded to tobacco quit question)	31.4% (164/523)
30-day intent-to-treat tobacco quit rate[2]	
% (quit/sampled)	10.8% (164/1525)
Satisfaction rate[1,3]	
% (satisfied/responded to satisfaction question)	91.0% (458/503)

[1] Responses of "refused" and "don't know" are excluded from respondent analyses.

[2] Tobacco abstinence percentages represent the percent abstinent from tobacco for 30 or more days at the time of the 7-month follow-up survey (30-day point prevalence quit rate).

[3] Percentages represent the percent satisfied (very, mostly, or somewhat) with services.

3. Bidder to describe experience in collaborating with the healthcare delivery system to promote effective tobacco dependence treatment and other effective tobacco policies or initiatives.

Bidder Response: (This Question addresses elements from Subsections V.A.2., V.B., V.F.1., V.F. 9., and V.F.13.)

Optum has extensive experience in working with health systems on quality improvement initiatives to systematically document and refer tobacco users to cessation treatment services. We have provided strategic planning and program design to support states in developing and implementing programs to train health care organizations to execute the recommendations of the Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence.

We have executed proactive, in-person training and technical assistance programs to health systems in Arkansas, New Mexico, South Carolina, and Washington, and have reached providers in Alaska, Maryland, Nebraska, and Oregon through phone-based systems change outreach. Our outreach has produced

measurable results. For example, Washington saw a 140 percent increase in reporting a provider referral to the cessation services program and fax referrals from outreach areas accounted for 70 percent of all fax referrals. In Arkansas, we increased calls to the cessation services program by 52 percent in outreach areas, fax referrals, and health care provider "how heard abouts" by 5 percent each quarter during the first nine months of the program. This exemplifies effective and sustainable provider referral practices, leading to a higher level of patient engagement in tobacco treatment activities. Our successful programs in Arkansas and Washington demonstrate our capacity to reach, involve, and mobilize members of the select priority populations in these states. We have achieved early, actionable results from these programs and sustained them over time. Our highly trained Outreach Specialists, performing academic detailing and using our established systems change protocol, have identified and effected sustainable systems change in disparate communities, working with health care providers, community leaders, local health districts, state Departments of Health and other stakeholders in achieving these outcomes. Our programs health systems change programs are designed to support identified best practices established by the CDC (Best Practices for Comprehensive Tobacco Control Programs 2014, pages 41-43). Optum has a great deal of experience supporting state clients in educating the healthcare community about Quitline services. We have partnered with the Wisconsin Center for Tobacco Research and Intervention, which provides trainings specifically for physicians and front line staff, which include information about the Clinical Practice Guidelines, Quitline services and referral programs.

In our response to Question 25 in this Attachment, we provide an example of how we have worked with our state clients and health systems to promote effective tobacco cessation treatment. We would be happy to discuss building an online training program for Nebraska-area providers, and, if of interest to TFN, we could tailor it to Medicaid providers. This training would support health care professionals in learning Nebraska's specialized MCO/Medicaid process. This, in turn, could promote growth in Quitline referrals, greater engagement of Nebraska's Medicaid populations, and increased participant satisfaction as the result of removing barriers to service. This training could also help providers decrease the time required to navigate MCO/Medicaid challenges and potentially lead to further engagement of health care providers and staff.

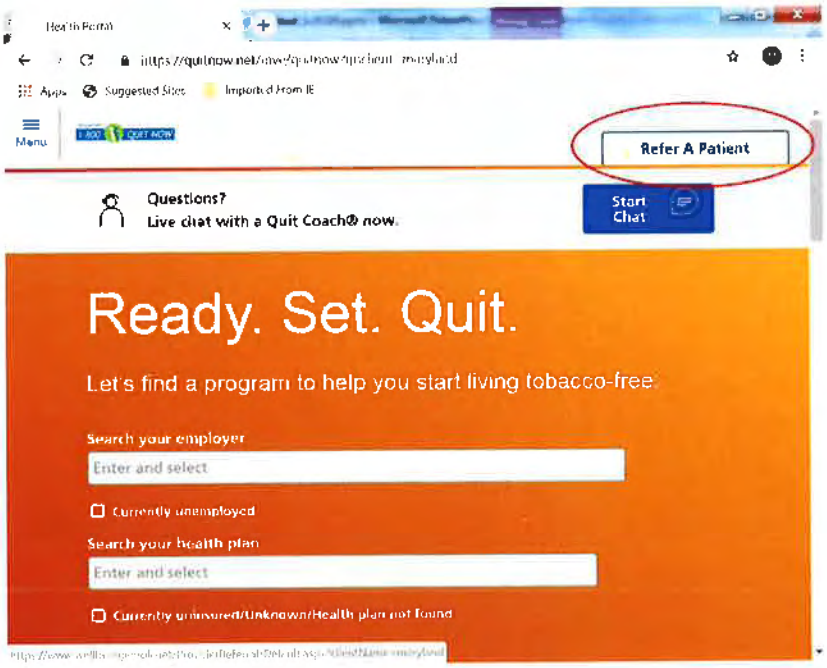
Our online trainings typically run 45-60 minutes and includes the following modules: *Why Treat Tobacco?*; the *Brief Tobacco Intervention*; *Making a Referral*; *Knowledge Assessment Quiz*: and an Appendix with links to tools and resources for providers. Optional modules on special topics such as communicating with Special Populations or Pharmacotherapy are available on an add-on basis. We are happy to include custom tutorials that focus on Medicaid topics such as benefits, how to use enrollment or referral systems, or other special Medicaid protocols as needed. Providers who take the training may receive continuing medical education

	(CME) credit for this training, which is accredited through the American Academy of Family Physicians (AAFP). We also have extensive experience teaching physicians and trainees about how to integrate Quitlines into clinical practice (utilizing the "Ask-Advise-Refer" model). This includes work implementing fax-to-quit and fax referral programs in multiple states, as well as developing trainings on the practical aspects of implementation. Optum has collaborated with community health centers across the country in the "Smoke-Free Public Housing: Helping Smokers Quit" project to increase the reach of community health centers and state Quitlines to Public Housing Authority (PHA) residents. The project is a joint partnership between the American Cancer Society (ACS), Smoking Cessation Leadership Center (SCLC) and NAQC. Through this project, Optum supported stakeholders to increase the demand for Quitline services, increase cross-sector collaborations between Quitlines, PHAs, and community health clinics, and develop resources to help Quitlines triage and connect PHA residents with evidence-based cessation services in their community. On a side note, as a part of Optum quitline services, healthcare providers may call the Quitline to get general information about services or to look for tobacco cessation information and materials to support their patient/client populations. Our coaches are trained and provided with resources to support these calls with physicians and health care professionals. Optum also has the ability to connect heath care professions with a representative at TFN for additional information. We look forward to leveraging our experience with health systems change initiatives to strategize with TFN on more ways we can help improve tobacco cessation services for Nebraska residents.
	System Capabilities
4.	Bidder's ability to accept referrals through an online form.
	Bidder Response: (This Question addresses elements from Subsections V.D., V.F.1. and V.F.8.) Optum has the ability to accept referrals through an online form, and we are currently offering this referral mechanism in eight of our state Quitlines, achieving higher rates of conversion (20% - 42%) to services than through an e-referral or fax referral (15% - 31%). The Online Provider Referral tool allows a health care professional to access a URL from their computer to complete the referral information online that is typically included in the fax referral form. Optum will then make a proactive call to the patient within 24 business hours of receipt and will fax the outcome reports back to the Health Insurance Portability and Accountability Act (HIPAA)-covered referring provider once all

attempts to reach the participant have been made. Providers also can add new clinics into the tool, which will be available in provider search functionality within 48 business hours. This tool is mobile responsive, which allows providers to make the referral from a tablet or laptop, eliminating the need for a paper referral to the cessation services program. All outcomes of the referral are sent back to the referring provider via fax.

In **Figure A.1.4.a. – Sample Homepage**, we have provided a screenshot below from a state which currently utilizes the online provider referral tool, with a provider referral button circled at the top right of the quitnow.net website. From there, providers will land on a page to begin the online referral for their patient.

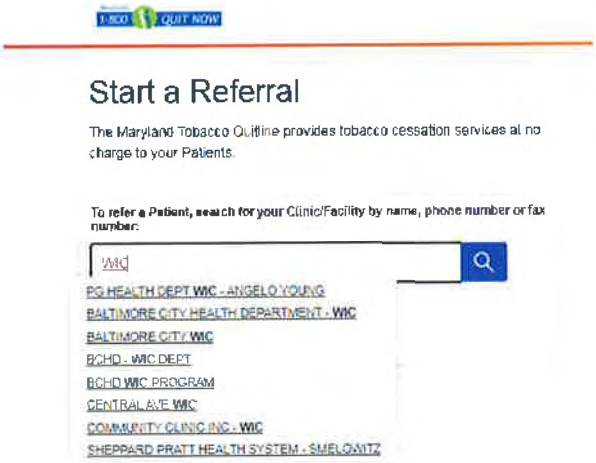
Figure A.1.4.a. – Sample Homepage



After clicking on the "Refer A Patient" link, providers can then start a referral as illustrated in the below screenshots **Figure A.1.4.b. – Sample Start Referral and Figure A.1.4.c. – Sample Start Referral Menu**. If they have already been added to the tool, their clinic name will display in the drop down menu for selection.

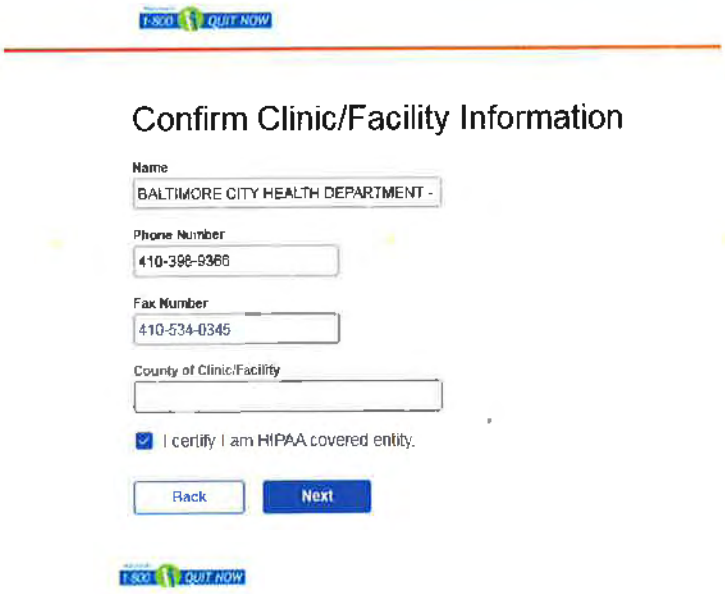
Figure A.1.4.b. – Sample Start Referral

Figure A.1.4.c. – Sample Start Referral Menu



If they are not in the drop down list, they can add themselves and confirm that their information is entered correctly as shown in **Figure A.1.4.d. – Sample Confirm Information**.

Figure A.1.4.d. – Sample Confirm Information



After completing this information, on the next screen they can enter their patient's information and submit the referral as shown in **Figure A.1.4.e. – Sample Patient Information** and **Figure A.1.4.f. – Sample Patient Information Continued.**

Figure A.1.4.e. – Sample Patient Information

1-800 QUIT NOW

Patient Information

First Name of Person Making Referral*

Last Name of Person Making Referral*

Patient First Name*

Patient Last Name*

Patient Date of Birth*

Patient State of Residence*

Maryland

Patient Zip Code*

Patient Primary Language*

Patient Primary Phone Number*

555-555-5555

When is the best time to call the primary phone number?*

Figure A.1.4.f. – Sample Patient Information Continued

May we leave a message at this number?*

- Yes
- No

Does the Patient have an alternate phone number?

- Yes
- No

☐ I provide services to the individual being referred, and certify that they have consented to be contacted by Maryland Tobacco Quitline. By providing the individual's telephone number(s), they've agreed to receive from Maryland Tobacco Quitline automated calls and pre-recorded messages at the telephone number(s) provided.

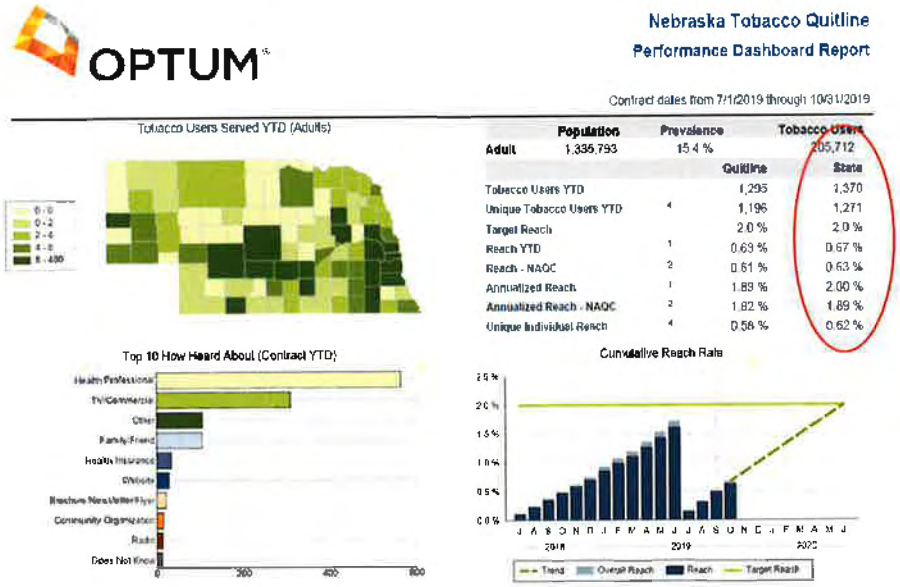
Back | Submit

1-800 QUIT NOW

5.	Bidder's ability to accept referrals through a secure email system.
	Bidder Response: (This Question addresses elements from Subsection V.F.1.) Optum currently has an established process and email address for Nebraska health care providers to refer their patients via our secure email system. While volume is minimal using this method, we are prepared to maintain it as part of our contract. All health care providers who send a referral through secure email are provided a summary of outcome information via fax.
6.	Bidder's ability to handle "live referrals" when a provider contacts the contractor with the client or patient in the room, and then once connected turn the interaction over to the client/patient to complete intake and set a date for the first coaching call.
	Bidder Response: (This Question addresses elements from Subsection V.F.1.) Optum has the infrastructure and staffing capacity to be responsive to when health care providers want to make a live referral. Over the course of our contract with the State, 95.8 percent of calls have been answered live, demonstrating our ability to quickly respond to incoming calls. Our registration agents are trained to assess each and every call for the particular need and can quickly identify calls initially being facilitated by a care provider, and then greet the patient warmly to complete the intake and either set a date for the first coaching call, or more typically, if the patient has time, connect the patient with a Quit Coach® for their first call. It is important to note that due to HIPAA, the registration must be completed by the patient, and health care providers cannot call to register an individual on their behalf.
7.	Bidder's ability to accept an electronic health record referral (e-Referral). The State has a preference for bi-directional e-Referral that meets NAQC standards.
	Bidder Response: (This Question addresses elements from Subsections V.D. and V.F.1.) Optum is a leader in e-referral innovation and capacity. After participating in the NAQC e-referral workgroups that developed national standards for e-referral, we launched our first bi-directional system with the State of Wisconsin in 2012. Since then, we have worked with 50 health care networks with e-referral capabilities to the Quitline, with 17 different EHR vendors, across 11 different states. We have the infrastructure, systems and talent to expand an e-referral system in the State of Nebraska and we see this as an important step in improving and increasing referrals from Medicaid managed care that is bi-directional and meets NAQC standards. We are prepared to also launch one health care system via sFTP at no cost.

8.	Bidder's ability to bill and receive reimbursement from all participating health plans and Medicaid for services provided.
	Bidder Response: (This Question addresses elements from Subsections V.A.2. and V.F.1.) Today, Optum contracts directly with over 1,000 employers and 35 health plans to provide our commercially offered Quit For Life® program. We have contracts, billing processes, and reporting in place with these clients in order to bill and receive reimbursement from our direct clients. We are able to extend this experience over to TFN, and can easily enter into agreements that would allow Optum to bill and receive reimbursement for TFN services provided to participating health plans, including those which cover Medicaid members. To do this, we would work with TFN to establish a standard set of services to provide and collaborate on a contract and scope of work that meets the needs of the health plan, Optum and TFN. Another avenue to direct billing would be to provide to health plans access to our commercially offered Quit For Life, offering them the opportunity to customize their program design based on their specific needs, obtain their own report suite and have access to quit and satisfaction outcomes for their populations. Our Quit For Life pricing would apply under this arrangement. In this model, as these callers accessed TFN, health plan information would be collected and our registration agents would inform them of their benefit through Quit For Life. The registration agent would then enroll them in Quit For Life under their contractual requirements. TFN could monitor the increased reach achieved through this model on the Monthly Dashboard report (excerpt shown below), where under the State column, Optum provides TFN a view into the increased enrollments as a result of all our direct contracts with employers and health plans. The sample monthly reporting dashboard **Figure A.1.8. – Dashboard** depicts relevant information we track and share with TFN:

Figure A.1.8. – Dashboard



The Quitline column above (to the left of the circled "State" column) represents tobacco users served through the Nebraska Tobacco Quitline. The circled State column represents all tobacco users served by Optum and the extended reach achieved through our direct contracts with both Nebraska-based employers and national employers which employ Nebraska residents.

What is described above is not claims-based billing directly to health plans or directly to Medicaid. Optum continues to work on our strategy to become an approved Medicaid provider in order to submit claims for NRT directly. Unfortunately, due to the complexities in each state regarding which parties can be approved Medicaid providers to do direct billing, we continue to look for a solution. We do feel that we are close, given our solutions across Optum and our deep relationships with managed care health plans. Optum does have an organizational NPI number. Through direct contracts for our commercially offered Quit For Life program,

	for four managed care health plans and one fee for service plan, we provide with our invoice a claim form with CPT codes. Reimbursement is not based on the claim form, but on the Optum invoice, while the claim form provides encounter data and allows the plan to manage their medical benefits. Until we can do direct billing to health plans and Medicaid via claims, we have an intermediate alternative, pending further discussion with TFN regarding the end goal and related requirements, so we can determine the base path forward.
	Business Operation Requirement
9.	Bidder to describe the office environment and the organization's capability to accommodate staff, records, telephone lines, computer hardware and other operations.
	Bidder Response: (This Question addresses elements from Subsections V.D., V.F.1., V.F.2., V.F.4., V.F.5., and V.F.6.) **Office Environment and Accommodating Staff**: Optum staffs its Quitlines with telecommuter staff, affording us greater flexibility and service reliability. With respect to these telecommuter staff, maintaining confidentiality and privacy remains of utmost importance. Therefore, we have instituted specific requirements for telecommute workers related to the location within their home and specific protocols that would protect the security and privacy of participant information and the work conducted by our staff on a daily basis. We require that all remote staff review and sign the Optum Telecommuter Policy, which requires telecommute staff to comply with the following requirements: • The work area is in a section of the residence that is private and separate from other parts of the residence. • All company documents are locked in a desk or filing cabinet when not used. • The computer screen and computer must be located away from the residence's windows. • The employee must utilize the computer provided by Optum Technology. • For employees with a work-at-home kit, they are required to only connect their computer with the Optum-provided network device. The use of wireless networking, such as Wi-Fi, is not allowed for company business with the work-at-home kit. • The computer must be locked to the employee's desk using a company-provided locking cable.

- If necessary, the employee must shred all paper and documents used in their employment with Optum and must do so using an Optum paper shredder.

Records: Optum designed our flexible and scalable proprietary participant database to track participants from intake through program completion to ensure that each call is a streamlined and effective experience for the participant and to meet the reporting and call auditing needs of our clients. The database maintains the data set recommended by NAQC, and for Nebraska, includes data collected from our phone system, our web portal, our participant database, and our referral network. We understand that TFN owns all participant data and other data related to the Nebraska Tobacco Quitline services, and we have proposed alternate contract language in Section III. Contractor Duites, subsection F. Ownership of Information and Data Deliverables for TFN review.

Data from all our systems feed into a central data warehouse that leverages Microsoft SQL Server, Reporting Services, and Analysis Services to provide a robust operational reporting and decision support platform. This platform allows us to not only meet TFN's reporting requirements, but also the requirements set by the CDC for states awarded funding.

Our custom-made database allows us to view all interactions that take place for a participant in the single interface. As a result, Intake Registration Specialists and Quit Coaches can gather new information into the file and can easily review past Quit Coach documentation on quit status data, NRT screening and dosing process, prior call history, and additional important notes during and after calls. This system allows any agent to answer a call from a Minnesota resident and to immediately have all past and current information about the participant from intake to the final call available to them, allowing for a seamless interaction with the participant.

We have validated our database systems with user loads in excess of 150 percent of our maximum daily load and over 200 percent of our average daily load, meaning we have the ability to handle a minimum of 1,500 additional enrollments each day.

Our production hardware is Intel-based, enterprise-class, with dual power supplies, network interfaces, and redundant storage. The current configuration has 24GB of memory, operates with 24 cores, and runs the Microsoft Windows Server 2008 R2 operating system.

Security: As an HIPAA-covered entity, we adhere to all applicable privacy and security requirements, including those of HIPAA, and comply with all applicable federal, state, and local laws pertaining to maintaining the confidentiality of protected health information (PHI) of individuals participating in our

	programs. We have established and implemented administrative, technical, and physical safeguards to support HIPAA privacy rules. To validate our security posture, we contract with a third party to perform an annual security audit and penetration test of our systems. We contracted with IBM to perform this originally in 2012. The IBM audit produced no significant findings, and we have not had any breaches of our systems since. **Backup, Storage, and Disaster Recovery:** We house the servers, storage, and network components that support our staff in a dedicated server room at our Minnesota headquarters. The facility provides physical and electronic access security, automated back-up power for our servers, isolated environmental controls, and fault-warning systems to maintain a stable production environment. Customer-facing systems are maintained in a second secure co-location facility that provides redundancies in systems, environmental controls, power supply, and connectivity. We do complete system backups on a weekly basis, with incremental backups done on a daily basis, and hourly archive backups. In addition to traditional backups, we also replicate all data into our ad hoc database, used for reporting. **Telephone Lines:** In 2019 alone, Optum processed more than 452,535 incoming calls to our tobacco cessation phone lines. Of these callers, 9,262 were Nebraska residents. Inclusive of incoming and outgoing, and our system handles more than a million calls per year. We have the technology, 24/7 open hours, staffing, and forecasting infrastructure to ensure a successful tobacco treatment call center for Nebraska residents. We continue to maintain call handling capabilities that allow us to provide timely, secure, and effective Quitline services to participants. All of our telephone and data traffic is routed over a dedicated, fully meshed MPLS (Multiprotocol Label Switching) network. We monitor volume metrics to identify issues and provide appropriate bandwidth to support communications requirements. Our SIP trunks handle up to 1,000 simultaneous calls. Our fully redundant enterprise phone system is located in two geographically dispersed data centers with one data center capable of handling the entire call volume. Our automated dialing system allows for blended inbound and outbound calling. This helps us reach more participants each day. **Computer Hardware:** We provide our Quitline staff with current computers and related hardware, enabling them to efficiently and effectively assist Quitline callers. As the current vendor for Quitline operations for Nebraska, all the computers and related hardware are already in place with our staff and fully functional. All hardware is handled as if PHI is physically stored on it. Hard drives of all company laptops are encrypted and all mobile devices are required to have password and encryption protection. All removable and fixed storage media is electronically and physically destroyed if it is no longer being used.

10.	Bidder to describe how and when the applicant will notify and coordinate with the National 1-800-QUIT-NOW (1-800-784-8669) and the 1-855-DÈJELO-YA (1-855-335-3569) numbers to assure calls to that number are routed to you as the provider for Nebraska.
	Bidder Response: (This Question addresses elements from Subsection V.C.) Because Optum is the current service provider for the Nebraska Tobacco Quitline, calls to the National 1-800-QUIT NOW number and 1-855-DEJELO-YA are already routed to Optum. Additionally, we maintain a collaborative relationship with the Centers for Disease Control and the National Institutes of Health to maintain call routing of Nebraska calls into our coaching center.
11.	Bidder to describe service availability for screening and initial counseling, including "live" response hours of operation per week, during the days and times specified in this Request for Proposal. Include description of how peak times for calls will be monitored and staffing modified to meet peak volume times.
	Bidder Response: (This Question addresses elements from Subsections V.D., V.E.2., V.F.1., V.F.2., V.F.3., V.F.4., and V.F.8.) Nebraskans can currently register for services 24/7 through Nebraska's online enrollment page. Once their online registration is complete, a Quit Coach will follow up with the participant within 24 hours for additional screening and their initial counseling call. Residents may also telephonically register 24/7 with the following exceptions: Independence Day (closed); Thanksgiving Day (closed); Christmas Day (closed); Christmas Eve (close at 3:00 p.m. EST); and New Year's Eve (close at 6:00 p.m. EST). Referrals may also be received 24/7 and once received, follow our telephonic availability for outbound outreach to finalize the registration, screening and initial coaching. We carefully plan staffing levels to match anticipated call volumes. Historical call arrival data is analyzed on a weekly basis by our workforce planning software — if it detects a shift in peak call times, it will automatically adjust Service Delivery work schedules to ensure we are adequately staffed during all hours of operation. Throughout each day, supervisors and workflow analysts closely monitor call volumes, service levels, and schedule adherence. They may shift resources between work types to ensure we reach performance standards.

	Real-time monitoring of call queues and service level performance is completed through two systems: all Quit Coaches and Registration Intake Specialists have a ticker that scrolls across the top of their computer monitor which alerts them to changes in queue status, and all supervisory staff use call center software designed for supervisors to track key performance indicators and staffing levels. Both systems are used to quickly allocate staff as necessary to manage spikes in call volumes. To expand access to services and reduce barriers, in 2020, we are piloting a Text2Enroll marketing approach with two of our state Quitlines. Realizing that more and more people text and want a quick way to initiate services, we are working collaboratively with our pilot states' marketing agency to initiate an ad campaign that encourages people to text a keyword, like "quit" to a specific number (for example text "quit" to 222-111). From there, text messages are sent to the residents to collect brief eligibility information and to begin engagement on a quit plan. Once the user completes their verification, a registration agent will proactively reach out to the individual to enroll them in the services that are offered by the Quitline. We are thrilled to be looking at ways to address declining telephonic volume and are eager to demonstrate that texting may be a future way tobacco users can access services.
12.	Bidder to describe how call standards listed in Request for Proposal will be monitored and achieved, and provide evidence of current call standard levels.
	Bidder Response: (This Question addresses elements from Subsections V.F.1., V.F.2., V.F.3., V.F.5., V.F.8., V.F.12., V.F.13., and V.H.) At Optum, the vitality of our services is the responsibility of our product owner, Shweta Bhan. Service metrics are consistently monitored and fall into one of three categories: reach, engagement, or outcomes. Reach metrics are associated with verifying that we achieve high enrollment volumes; for example, metrics monitored are related to telephony service metrics, such as live response, timeliness to respond to referrals, and percent of participants enrolling from our online enrollment platform. Since the chances of successfully quitting increase as participants interact and utilize more quit tools and resources, monitoring engagement is a critical component in driving outcomes. In this area, metrics monitored include call completion, engagement with our web-based services, percent of participants opting in for text messaging, and percent receiving NRT. Optimal outcomes are, of course, our end goal. We strive to help more people be successful in quitting tobacco for good. We actively monitor the quit and satisfaction goals of our services.

	Each year, Optum sets target goals associated with each metric, in each category. Once those targets are set, Ms. Bhan works collaboratively with our Operations management team to make sure we have the staff plan, technology, and reporting capability in place to achieve those targets. On a monthly basis, Ms. Bhan reviews key performance metrics with Optum's executive and leadership team, giving visibility to how we are performing against each target. In instances where we are underperforming against a target, Ms. Bhan has the attention and support of the leadership team to identify the root cause of the underperforming metric and mobilize a team to address improvement for that metric. As a current client of Optum, TFN currently receives our Quarterly Performance Management Report, which is a report that provides transparency and visibility to our clients on service metrics. Due to the changing landscape of Quitline services beyond telephonic counseling, Optum has revised the metrics we will monitor should we be awarded the contract. These metrics will fall into the three categories stated above (reach, engagement, outcomes) and will be more relevant to where our product and operations teams spend time in monitoring program performance to help us provide the best participant experience. For purposes of our response, we have listed the call standards and our past performance in Nebraska from the 3rd quarter of 2019 in the table below in **Table A.1.12 – Call Standards**. We look forward to negotiating with TFN our new approach to monitoring quality and the metrics to be reported quarterly. A sample of our revised Quarterly Performance Report has been included as Appendix A.1.12. Quarterly Performance Report.

Table A.1.12 – Call Standards

	CALL STANDARD	OPTUM 3RD QTR 2019 RESULT
a.	90% of calls received during operation hours to the Quitline shall receive a live response.	97%
b.	The average live answer speed shall be within 30 seconds.	26 Seconds
c.	Less than 5% abandonment for calls waiting greater than 30 seconds following the initial client queue message.	2.6%
d.	100% of self-help materials shall be sent within one day of registration.	N/A*
e.	95% of voicemail messages shall be initiated for return within one day.	100%
f.	70% to 80% of callers interested in speaking with a Quitline Specialist shall be transferred directly after completing registration. The remaining 20% to 30% will be contacted within the time frame that the participant requests.	95%
g.	The Contractor must reach, or document an attempt to reach, 90% of multiple call participants during the established appointment time for all intervention calls.	86%
h.	Contractor must attempt to contact all fax referrals within 24 hours of receipt.	N/A*
i.	70% of multiple call participants will receive a time-sensitive quit date call within 48 hours of their quit date.	84%
j.	80% of calls during airing of federal campaigns are answered within 30 seconds.	N/A*

**We do not currently report on these metrics. However, our policy is to ship self-help materials within one business day, to attempt contact of fax referral participants within one business day of the referral, and to increase available staffing for national campaigns so that we can continue providing optimal service.*

13. Bidder to describe holiday coverage, and how calls will be handled outside "live" hour coverage.

Bidder Response: (This Question addresses elements from Subsection V.F.2.)

Optum only closes our Quitlines on three holidays; Independence Day, Thanksgiving Day, and Christmas Day; with early closure on Christmas Eve (3:00 p.m. EST) and New Year's Eve (6:00 p.m. EST).

To accommodate calls on the holidays listed above, we provide a robust voice-message system that handles multiple, simultaneous callers. The system allows customization of the structure and content of the greeting

	message and lets callers request a return call as well as listen to quit tips on 10 topics in English and Spanish. Our Quit Coaches return messages the next business day in the time frame requested by the caller. Participants may register for services on these holidays via quitnow.net/Nebraska.
14.	Bidder to describe how a regularly updated referral resource database of community services will be operated in collaboration with TFN.
	Bidder Response: (This Question addresses elements from Subsections V.F.10. and V.G.) Optum currently houses a database of community programs available to Nebraska tobacco users. Quit Coaches use the referral resource database to refer participants to community-based services based on their ZIP code or county of residence. Should additional resources be identified, Optum will work with TFN to capture program information such as cost, availability of program, and contact information. We then enter this information into the database. We can update the database anytime TFN provides updated information. Upon request, referrals to community resources can be reported on a monthly basis in the Referral to Community Resources Report as part of Optum's standard suite of reports. Optum recommends exporting all resource information to TFN for review and updating on an annual basis at minimum. Our Client Services Manager, Jessica Benson, has worked, and will continue to work with TFN to maintain accurate and up-to-date lists of resources. Please see additional detail on maintenance of our community resources database in Question 22 later in this document.
15.	Bidder to provide an assessment of your organization's strengths and weaknesses in addressing the scope of work described in this Request for Proposal.
	Bidder Response: (This Question addresses elements from Subsections V.C., V.D., V.F.8., and V.G.) Our strengths include: Core Mission: As we indicated earlier, tobacco cessation services lie within our Prevention & Well-being area, where all products are focused on improving the lives of individuals. In this area we have vast resources, talent and infrastructure to focus our resources on the needs of our participants and our clients' unique goals and objectives. Relationship Continuity: Optum and TFN have developed a strong, mutually beneficial relationship built on trust and commitment to a common cause. In addition, Optum, the Nebraska Medicaid MCOs, Nebraska Department of Health, and Heritage Health have developed a strong working relationship to assist Medicaid

	members to access their benefits and cessation medications. We are very proud of our relationship with Medicaid and our partners and MCOs in Nebraska. We have learned together and enjoyed sharing our collective expertise. Integration: Our Quitline services are a part of a broader suite of coaching services available, thus we are able to integrate and leverage the capabilities of those other products easily, such as the addition of online expert-led learning program (from our digital wellness solution), and our group coaching planned in our youth vaping program, which comes from our diabetes weight management program,Real Appeal®. Medicaid: We have significant experience in serving Medicaid participants and in working with Medicaid health plans across the country. Stability: Optum is a large organization and offers stability of our operations on a macro level, while we also have a micro level staff working on our Quitlines that have long tenures with both Optum and Quitline service provision. Continuity: Optum utilizes a robust, science-based approach to tobacco cessation, which incorporates the 5 Keys to Quitting across all the tools we offer, providing continuity of services to participants, no matter which services they prefer to utilize in quitting tobacco. Convenience: We offer a multi-model approach, giving participants the service options that best suit their needs (telephonic, online, email, chat, text, or mix) allowing them to quit while using the technology they want. Scale: The size of our operation means our clients enjoy a level of security in knowing we have a robust technology platform and the largest and most senior coaching staff in the industry. Our clients also benefit from having access to the best practices employed by all our other clients. The scaling of our business is a direct result of our clients' growth and success. We never lose sight of our most important assets: the participants we serve on a daily basis and clients who provide funding to reduce the prevalence of tobacco use in their states. Industry Leadership: We are committed and active participants in the advancement of the science of tobacco cessation treatment and are widely known and respected for our long history of conducting rigorous scientific research and translating the results into evidence-based products and services.

	NAQC: We are a founding member of NAQC, which is committed to maximizing the access to, use of, and effectiveness of Quitlines. We participate in national committees and workgroups to inform tobacco control and treatment policies. ATTUD: We are also founding members of Association for the Treatment of Tobacco Use and Dependence (ATTUD), a professional society devoted to the promotion of and increased access to evidence-based tobacco treatment for the tobacco user by identifying standards of practice for Tobacco Treatment Specialists. CTTTP: We are part of the leadership team for The Council for Tobacco Treatment Training Programs. This council is the accrediting body for tobacco treatment training programs. Through these achievements, we bring a wealth of knowledge of tobacco cessation best practices, and a commitment to the State of Nebraska to continue to help TFN meet its strategic goals for tobacco control. Research: Optum staffs the Optum Center for Wellness Research (OCWR), which focuses on externally funded research that aligns with the Optum mission to improve health care for everyone. OCWR's mission is to increase the use and success of health improvement programs so that people can live healthier lives. OCWR conducts rigorous scientific research and translate the results into evidence-based products and services. The OCWR team of highly trained scientists and research staff has expertise in clinical and behavioral research, program design and development, and program evaluation. OCWR staff conducts studies funded by the National Cancer Institute, the National Institute of Drug Abuse, and the American Cancer Society. OCWR has also completed projects funded by the CDC Office of Smoking and Health, and state departments of health. We offer a more detailed description of OCWR and some of its research activities in Question 39 later in this document. Cognitive Behavioral Practices: Optum has perfected the use of cognitive behavioral therapy principles to help participants be successful in their efforts to quit tobacco. We do not distribute untailored advice — we listen carefully to our participants and use cognitive behavioral and motivational interviewing techniques to address areas of low confidence, build coping skills, and develop customized quit plans. Potential weaknesses include: Automated Answering System: We use an automated answering system for incoming calls to inform callers that calls may be recorded, and, for our English language lines, to distinguish between English- and Spanish-speaking callers.

	Appointments: Currently, we do not use an appointment system for the proactive follow-up counseling sessions. Instead, we leverage off a participant's three-hour "best time" window to reach out to them. With participant permission, we will leave a message encouraging them to call back at their earliest convenience. Having staff available 24/7 allows participants to return our calls any time of the day or night. Setting appointments is supported in our other coaching products, allowing us to potentially leverage that capability in the future. Counselor Continuity: We will accommodate any request by a participant to work with a single Quit Coach; however, proactively scheduling with the same Quit Coach is not our standard practice. Quit Coaches leave detailed notes in participants' files that are used by the next Quit Coach to quickly establish a bond of familiarity that is conducive to a positive counseling session. Our experience has shown that different Quit Coaches have different "gems" of knowledge that can be shared and the participant can benefit from speaking with different Coaches.
	Work Plan and Timeline
16.	Bidder to provide a detailed work plan including a timeline of activities to guide the implementation of the Quitline from date of award to "go live" date. Indicate responsible party, milestones and specific date estimates. Include a narrative description of the individual items or the timeline as a whole, as needed. Subsequent work plans may be developed in collaboration with TFN when protocols change or other service adjustments are needed.
	Bidder Response: (This Question addresses elements from Appendix A.1.16. Work Plan) As the current Quitline vendor for Nebraska, many of the key elements in our Work Plan are already in place and functional. To support the ongoing success of TFN's program, Optum's designated Client Services Manager, Jessica Benson, will conduct an official kick-off meeting to monitor that all elements of TFN's Scope of Work are met. This will include confirmation of services and identification of any new service offerings or program enhancements requiring implementation, fiscal year evaluation planning, review of reporting requirements, and goal-setting for the new contract period. The Work Plan includes specific tasks required for a successful implementation or transition of services, and includes each specific task, the start date of each task, the completion (end) date of each task, and whether the task falls under Optum's responsibility or under TFN's responsibility.

	The Work Plan also includes specific tasks and steps related to the following areas: • Contract deliverables and execution • Program budget and projections • The registration process • Communication coordination • Addressing any staff training needs • Fax and electronic referral capability • Quality assurance plan • Billing • Goal setting for the Quitline program • Any application development/deployment • Compiling health plan information • Reporting parameters and frequency • Telecommunications • Quit materials • Text services A detailed Work Plan, including specific activities, milestones, completion dates, and responsible parties is attached as Appendix A.1.16. Work Plan.
	Counseling Technical Requirements
17.	Bidder should provide a description of the proposed Counseling System 1. Protocols for the first contact during live hours. 2. Protocols to triage the caller's need for services. 3. Protocols to assess a tobacco user's readiness to quit. For the caller ready to quit, detail how the following will be provided: **a.** Registration for services **b.** Initial counseling for successful quitting **c.** Provision of self-help materials or other resources **d.** Assessment of caller's interest in proactive cessation counseling **e.** Assessment of caller's insurance status including Medicaid and Medicare and feedback to the caller about the availability of tobacco dependence treatment coverage through their health insurance.

	f. Describe how comprehensive, proactive follow-up cessation counseling will be provided. Provide evidence that counseling is based on protocols that research in randomized trials has demonstrated to be effective in supporting people as they cease the use of tobacco products and in preventing relapse. **g.** Describe how cessation counseling will be provided to educate on nicotine replacement therapy options, how the caller will be screened for medical eligibility and how the proper nicotine replacement therapy will be selected for the caller.
	Bidder Response: (This Question addresses elements from Subsections V.A.1., V.C., V.D., V.E.1., V.E.2., V.F.3., V.F.8., V.G., V.H., and V.K.) **Description of Counseling System** **Coaching Approach** The Quit For Life intervention is founded on a proprietary model — ASM (Awareness, Skill Building, and Maintenance) and Social Cognitive Theory. The ASM provides a holistic, personalized approach that looks at all dimensions of behavior change. Changing our participants' behaviors isn't just about the education, expertise, and coaching that we provide; it is also about considering the participant's emotions, personal values, social influences, and their drive to improve or manage their health. The ASM Behavior Change Model helps participants recognize their health behaviors by reframing their situation in a way that is positive, easy to identify with, and speaks to each consumer's emotions and values. This new frame of mind can create a world of possibilities. **Awareness:** The goal of the Awareness phase is to raise our participants' self-awareness of their behaviors and lifestyle choices. It is about helping participants see where they are at today and where they could be tomorrow. **Skill Building:** The goal of Skill Building is to help participants master a behavior change, whether this means forming a new behavior or changing an existing behavior. Coaches support skill building by breaking larger tasks into smaller, more attainable steps. **Maintenance:** The goal of the Maintenance phase is to make sure participants have the confidence and support they need to sustain their behaviors over the long term. To make a difference, behavior change must last. This phase aims to help participants sustain behavior change through practice, repetition, aligning with core values, and adopting a healthy lifestyle.

Social Cognitive Theory

Along with the ASM Model, coaches integrate the principles of social cognitive theory (SCT). SCT describes how personal factors (P – biological and thoughts and emotions), environmental factors (E – social and physical), and human behavior (B – automatic and conscious) influence each other in ways that can promote healthy or unhealthy behaviors.

Self-efficacy is a central concept in SCT. Simply put, a person needs to believe the change will benefit them, they have the skills to change, and that they can perform these skills. Self-efficacy is assessed by learning about the person's motivation for the behavior change and confidence that they can achieve their goals.

These factors help the Coach understand the participant's world and provide guidance for action planning.

Call Structure

Each coaching call is structured but not scripted. During the call, the Coach assesses the caller's needs, builds and shares insight, and collaborates on an action plan.

During the exploration, the Coach assesses the participant's readiness and reasons for quitting, tobacco use, quit history, social support, environment, thoughts, motivation, and confidence to change behavior.

Insight is where the Coach shares strengths and challenges and proposes an agenda.

The action phase is when the Coach and participant collaborate on a plan. The plan is set up using incremental goals and SMART steps *(Specific, Measurable, Achievable, Realistic, Time-bound).*

Eye on the Prize: Quitting Tobacco and Staying Tobacco Free

During each call, Coaches keep their eye on the prize — all of the actions in the call are designed to lead the participant to their outcome goal — quitting tobacco or staying tobacco-free.

Coaches facilitate the adoption of the behaviors that we know lead to success:

- Setting a quit date
- Using quit medications effectively
- Managing urges
- Getting support,
- Tobacco proofing environment

Intervention Strategies: During coaching calls, the Coach employs multiple counseling strategies depending on the participant's needs including: skill building, education, reinforcement and modeling, motivational interviewing, and cognitive behavioral therapy.

Motivational Interviewing (MI) is a therapeutic approach designed to help individuals explore and resolve ambivalence about their intention for behavior change in a non-confrontational manner. MI has been proven effective across a broad range of brief behavioral interventions, including interventions delivered by telephone. Coaches are trained in using five MI counseling techniques: expressing empathy, developing a discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy. In this way, Coaches help individuals increase their awareness, empower individual responsibility for behavior, instill a sense of self-efficacy, and use goal-setting to move from behavioral intention to behavioral action.

Cognitive Behavioral Therapy (CBT) is a therapeutic approach that helps individuals identify and correct unhelpful thought patterns that adversely affect their emotional, behavioral, and physical health. Coaches are trained in using CBT strategies, and work with individuals to help them develop their skills for correcting automatic thoughts and their conditional rules that previously sabotaged their health goals. CBT has been proven to be effective for a broad range of conditions.

1. Protocols for the first contact during live hours.

First-time callers will be routed to a Registration Specialist, who will provide the following friendly, live greeting in English or Spanish as appropriate: *"Nebraska Tobacco Quitline, this is [Name]. How can I help you today?"* while callers who are already enrolled will be routed directly to a Quit Coach, bypassing the registration process.

For those not already enrolled, the registration specialist explains available services to the caller, assesses their insurance status and employment for triage, completes an assessment of the caller's tobacco use history, obtains permission for follow-up, and determines the caller's readiness to quit by asking whether the caller is ready to set a quit date within the next 30 days (which is later confirmed by a Quit Coach when the participant is transferred for their initial coaching call). Additionally, we screen callers for Medicaid coverage and if so, the Quit Coach explains the enhanced benefits for which they are eligible through their Medicaid health plan.

For the few tobacco users who call and state they are not ready to quit, the Registration Intake Specialist encourages the caller to talk to a Quit Coach to help move them along the quit continuum and uncover the barrier(s) to quitting. We find these callers are the most vulnerable and often simply need to talk to a Quit

Coach to help them understand there is help. Most people who call are interested in quitting and our Registration Specialists connect them to a Quit Coach to start a tailored quitting plan.

Tobacco users not interested in speaking with a Quit Coach are provided with information to promote quitting, printed materials, referral to web-based services, and encouragement to call the Quitline again when they would like further assistance with quitting.

2. Describe proposed protocols to triage the caller's need for services.

Each Quitline caller's need for services is assessed by a Registration Intake Specialist who asks whether the caller is calling for themselves, for someone else, or is a health care professional. Depending on the response, the Registration Intake Specialist sets up the enrollment for the correct caller type in our participant management system. Due to the number of health plans and employers Optum contracts with for our commercially offered program, Quit For Life, we take a proactive approach in assessing eligibility for these services, which offsets the cost of services for TFN. We also have the ability to triage to non-Optum cessation benefits as provided by TFN.

Tobacco users served through Optum clients are transferred to a Quit Coach for their first counseling session and decision support for pharmacotherapy. Proxy callers and providers are sent printed materials and offered a transfer to a Quit Coach. Our Quit Coaches will also offer referrals to other cessation services available in Nebraska through our community resource referral database.

More of our states are embracing the power of choice and have launched our ala-carte service offering called Individual Services. Individual Services includes four, stand-alone services including: text messaging only, email program only, materials only, or a 2-week NRT starter kit with a follow-up call. When callers access services telephonically, our Registration Agents help guide the caller in making a decision as to what service is right for them and triages them accordingly into that service. Should TFN want to further explore the value of offering Individual Services, Optum is happy to discuss post award.

3. Protocols to assess a tobacco user's readiness to quit. For the caller ready to quit, detail how the following will be provided:

For first-time callers to the Quitline, our Quitline staff will assess the caller's readiness to quit tobacco use, based on the caller's stage in the Quit Continuum:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Termination

We utilize pre-defined questions regarding the caller's prior and current tobacco use, previous attempts to quit, challenges to quitting, and other issues in making a determination regarding the person's readiness to quit. Our goal is to make sure that callers know that there are options available to them to pursue and maintain a quit plan. Callers who indicate readiness to quit are then transferred to a Quit Coach for the initial coaching session. If a participant does not want to be transferred immediately, they are called back during an agreed-upon time frame.

a. Registration for services

Initial Phone Intake Process: All new callers to the Quitline are connected with a Registration Specialist, who provides a friendly, welcoming, and Nebraska-tailored greeting in English or Spanish. The registration specialist explains available services to the caller, completes an assessment of the caller's tobacco use history, determines the caller's readiness to quit, and obtains permission for follow-up.

The final step in the registration process for tobacco users who are ready to quit is an immediate transfer to a Quit Coach for the initial coaching session. If a participant does not want to be transferred immediately, they are called back during an agreed-upon time frame.

Tobacco users not interested in speaking with a Quit Coach are provided with information to promote quitting, printed materials, referral to web-based services, and encouragement to call the Quitline again when they would like further assistance with quitting.

Initial Web Intake Process: Nebraska residents may visit **www.quitnow.net/nebraska** to learn about any service offered by TFN. The site is already branded with the Nebraska Tobacco Quitline logo. On this page, visitors can begin the registration process, get answers to questions, see all the program services for which they may be eligible, start a chat with a Quit Coach, or switch to a Spanish language version of the site. Registered callers can log in to their account and go directly to their approved resources. Screenshots from the main webpage are shown below in **Figure A1.17.a – Hompage Welcome** and **Figure A.1.17.b – What to Expect** below:

Figure A1.17.a – Hompage Welcome

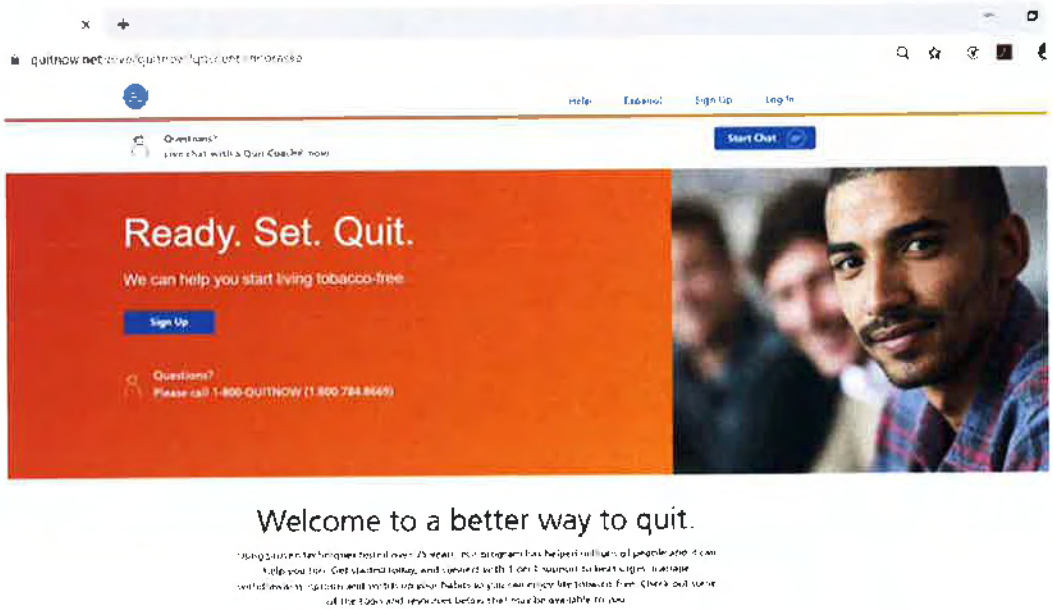
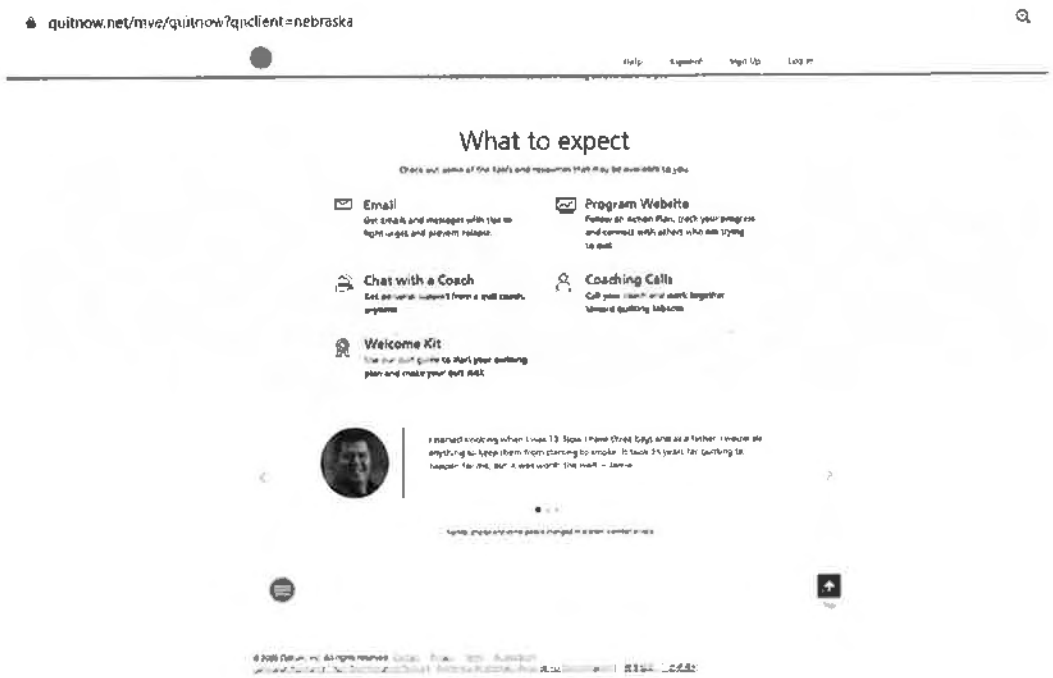


Figure A.1.17.b – What to Expect



The data collected during online enrollment is similar to what is collected during enrollment via the phone to ensure data consistency, including any customized question-and-answer options. Participants needing extra support with the online enrollment process may contact a Quit Coach via email or chat.

Our web enrollment platform is both ADA compliant and mobile responsive.

b. Initial counseling for successful quitting

The Assessment and Planning call is the first coaching call in our multiple-call program. During this call, the Quit Coach completes a thorough assessment, which includes the caller's tobacco use history, number of previous quit attempts, length of longest quit, causes of relapse, tobacco use per day, time to first use after waking, level of motivation, confidence in their ability to quit and stay quit, presence of other tobacco users at work and home, and the presence and effects of chronic diseases and other conditions such as pregnancy. Quit Coaches use this assessment data to help the participant develop their personalized quit plan in accordance with the USPHS Clinical Practice Guideline. This planning process includes encouraging participants to track their tobacco use during the time prior to their quit date, to use exercises in the Quit Guide and on the online portal to identify personalized coping strategies to deal with urges to use tobacco, and to practice quitting for short periods prior to the planned quit date to increase confidence in their ability to quit for good. Participants who are ready to set a quit date also receive decision support for available pharmacotherapy options and a dosing regimen for NRT with detailed use instructions.

For participants not ready to quit, Quit Coaches use motivational interviewing to shift the decisional balance to quit, as recommended in the 2008 USPHS Clinical Practice Guideline Update. Along the way, the Quit Coach and participant discuss incremental steps the participant can take, from identifying social support by making a first visit to Web Coach, to trying a practice quit. Quit Coaches help participants build confidence, reframe unproductive thoughts about quitting, and learn important quit skills. The goal is to shift participants to a stage in which they are ready to make a quit attempt.

If the participant does not have time for the first coaching call immediately after enrolling, they are called back at a time convenient for them. We will attempt to reach the participant on up to five different days before closing the file.

Callers enrolling via our online enrollment process receive a call from a Quit Coach within 24 hours. Quit Coaches cover the same information indicated above.

c .Provision of self-help materials or other resources

For ready-to-quit callers, we offer materials (such as the Quit Guide and other appropriate materials described in Question 29, as well as referrals to community cessation resources for which they may be eligible as indicated in Question 14, after their initial Quitline registration and thereafter upon request, as well as access to our online portal.

d. Assessment of caller's interest in proactive cessation counseling

After it is determined that a caller is eligible to receive proactive cessation coaching based on the eligibility criteria established by TFN, an assessment of each caller's interest in receiving proactive cessation coaching is completed by Quit Coaches during the first counseling session. The Quit Coach asks the participant, *"The State of Nebraska is offering additional sessions with a coach to further support you with your quit; is this something you are interested in?"* If the answer is affirmative, the Quit Coach automatically enrolls the participant. If the participant isn't interested, the Quit Coach continues with the initial coaching intervention. Callers are encouraged to contact the Quitline again if they would like to receive additional coaching sessions.

e. Assessment of caller's insurance status including Medicaid and Medicare and feedback to the caller about the availability of tobacco dependence treatment coverage through their health insurance.

As described above, the Registration Intake Specialist collects employer and insurance provider information for all callers to the Quitline and evaluates the cessation benefits offered by these sources. If a caller is eligible for cessation benefits through a direct contract that Optum has with their employer or health plan, the Registration Intake Specialist triages the caller to this benefit. This helps reserve Quitline funding for individuals who do not otherwise have access to cessation benefits. In addition, we have customized the questions for Nebraska participants to clarify whether they are solely covered by Medicaid, or whether the individual is dually covered by Medicaid and Medicare. Having this information helps the Quit Coach set expectations around what benefits are available through Medicaid depending on a caller's specific insurance coverage.

For those with no insurance, we explain that they are also eligible for Quitline services, as well as NRT (patches, gum, lozenges) offered through the Quitline as determined by the State, and we help them understand their benefits and how to use all the resources available to them to strengthen their quit attempt. Optum acknowledges that it is responsible for all packaging and postage necessary to provide NRT to eligible Nebraska Quitline participants.

f. Describe how comprehensive, proactive follow-up cessation counseling will be provided. Provide evidence that counseling is based on protocols that research in randomized trials has demonstrated to be effective in supporting people as they cease the use of tobacco products and in preventing relapse.

Optum's tobacco cessation services are evidence-based, culturally appropriate, and incorporate effective strategies for nicotine addiction treatment as outlined in the U.S. Department of Health and Human Services Public Health Service, Clinical Practice Guidelines for Cessation. Six large federally and state-funded randomized clinical trials have demonstrated the effectiveness of our program[12345]. In addition, a number of independent public and private institutions have evaluated and approved our program as effective and evidence-based, including: North Carolina Chapel Hill (the National Cancer Institute's landmark tobacco cessation study), the University of Northern Iowa (UNI), the University of Oklahoma (College of Public Health), the University of Arkansas Little Rock, Wyoming Survey and Analysis Center, Professional Data Analysts, Inc., The Gilmore Research Group, and Social Solutions International.

The timing of proactive calls is relapse-sensitive. Callers who are ready to quit within 30 days will receive up to five follow-up coaching calls; our coaching program consists of one initial and four proactive follow-up coaching calls. This model has been proven effective and cost-effective in multiple federally and state funded randomized trials.[123456] Participants may also call in for additional support at any time.

A primary focus of the follow-up coaching calls is relapse prevention. Recognizing that the first 2 weeks after the quit date represent the period during which recent quitters are at the highest risk for relapse, the quit date call, and quit date follow-up calls present opportunities to fine-tune both behavioral and pharmacological care strategies.

The content of each follow-up call will be tailored to where the participant is in the quit continuum. For those who are quit but struggling, coaching content will include identifying new coping strategies, including strategies to structure the environment to support total tobacco abstinence. Quit Coaches will use cognitive behavioral coaching and practical skill-building to reinforce effective coping strategies for urge situations and to counter unproductive thoughts, assess for future high-risk situations, help the participant manage stress, and build self-efficacy. Medication use will continue to be monitored to assure use compliance and to assess and problem-solve any potential side effects. The goal is to prevent both lapses and relapse. In each call, the Quit Coach will assess the participant's status and progress, build on the information previously gathered, identify barriers, and reinforce successes.

g. Describe how Cessation Counseling will be provided to educate on Nicotine replacement therapy options, how the caller will be screened for medical eligibility and how the proper nicotine replacement therapy will be selected for the caller.

Participants who are ready to set a quit date also receive decision support for available pharmacotherapy options (nicotine replacement therapy and FDA-approved cessation medications) and a dosing regimen for NRT with detailed use instructions that takes the participant's current level of nicotine dependence into account. Quit Coaches explain the differences in medication categories (nicotine replacement therapy vs. prescription medications), the different delivery systems (patch, gum, lozenge, etc.), and talk neutrally about the pros and cons of medications, including their common side-effects and contraindications. Quit Coaches tailor discussions about medications to the individual knowledge and needs of each caller. Additionally, as indicated earlier, we screen callers for Medicaid coverage and if they are enrolled, the Quit Coach explains the enhanced benefits for which they are eligible through their health plan or MCO.

Acting as thought leaders, Optum's clinical team was part of a group of well-known experts who petitioned the FDA to modify NRT labeling to remove restrictions on combination NRT. As a result, the FDA announced proposed labeling changes

To address the Vaping epidemic, one of the changes that we have made is to design a dosing algorithm to support dual users (combustible cigarettes and e-cigarettes) and mono users (e-cigarettes only). We developed the algorithm by empirically assessing appropriate dosing of the nicotine replacement based on possible scenarios, and then devised a formula that would deliver the appropriate dose. The algorithm considers the level of the participant's nicotine dependence and takes into account the use of just the nicotine patch alone, and in combination with gum or lozenge. In early 2020, we will be building the algorithm into our database to support Quit Coaches in providing more specific guidance of NRT for callers who use e-cigarettes.

1 Orleans CT, Schoenbach VJ, Wagner E, et al. Self-help quit smoking interventions: Effects of self-help materials, social support instructions, and telephone counseling. *Journal of Consulting and Clinical Psych.*, 1991;59(3):439-448.

2 Curry SJ, Grothaus LC, McAfee T, Pabiniak C. Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. *N Engl J Med.* Sep 3 1998;339(10):673-679.

3 Swan GE, McAfee T, Curry SJ, et al. Effectiveness of bupropion sustained release for smoking cessation in a health care setting: a randomized trial. *Arch Intern Med.* Oct 27 2003;163(19):2337-2344.

4 Hollis JF, McAfee T, Fellows JL, Zbikowski SM, Stark M, K. R. The effectiveness and cost effectiveness of telephone counseling and the nicotine patch in a state tobacco quitline. *Tob Control.* 2007;16(Suppl 1):i53-59.

5 McAfee TA, Bush T, Deprey TM, Mahoney LD, Zbikowski SM, Fellows JL, McClure JB. Nicotine patches and uninsured quitline callers. A randomized trial of two versus eight weeks. *Am J Prev Med.* 2008 Aug;35(2):103-10.

18.	Bidder should describe any unique protocols or experience working with each of the following populations: a. Medicaid eligible b. Uninsured/Low Socioeconomic Status c. Pregnant women d. Senior adults e. Veterans f. Smokeless tobacco users g. Electronic Nicotine Delivery Systems (ENDS) users h. Behavioral health tobacco users i. Diverse ethnic, racial and cultural minorities, particularly Native Americans.
	Bidder Response: (This Question addresses elements from Subsections V.B., V.E.1., V.E.3., V.F.4., V.F.11., V.G., and V.H.) [redacted]

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19.	Bidder should describe how services will be provided to callers with limited English proficiency.
	Bidder Response: (This Question addresses elements from Subsection V.G.) According to **www.statisticalatlas.com**, there are more than 80,000 Nebraska residents with limited English proficiency, and of those, 74 percent are Spanish speakers. Optum provides Quitline services in English and Spanish, and we also contract with **Language Line Services** to provide live interpretation services for participants who speak languages other than English or Spanish. Language Line Services supports interpretations in more than 240 languages and dialects. The Quit Coach and interpreter are both on the phone with the participant throughout the call. With 9,000 trained professionals, Language Line Services has 99.99 percent platform availability and boasts a 13.4 second connect line for its most used languages (i.e., Arabic) and a 34.5 second connect time for all other languages. This service is available during all hours of operation. Our printed Quit Guide is available in both English and Spanish, and we offer specialized, Spanish-language materials for pregnant women and smokeless tobacco users. Additionally, a culturally adapted, Spanish-language version of our online portal service is also available.
20.	Bidder should provide recommendations for managing the funds available under this contract should call volume exceed, or not meet expectations.
	Bidder Response: (This Question addresses elements from Subsection V.F.4.) Optum's account managers are experts at making recommendations for reaching goals while managing available Quitline funds, particularly when multiple funding sources are involved. TFN's Associate Client Services Manager, Jessica Benson, will remain in contact with TFN during the year and monitor the services provided versus budgeted levels. We can respond by making TFN-prescribed changes to the service package should volume exceed, or not meet exceptions. We have existing experience in doing this. For example, in 2019 with TFN concurrence, we increased available NRT from two weeks to four weeks when additional funding was available. In 2018, we suspended the two week NRT benefit, again with TFN concurrence, when funding was running low. Other recommendations should volume be lower than expected are: • Increasing NRT to the recommended level of eight weeks, from two or four weeks • Developing and implementing online provider training • Building strategies to increase provider referrals

	• Building communication strategies with Medicaid to increase participation • Adding intensive programs for priority populations, such as tobacco users with behavioral health conditions or American Indians • Building e-referral connections with health systems identified by TFN Recommendations for when volume is exceeding expectations are: • Reducing the amount of NRT provided • Reducing the number of calls delivered • Changing eligibility for certain populations To further assist TFN in monitoring available budget, we will provide a monthly billing schedule that will track each line item and will show remaining the balance on contract after each month. The Client Services Manager will include the budget in meetings held with TFN and will strategically analyze the budget with actual and projections to verify that TFN is on track to remain at or under budgeted levels. Optum has a complex forecasting process and helps identify if the budget is being over- or under-spent and can provide proactive solutions to assist the State in remaining on budget. We understand the importance of remaining on budget for states, and work to provide solutions to stretch state dollars in tobacco cessation goals. Communication between Optum and TFN is critical to successfully manage Quitline funds. Understanding TFN's preferred service options can help when making difficult decisions to reduce services in a timely manner, should this be necessary. In the reverse situation, keeping TFN informed regarding what service expansion options are available can help TFN prioritize expanded service options or NRT offerings based on the State's goals. Optum looks forward to a continued open dialogue regarding management of Quitline funds, with the underlying goal of being transparent and proactive in our communication.
21.	Bidder should describe how insured callers will be linked to their healthcare system to access a tobacco dependence treatment benefit, if available, or to their healthcare professional for prescription cessation aids or other medical follow-up as appropriate.
	Bidder Response: (This Question addresses elements from Subsections V.A.2. and V.F.1.) All callers to the Quitline are asked for employer and health plan information during the enrollment process. Our Registration Intake Specialists cross-reference the information provided by the participant against other options in our database. If we have record that the individual has a cessation benefit, our Specialists will

	advise the caller of their benefit and transfer the caller to those services. All triage activities are reported monthly in the Monthly Services Report. As mentioned prior, Optum is the service provider for over 1,000 employers and 35 health plans. Of those, nine are based in Nebraska, resulting in 247 enrollments for eligible Nebraskans since 2009. Additionally, nationwide we have a total of 494 employer contracts whose benefits touch Nebraska residents. These contracts allow the State to extend its reach. Optum has also a sophisticated custom process to support connecting Medicaid callers to their health system in order to access their benefit offered through these plans. Our health plan "pick list" has been customized to include the managed care plans offered today in Nebraska. As Registration Specialists select those plans, information is provided to the Specialist to guide them in the next best step. If the caller is interested in medication, the individual is advised to connect with their health care provider and ask them to make a referral to the Quitline. If the caller is not interested in medication, the appropriate health plan is selected and the registration process continues. Our system also allows us to enter specific access instructions by plan for medication, as well as customer service numbers, should the insured caller have questions.
22.	Bidder should describe protocols for referral to community-based services.
	Bidder Response: (This Question addresses elements from Subsections V.F.10. and V.G.) Optum's coaching application includes a database of tobacco cessation resources in Nebraska. Quit Coaches use this database to refer participants to community-based services based on the participant's ZIP code or county of residence when requested. Quit Coaches are expected to offer community resource referrals during the Assessment and Planning call, according to participant interest. Optum's team members make the referral by providing the caller with either the phone number or URL of the resource. Additionally, Registration Intake Specialists and Quit Coaches also have access to a list of national resources for alcohol abuse, depression, suicide, domestic abuse, etc., and provide referrals to callers, if necessary. We update this database as community resources notify us of updated information and/or as TFN provides updates. Our online services also include a list of community cessation resources available to Nebraska residents. Our Client Services Manager, Jessica Benson, will continue to work with TFN to verify that resources are continually up to date.

	Referrals to Community Cessation Resources: Quit Coaches can use our referral resource database to refer participants to community-based services based on the participant's ZIP code or county of residence, as well as characteristics of the participant (such as being a Veteran or being pregnant). The database is updated as community resources notify us of updated information, as we discover new referral resources, and/or as TFN provides updates. Selected information from our database of Nebraska community resources is provided in **Table A.1.22. – Community Resources** below, including four resources that serve all the counties in Nebraska:

Table A.1.22. – Community Resources

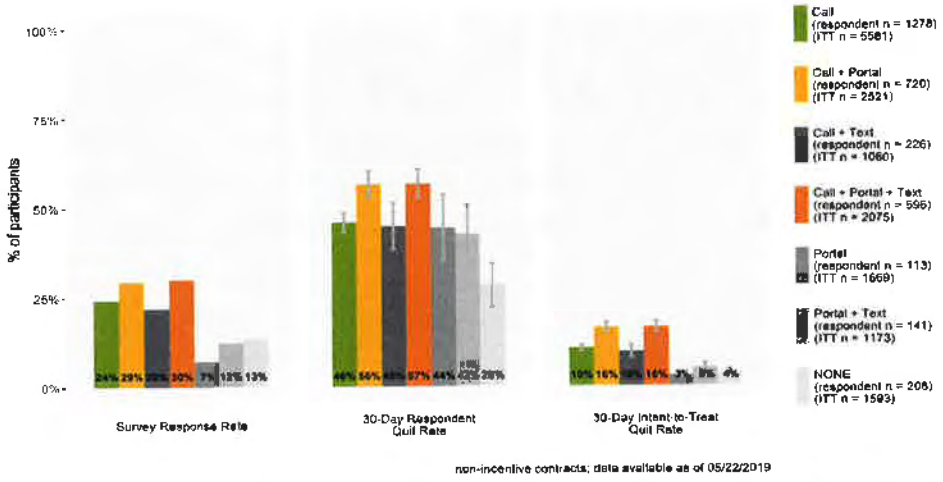
Community Resource	Areas Served
Alegent Health	Douglas County
Beatrice Community Hospital	Gage County
Boone County Health Center	Boone County
Bryan LGH Medical Center	Lancaster County
Central Community College – Hastings Campus	Adams County
Central Nebraska Community Services	Sherman County
Columbus Community Hospital	Platte County
Creighton Cardiac Center	Douglas County
Fremont Area Medical Center	Dodge County
Friends Health Connection	All 93 Nebraska Counties
Good Samaritan Health Systems	Buffalo County
Great Plains Regional Medical Center	Lincoln County
Memorial Hospital	Hamilton County
Methodist Hospital – Quit Smart	Douglas County
Nebraska Health and Human Services System	Lancaster County
Nebraska Medical Center	Douglas County
Panhandle Substance Abuse Council	Scotts Bluff County
Quit VET	All 93 Nebraska Counties
Regional West Medical Center	Scotts Bluff County
Saint Elizabeth Wellness Center	Lancaster County
Text4Baby	All 93 Nebraska Counties
Tri Valley Health System	Furnas County
York General Hospital	York County
Young Families Program	Lancaster County
Nicotine-Anonymous	All 93 Nebraska Counties

23.	Bidder should describe coaching services and how they will utilize technology (e.g. web-based coaching, app, text messaging) included in this project and made available to all Nebraska tobacco users.
	Bidder Response: (This Question addresses elements from Subsections V.G. and V.K.) Our tobacco cessation service is a clinically proven program that uses an evidence-based combination of multi-module ways to help Nebraska tobacco users quit. Today, TFN is leveraging our integrated web coaching technology, which includes emails and chat, and our and text messaging technology, part of that multi-module experience. We have proposed that TFN consider launching our stand-alone web based coaching, as well as unbundled, individual services (email only, text only, materials only or NRT starter kit). To access the program, we offer an expansive set of technology entry points including telephonic, online enrollment, and fax, online and electronic referrals from health care providers. As indicated earlier, in 2020 we are piloting the ability to text to enroll. Once enrolled, the program offers multiple options to support participants through their quit journey through a critical, comprehensive mix of telephonic coaching, medication delivered direct mail order, print materials, and digital tools including: online education, expert-led, video-based online learning, text messaging, a mobile app (currently available for our employers), and accessibility to our Coaches through email, chat, or by phone. **Participants may choose to quit how they want, using the technology they want, when they want.** All our systems are integrated and work together to track participants through their quit journey. Additionally, as discussed earlier, we know that the more participants engage with quit tools or resources we offer, the better the outcomes as a whole. **Table A.1.23 – Text2Quit** Integration below illustrates how we monitor a participant's use of additional tools or resources (in this case, Text2Quit), to capitalize on their engagement and momentum to better assist them in quitting. **Figure A.1.23 – Better Outcomes** shows how a participant engaging in multiple tools or resources results in better outcomes.

Table A.1.23 – Text2Quit Integration

Participant Action	What Happens in Our Systems
Participant changes their quit date via Text2Quit	Quit Coaches are updated immediately
Participant changes their quit date with a Quit Coach	Text2Quit messages adapt to the new quit date
Participant indicates a relapse via Text2Quit	Quit Coaches are updated immediately
Participant orders a medication with a Quit Coach	Participant receives tips via Text2Quit for the medication they ordered
Participant reschedules an upcoming coaching call	Text2Quit notification schedule for sending a text reminder for the participant's upcoming call is automatically adjusted

Figure A.1.23 – Better Outcomes



24.	It is important that Nebraska callers feel that when they reach the Nebraska Tobacco Quitline, they have found meaningful help, and that the Quitline staff will go the extra mile to assure that their needs are met—whether for information and referral, immediate counseling assistance, linkage to a healthcare professional or health plan for tobacco dependence treatment benefits, or just reassurance that this is a difficult and important step and the Quitline's professional staff are capable of facilitating them through a quit process that will lead to success. Describe how your organization will assure that this quality is conveyed in each call when dealing with Nebraska callers and provide examples. Bidder to provide two audio files of calls/counseling sessions on either CD_ROM, or DVD format for each of the following call types (for a total of six (6) recorded sessions): 1. Initial call and registration for services 2. Initial counseling/assessment call 3. Follow-up counseling call Audio copies of actual calls are preferred; however, a role-played session is acceptable. Please indicate whether the recordings provided are actual sessions or role-played calls.
	Bidder Response: (This Question addresses elements from Subsections V.A.1., V.E.2., V.F.3., V.F.5., V.F.6., V.F.8., and V.G.) Our audit and monitoring processes described below focus on Quit Coach interactions being technically proficient, providing expert-driven information, and in thoroughly understanding and addressing a participant's situation and needs. Our Quit Coaches use a non-judgmental, personalized approach to help participants navigate the challenges and obstacles associated with their quit goal, and provide input and advice tailored to each participant's circumstances. Our coaching protocols, including those designed for priority populations, use an empathetic approach to assist participants to quit, and build on any previous quit attempts the participant may have had, in order to overcome the challenges that prevented them from quitting or caused them to relapse.

As we also discuss in Question 40 later in this document, a critical element of our quality assurance plan is our call quality program, which consists of ongoing trainings, routine evaluation of recorded calls, and monthly meetings with a supervisor. We use recording software to digitally capture not only the audio portion of the call, but also the staff member's computer screen at the time of the interaction. This visual information complements the audio portion of the call and helps supervisors analyze the content of coaching sessions while also confirming the accuracy of data collected and documented by staff.

Actual Quitline Participant
Quote

"I think it's been good. I liked having a real human call me to check-in with me. That's the biggest part, I think. Being able to share with someone that I have quit smoking and I am excited about it. You want validation and feedback and people to be proud of you, right? Humans want that."

— **American Indian Quitline Participant**

Centralized Audit Team

We use a standardized tool to evaluate Quit Coaches in call performance. These audits are performed by auditors from our Centralized Audit Team. Examples include the following elements:

- Thoroughly assessing information about the participant's tobacco history and current use patterns
- Incorporating assessed information into a quit plan, tailored to the needs of the individual
- Expertly applying information about quit medications and adhering to clinical protocols to help the participant access and use quit medications effectively
- Expertly applying information about the impact quitting will have on certain chronic diseases and pregnancy
- Engaging the participant in the quitting process by using motivational interviewing and cognitive behavioral therapy principles to facilitate behavior change

Optum's Centralized Audit Team performs calibrations and inter-rater sessions regularly to consistently and accurately interpret and apply quality expectations, as determined by Operations.

Call Monitoring

When supervisors evaluate a staff member's work, they select a call at random from the pool of available recordings. This reinforces the message that each conversation holds the same importance. Supervisors use a proprietary tool to evaluate Quit Coaches in 20 skill areas. Examples include: thoroughly assessing information about the participant's tobacco history and current use patterns; incorporating assessed information into a quitting plan, tailored to the needs of the individual; expertly applying information about quit medications and adhering to clinical protocols to help the participant access and use quit medications

effectively; expertly applying information about the impact quitting will have on certain chronic diseases and pregnancy; engaging the participant in the quitting process by using motivational interviewing and cognitive-behavioral therapy principles to facilitate behavior change.

In weekly meetings, our director of call quality conducts call monitoring calibration sessions with supervisors to consistently and accurately interpret and apply quality expectations. Supervisors also receive individual oversight of their work via ad hoc requests to provide input about an evaluation and through random checks of their completed evaluations.

Quality Assurance and Review of Services: Our commitment is to provide each participant the best Quitline experience possible. We achieve this through adherence to a quality assurance plan that tracks key performance metrics in three categories: reach, engagement, and outcomes. We are committed to transparency and all categories and metrics will be reported to TFN quarterly via our Performance Management Report. Should there be any issues, a process improvement plan will be initiated immediately to determine the root cause and we will devise a solution to remedy the issues. This resolution will be implemented and we will communicate with TFN throughout each stage in this process.

As we discussed in our response to Question 12 in this document, we constantly monitor and measure service metrics in: reach, engagement, or outcomes. Reach metrics are associated with verifying that we achieve high enrollment volumes. Metrics monitored are related to telephony service metrics, such as live response, timeliness to respond to referrals, and percent of participants enrolling from our online enrollment platform.

Since the chances of successfully quitting increase as participants interact and engage with more quit tools and resources, monitoring engagement is a critical component in evaluating the health of our services. Metrics monitored include call completion, engagement with our web-based services, percent of participants opting in for text messaging, and percent receiving NRT.

Optimal outcomes are, of course, our end goal. We strive to help more people be successful in quitting tobacco for good. We actively monitor the quit and satisfaction goals of our services.

As a current client of Optum, TFN currently receives our Quarterly Performance Management Report, which is a report that provides transparency and visibility to our clients on service metrics. Due to the changing landscape of Quitline services beyond telephonic counseling, Optum has revised the metrics we will monitor should we be awarded the contract. These metrics will fall into the three categories stated above (reach,

	engagement, outcomes) and will be more relevant to where our product and operations teams spend time in monitoring program performance to help us provide the best participant experience. [redacted]
	Technical Assistance for Health Care Professionals
25.	Bidder to describe how the Quitline will provide technical assistance and consultation to TFN staff working with healthcare professionals on a variety of effective tobacco dependence treatment issues.
	Bidder Response: (This Question addresses elements from Subsections V.A.2., V.F.9., V.F.13., and V.G.) We have 30 years of experience supporting our Quitline clients in educating the health care community about Quitline services. We are experts in systems change and have a department devoted to the design, development, and delivery of health care provider training and technical assistance. We offer a variety of ways we can assist TFN staff working with health care providers. For example, we can offer technical assistance aimed at health care providers to assist them with implementing systems to support the routine identification and treatment of patients who use tobacco. We have conducted training sessions geared toward the staff of our state partners to validate that those interacting with health care providers are aware and educated on Quitline services. We also routinely attend state tobacco control meetings and stakeholder conferences to interact with attendees and provide presentations on Quitline services. In Nebraska, we can also interact with MCOs, either in collaboration with TFN staff, or on behalf of TFN staff, to educate MCO staff on Quitline services and the Nebraska Medicaid NRT benefit. We are happy to participate in up to two state conferences or symposia to educate or inform administrators, health care professionals, insurers, and other stakeholders about the Quitline and available services. We also offer other innovative training and outreach services using online training (such as webinars) and in-person academic detailing to build sustainable systems in health care practices to allow providers to identify tobacco users, advise them to quit, and refer those willing to quit to the Quitline or other resources. These tailored training services may include a) CME accredited online training on the brief tobacco intervention, b) supplementary webinars, c) a health care provider website to host the training and provide resources and

	content specifically designed for clinicians, d) toolkit dissemination, and e) highly trained outreach specialists performing academic detailing onsite or remotely to clinics in prioritized areas of a region. This approach is designed to provide early, actionable results and to sustain these results over time. We are happy to discuss supporting TFN's goals and objectives in this regard. Additionally, we have a department devoted to the design, development, and delivery of health care provider training and technical assistance. These services include providing technical assistance to health care systems to assist them with implementing systems to support the routine identification and treatment of patients who use tobacco. We would welcome the opportunity to work with TFN on expanding provider outreach initiatives in Nebraska. In conclusion, we see a great opportunity for Optum to provide additional consultation and technical assistance to TFN staff through additional training, interaction, and collaboration, which we believe could yield great benefit in providing to TFN staff the knowledge and insight necessary to successfully collaborate with Nebraska's health care providers.
26.	Bidder to describe the medical director's role in working with the Quitline staff and healthcare professionals to resolve complex issues.
	Bidder Response: (This Question addresses elements from Subsections V.F.4. and V.F.9.) Daniel Sullivan, MS, MD, has served as our Clinical Medical Director since 2006, and provides oversight and backup for our clinical team. Dr. Sullivan leads our Clinical Team in consistently reviewing and updating our protocols in the following areas, which are then formalized and passed down through training updates for our Quit Coaches and Supervisors: • **Pharmacotherapy:** Dr. Sullivan's team stays abreast of new developments in NRT and other medications intended for use in quitting tobacco, including any contraindications related to NRT we provide, as well as contraindications for other popular quit medications available by prescription in which callers may express an interest Dr. Sullivan's team validates that our protocols protect the health and safety of Quitline callers, and that they meet or exceed the latest FDA standards and information. For instances which fall outside the existing protocols, Dr. Sullivan and the Clinical Team can advise on specific cases, or consult with a participant's health care provider, with the participant's permission, regarding any medication concerns. Some of Dr. Sullivan's team's efforts in this regard have resulted in the NRT screening protocol explained in detail in Section 12. (h). later in this proposal.

	• **Complex issues:** Dr. Sullivan's team provides training information and guidance on callers with chronic or multiple conditions, including mental health issues, to verify that any NRT or Quit protocols are in harmony with each participant's health concerns and treatment. For participants with complex health concerns who have a designated health care provider, or especially in cases of referrals from health care providers, Dr. Sullivan or his Clinical Team can work in consultation with the participant's health care provider to address any potential issues, again, with the participant's permission. Dr. Sullivan's Clinical Team is available 24 hours a day to assist Quit Coach staff in addressing health events, questions that need clinical input, or urgent medical concerns. In some instances, our clinical team can resolve an issue via a chart review, a conversation with the Quit Coach, and/or a review of the recorded call. If necessary, they may call the participant directly, or call the participant's health care provider as indicated above, to coordinate care.
27.	Bidder to describe how the Quitline will provide participant information with their healthcare provider and/or MCOs
	Bidder Response: (This Question addresses elements from Subsections V.D., V.F.1., and V.F.9.) When a provider refers a patient to Quitline services (via phone, fax, e-referral, online, or secure email), our staff contact the referred individual within 24 business hours of receipt of the referral. We make three to five attempts at different times to contact the individual prior to considering the individual "unreachable." Because we manage the process in our database, we are easily able to track attempts and report outcomes. After the referral, we generate a "Referral Outcome Report" and send it to the HIPAA-verified provider (or MCO) within 1 week of reaching or registering the individual for services. The report includes information referral disposition, medication sent, quit date, quit status, and referring health care provider. Optum then generates a second outcome report to the same provider (or MCO) based the result of the third call with the participant. Each month, we also produce summary reports of fax-referral outcomes by services and by referring provider. We believe that the fax and electronic referral programs are integral to the success of TFN's tobacco cessation program. They provide a direct link to Quitline services resulting from the provider/patient relationship, while removing the burden of the initial call being made by the patient. We are confident that our experience in electronic referrals and standard referrals would allow us to work in consultation with TFN and partnering organizations to increase the number of electronic and standard fax referrals and subsequent enrollments to Nebraska Tobacco Quitline. We also have the capacity to receive electronic referrals via an

	Electronic Health Record (EHR), provided that the referring entity has the technology to support the sharing of data using our standard data feed layout and can transfer data to us via HIPAA-compliant methods. **Phone Referrals:** For phone referrals, providers can contact Optum using the Quitline toll-free number. If the physician or clinician is seeking information about the program or ways of referring a patient, the Intake Registration Specialist provides the information and reviews the processes for referring a patient, including the options of referring the patient via eReferral, fax referral, or the web. The Specialist also offers to send the provider information regarding the program and tobacco use that the clinician can use or provide to the patient **Special Circumstances:** As described in Question 26 above, in certain cases, such as pharmacotherapy issues (like contraindications) or participants with chronic conditions, our Quit Coaches, Supervisors, or our Clinical Staff can contact a participant's health care provider directly, **always with the participant's prior permission**, regarding any specific concerns and to coordinate the participant's treatment with the participant's provider or MCO. **Coordination of Care** When speaking with a provider or third party to coordinate a participant's tobacco treatment care, Optum carefully follows HIPAA guidelines to only discuss private health information (PHI), if it is deemed necessary and appropriate. For example, this interaction may be to assist with the necessary steps that the provider is required to make a tobacco cessation medication benefit available to the participant. Our staff has clear guidelines about HIPAA and PHI disclosure to safeguard participant privacy. When speaking with COC (coordination of care) providers, our coaches and supervisors must always take measures to reasonably ensure they are speaking with a valid provider and only discuss the "minimum necessary" information to resolve a care coordination issue. The following steps are part of our provider interaction protocol: • Verify participant's (patient's) information by obtaining name and two additional pieces of participant's Protected Health Information (PHI) • Verify COC Provider information — including name of company/clinic, representative's name, title, and phone number and document this • Perform an intuition and file notes check to see if it makes sense why we are being asked to provide the requested information

	• If the information gathered doesn't "add up," our Coaches will err on the side of caution, note the caller's contact information, and consult with a Supervisor to determine if the request is necessary and appropriate for follow-up An example: Provider is asking if we have received the PA (Prior Authorization) they sent. The coach sees a file note indicating the PA was received and participant was enrolled. The coach may confirm this with the provider.
28.	Bidder to describe the online training for healthcare providers; how it will be developed, monitored, analytics tracked and reported, and continuing education will be processed/provided.
	Bidder Response: (This Question addresses elements from Subsections V.A.2., V.D., and V.F.9.) Optum has more than 30 years of experience supporting our Quitline clients in educating the health care community about Quitline services. We are experts in systems change and have a department devoted to the design, development, and delivery of health care provider training and technical assistance programs. We have worked with over a dozen states to create engaging, continuing medical education (CME)-accredited, interactive online trainings for health care providers and patient-facing staff. Through our web-based format, we provide broad, unlimited, remote access to the trainings. Optum has the capacity to develop trainings that address topics, including, but not limited to, the Brief Tobacco Intervention (BTI), the cessation services experience, cessation services referral methods, systems change for nicotine addiction treatment, and provider specialty-specific modules. The trainings may be augmented with additional topic-based modules, as client priorities change. As described in our response to Questions 3 and 25, we would be happy to discuss building a customized online provider training, oriented to providers who see Medicaid members, for the state of Nebraska. **Optum Training Services:** Optum's Training Services Division specializes in evidence-based tobacco cessation education and outreach for providers and their clinical staff. Optum currently manages 11 training contracts, working with state health departments, health systems, grantees, and other partners in nine states and districts. Our team comprises an accomplished Program Manager, Technical Training Manager, Training and Content Developers, and Evaluators. Throughout the past 20 years of operating provider training services, we have engaged over 16,000 health care providers and staff. (CONFIDENTIAL CONTENT BEGINS)

	Online Training Development: In working with our state clients to develop online trainings, we complete the following activities: • **Needs Assessment:** Optum conducts a comprehensive needs assessment to understand current tobacco treatment and ultimately increase the quit attempts among individuals served by state organizations. Key stakeholders include state clients, health care providers selected as a representative of those served by the training, and other identified stakeholders. • **Content and Script Development:** This task includes customizing Optum's BTI training content by developing new content and utilizing existing content and narration scripting to reflect state branding (e.g., cessation services branding), writing scripts relevant to the state, and for audio or video demonstrations of three patient-provider demonstrations and interactions. Existing cessation services calls and/or sample calls can be leveraged and utilized. • **Training Design and Development:** This includes the graphical, instructional, and interactivity design and development of the training, as well as coordinating the actual training build (e.g., placement of audio and animation). Optum can work with state clients to include tailored graphics, colors, and logos and provide interactive knowledge assessments with customization in this development. • **Talent Selection and Production Preparation:** Optum works to identify, screen, and select talent to conduct agreed-upon narration. We work with the state client to identify appropriate "health care professionals" and "patients" for the provider demonstrations to meet the demographic needs of the state. • **Audio Production (as needed):** When a narrated training is developed, Optum engages a production team to provide narration recording, call demonstration recording/editing of existing calls, provider interaction recording, editing, and incorporating content into the training. • **Photos:** Optum acquires (purchases or photographs) and edits general training photos, as well as photos for the call demonstrations and provider interactions. In addition, we insert the photos into the training and sequence them with any agreed-upon audio. • **Usability Review:** We facilitate a review process with the stakeholders involved in the training design. As part of the review, Optum coordinates the collection of feedback, consolidates feedback, and modifies the training (as determined appropriate and approved by the state). Typically, there is

additional review of the finished product by the state's Medical Director and/or Public Information Officer.

- Our online training services include hosting, maintenance, and tracking of the trainings in general as well as the application, maintenance, and tracking of CME accreditation. Optum hosts the online trainings on a server and provides regular maintenance and enhancements. The trainings are updated as necessary to reflect branding changes, changes to contact information, updated links, and like information. Optum tracks and delivers provider/trainee usage rates on a quarterly basis, through hosting and maintenance reports. These reports include the following:
  - Items added to the trainings, items deleted from the trainings
  - The dates of any training updates
  - Online total views, unique viewers, and training completion numbers
  - A list of professionals who successfully completed the accredited training and quiz/evaluation during the quarter
- To ensure that busy providers are motivated to engage in our trainings, we focus on reducing barriers to access. Providers can opt into completing an information/demographic form with data remembered by our training application each time the provider opens the training with the same system. The application also allows providers to pick up learning where they left off. For the convenience of providers, the trainings are designed to be accessed via desktop, laptop, tablet, or smartphone. In addition, we find that offering continuing education credits motivates providers to participate in the online training. Thus Optum prepares and maintains the online training for CME accreditation by the American Academy of Family Physicians. Optum develops and programs the CME quiz, and the CME evaluation required for accreditation. Additionally, Optum will complete the CME application, submit the application to the American Academy of Family Physicians, and be responsible for application fees. Per AAFP requirements, Optum maintains a list of providers who qualify for the CME credit. Upon completion of the credit requirement, the provider may print a certificate of completion to present to their licensing body. (CONFIDENTIAL CONTENT ENDS)

We would be happy to discuss building an online training program for Nebraska-area providers, and, if of interest to the Department, we could tailor it to Medicaid providers. Our online trainings typically run 45 to 60 minutes and include the following modules: *Why Treat Tobacco?*; the *Brief Tobacco Intervention*; *Making a Referral*; *Knowledge Assessment Quiz*; and an Appendix with links to tools and resources for providers.

	Optional modules on special topics such as communicating with Special Populations or Pharmacotherapy are available on an add-on basis. We are happy to include custom tutorials that focus on Medicaid topics such as benefits, how to use enrollment or referral systems, or other special Medicaid protocols as needed. Providers who take the training may receive continuing medical education (CME) credit for this training, which is accredited through the American Academy of Family Physicians (AAFP).
	Support Materials
29.	Bidder to describe what resource materials are available for, or will be developed and will be provided to: a. Proxy callers b. Healthcare professionals c. Tobacco users, not ready to quit d. Tobacco users, ready to quit but not interested in ongoing counseling e. Specific populations (e.g. racial and ethnic minority groups, mentally ill, and rural populations).
	Bidder Response: (This Question addresses elements from Subsections V.B., V.E.1., V.E.3., V.F.3., V.F.8., V.F.11., and V.F.13.) Optum offers a variety of self-help and support materials to Quitline callers to facilitate or enhance their quit efforts, including those indicated in **Table A.1.29. – Support Materials** below.

Table A.1.29. – Support Materials

Material	Intended Audience	Developed By
You Can Quit Smoking	All callers/tobacco users,	Optum
Usted Puede Dejar de Fumar	Spanish-speaking tobacco users	Optum
Need Help Putting Out That Cigarette?	Pregnant tobacco users	American College of Obstetricians and Gynecologists and Smoke-Free Families
Quitting Smokeless Tobacco (also available in Spanish)	Those who use smokeless tobacco only	Optum
Life Matters – Tips and Tools to Help You Quit Commercial Tobacco	American Indians who use commercial tobacco	Developed in collaboration by the University of Arizona Healthcare Partnership and Indian Health Services
LGBTQ COMMUNITIES: Motivation to Quit Smoking	Gay, Lesbian, Bisexual, Transgender, Queer who use tobacco	National LGBTQ Tobacco Control Network (partially funded by the CDC)
Ally Guide: A Guide to Help You Help Them Quit	Those supporting another's effort to quit/Proxy callers	Optum

All callers are eligible to receive certain printed materials upon request. These materials are shipped directly to the caller via U.S. Priority Mail on the first business day after the request is submitted.

For health care professionals, we offer any or all of the materials we have developed for our Quitline populations, from the Quit Guide, which supports all Quitline callers, to the specific materials developed for anyof our priority populations indicated above. As a part of our Training and Outreach services and work to develop an online training, we can also discuss what materials for health care providers may be needed.

30.	Bidder to provide copies of all self-help and other support materials listed in Request for Proposal. Clearly label the materials to indicate the intended audience.
	Bidder Response: (This Question addresses elements from Subsections V.F.3., V.F.8., V.F.11., and V.F.13.) Optum has provided copies of support materials in Appendix A.1.30. Self-help and Support Materials as specified in RFP 6204 Z1, including materials for: • Proxy callers • Health care professionals • Tobacco users, not ready to quit • Tobacco users, ready to quit but not interested in ongoing counseling • Specific populations (e.g., racial and ethnic minority groups, mentally ill, and rural populations).
	Quitline Promotion
31.	Bidder to describe how the Quitline will work with TFN to respond to calls generated as a result of paid media promotion, earned media promotion, and promotion through health systems.
	Bidder Response: (This Question addresses elements from Subsections V.B., V.D., V.F.1., V.F.12. and V.F.13.) Throughout the course of the contract, our Client Manager stays in close contact with TFN to discuss any planned media that may impact call volume. Where there is planned media around the Nebraska Tobacco Quitline, the Client Manager translates this promotional information into a detailed enrollment forecast provided to our operational and finance teams to determine the necessary increase in staffing levels needed to support the promotional event. Although we appreciate advanced knowledge of promotional events, we understand that early knowledge is not always possible and have additional short-term staffing levers that we can immediately activate in times of high call volume. Should TFN give Optum only a few days advance notice for a promotional activity we alert our service delivery staff to expect a boost in response. At no added cost to TFN, we boost short-term capacity by offering overtime to our full-time staff and extra hours to those who normally work part-time. If needed, we can use supervisors and trainers to increase capacity and we call upon analysts and managers when needed. Beyond those resources, we have a pool of cross-trained staff members, many who formerly served

as Quit Coaches or Registration staff, who can step in when circumstances dictate. Optum has supported and will continue to support Nebraska's efforts to ensure maximum utilization of Quitline funding through different campaigns.

An important distinction for Optum is the size of our infrastructure and staffing, which allows us considerable flexibility and enables us to successfully accommodate changing call volumes.

Optum has a vast and stable technology infrastructure that supports the overall operation of our Quitline services, including any required changes in staffing related to call volumes. In 2019 alone, we processed more than 452,535 incoming calls to our tobacco cessation phone lines using our technology infrastructure. Our technical foundation includes the following capabilities:

- Technical systems
- Phone System
- Automated Answering System
- Interactive Online Training
- Workforce Planning
- Integrated Voice and Data Systems
- Voice Messaging
- Web Services
- Quality Management Systems
- Data Warehouse and Reporting Systems

Through our staffing plan, we move staff between inbound and outbound work modes if incoming call volumes are higher or lower than forecasted. We continually monitor our performance and can adjust routing of calls to protect service levels across all clients. For example, if a surge in call volumes from one state exceeds other proactive measures, we will lower the priority setting on our phone switch for calls from that state. This allows calls from other states to move ahead in our call queue, thereby minimizing impact on other state clients. During periods when an individual client or event is driving higher than forecasted demand, we proactively communicate our management plan and resulting performance to our clients.

Optum has the resources and capabilities to respond quickly and effectively to short and long periods of high demand prompted by state or national promotional campaigns or current events.

An example of our successful staffing during a time of high call volume is the Centers for Disease Control and Prevention's (CDC) national TIPS campaign that occur annually and produces unprecedented call volumes within many states, including Nebraska. The initial estimate for the campaign was an increase in call volumes of between 7 percent and 30 percent. However, we have routinely seen significantly higher call volumes. For example, during the first weeks of the TIPS campaign, we experienced an average increase of

	42 percent in our call volumes as compared to the previous week. We plan for this increase and adjust our staffing accordingly, minimizing any impact on our response or call abandonment rates. We also initiate our Operations Playbook activity, which is a standard set of actions Operations takes when volume exceeds forecasted levels. These tactics include offering overtime, suspending all off phone time (e.g. team meetings), suspending all time off and asking Supervisors to assist in providing coaching. We proactively have a plan in place to respond quickly to demand.
32.	Bidder to describe how the Contractor can assist TFN or media Contractor to assure effective coordination with media promotion, promotion to healthcare professionals, and other tobacco control activities in Nebraska.
	Bidder Response: (This Question addresses elements from Subsections V.A.2. and V.F.13.) Promotion of Quitlines is at a turning point as fewer people are watching local TV, listening to local radio or reading local print news, all of which have been the traditional ways in which states have promoted services. The CDC's TIPS Campaign has done a fair job of filling the gap of declining volume and reach, but entering its 9th year, year-over-year volume is beginning to decline, thus, tobacco control as a whole needs new strategies to help promote and market services in the ways in which people of today are obtaining health related information. Optum is evolving in how we have historically supported our states with promotion. In the past, we played more of a supportive role, collaborating and responding to the volume generated by local media vendors selected by our state clients. But in today's world, where people are going online to access information and services, we are expanding and leveraging some existing capabilities we have in consumer marketing, consumer engagement and social and digital media to our state quitlines. In 2020, we are piloting a digital campaign for South Carolina in order to drive increased reach and enrollment through social media promotion, where we will be responsible for driving digital marketing strategies for the state. We are also engaging organizations that are already leaders in the field, like Rescue, to explore best practices and how our organizations can work more closely, particularly in States where we both have a presence. We look forward in sharing the results of these marketing pilots. Until then, we welcome TFN's marketing vendor join us in our monthly calls to make sure we stay coordinated around promotion. **Health Care Professionals:** Providers may call the Quitline to get general information about services or to look for tobacco cessation information and materials to support their patient/client populations. Our coaches are trained and provided with resources to support these calls with physicians and health care professionals.

	Optum also has the ability to connect health care professionals with a representative at TFN for additional information. Optum also has extensive experience developing provider materials or toolkits to support tobacco treatment practices and coordination with the Quitline. These materials may include promotional flyers, brief tobacco intervention job-aids, resource lists, fact sheets, presentations, and posters. Individualized printed materials for specific provider types (e.g., behavioral health, oral health, and Medicaid providers) have been designed to help these providers engage their particular patient populations or to support specific tobacco control campaigns. **Other Tobacco Control Activities:** As the largest Quitline provider in the country, Optum is in a unique position to monitor tobacco control efforts in other states, or nationally, such as the recent law enacted raising the national minimum age for purchasing tobacco products from age 18 to age 21. We understand that tobacco cessation programs such as Nebraska's Tobacco Quitline are just one part of a comprehensive tobacco control effort, which includes education and policy/law changes. Our national presence and cumulative experience afford us the expertise to consult with states on tobacco control activities in their state and the pros and cons of such strategies, including: • Tobacco prevention programs • Tobacco taxes • Smoke-free air policies • Establishing vaping products purchase guidelines • Tobacco retailer licensure requirements We have collaborated with our state partners when other local tobacco control activities are initiated, including asking whether an increase in tobacco tax is the reason for their call, asking whether the individual lives in public housing, and modifying eligibility based on age with regard to Tobacco 21 laws. We look forward to staying connected with TFN to understand the entire picture of tobacco control in the State, not just limited to tobacco cessation services.

	Reporting Requirements
33.	Describe the applicant organization's computerized tracking system to document Quitline activity, including the ability to tabulate discrete individuals, services provided, call patterns, caller demographics, and the analysis and reporting of data on a monthly, quarterly, and annual basis.
	Bidder Response: (This Question addresses elements from Subsections V.F.5., V.F.6., V.I., and V.K.) Optum designed our flexible and scalable proprietary participant database to track participants from intake through discharge to ensure that each call is a streamlined and effective experience for the participant and to meet the reporting and call auditing needs of our clients. The database maintains the data set recommended by NAQC, and for Nebraska, includes data collected from our phone system, our web portal, our participant database, and our referral network. The system consists of a relational database application, completely custom-designed for the data requirements of our clients, and includes four user interfaces that support our phone-based coaching program. We optimize the system's interfaces or tabs for the needs of our service delivery team because we built them ourselves instead of relying on a standard, off-the-shelf application. The registration tab collects the data needed to enroll a caller. The client-specific greeting and list of questions changes dynamically based on participant responses. For example, if a caller reports that he is male, questions regarding pregnancy vanish. Quit Coaches utilize the other three tabs to gather quit status data, guide the NRT screening and dosing process, track prior call history, and to record notes during and after calls. We have provided a list sample of database elements we collect in the **Table A.1.33. – Database Elements** below, and are happy to provide a complete copy of our Data Dictionary with all data fields explained in detail upon TFN request.

Table A.1.33. – Databse Elements

NEBRASKA TOBACCO QUITLINE DATABASE ELEMENTS			
Consent to follow up	Secondary phone	Race	Cigar frequency
Account name	Secondary phone type	Ethnicity	Pipe frequency
Registered on date	Can leave message	Education	Slt frequency
Person id	Address 1	Sexual orientation	Past quit method
Legacy person id	Address 2	Health plan	Cigarettes per day
First name	City	Other tobacco users	1st cig after waking
Last name	State	How heard about	Language
Email address	Zip	Caller type	Start age
Email ok to contact	County	Stage of change	Motivation
Primary phone	Birth date	Quit duration	Confidence level
Primary phone type	Gender id	Quit attempts	Entry method
Primary phone best time	Pregnancy group	Cigarette frequency	

Data from all our systems feed into a central data warehouse that leverages Microsoft SQL Server, Reporting Services, and Analysis Services to provide a robust operational reporting and decision support platform. This platform allows us to not only meet TFN reporting requirements, but also the requirements set by the CDC for states awarded funding.

Our custom-made database allows us to view all interactions that take place for a participant in the single interface. As a result, Intake Registration Specialists and Quit Coaches can gather new information into the file and can easily review past Quit Coach documentation on quit status data, NRT screening and dosing process, prior call history, and additional important notes during and after calls. This system allows any agent to answer a call from a Nebraska resident and to immediately have all past and current information about the participant from intake to the final call be available to them allowing for a seamless interaction with the participant.

34.	Describe precautions to ensure that files and programs can be re-created in the event of loss by any cause, including plan to safeguard data files (frequency of back-up copies, storage location, methodology for restoring from backup copies when activity has been processed in the interim.)
	Bidder Response: (This Question addresses elements from Subsections V.D., V.E.1., V.F.2., V.F.5., and V.I.) Optum is the largest provider of Quitline services in the country, managing 25 separate and unique Quitlines for our state partners. As indicated above in Section 3 (c), and due to our national presence and infrastructure, our data backup and data recovery systems include redundant servers and data warehouses in different parts of the country to protect and store confidential participant data and information within high levels of security. Optum affirms that as a founding member of NAQC, our data collection and storage practices are compliant with NAQC Minimal Data Set (MDS) standards, as well as fully compliant with HIPAA regulations. In 2019, we provided comments on the NAQC MDS Update Recommendations and are awaiting final recommendations before making updates to our systems to remain fully in compliance. The site and server software that we use to proactively monitor all critical infrastructure components operates on a 24/7 basis. This monitoring software checks the functionality of hardware systems, including, but not limited to, servers; PBX (telephony); network equipment; and, software infrastructure systems including database software, line-of-business applications and web server page rendering responsiveness. Our system also includes processes and plans to address natural and other emergencies, such as floods, fire, weather-related, electrical, or other changes and disruptions to Quitline services. These plans ensure that there is no disruption in access to or delivery of Quitline services during such events. These plans include technological backups that protect and store participant data and information within high levels of security. Our production hardware is Intel-based, enterprise-class, with dual power supplies, network interfaces and redundant server storage at our main site in Minnesota. The current configuration has 24GB of memory, operates with 24 cores, and runs the Microsoft Windows Server 2008 R2 operating system. We do complete system backups on a weekly basis, with incremental backups done on a daily basis, and hourly archive backups. In addition to traditional backups, we also replicate all data into our ad hoc database, used for reporting.

35.	Describe systems to ensure confidentiality of caller records.
	Bidder Response: (This Question addresses elements from Subsections V.D. and V.F.5.) We have been at the forefront of collecting and housing sensitive or confidential data for more than 30 years and have invested in the best safeguards available to protect that information. Our policies and procedures adhere to all applicable federal and State laws and administrative rules governing confidentiality. We maintain extensive information technology policies and procedures that test the vulnerability of our operating systems, applications, and network devices that support our Tobacco Quitline activities. These policies and procedures are routinely reviewed and updated as required to meet the highest industry standards and Nebraska requirements. At Optum, vulnerability assessments are conducted during development and deployment and monthly throughout the life of the information system. Penetration tests of Optum's external web portals are performed annually by a third party selected from a list of three to four industry-leading security vendors and internal Ethical Hacking team. Standard operating procedure is to select specific portals to be included in each annual test. The external vulnerability scanning, performed as part of the penetration tests, includes scans for web application vulnerabilities in accordance with the Open Web Application Security Project (OWASP) guidance. In addition to the external network penetration test, Optum performs periodic penetration testing, application web-based scanning, and static code analysis for highly visible portals. In addition, Optum maintains extensive policies and procedures that test the vulnerability of our web-based services. These policies and procedures are routinely reviewed and updated as required to meet the highest industry standards. Optum deploys a multi-layered security approach for network perimeter protection. This approach includes Firewalls, Proxies, Intrusion Detection Systems/Intrusion Prevention Systems, Content Filtering, Email Protection, Anti-Malware, Multi-layered Demilitarized Zone (DMZ), Web Application Firewalls, and other tools. Optum utilizes a Network Access Control program internally referred to as Enterprise Admission Control (EAC). EAC is designed to control and monitor which computers and devices connect to the Optum internal network, further protecting the internal network from unauthorized access. Antivirus software is installed on all user computing devices. Optum has deployed endpoint antivirus (AV) protection on all devices, which monitors for compliance on a routine basis. AV deployment adheres to the enterprise standard and assures a centralized management tied to formal access control. End-user

	management is disabled. The antivirus software is both heuristic and signature based. The AV program is incorporated into Optum's formal incident response process. Access to information technology systems may only be granted when based upon documented business justification and approved by Management. Users are granted minimum necessary access to allow them to perform their job responsibilities. To access Optum information technology systems, all users must authenticate with a unique user ID and password to verify the person or entity seeking access is the one claimed. As an HIPAA-covered entity, we have privacy and security policies to maintain the confidentiality of protected health information (PHI) of individuals participating in our programs. We have established and implemented administrative, technical, and physical safeguards to support HIPAA privacy rules. For compliance purposes, we have privacy and security officers, and have established and implemented administrative, technical, and physical safeguards to support privacy and security. We secure electronic and paper participant records that contain PHI, and limit the use and disclosure of information, as required. All hardware is handled as if PHI is physically stored on it. Hard drives of all company laptops are encrypted and all mobile devices are required to have password and encryption protection. All removable and fixed storage media is electronically and physically destroyed if it is no longer being used. All new staff members receive HIPAA training, sign a confidentiality statement, and are required to adhere to privacy and security policies and procedures. HIPAA training is required annually, and in some cases more frequently. Our business associates are required to sign confidentiality agreements requiring compliance with HIPAA privacy and security regulations.
36.	Describe the organization's current process for issuing a Notice of Privacy Practices and obtaining permission from participants to be contacted for evaluation.
	Bidder Response: (This Question addresses elements from Subsections V.E.1. and V.F.5.) Optum sends a notice of Privacy Policy to all participants in the Nebraska Tobacco Quitline in one of two ways: • They are either sent to the address provided by the participant with Quitline reading materials after a participant enrolls telephonically (with the Quit Guide and Ally Guide), or • They are presented for review (with an option for a printable version) when a participant enrolls online, and must be agreed to before the participant can continue with the online enrollment process

	During either the telephonic or online registration process, we ask each participant, "Is it okay to contact you in the future to evaluate our services?" to which the participant may either give a yes or no response. Participants who respond with a "no" are not contacted for evaluation. We also ask participants for consent to contact them via email for the tobacco cessation program in general. Participants who consent to evaluation but do not consent to contact via email would be contacted for evaluation by phone, but would not receive email invitations to complete the evaluation survey online.
37.	Bidder to provide a sample of the monthly report, with definitions of each item contained in the report, with proposal response.
	Bidder Response: (This Question addresses elements from Subsections V.F.5., V.F.8., V.H., and V.I.) We currently provide to TFN an array of monthly reports addressing multiple Quitline metrics with both aggregate and granular data. We pride ourselves on our data management and reporting capabilities and we are able to run the majority of our reports for any time period TFN requests (weekly, monthly, quarterly, or annually). We have included **Table A.1.37 – Monthly Reports** below delineating the monthly reporting suite we provide to TFN, and have also included sample monthly reports we currently provide as Appendix A.1.37.a. Samples of Monthly Reports, along with a Data Dictionary containing related definitions as Appendix A.1.37.b. Data Dictionary. We look forward to sharing some proposed changes to the reporting package we believe will better illustrate our performance and metrics achieved through the Nebraska Tobacco Quitline.

Table A.1.37 – Monthly Reports

Report Name	Description	Frequency (Monthly)
Dashboard	Gives stakeholders, decision makers, and clients a snapshot of Quitline service activity, comparisons to state BRFSS data, and progress toward reducing the number of tobacco users in the State	Monthly
County Utilization Dashboard	Gives stakeholders, decision makers, and clients a snapshot of Quitline service activity, comparisons to state BRFSS data, and progress toward reducing the number of tobacco users in the State broken out by County	Monthly
Caller Type by County	A count of callers by type (Tobacco User, Proxy, Provider, General Public, or Other) by County. This report also runs for web	Monthly
State Demographic	Aggregate demographic account of registered participants	Monthly
State Demographic Integrated Web	Aggregate demographic account of integrated web participants	Monthly
State Demographic Pregnancy Program	Aggregate demographic account of registered participants in the pregnancy program	Monthly
E-cigarette Summary	Count of participants' responses to the question "Have you used an e-cigarette or other electronic vaping product in the past 30 days?"	Monthly
How Heard About by County	Count of registered participants' self-reported answers to the question asked at registration "How did you hear about the program?" by region	Monthly
Mental Health	Count of Participants' responses to the Substance Abuse, Mental Health, and Emotional Challenges question, reported by County	Monthly
Referral – Services Requested at Registration	Aggregate breakdown of service type requested at registration for referred participants by clinic/provider	Monthly
Referral Report	Aggregate breakdown of monthly referral handling and participant outcomes by clinic/provider	Monthly
Services	Comprehensive breakdown of the services provided to registered participants. The monthly report includes the breakdown of NRT fulfilled	Monthly

Table A.1.37 – Monthly Reports (Continued)

Report Name	Description	Frequency (Monthly)
State Services Pregnancy Program	Comprehensive breakdown of the services provided to registered participants. The monthly report includes the breakdown of NRT fulfilled. Ran for pregnancy program	Monthly
Tobacco Users by Health Plan	Count of registered participants' self-reported answers to the question asked at registration about health plan (health insurance) coverage. This report also runs for web enrollments	Monthly
Medicaid Billing Report	Monthly breakout of costs of services and NRT utilized by Medicaid participants	Monthly
State NRT Shipments	Breakout of NRT shipment detail	Monthly
State Caller Type by County	Count of Quitline registrations by County	Monthly
Custom Questions Report	Currently this is a count of participants' responses to the question "Do you currently live in public housing (sometimes called subsidized housing)?" Custom Questions report can be any custom questions asked by Service Delivery	Monthly
State Quitline Experience Extract (Identified Data)	Data extracts with participant level identifiable participant level demographic and service utilization data	Monthly
State Quitline Experience Extract (De-identified Data)	Data extracts with participant level de-identifiable participant level demographic and service utilization data	Monthly
State Quitline Experience Extract Addendum	Data extracts with participant level de-identifiable participant level demographic and service utilization data (custom questions)	Monthly
State Quitline Recruitment Experience Extract	Data extracts with participant level demographic and service utilization data for both provider referrals and registrations/enrollments	Monthly

38.	Bidder to describe how data will be collected and provided on a monthly, quarterly and annual basis for data analysis to evaluate and improve services provided.

Bidder Response: (This Question addresses elements from Subsections V.E.1., V.F.5., and V.I.)

We have been collecting Quitline data since we began providing services for our first Quitline state client in 1998. As our systems and technology have improved, our data collection has become more sophisticated, allowing us to track virtually any data element our state clients need, and report on it at intervals specified by our clients. Our data analytics have also become more sophisticated, allowing us to do deep dives into a state's Quitline data to spot trends, issues, and successes.

At enrollment, we ask participants a set of basic questions that are in alignment with NAQC MDS recommendations. Baseline data collection includes demographics (gender, race/ethnicity, education, age), reasons for calling, services requested, how heard about, current tobacco use (type, frequency, amount) or last tobacco use, nicotine dependence, pregnancy status, and chronic conditions. We also track data through ongoing coaching calls with participants to determine how receptive they are to the services, information, and materials we provide. We have provided a list of data elements we collect during this process in Appendix A.1.37.b. Data Dictionary (Proprietary Information). These data elements, coupled with subsequent interactions with our Quit Coaches and our tobacco cessation systems, provides a wealth of information that allows us to report to TFN a great variety of monthly, quarterly, and annual reports on Quitline activity and participants, on either an aggregate or granular level.

> We have learned over the years that our most tangible deliverable to our Quitline clients is data, and we take pride in collecting and reporting this data in a transparent and high-quality manner.

As described in Question 33 in this document, data from all of our systems feed into a central data warehouse that leverages Microsoft SQL Server, Reporting Services, and Analysis Services to provide a robust operational reporting and decision support platform. From this central database, we are able to monitor and provide Quitline-specific metrics to TFN via monthly, quarterly, and annual reports and/or data extracts, including caller demographics, referral source, tobacco use status, tobacco use type, state of readiness, and quit status. We also provide in our response to Question 33 further detail on our data collection capabilities and practices.

Data Analysis for Evaluation and Quality Improvement: We analyze Quitline data for trends, potential problems, and success rates to determine areas that are working well and those that require greater emphasis, focus, or adjustment to better suit the needs of participants. Client Services Manager Jessica Benson will also review this data and make recommendations regarding Nebraska Tobacco Quitline goals

	and service changes. She will also provide TFN with information about innovative delivery systems, technologies, or cessation protocols to consider implementing in the future. Such data monitoring has led us to introduce new programs like the American Indian Commercial Tobacco Cessation Program, or to suggest enhancements in cultural competency training driven by various metrics we track with Priority Populations. Optum's standard report suite is comprehensive and flexible. We are able to run the majority of our reports for any time period TFN requests (weekly, monthly, quarterly, or annually). Our goal with this flexibility is to make sure we deliver worthwhile information to support TFN in meeting its goals and objectives for Quitline services. Reports we provide to TFN are listed in the tables below. Optum's standard reporting includes year-to-date data, including, but not limited to, Quitline reach, number and type of callers, services provided to those callers, insurance status, and demographic information. **Monthly, Quarterly, and Annual Reporting:** In addition to the sample reports expressed in the table in our response to Question 37 above and delineated in Appendix A.1.37.a. Samples of Monthly Reports, Optum can run reports on any of the data elements listed in the table above for any date range, including annually, and we look forward to meeting with TFN to determine their needs in this regard.
	Quality Assurance/Quality Improvement
39.	Describe the mechanism by which current, science-based, high quality services are maintained, such as use of a Scientific Panel or Advisory Board. Provide a list of Advisory Board members, if applicable.
	Bidder Response: (This Question addresses elements from Subsections V.A.1., V.C., V.E.2., V.F.6., and V.F.8.) Optum's tobacco cessation services are **evidence-based**, culturally appropriate, and incorporate effective strategies for nicotine addiction treatment as outlined by the United States Department of Health and Human Services Public Health Service (USPHS), Clinical Practice Guidelines for Cessation. These guidelines have been woven into our overall processes and protocols and are routinely reviewed and refined based on any updated standards. Our clinical and quality support team actively watches for updates to the USPHS Clinical Practice Guidelines and incorporates new recommendations into our protocols. We also regularly review the scientific and behavioral literature on treating tobacco use and dependence and assess new evidence or substantive changes to existing evidence to determine if it needs to be included in our protocols. Treatment protocols are modified when sufficient evidence exists that demonstrates opportunities for increased reach and effectiveness of our program.

	The Quit For Life intervention is based on the Clinical Guidelines, U.S. Public Health Service Clinical Practice Guideline 2008 Update: Treating Tobacco Use and Dependence. Our Quit Coach training curriculum has been accredited by the Council of Tobacco Treatment Training Programs (CTTTP) Association for the Treatment of Tobacco Use and Dependence (www.attud.org). ATTUD (Association for the Treatment of Tobacco Use and Dependence) established The Council for Tobacco Treatment Training Programs (www.ctttp.org/) as an independent panel of experts to conduct a rigorous review of training programs for Tobacco Treatment Specialists. Accreditation demonstrates that an independent panel has carefully reviewed the training program and determined that it meets the Core Competencies as established by ATTUD. Since 1986, the Quit For Life Program has delivered evidence-based care for all tobacco users. Our training program and treatment protocols are regularly reviewed to assure that they are consistent with scientific, evidence-based best practices. Accreditation by CTTTP is an endorsement of the quality of our coaching services. Our counseling for Quitline participants is grounded in Social Cognitive Theory (SCT) and emphasizes environmental, personal (cognitive/emotional), and behavioral domains as interactive components of long-term, successful behavior change. SCT has been widely tested and applied in tobacco cessation, and its constructs have been found repeatedly to be robust tools for enabling behavior change. Furthermore, SCT's dynamic constructs for improving emotional, cognitive/motivational processes, and behavioral competencies, and altering social conditions under which people live and work, make it an ideal overarching model for improving the well-being of individuals. Quit Coaches utilize cognitive behavioral therapy, motivational interviewing, and principles of self-efficacy to achieve effective behavior change for tobacco abstinence. Each counseling call is structured but not scripted, and addresses the environmental, personal (cognitive/emotional), and behavioral domain of SCT. This approach allows our coaches to respond to each participant's individual circumstances and needs as the call unfolds, while making sure that the intervention follows logical steps of exploring the participant's goals and needs, developing insight, and setting a concrete action plan. **Science-based, High-quality Services:** Dr. Katrina Vickerman is the Director of the **Optum Center for Wellbeing Research (OCWR)**, which focuses on externally funded research. Dr. Vickerman earned her master's degree and PhD in clinical psychology from the University of Southern California. OCWR has a total

	of nine staff and conducts rigorous scientific research and translates the results into evidence-based products and services: • Katrina Vickerman, PhD, Director and Principal Scientist • Terry Bush, PhD, Principal Scientist • Kelly Carpenter, PhD, Principal Scientist • Ryan Hedrix, Research Assistant • Johnathan Hsu, Research Assistant • Alula Torres, Senior Grant Manager • Lyndsay Miles, Grant Manager • Michael Kaplan, Grant Manager • Erica Salmon, Associate Grant Manager The OCWR focuses on externally funded research that aligns with the Optum mission to improve health care for everyone. OCWR's mission is to increase the use and success of health improvement programs so that people can live healthier lives. OCWR conducts rigorous scientific research and translates the results into evidence-based products and services. The OCWR team of highly trained scientists and research staff has expertise in clinical and behavioral research, program design and development, and program evaluation. OCWR staff conducts studies funded by the National Cancer Institute, the National Institute of Drug Abuse, and the American Cancer Society. OCWR has also completed projects funded by the CDC Office of Smoking and Health, and state departments of health. The Optum Center for Wellbeing Research currently has ten tobacco cessation research trials in progress examining questions such as: • The effect of tailored coaching and materials in assisting smokers who enroll in the Quitline using e-cigarettes and combustible cigarettes to achieve better smoking cessation rates (funded by the National Council on Drug Abuse and in conjunction with the Universities of Oklahoma and Florida) • The feasibility of Quitline callers who fail to quit with standard Quitline treatment then switching completely to e-cigarettes as a harm reduction strategy (funded by the National Council on Drug Abuse and in conjunction with the University of Oklahoma)

- The combination of treatment factors (number of calls, mono versus combo nicotine replacement therapy, text messaging, incentives) which best increases quitting success and maximizes treatment cost-effectiveness among low income smokers who previously failed to quit with standard Quitline treatment
- The effect of adding a culturally tailored video for African American smokers in improving quit rates over standard Quitline treatment

Previously published OCWR research studies include:

- A 2013 study on the number of Quitline callers who ever reported use of e-cigarettes at the time of the 7-month follow-up survey (funded by Optum) which revealed at that time that approximately 30 percent of Quitline callers had ever used e-cigarettes
- A 2016 study focused on quit outcomes for Optum's commercial tobacco cessation clients related to the reported usage rate of e-cigarettes to quit or reduce the number of tobacco cigarettes used and the effectiveness of e-cigarette use in quitting smoking as compared to e-cigarette use to reduce use of tobacco cigarettes and those who did not use e-cigarettes in their quit efforts. This study was funded by the CDC
- A 2017 qualitative study funded by Optum, the CDC, and the Oklahoma Tobacco Settlement Endowment Trust, interviewing Oklahoma Quitline participants who used both tobacco cigarettes and e-cigarettes at the time of enrollment in the Quitline
- A 2019 analysis of e-cigarette use across 24 state Quitlines based on data from 2014 to 2018
- In addition to OCWR informing our training and service enhancement, we also have a panel of national experts with whom we consult when working on intervention updates and innovations. Etta Short, our Clinical Program Consultant for Prevention and Wellbeing, has developed this network of industry leaders over the years through her experience in tobacco control and as a Board Member of the Council for Tobacco Treatment Training Programs. This panel includes the following contributors:
  - Tim McAfee, MD, MPH (former Director of Smoking and Health, CDC)
  - Dongbo Fu, MD, PhD, MPH (World Health Organization)
  - Christine Sheffer, PhD (Roswell Park)
  - Paul Fishman, PhD (University of Washington)

	– Optum's medical team members including: • Tanise Edwards, MD • Marva Ayers, MD • Dan Sullivan, MD Additionally, Mary Kokstis, our Senior Director of Product Management and State Quitlines, is a Board Member of the North American Quitline Consortium, and maintains working relationships with sections of the CDC that are affiliated with tobacco cessation.
40.	Describe the quality assurance plan as it relates to both Quitline operations and clinical service delivery. Provide a sample of a service performance report.
	Bidder Response: (This Question addresses elements from Subsections V.F.6. and V.F.8.) Optum is a metrics-driven organization that focuses on monitoring performance on an ongoing basis and using quality metrics to constantly improve our programs. On a monthly basis, our tobacco cessation product owner presents monthly and year-to-date outcomes of our product health metrics, compared to set targets. Areas addressed in our quality metrics tracking include participant enrollment and engagement metrics and clinical outcomes. A root cause analysis is conducted whenever significant changes in metrics are identified, and workgroups from the departments involved are assigned responsibility for resolving the issues. **Call Quality Program:** A critical element of our quality assurance plan is our call quality program, which consists of ongoing trainings, routine evaluation of recorded calls, and monthly meetings with a supervisor. We use recording software to digitally capture not only the audio portion of the call, but also the staff member's computer screen at the time of the interaction. This visual information complements the audio portion of the call and helps supervisors analyze the content of coaching sessions while also confirming the accuracy of data collected and documented by staff. **Centralized Audit Team** We use a standardized tool to evaluate Quit Coaches in call performance. These audits are performed by auditors from our Centralized Audit Team. Examples include the following elements: • Thoroughly assessing information about the participant's tobacco history and current use patterns • Incorporating assessed information into a quit plan, tailored to the needs of the individual

- Expertly applying information about quit medications and adhering to clinical protocols to help the participant access and use quit medications effectively
- Expertly applying information about the impact quitting will have on certain chronic diseases and pregnancy
- Engaging the participant in the quitting process by using motivational interviewing and cognitive behavioral therapy principles to facilitate behavior change

Optum's Centralized Audit Team performs calibrations and inter-rater sessions regularly to consistently and accurately interpret and apply quality expectations, as determined by Operations.

Call Monitoring

When supervisors evaluate a staff member's work, they select a call at random from the pool of available recordings. This reinforces the message that each conversation holds the same importance. Supervisors use a proprietary tool to evaluate Quit Coaches in 20 skill areas. Examples include: thoroughly assessing information about the participant's tobacco history and current use patterns; incorporating assessed information into a quitting plan, tailored to the needs of the individual; expertly applying information about quit medications and adhering to clinical protocols to help the participant access and use quit medications effectively; expertly applying information about the impact quitting will have on certain chronic diseases and pregnancy; engaging the participant in the quitting process by using motivational interviewing and cognitive-behavioral therapy principles to facilitate behavior change.

In weekly meetings, our director of call quality conducts call monitoring calibration sessions with supervisors to consistently and accurately interpret and apply quality expectations. Supervisors also receive individual oversight of their work via ad hoc requests to provide input about an evaluation and through random checks of their completed evaluations.

Quality Assurance and Review of Services: Our commitment is to provide each participant the best Quitline experience possible. We achieve this through adherence to a quality assurance plan that tracks key performance metrics in three categories: reach, engagement, and outcomes. We are committed to transparency and all categories and metrics will be reported to TFN quarterly via our Performance Management Report. Should there be any issues, a process improvement plan will be initiated immediately to determine the root cause and we will devise a solution to remedy the issues. This resolution will be implemented and we will communicate with TFN throughout each stage in this process.

	As a current client of Optum, TFN currently receives our Quarterly Performance Management Report, which is a report that provides transparency and visibility to our clients on service metrics. Due to the changing landscape of Quitline services beyond telephonic counseling, Optum has revised the metrics we will monitor should we be awarded the contract. These metrics will fall into the three categories stated above (reach, engagement, outcomes) and will be more relevant to where our product and operations teams spend time in monitoring program performance to help us provide the best participant experience. For purposes of our response, we have listed the call standards and our past performance in Nebraska from the 3rd quarter of 2019 in the table below. We look forward to negotiating with TFN our new approach to monitoring quality and the metrics to be reported quarterly. A sample of our revised Quarterly Performance Report has been included as Appendix A.1.12. Quarterly Performance Report. **Secret Shopper Exercises** After receiving notification that a secret shop has been completed, Associate Client Manager Jessica Benson will request a conference call with TFN to review the results and feedback. Areas of success will be celebrated and all parties will agree upon areas that need improvement. Secret shoppers' identifying information will be requested to conduct a file review for calls including content that highlighted the need for service improvements. This information will also be used to provide a credit back to TFN for billable services provided to secret shoppers (excluding any NRT shipped). Both the secret shoppers' experience and the file review results will be compiled in a comprehensive document, to be reviewed again by both Optum and TFN for agreement on areas of improvement. Should an issue that warrants a quality improvement plan be identified during a secret shopper campaign, Optum will work with TFN to identify the actions needed to resolve the issue. This may include additional training or database alterations to better support service delivery staff. The plan will outline the tasks agreed upon that are necessary for resolution of the issue, target due dates, and key stakeholders. As tasks are completed, updates will be communicated to TFN until all parties are satisfied that the issue has been resolved. Quality Improvement Measure: We welcome opportunities to address quality improvement in our services and will take a systematic approach when attending to client feedback. As an example, we responded to the result of a Spanish language "secret shopper" experience in August, 2019 by reviewing caller feedback, performing our own set of call and service reviews, comparing treatment and service standards to what was observed, working with the client to develop goals for improvement, creating action plans, and meeting regularly with the client and subject matter experts to review progress. As a result of this process, we were

	able to review Spanish-language call routing and increase the availability of live agents for these callers. By October of 2018, we had achieved our live connection goal, ensuring that our Spanish language callers received high quality service in a timely manner. Our client was pleased with the result of this evaluation, the impact of improved service levels, and our commitment to continuous quality improvement. **Secret Shopper Exercises**
41.	Describe how the Quitline will address complaints internally, as well as the types of complaints that will be expected to be addressed by TFN and the process by which such calls will be referred to TFN for follow-up, while maintaining participant privacy under HIPAA.
	Bidder Response: (This Question addresses elements from Subsections V.D., V.F.5., and V.F.6.) All complaints (including the participant file number, call number on which the complaint occurred, and Quit Coach name) are recorded in a Complaint database, called Compass Issues Management. Supervisors receive notification of the complaint and investigate and resolve the issue within 10 business days. If a complaint requires a call back, the Supervisor will handle the call back to the participant. **Referrals to TFN:** If the complaint is outside of what we typically hear (need for more calls, have not heard from the Quitline, etc.), or if the participant makes threatening statements to contact legislators and/or funders, the complaint will be immediately escalated to Client Services Manager Jessica Benson, who will notify TFN, describe the situation, and work with TFN to determine the best course of action. Any escalated complaint is also reported to Mary Kokstis, Director of Quit For Life/Tobacco Cessation, and brought to the attention of the entire management team. **HIPAA:** All interactions with and information received from participants is regarded and treated with the same confidentiality policies that govern all our health care interactions and data, which are described in detail in the response to Question 35 in this document.
	Service Delivery Protocol
42.	Must provide services to all clients at a minimum of age 16 year and older. Describe the age populations the bidder would provide services to.
	Bidder Response: (This Question addresses elements from Subsection V.F.8.) [redacted]

	[redacted]
	Surveillance and Evaluation
43.	Describe how the Quitline will collaborate with TFN and any applicable third party to facilitate evaluation of the quality and effectiveness of services and referrals.
	Bidder Response: (This Question addresses elements from Subsections V.F.6. and V.F.7.) Optum has extensive experience working with third-party evaluators to assess the quality of our services and to make adjustments and enhancements as needed to improve both outcomes and the overall participant experience. We have worked with the following third-party evaluators and we welcome the opportunity to work with TFNs third party evaluator: • University of Wisconsin • North Carolina Chapel Hill (Landmark Tobacco Cessation National Cancer Institute study) • Georgia State University (Institute of Public Health) • Professional Data Analysts, Inc. • University of Oklahoma (College of Public Health) • University of Arkansas at Little Rock • Social Solutions International • Wheeler Employee Assistance Program

	In working with third-party evaluators, Optum can provide data extracts containing demographics, cessation program usage, web usage, and NRT fulfillment status to TFN and any designated third-party evaluator on a monthly basis. We will work closely with TFN and the third-party evaluator to create custom extracts for surveying and evaluation of participants. To accommodate the needs of the evaluator, we will run and deliver these extracts earlier than standard reports and extracts. All data will be transmitted through our secure email system. All data files include a single unique identifier for each participant so that data from multiple files can be linked for analysis. We can support comma delimited, Excel, tax delimited, and other delimited formats. Extracts will be delivered electronically in an HIPAA-compliant manner. All data files include a single unique identifier for each participant, which ensures that once submitted (should data also be delivered to the CDC for warehouse purposes), intake data can be linked to the outcomes data provided by the evaluator. In addition to CDC data submission, we have reporting and protocols in place for data sharing, and we are able to accommodate requests to work with third parties on reporting needs. Aggregate reports can be provided in a PDF or other easy-to-read format that can be imported into programs such as Excel, Access, SQL, or any other program that can import a CSV or XML file. One of the first steps in beginning work with a third party evaluator is to establish a contract between Optum and the evaluator in order to be able to share identifiable data in a HIPAA-complaint manner.
44.	Describe how the client database will be provided to TFN monthly and quarterly, in the form and measures determined by TFN and National Quitline Data Warehouse, to assure confidential, efficient means of transferring the database as needed in order to conduct evaluation. Include a plan to address HIPAA requirements as necessary to assure that TFN or the applicable third party has full access to the client database.
	Bidder Response: (This Question addresses elements from Subsections V.D., V.F.5., V.F.6., V.F.7., and V.I.) Optum will continue to provide service utilization and demographic information in a confidential and efficient way in order to conduct evaluation. In addition to our monthly suite of reports we currently email to TFN, Optum will continue to deliver a de-identified Quitline Experience Extract containing call data, on a schedule that meets TFN needs. Currently, the extract is sent monthly via a secure SFTP site and credentials are sent securely to individuals TFN has identified for receipt. TFN then submits the data to the Warehouse as needed. All data is collected, stored, and delivered in a manner that is compliant with both HIPAA and NAQC standards for confidentiality and data security, as described in our response to Question 35 of this

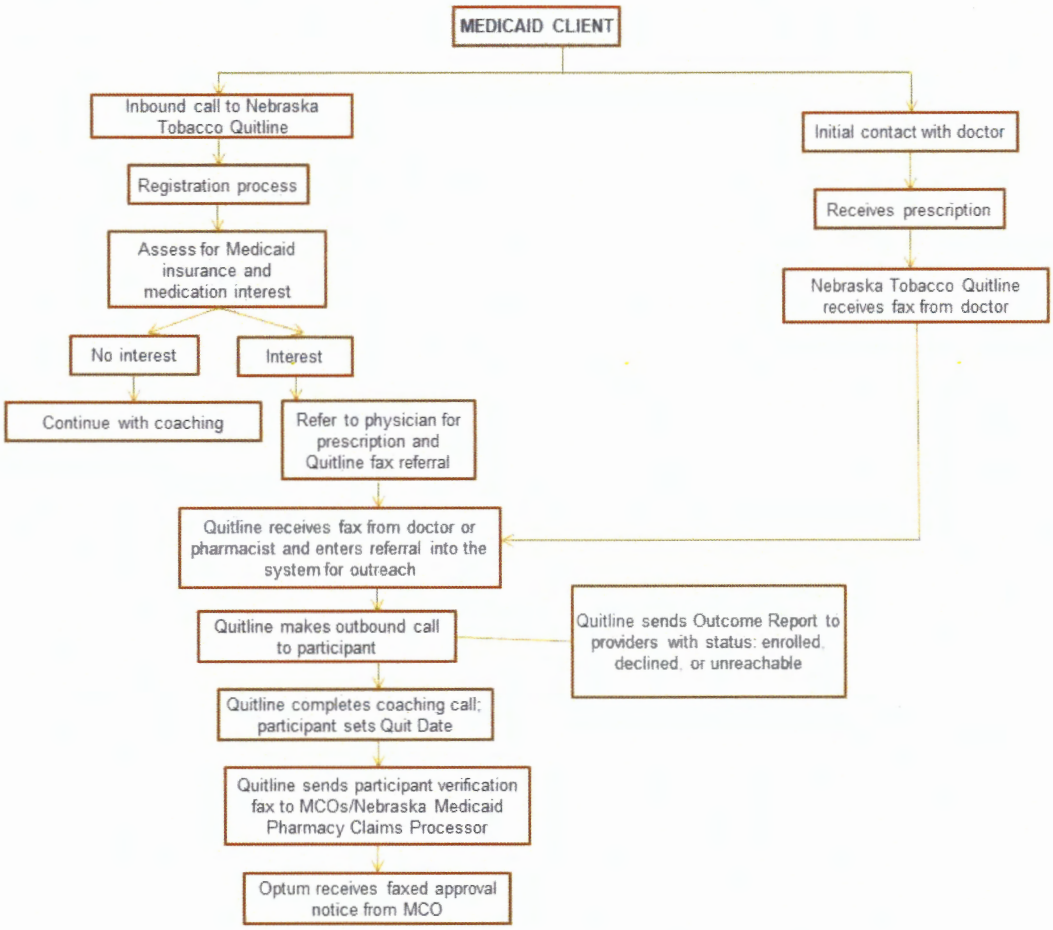
	Attachment 1. Optum will collaborate with TFN and any applicable third party designated by the State to provide access to all necessary data in a secure and confidential manner.
45.	Describe opportunities for Nebraskans to engage in Quitline-related research in conjunction with other states or other Quitline clients.
	Bidder Response: (This Question addresses elements from Subsection V.F.7.) We are always eager to enhance Quitline services through collaborative research opportunities with our state clients, and we have been involved in research projects with several of them, including Nebraska, Connecticut, Washington, DC, Wisconsin, and North Carolina. In fact, the state of Nebraska participated in a project funded by the Centers for Disease Control and Prevention to measure satisfaction among quitline callers exposed to the 2017 Tips From Former Smokers television media campaign promoting free nicotine replacement therapy (NRT). Findings indicated that satisfaction with coaching calls and conversations about NRT remained high throughout the media promotion period, and no differences were noted during weeks with versus without the televised Tips media. Also, the state of Nebraska participated in the Oral health study, resulting in four publications and several presentations. The study recruited smokers who called the Quitlines in three states and were eligible to participate based on being high risk for dental disease. Participants were randomized to standard of care or an integrated oral health intervention. The results suggested an increase in quit rates among those in the intervention and improved oral hygiene. Our process prior to engaging a state in a collaborative effort begins with the Client Services Manager having conversations with a client to understand elements such as how such collaboration would impact volume, the registration process, and the overall Quitline budget. We do not proceed with any research project involving a state's residents without that state's prior approval, which we usually request via a letter of support, as we have done with TFN in the past. In some cases, states come to us with an idea for a tobacco-cessation research project, and we collaborate with them to design, implement, and monitor the project, and measure the results. Another avenue for collaboration are research scientists within the state who are studying best practices related to cessation. In addition, as discussed in the response to Question 39 of this Attachment 1, we describe the research efforts of the Optum Center for Wellness Research, which often involve state Quitline populations, as well as some current and recent research projects we have conducted.

	Some possible research projects we could offer in Nebraska include the use and resulting benefit of offering an incentive program for Medicaid Quitline callers to increase reach and engagement, or participation in a SmokeFree Homes research study. We are also happy to look at piloting *our Live Vape Free* program with TFN, or to collaborate on opportunities to drive reach through digital marketing campaigns. We look forward to working with TFN on future research projects, either brought forward by TFN or by another agency in which Nebraska's Quitline participants would be eligible for inclusion. Our Client Services Manager, Jessica Benson, will maintain an ongoing dialogue with TFN about possible research projects, and we look forward to collaborating with TFN in the future.
	NRT
46.	Provide current screening protocols.
	Bidder Response: (This Question addresses elements from Subsections V.F.8. and V.H.) Quit Coaches address the elements of an effective quit plan (which includes pharmacotherapy), during every call, regardless of whether or not the participant is eligible to receive pharmacotherapy through the Quitline. Quit Coaches explain the differences in medication categories (nicotine replacement therapy vs. prescription medications), the different delivery systems (patch, gum, lozenge, etc.), and talk neutrally about the pros and cons of medications, including their common side effects and contraindications. Quit Coaches tailor discussions about medications to the individual knowledge and needs of each caller. At each intervention, Quit Coaches assess for proper use of pharmacotherapy, provide guidance to correct misuse, and advise participants in order to optimize the medicine's effectiveness. We make every possible effort to answer callers' questions about medications via the Quitline, so that we do not need to refer them to other sources to get the information they need. If we identify medical contraindications, we will send a form to the participant's doctor or other health care provider to obtain a waiver prior to sending the product to the participant. **Screening Protocols:** The screening process identifies medical conditions or medications that may complicate the use of FDA-approved cessation medications. We break down screening of participants for the nicotine patch, nicotine gum, nicotine lozenge, bupropion SR, or Varenicline into two sets of questions. These include Exclusionary and Non-Exclusionary questions. These questions are based on a review of cautions included on the manufacturer's package labeling, the FDA approval process, and information in the Physician's Desk Reference.

	A "NO" answer to all NRT Exclusionary questions enables the treatment application to add the selected medication to the participant's treatment plan and provides the Quit Coach with an NRT dosage regimen based on established criteria that takes the participant's nicotine dependence level into account, including the amount of tobacco use per day and time to first use of tobacco after waking. A "NO" answer to all prescription medication Exclusionary questions allows the Quit Coach to add the medication to the participant's treatment plan and advise them to see their health care provider for a prescription. A "YES" answer to any NRT Exclusionary question serves to explore other medication options or to refer the participant to their health care provider to determine whether the requested form of pharmacotherapy is medically appropriate for them and does not allow the Quit Coach to add the medication to the participant's treatment plan. We provide the Quit Coach with scripting to explain the process the participant needs to follow to receive NRT from the Quitline, which includes obtaining written approval from their health care provider indicating that the provider approves the receipt of NRT through the Quitline. A "YES" answer to any prescription medication Exclusionary question serves to encourage the participant to consider an alternate cessation medication or to advise the participant to inform their health care provider of the exclusionary criteria when seeking a prescription. Protocols for Non-Exclusionary questions are less stringent and are purely advisory in nature. These questions explore medical conditions or medications considered less of a potential risk to the participant. A "YES" answer prompts the Quit Coach to advise the participant to inform their physician of intention to use the selected form of pharmacotherapy. We ask the following questions of all participants that are applicable for all forms of NRT, including patch, gum, and lozenge, except where otherwise noted. **Exclusionary Questions:** (Quit Coaches will explore alternate medication options with participants or refer them to their health care provider for approval to use NRT if they answer "YES" to any of these questions.) • Have you had a heart attack within the last 2 weeks? • Have you had a stroke or TIA within the last 2 weeks? • Are you currently pregnant? (only displays for females age 50 or younger) • Are you under 18 years of age? • Have you been told within the last 6 months that you have a very rapid or irregular heart beat that required you to change your activities or take medication?

	• Have you been told within the last 6 months that you have serious or worsening angina/heart pain? • Have you ever had a reaction to using a patch medication or adhesive tape? (patch only) **Non-Exclusionary Questions**: (Quit Coaches will advise participants to inform their health care provider of intent to use NRT if they answer "YES" to any of these questions.) • Are you planning to use Zyban (also called bupropion or Wellbutrin) or Chantix at the same time as you use the NRT (patch, gum, or lozenge)? • Are you planning to get pregnant within the next 3 months? (women age 50 or younger) • Are you currently breastfeeding? (women age 50 or younger) • Do you currently have high blood pressure not controlled by medication? • Do you have any difficulties chewing gum that involves the jaw, mouth, or dental problems (gum only)? Our Product Management Department and Clinical Team conduct ongoing surveillance of existing and new cessation medications. The proper use of existing medications continues to evolve as the scientific evidence base grows. This surveillance includes monitoring existing medications for trends in adverse events and fully assessing any emerging cessation medication options. We modify our dosing protocols as new scientific evidence becomes available, including updates from the FDA, the manufacturer of the pharmacotherapy, the USPHS Clinical Practice Guideline, and input from our Scientific Advisory Board.

Appendix V.F.5.c. Alternate Nebraska Medicaid Flow Chart Process


MEDICAID CLIENT
Inbound call to Nebraska Tobacco Quitline
Registration process
Assess for Medicaid insurance and medication interest
No interest
Interest
Continue with coaching
Refer to physician for prescription and Quitline fax referral
Initial contact with doctor
Receives prescription
Nebraska Tobacco Quitline receives fax from doctor
Quitline receives fax from doctor or pharmacist and enters referral into the system for outreach
Quitline makes outbound call to participant
Quitline sends Outcome Report to providers with status: enrolled, declined, or unreachable
Quitline completes coaching call; participant sets Quit Date
Quitline sends participant verification fax to MCOs/Nebraska Medicaid Pharmacy Claims Processor
Optum receives faxed approval notice from MCO

Appendix VI.A.1.b. UnitedHealth Group Form 10-K 2018

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2018

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated

(Exact name of registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**41-1321939** **(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota** **(Address of principal executive offices)**	**55343** **(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE **(Title of each class)**	**NEW YORK STOCK EXCHANGE, INC.** **(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2018 was $234,490,429,732 (based on the last reported sale price of $245.34 per share on June 30, 2018, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2019, there were 959,538,515 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2019 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes the provision of health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

Through UnitedHealthcare and Optum, in 2018, we processed more than three-quarters of a trillion dollars in gross billed charges and we managed more than $250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

- strong local-market relationships;

- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1.3 million physicians and other health care professionals and more than 6,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. UnitedHealthcare Employer & Individual provides access to medical services for 27 million people on behalf of our customers and alliance partners, including employer customers serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace,

UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options, and offer a spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs, consumer education and other digital offerings.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products, which complement its service offerings by improving quality of care, engaging consumers and providing cost-saving options. Consumers served by UnitedHealthcare Employer & Individual can access clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individual consumers) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. Through its broad network, UnitedHealthcare Employer & Individual delivers dental, vision, hearing, life, transportation, critical illness and disability product offerings using an integrated approach in private and retail settings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 4.9 million people through its Medicare Advantage products as of December 31, 2018.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below that of traditional Medicare, while helping seniors live healthier lives. Through our HouseCalls program, nurse practitioners performed 1.5 million in-home preventive care visits in 2018 to address unmet care opportunities and close gaps in care. Our Navigate4Me program provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across

home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2018, UnitedHealthcare enrolled 9.0 million people in the Medicare Part D programs, including 4.7 million individuals in the stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.9 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

Premium revenues from CMS represented 30% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2018, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and people without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families (TANF), Children's Health Insurance Programs (CHIP), Dual SNPs (DSNPs), Aged, Blind and Disabled and other federal, state and community health care programs. As of December 31, 2018, UnitedHealthcare Community & State participated in programs in 30 states and the District of Columbia, and served 6.5 million people; including 1 million people through Medicaid expansion programs in 15 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care

providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants that can affect people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only 50% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care, which represents a population of nearly 8 million people; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care. This expansion includes integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care; typically, the 5% who are most at risk drive over 50% of states' medical costs.

UnitedHealthcare Global

UnitedHealthcare Global serves 6.2 million people with medical benefits, residing principally in Brazil, Chile, Colombia and Peru but also in more than 130 other countries. UnitedHealthcare Global owns and operates more than 300 hospitals, specialty centers, primary care and emergency services clinics in South America and Portugal. UnitedHealthcare Global provides a comprehensive range of health and mobilization capabilities and supports the health systems of individual nations with support for improving health care financing and delivery. Clients include multi-national and local businesses, governments and individual consumers around the world.

Global Markets. UnitedHealthcare Global serves local populations in select markets around the world, primarily in Brazil; Chile; Colombia; Peru; and Portugal, by touching nearly every aspect of health care and leveraging expertise in clinical care management and health care data to improve outcomes, raise quality and constrain costs.

In Brazil, Amil provides health benefits to 4.1 million people through a broad network of owned and affiliated clinics, hospitals and care providers. Dental benefits are also provided to 2.2 million people. Amil's members have access to a provider network of physicians and other health care professionals, hospitals, laboratories and diagnostic imaging centers. Americas Serviços Médicos offers health care delivery in Brazil through hospitals, ambulatory clinics and surgery centers to Amil members and consumers served by the external payer market.

Empresas Banmédica provides health benefits and health care services to 2.1 million people in Chile, Colombia and Peru through a network of owned and affiliated clinics, hospitals and care providers. Empresas Banmédica owns and operates hospitals, clinics and outpatient centers.

Lusíadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

Global Solutions. UnitedHealthcare Global includes other diversified global health services with a variety of offerings for international customers.

Optum

Optum is a technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.

- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers, health plans, and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight specializes in data and analytics and other health care information technology services, and delivers operational services and support; and
- OptumRx provides pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of 93 million unique individuals. OptumHealth enables population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health and by coordinating care for the most medically complex patients.

OptumHealth serves patients and care providers through its local ambulatory care services business and delivers care through a physician-led, patient-centric and data-driven organization comprised of more than 35,000 employed, managed or contracted physicians. OptumHealth also enables care providers' transition from traditional, fee-for-service care delivery to performance- based delivery and payment models that improve the focus on patient health and outcomes, such as those emerging through accountable care organizations (ACOs) and local care provider partnerships. Through strategic partnerships, alliances and ownership arrangements, OptumHealth helps care providers adopt new approaches and technologies that improve the coordination of care across all providers involved in patient care. MedExpress' neighborhood care centers provide urgent and walk-in care services with a consumer-friendly approach and Surgical Care Affiliates' independent ambulatory surgical centers and surgical hospitals provide high-value surgical services at a substantially lower cost than a traditional in-patient hospital setting.

OptumServe provides a wide range of health services specifically tailored to active military and veterans and the agencies that support them.

OptumHealth serves people through population health services that meet both the preventive care and health intervention needs of consumers across the care continuum—physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OptumHealth engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.

Optum Financial Services, through Optum Bank, a wholly-owned subsidiary, serves consumers through 5.2 million health savings and other accounts approaching $10 billion in assets under management as of

December 31, 2018. During 2018, Optum Bank processed nearly $160 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, digital payment systems.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served, or on a fee-for-service basis, where it delivers medical services to patients in exchange for a contracted fee. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, the Department of Defense, the Veterans Administration and other federal procurement agencies).

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on technology, research and consulting and managed services that help improve the quality of care and drive greater efficiency in the health care system. Technology includes population health and risk analytics, administrative and clinical technology for claims editing, risk adjustment and payment integrity, health information and electronic data exchange and technology strategy and management. Research and consulting helps organizations reduce administrative costs and implement best practices to improve clinical performance. Managed services provides solutions such as revenue cycle management, risk analytics, payment integrity outsourcing and state Medicaid data and technology management. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2018 was $17.0 billion, of which $8.6 billion is expected to be realized within the next 12 months. The aggregate backlog includes $6.2 billion related to intersegment agreements. OptumInsight's aggregate backlog at December 31, 2017, was $15.0 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight believes it is well positioned to address the needs of four primary market segments: care providers (e.g., physicians and hospital systems), health plans, governments and life sciences companies.

Care Providers. Serving more than four out of five U.S. hospitals and more than 100,000 physicians, OptumInsight assists care providers in meeting their challenge to improve patient outcomes and care amid changing payment models and pressures. OptumInsight brings a broad array of solutions to help care providers

meet these challenges, with particular focus on clinical performance and quality improvement, population health, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Health Plans. OptumInsight serves three out of four U.S. health plans through cost-effective, technology-enabled solutions that help them improve efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals, and build and manage strong networks of care.

Governments. OptumInsight provides services tailored to government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting.

Life Sciences. OptumInsight provides services to global life sciences companies. These companies look to OptumInsight for data, analytics and expertise in core areas of health economics and outcomes research, market access consulting, integrated clinical and health care claims data and informatics services, epidemiology and drug safety, and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to 65 million people in the United States through its network of more than 67,000 retail pharmacies, multiple home delivery, specialty and compounding pharmacies and through the provision of home infusion services. In 2018, OptumRx added capabilities in managing limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology as well as capabilities to serve the growing pharmacy needs of people with behavioral health and substance use disorders, particularly Medicare and Medicaid beneficiaries.

OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individual consumers through enhanced services, elevated clinical quality and cost trend management.

In 2018, OptumRx managed $91 billion in pharmaceutical spending, including $40 billion in specialty pharmaceutical spending.

OptumRx provides pharmacy care services to a number of health plans, including a substantial majority of UnitedHealthcare members, large national employer plans, unions and trusts and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

OptumRx offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner, which are designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that affect member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care, using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and members.

As of December 31, 2018, OptumRx operated four home delivery pharmacies in the United States, which provide patients with access to maintenance medications and enables OptumRx to manage clients' drug costs through operating efficiencies and economies of scale. As of December 31, 2018, OptumRx's specialty pharmacy operations included more than 70 specialty and infusion pharmacies located throughout the United States that are used for delivery of advanced medications to people with chronic or genetic diseases and disorders. OptumRx also operates community mental health facility pharmacies, which help align benefits, care management and pharmacy services for those living with complex, chronic medical and behavioral health issues.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust compliance.

The Tax Cuts and Jobs Act. In December 2017, the U.S. federal government enacted a tax bill (Tax Cuts and Jobs Act or Tax Reform). The Tax Cuts and Jobs Act changed existing United States tax law and included numerous provisions that affected our results of operations, financial position and cash flows. For instance, Tax Reform reduced the U.S. corporate income tax rate and changed business-related exclusions and deductions and credits.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposed requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extended parts of HIPAA privacy and security provisions to business associates; added federal data

breach notification requirements for covered entities and business associates and reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthened enforcement and imposed higher financial penalties for HIPAA violations and, in certain cases, imposed criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by that state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to

state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and protected health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices that involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

OptumRx's businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery, specialty and compounding pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our home delivery, specialty and compounding pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery, specialty and compounding pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. Additionally, certain of our pharmacies that participate in programs for Medicare and state Medicaid providers are required to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affect both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards that impact PBM pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve, which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; sales, marketing and pricing. See Part I, Item 1A, "Risk Factors" for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2018, we employed 300,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 12, 2019, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	66	Executive Chair of the Board
David S. Wichmann	56	Chief Executive Officer
Steven H. Nelson	59	Executive Vice President; Chief Executive Officer of UnitedHealthcare
Andrew P. Witty	54	Executive Vice President; Chief Executive Officer of Optum
John F. Rex	56	Executive Vice President; Chief Financial Officer
Thomas E. Roos	46	Senior Vice President; Chief Accounting Officer
Marianne D. Short	67	Executive Vice President; Chief Legal Officer
D. Ellen Wilson	61	Executive Vice President; Chief Human Resources Officer

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Executive Chair of the Board of UnitedHealth Group and has served in that capacity since September 2017. Mr. Hemsley previously served as Chief Executive Officer from 2006 to August 2017. He has been a member of the Board of Directors since 2000.

Mr. Wichmann is Chief Executive Officer of UnitedHealth Group and a member of the Board of Directors and has served in that capacity since September 2017. Mr. Wichmann previously served as President of UnitedHealth

Group from November 2014 to August 2017. Mr. Wichmann also served as Chief Financial Officer of UnitedHealth Group from January 2011 to June 2016. From April 2008 to November 2014, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Nelson is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since August 2017. Mr. Nelson served as Chief Executive Officer of UnitedHealthcare's Medicare & Retirement, from March 2014 to August 2017. He served as Chief Executive Officer of UnitedHealthcare Community & State from August 2012 to March 2014. From January 2008 to July 2012 he served as President of UnitedHealthcare Community & State and then as Chief Executive Officer of UnitedHealthcare Employer & Individual's West Region business.

Mr. Witty is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2018. He previously served as a UnitedHealth Group director from August 2017 to March 2018. Prior to joining UnitedHealth Group, Mr. Witty was CEO and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex spent over a decade at JP Morgan, a global financial services firm, and its predecessors, concluding his tenure as a Managing Director.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President and Chief Human Resources Officer of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments, concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise nearly 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for and effectively manage medical costs. In addition, our OptumHealth business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, or effectively price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts are typically based on a fixed monthly rate per individual served for a 12-month period

and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2018 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2018 would have been reduced by approximately $305 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. Under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. Any such assessment could expose our insurance entities and other insurers to the risk that they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. For example, some of our UnitedHealthcare and Optum businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations that are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being considered, and we cannot predict if the ACA will be further modified or repealed or replaced. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part; and a federal district court struck down the ACA in its entirety as unconstitutional in 2018. That opinion has been stayed and appealed. Further, the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while the Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and enforcement of industry regulations that could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial

revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system that provides various quality bonus payments to Medicare Advantage plans that meet certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models that apply to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers for Medicare Advantage plans,

as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. For example, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and corporate integrity agreements. Additionally, such investigations, audits or reviews sometimes arise out of, or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we sustain cyber-attacks or other privacy or data security incidents that result in security breaches that disrupt our operations or result in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place that are intended to detect, contain and respond to data security incidents and that provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to anticipate these techniques or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause system shutdowns that could negatively affect our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise information security. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human error; malicious social engineering; or other events that could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or

cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers that utilize protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information is regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA imposed further restrictions on our ability to collect, disclose and use protected personal information and imposed additional compliance requirements on our business.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect that there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union's General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. The new regulation superseded prior European Union privacy and data protection legislation, imposed more stringent European Union data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, goes into effect in 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the FDA and Boards of Pharmacy. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine that fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other health care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services that are useful and relevant to consumers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care

usage, and we may face challenges from new technologies and market entrants that could affect our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances the amount is either not defined or is established by a standard

that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of some of our businesses, including OptumHealth and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. If we were subjected to similar investigations and enforcement actions, such actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2018. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could adversely affect our profitability and equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2018, our goodwill and other intangible assets had a carrying value of $68 billion, representing 45% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the financial covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Legal Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED SHAREHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2019, there were 11,948 registered holders of record of our common stock.

DIVIDEND POLICY

In June 2018, our Board of Directors increased the Company's annual cash dividend rate to shareholders to $3.60 per share compared to $3.00 per share, which the Company had paid since June 2017. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2018, we repurchased 3.3 million shares at an average price of $256.15 per share. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock.

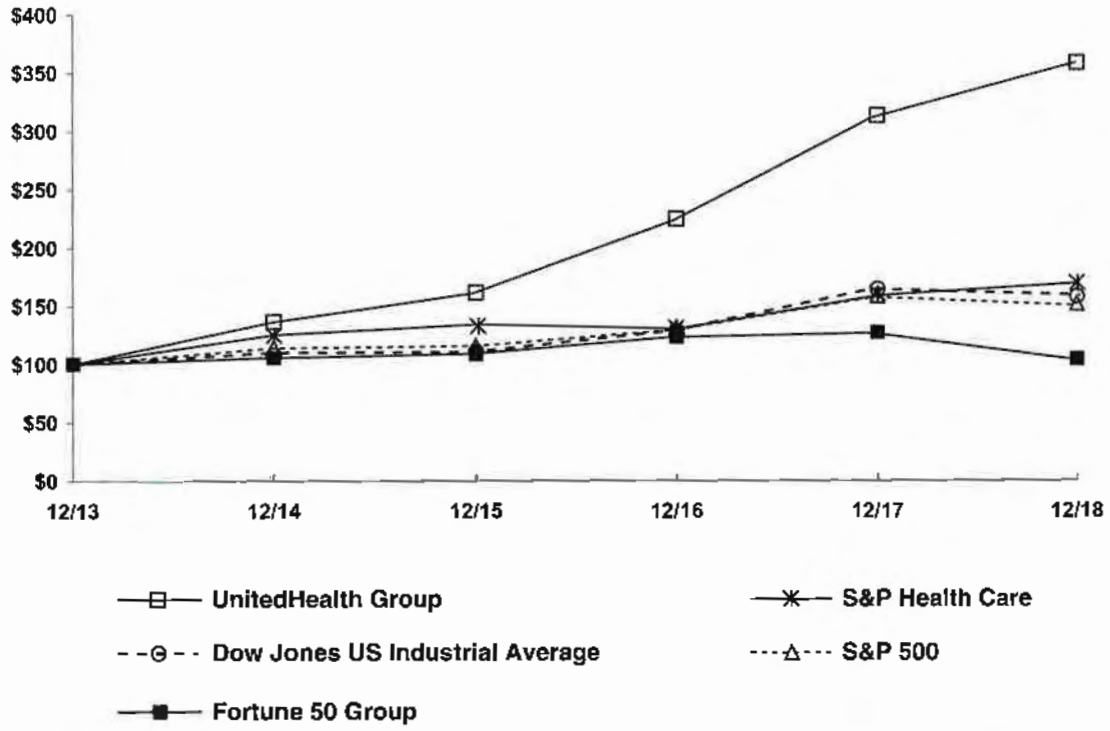
PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index, the S&P Health Care Index and the Dow Jones US Industrial Average Index for the five-year period ended December 31, 2018. We have also included the customized peer group of certain *Fortune 50* companies that we have compared ourselves to in prior years. We believe that these indices provide a more meaningful comparison than the previous subset of the Fortune 50 given our diverse businesses. The comparisons assume the investment of $100 on December 31, 2013 in our common stock and in each index, and that dividends were reinvested when paid.

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. We are not included in this *Fortune 50* Group index. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies are weighted according to the stock market capitalizations of the companies at January 1 of each year.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P Health Care Index, the Dow Jones US Industrial Average Index, the S&P 500 Index, and Fortune 50 Group



	12/13	12/14	12/15	12/16	12/17	12/18
UnitedHealth Group	**$100.00**	**$136.46**	**$161.37**	**$223.35**	**$312.29**	**$357.64**
S&P Health Care Index	**100.00**	**125.34**	**133.97**	**130.37**	**159.15**	**169.44**
Dow Jones US Industrial Average	**100.00**	**110.04**	**110.28**	**128.47**	**164.58**	**158.85**
S&P 500 Index	**100.00**	**113.69**	**115.26**	**129.05**	**157.22**	**150.33**
Fortune 50 Group	**100.00**	**105.33**	**108.75**	**123.33**	**126.45**	**103.96**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Years Ended December 31, 2018	2017 (a)	2016	2015 (b)	2014
Consolidated operating results					
Revenues	$226,247	$201,159	$184,840	$157,107	$130,474
Earnings from operations	17,344	15,209	12,930	11,021	10,274
Net earnings attributable to UnitedHealth Group common shareholders	11,986	10,558	7,017	5,813	5,619
Return on equity (c)	24.4%	24.4%	19.4%	17.7%	17.3%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 12.45	$ 10.95	$ 7.37	$ 6.10	$ 5.78
Diluted earnings per share attributable to UnitedHealth Group common shareholders	12.19	10.72	7.25	6.01	5.70
Cash dividends declared per common share	3.45	2.875	2.375	1.875	1.405
Consolidated cash flows from (used for)					
Operating activities	$ 15,713	$ 13,596	$ 9,795	$ 9,740	$ 8,051
Investing activities	(12,385)	(8,599)	(9,355)	(18,395)	(2,534)
Financing activities	(4,365)	(3,441)	(1,011)	12,239	(5,293)
Consolidated financial condition					
(as of December 31)					
Cash and investments	$ 46,834	$ 43,831	$ 37,143	$ 31,703	$ 28,063
Total assets	152,221	139,058	122,810	111,254	86,300
Total commercial paper and long-term debt	36,554	31,692	32,970	31,965	17,324
Redeemable noncontrolling interests	1,908	2,189	2,012	1,736	1,388
Total equity	54,319	49,833	38,177	33,725	32,454

(a) Includes the impact of the revaluation of our net deferred tax liabilities due to Tax Reform enacted in December 2017.

(b) Includes the effects of the July 2015 acquisition of Catamaran Corporation (Catamaran) and related debt issuances.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

This selected financial data should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements and Supplementary Data." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in data analytics and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform changes. The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A provision in the 2018 federal budget imposed a one year moratorium for 2019 on the collection of the Health Insurance Industry Tax. Pricing for contracts that cover a portion of calendar year 2019 reflected the impact of the moratorium. The industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted the competitive pricing environment.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect continued Medicaid revenue growth due to anticipated changes in mix and increases in the number of people we serve; we also believe that the payment rate environment creates the risk of downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider payment models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2018, we served nearly 17 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2018, our contracts with value-based elements totaled $74 billion in annual spending, including $18 billion through risk-transfer agreements.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2019 Medicare Advantage rates resulted in an increase in industry base rates of 3.4%, short of the industry forward medical cost trend, which creates continued pressure in the Medicare Advantage program.

The ongoing pressure on Medicare Advantage funding places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums that supplement the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

As Medicare Advantage payments change, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products, such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

Tax Reform. Tax Reform was enacted by the U.S federal government in December 2017, changing existing United States tax law, including reducing the U.S. corporate income tax rate. In 2018, the impact of Tax Reform was partially offset by the return of the nondeductible Health Insurance Industry Tax.

Health Insurance Industry Tax. After a moratorium in 2017, the industry-wide amount of the Health Insurance Industry Tax in 2018 was $14.3 billion, with our portion being $2.6 billion. The return of the tax impacted year-over-year comparability of our financial results, including revenues, the medical care ratio (MCR), operating cost ratio and effective tax rate. A one year moratorium is imposed on the collection of the Health Insurance Industry Tax in 2019.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2018 year-over-year operating comparisons to 2017.

- Consolidated revenues increased by 12%, UnitedHealthcare revenues increased 12% and Optum revenues grew 11%.
- UnitedHealthcare's addition of 2.2 million people through acquisition and 250,000 through organic growth was offset by 2.9 million fewer people served as a result of completion of its commitment under the TRICARE military health care program.
- Earnings from operations increased by 14%, including increases of 7% at UnitedHealthcare and 23% at Optum.
- Diluted earnings per common share increased 14% to $12.19.
- Cash flows from operations were $15.7 billion, an increase of 16%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
Revenues:							
Premiums	$178,087	$158,453	$144,118	$19,634	12%	$14,335	10%
Products	29,601	26,366	26,658	3,235	12	(292)	(1)
Services	17,183	15,317	13,236	1,866	12	2,081	16
Investment and other income	1,376	1,023	828	353	35	195	24
Total revenues	226,247	201,159	184,840	25,088	12	16,319	9
Operating costs:							
Medical costs	145,403	130,036	117,038	15,367	12	12,998	11
Operating costs	34,074	29,557	28,401	4,517	15	1,156	4
Cost of products sold	26,998	24,112	24,416	2,886	12	(304)	(1)
Depreciation and amortization	2,428	2,245	2,055	183	8	190	9
Total operating costs	208,903	185,950	171,910	22,953	12	14,040	8
Earnings from operations	17,344	15,209	12,930	2,135	14	2,279	18
Interest expense	(1,400)	(1,186)	(1,067)	(214)	18	(119)	11
Earnings before income taxes	15,944	14,023	11,863	1,921	14	2,160	18
Provision for income taxes	(3,562)	(3,200)	(4,790)	(362)	11	1,590	(33)
Net earnings	12,382	10,823	7,073	1,559	14	3,750	53
Earnings attributable to noncontrolling interests	(396)	(265)	(56)	(131)	49	(209)	373
Net earnings attributable to UnitedHealth Group common shareholders	$ 11,986	$ 10,558	$ 7,017	$ 1,428	14%	$ 3,541	50%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 12.19	$ 10.72	$ 7.25	$ 1.47	14%	$ 3.47	48%
Medical care ratio (a)	81.6%	82.1%	81.2%	(0.5)%		0.9%	
Operating cost ratio	15.1	14.7	15.4	0.4		(0.7)	
Operating margin	7.7	7.6	7.0	0.1		0.6	
Tax rate	22.3	22.8	40.4	(0.5)		(17.6)	
Net earnings margin (b)	5.3	5.2	3.8	0.1		1.4	
Return on equity (c)	24.4%	24.4%	19.4%	—%		5.0%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2018 RESULTS OF OPERATIONS COMPARED TO 2017 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by the increase in the number of individuals served through risk-based products across our UnitedHealthcare benefits businesses; pricing trends, including the Health Insurance

Industry Tax in 2018; and growth across the Optum business, primarily due to expansion and growth in care delivery, pharmacy care services, managed services and advisory services.

Medical Costs and MCR

Medical costs increased due to growth in people served through risk-based products and medical cost trends. The MCR decreased due to the revenue effects of the Health Insurance Industry Tax, which more than offset business mix changes and a lower level of favorable reserve development.

Reportable Segments

See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more information on our segments. The following table presents a summary of the reportable segment financial information:

	For the Years Ended December 31,			Change		Change	
(in millions, except percentages)	2018	2017	2016	2018 vs. 2017		2016 vs. 2015	
Revenues							
UnitedHealthcare	$183,476	$163,257	$148,581	$20,219	12%	$14,676	10%
OptumHealth	24,145	20,570	16,908	3,575	17	3,662	22
OptumInsight	9,008	8,087	7,333	921	11	754	10
OptumRx	69,536	63,755	60,440	5,781	9	3,315	5
Optum eliminations	(1,409)	(1,227)	(1,088)	(182)	15	(139)	13
Optum	101,280	91,185	83,593	10,095	11	7,592	9
Eliminations	(58,509)	(53,283)	(47,334)	(5,226)	10	(5,949)	13
Consolidated revenues	$226,247	$201,159	$184,840	$25,088	12%	$16,319	9%
Earnings from operations							
UnitedHealthcare	$ 9,113	$ 8,498	$ 7,307	$ 615	7%	$ 1,191	16%
OptumHealth	2,430	1,823	1,428	607	33	395	28
OptumInsight	2,243	1,770	1,513	473	27	257	17
OptumRx	3,558	3,118	2,682	440	14	436	16
Optum	8,231	6,711	5,623	1,520	23	1,088	19
Consolidated earnings from operations	$ 17,344	$ 15,209	$ 12,930	$ 2,135	14%	$ 2,279	18%
Operating margin							
UnitedHealthcare	5.0%	5.2%	4.9%	(0.2)%		0.3%	
OptumHealth	10.1	8.9	8.4	1.2		0.5	
OptumInsight	24.9	21.9	20.6	3.0		1.3	
OptumRx	5.1	4.9	4.4	0.2		0.5	
Optum	8.1	7.4	6.7	0.7		0.7	
Consolidated operating margin	7.7%	7.6%	7.0%	0.1%		0.6%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
UnitedHealthcare Employer & Individual	$ 54,761	$ 52,066	$ 53,084	$ 2,695	5%	$ (1,018)	(2)%
UnitedHealthcare Medicare & Retirement	75,473	65,995	56,329	9,478	14	9,666	17
UnitedHealthcare Community & State	43,426	37,443	32,945	5,983	16	4,498	14
UnitedHealthcare Global	9,816	7,753	6,223	2,063	27	1,530	25
Total UnitedHealthcare revenues	$183,476	$163,257	$148,581	$20,219	12%	$14,676	10%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
Commercial:							
Risk-based	8,495	8,420	8,820	75	1%	(400)	(5)%
Fee-based	18,420	18,595	18,900	(175)	(1)	(305)	(2)
Fee-based TRICARE	—	2,850	2,860	(2,850)	(100)	(10)	—
Total commercial	26,915	29,865	30,580	(2,950)	(10)	(715)	(2)
Medicare Advantage	4,945	4,430	3,630	515	12	800	22
Medicaid	6,450	6,705	5,890	(255)	(4)	815	14
Medicare Supplement (Standardized)	4,545	4,445	4,265	100	2	180	4
Total public and senior	15,940	15,580	13,785	360	2	1,795	13
Total UnitedHealthcare — domestic medical	42,855	45,445	44,365	(2,590)	(6)	1,080	2
International	6,220	4,080	4,220	2,140	52	(140)	(3)
Total UnitedHealthcare — medical	49,075	49,525	48,585	(450)	(1)%	940	2%
Supplemental Data:							
Medicare Part D stand-alone	4,710	4,940	4,930	(230)	(5)%	10	—%

The overall increase in people served through risk-based benefit plans in the commercial group market was due to growth in services to small groups. Fee-based commercial group business declined primarily due to customers converting their retirees to Medicare Advantage plans, as well as certain customers expanding the number of carriers and reconfiguring geographies served. Medicare Advantage increased year-over-year due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. The decrease in people served through Medicaid was primarily driven by states adding new carriers to existing programs, reduced enrollment from state efforts to manage eligibility status and the sale of our New Mexico Medicaid plan. Medicare Supplement growth reflected strong customer retention and new sales. International growth was primarily driven by an acquisition in the first quarter.

UnitedHealthcare's revenue and earnings from operations increased due to growth in the number of individuals served across its risk-based businesses, a higher revenue membership mix, rate increases for underlying medical cost trends and the impact of the return of the Health Insurance Industry Tax. UnitedHealthcare's operating margin decreased slightly due to the performance of our traditional community-based TANF Medicaid business.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below, as well as productivity and overall cost management initiatives.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery and behavioral health, digital consumer engagement and health financial services.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in data analytics product and service offerings and managed services as well as organic and acquisition-related growth in advisory services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to growth in specialty pharmacy, home delivery services, and overall prescription growth. OptumRx fulfilled 1,343 million and 1,298 million adjusted scripts in 2018 and 2017, respectively.

2017 RESULTS OF OPERATIONS COMPARED TO 2016 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by organic growth in the number of individuals served across our UnitedHealthcare benefits businesses and growth across the Optum business. The increase was partially offset by revenue decreases due to the withdrawals of the ACA-compliant products in the individual market and the effects of the Health Insurance Industry Tax moratorium.

Medical Costs and MCR

Medical costs increased due to risk-based membership growth and medical cost trends. The MCR increased due to the effects of the Health Insurance Industry Tax moratorium, offset primarily by the reduction in individual ACA business, medical management initiatives and an increase in favorable medical cost reserve development.

Income Tax Rate

Our effective tax rate decreased primarily due to the impact of Tax Reform and the Health Insurance Tax moratorium. The provision for income taxes included a $1.2 billion benefit from the revaluation of net deferred tax liabilities.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue increase was due to growth in the number of individuals served across its businesses and price increases for underlying medical cost trends, which were partially offset by the reduction of people served in ACA-compliant individual products and the impact of the Health Insurance Industry Tax moratorium.

The increase in UnitedHealthcare's earnings from operations was led by diversified growth and increased operating margin. The 2016 results included losses in ACA-compliant individual products and guaranty fund assessments.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in revenue management services and business process services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to client and consumer growth. In 2017, OptumRx fulfilled 1.3 billion adjusted scripts compared to 1.2 billion in 2016.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies.

In both 2018 and 2017, our U.S. regulated subsidiaries paid their parent companies dividends of $3.7 billion. See Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017	Change 2017 vs. 2016
Sources of cash:					
Cash provided by operating activities	$ 15,713	$ 13,596	$ 9,795	$ 2,117	$ 3,801
Issuances of long-term debt and commercial paper, net of repayments	4,134	—	990	4,134	(990)
Proceeds from common share issuances	838	688	429	150	259
Customer funds administered	—	3,172	1,692	(3,172)	1,480
Other	—	—	37	—	(37)
Total sources of cash	20,685	17,456	12,943		
Uses of cash:					
Cash paid for acquisitions, net of cash assumed	(5,997)	(2,131)	(1,760)	(3,866)	(371)
Cash dividends paid	(3,320)	(2,773)	(2,261)	(547)	(512)
Common share repurchases	(4,500)	(1,500)	(1,280)	(3,000)	(220)
Repayments of long-term debt and commercial paper, net of issuances	—	(2,615)	—	2,615	(2,615)
Purchases of property, equipment and capitalized software	(2,063)	(2,023)	(1,705)	(40)	(318)
Purchases of investments, net of sales and maturities	(4,099)	(4,319)	(5,927)	220	1,608
Other	(1,743)	(539)	(581)	(1,204)	42
Total uses of cash	(21,722)	(15,900)	(13,514)		
Effect of exchange rate changes on cash and cash equivalents	(78)	(5)	78	(73)	(83)
Net (decrease) increase in cash and cash equivalents	$ (1,115)	$ 1,551	$ (493)	$ (2,666)	$ 2,044

2018 Cash Flows Compared to 2017 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings in 2018 and the impact to 2017 cash flows from operating activities due to a change in net deferred tax liabilities from Tax Reform, partially offset by changes in working capital accounts.

Other significant changes in sources or uses of cash year-over-year included net issuances of debt in 2018 compared to net repayments in 2017, an increase in cash paid for acquisitions, increased share repurchases and a decrease in customer funds administered due to the timing of government payments.

2017 Cash Flows Compared to 2016 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings and changes in working capital accounts, partially offset by the change in net deferred tax liabilities driven by tax reform.

Other significant changes in sources or uses of cash year-over-year included net repayments of debt compared to 2016 net proceeds from debt issuances, which were partially offset by lower net purchases of investments.

Financial Condition

As of December 31, 2018, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $44.7 billion included $10.9 billion of cash and cash equivalents (of which $925 million was

available for general corporate use), $31.9 billion of debt securities and $2.0 billion of investments in equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.3 years and a weighted-average credit rating of "Double A" as of December 31, 2018. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. As of December 31, 2018, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was 38%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements and Supplementary Data."

Credit Ratings. Our credit ratings as of December 31, 2018 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	A-	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Dividends. In June 2018, our Board increased our annual cash dividend rate to shareholders to $3.60 per share from $3.00 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2018, under our various contractual obligations and commitments:

(in millions)	2019	2020 to 2021	2022 to 2023	Thereafter	Total
Debt (a)	$ 3,463	$ 8,970	$ 7,396	$ 37,988	$ 57,817
Operating leases	669	1,103	761	1,343	3,876
Purchase and other obligations (b)	1,216	2,205	808	175	4,404
Other liabilities (c)	1,206	260	257	5,213	6,936
Redeemable noncontrolling interests (d)	1,276	380	25	227	1,908
Total contractual obligations	$ 7,830	$ 12,918	$ 9,247	$ 44,946	$ 74,941

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty and remaining capital commitments for venture capital funds and other funding commitments. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2018.

(c) Includes obligations associated with contingent consideration and payments related to business acquisitions, certain employee benefit programs, amounts accrued for guaranty fund assessments, unrecognized tax benefits, and various long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions, future settlements, unrecognized tax benefits and other liabilities have been classified as "Thereafter."

(d) Includes commitments for redeemable shares of our subsidiaries. When the timing of the redemption is indeterminable, the commitment has been classified as "Thereafter."

Pending Acquisitions. In December 2017, we entered into an agreement to acquire a company in the health care sector for a total of approximately $4.3 billion, which is not reflected in the table above.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2018, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements and Supplementary Data" for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2018, our days outstanding in medical payables was 50 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2018, 2017 and 2016 included favorable medical cost development related to prior years of $320 million, $690 million and $220 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2018:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 550
(0.50)	366
(0.25)	182
0.25	(181)
0.50	(362)
0.75	(541)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, including but not limited to, pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and

mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2018:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 703
2	469
1	234
(1)	(234)
(2)	(469)
(3)	(703)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2018; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2018 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2018 net earnings would have increased or decreased by approximately $140 million.

For more detail related to our medical cost estimates, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Revenues

We derive a substantial portion of our revenues from health care insurance premiums. We recognize premium revenues in the period eligible individuals are entitled to receive health care services. Customers are typically billed monthly at a contracted rate per eligible person multiplied by the total number of people eligible to receive services.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS' retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. For more detail on premium revenues, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Risk adjustment data for our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us.

Goodwill and Intangible Assets

Goodwill. We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change that indicate the carrying value may not be recoverable. When testing goodwill for

impairment, we may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a multi-step test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: customer and/or membership growth, medical trends and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the "Medical Cost Trend" section of Executive Overview-Business Trends and the "Medical Costs Payable" critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future. As of October 1, 2018, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

Intangible Assets. Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset's (or asset group's) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators, including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value and other factors.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we compare its

estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not impaired in 2018.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers that constitute our client base. As of December 31, 2018, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2018, we had $14 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2018, $9 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2018, $30 billion of our investments were fixed-rate debt securities and $32 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2018 and 2017 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2018			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 276	$ 189	$ (2,242)	$ (5,017)
1	138	94	(1,140)	(2,724)
(1)	(138)	(94)	1,118	3,155
(2)	(276)	(189)	2,196	6,953

	December 31, 2017			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 300	$ 170	$ (1,958)	$ (4,546)
1	150	85	(933)	(2,460)
(1)	(150)	(85)	950	2,923
(2)	(197)	(133)	1,773	6,414

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2017, the assumed hypothetical change in interest rates does not reflect the full 200 basis point reduction in interest income or interest expense in 2017, as the rate cannot fall below zero.

(b) As of December 31, 2018 and 2017, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Global's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Global's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2018, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately $600 million and $1.4 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2018, we had $2.0 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 12, 2019 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinions

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/S/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 10,866	$ 11,981
Short-term investments	3,458	3,509
Accounts receivable, net of allowances of $712 and $641	11,388	9,568
Other current receivables, net of allowances of $502 and $440	6,862	6,262
Assets under management	3,032	3,101
Prepaid expenses and other current assets	3,086	2,663
Total current assets	38,692	37,084
Long-term investments	32,510	28,341
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $4,141 and $3,694	8,458	7,013
Goodwill	58,910	54,556
Other intangible assets, net of accumulated amortization of $4,592 and $4,309	9,325	8,489
Other assets	4,326	3,575
Total assets	$ 152,221	$ 139,058
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 19,891	$ 17,871
Accounts payable and accrued liabilities	16,705	15,180
Commercial paper and current maturities of long-term debt	1,973	2,857
Unearned revenues	2,396	2,269
Other current liabilities	12,244	12,286
Total current liabilities	53,209	50,463
Long-term debt, less current maturities	34,581	28,835
Deferred income taxes	2,474	2,182
Other liabilities	5,730	5,556
Total liabilities	95,994	87,036
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,908	2,189
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 960 and 969 issued and outstanding	10	10
Additional paid-in capital	—	1,703
Retained earnings	55,846	48,730
Accumulated other comprehensive loss	(4,160)	(2,667)
Nonredeemable noncontrolling interests	2,623	2,057
Total equity	54,319	49,833
Total liabilities, redeemable noncontrolling interests and equity	$ 152,221	$ 139,058

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Premiums	$178,087	$158,453	$144,118
Products	29,601	26,366	26,658
Services	17,183	15,317	13,236
Investment and other income	1,376	1,023	828
Total revenues	226,247	201,159	184,840
Operating costs:			
Medical costs	145,403	130,036	117,038
Operating costs	34,074	29,557	28,401
Cost of products sold	26,998	24,112	24,416
Depreciation and amortization	2,428	2,245	2,055
Total operating costs	208,903	185,950	171,910
Earnings from operations	17,344	15,209	12,930
Interest expense	(1,400)	(1,186)	(1,067)
Earnings before income taxes	15,944	14,023	11,863
Provision for income taxes	(3,562)	(3,200)	(4,790)
Net earnings	12,382	10,823	7,073
Earnings attributable to noncontrolling interests	(396)	(265)	(56)
Net earnings attributable to UnitedHealth Group common shareholders	$ 11,986	$ 10,558	$ 7,017
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 12.45	$ 10.95	$ 7.37
Diluted	$ 12.19	$ 10.72	$ 7.25
Basic weighted-average number of common shares outstanding	963	964	952
Dilutive effect of common share equivalents	20	21	16
Diluted weighted-average number of common shares outstanding	983	985	968
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	6	5	3

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2018	2017	2016
Net earnings	$12,382	$10,823	$7,073
Other comprehensive (loss) income:			
Gross unrealized (losses) gains on investment securities during the period	(294)	209	(73)
Income tax effect	67	(72)	26
Total unrealized (losses) gains, net of tax	(227)	137	(47)
Gross reclassification adjustment for net realized gains included in net earnings	(62)	(83)	(166)
Income tax effect	14	30	60
Total reclassification adjustment, net of tax	(48)	(53)	(106)
Total foreign currency translation (losses) gains	(1,242)	(70)	806
Other comprehensive (loss) income	(1,517)	14	653
Comprehensive income	10,865	10,837	7,726
Comprehensive income attributable to noncontrolling interests	(396)	(265)	(56)
Comprehensive income attributable to UnitedHealth Group common shareholders	$10,469	$10,572	$7,670

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2016	953	$ 10	$ 29	$37,125	$ 56	$ (3,390)	$ (105)	$33,725
Adjustment to adopt ASU 2016-09				28				28
Net earnings				7,017			40	7,057
Other comprehensive (loss) income					(153)	806		653
Issuances of common stock, and related tax effects	9	—	191					191
Share-based compensation			455					455
Common share repurchases	(10)	—	(316)	(964)				(1,280)
Cash dividends paid on common shares ($2.375 per share)				(2,261)				(2,261)
Acquisition of redeemable noncontrolling interest shares			(143)					(143)
Redeemable noncontrolling interest fair value and other adjustments			(216)					(216)
Distributions to nonredeemable noncontrolling interest							(32)	(32)
Balance at December 31, 2016	952	10	—	40,945	(97)	(2,584)	(97)	38,177
Net earnings				10,558			194	10,752
Other comprehensive income (loss)					84	(70)		14
Issuances of common stock, and related tax effects	26	—	2,225					2,225
Share-based compensation			582					582
Common share repurchases	(9)	—	(1,500)					(1,500)
Cash dividends paid on common shares ($2.875 per share)				(2,773)				(2,773)
Acquisition of redeemable noncontrolling interest shares			283					283
Redeemable noncontrolling interest fair value and other adjustments			113					113
Acquisition of nonredeemable noncontrolling interests							2,112	2,112
Distributions to nonredeemable noncontrolling interest							(152)	(152)
Balance at December 31, 2017	969	10	1,703	48,730	(13)	(2,654)	2,057	49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				11,986			273	12,259
Other comprehensive loss					(275)	(1,242)		(1,517)
Issuances of common stock, and related tax effects	10	—	814					814
Share-based compensation			620					620
Common share repurchases	(19)	—	(2,974)	(1,526)				(4,500)
Cash dividends paid on common shares ($3.45 per share)				(3,320)				(3,320)
Redeemable noncontrolling interests fair value and other adjustments			(163)					(163)
Acquisition of nonredeemable noncontrolling interests							521	521
Distributions to nonredeemable noncontrolling interests							(228)	(228)
Balance at December 31, 2018	960	$ 10	$ —	$55,846	$ (264)	$ (3,896)	$ 2,623	$54,319

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2018	2017	2016
Operating activities			
Net earnings	$12,382	$10,823	$ 7,073
Noncash items:			
Depreciation and amortization	2,428	2,245	2,055
Deferred income taxes	42	(965)	81
Share-based compensation	638	597	485
Other, net	(71)	217	(82)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(1,351)	(1,062)	(1,357)
Other assets	(750)	(630)	(1,601)
Medical costs payable	1,831	1,284	1,849
Accounts payable and other liabilities	526	930	1,494
Unearned revenues	38	157	(202)
Cash flows from operating activities	15,713	13,596	9,795
Investing activities			
Purchases of investments	(14,010)	(14,588)	(17,547)
Sales of investments	3,641	4,623	7,339
Maturities of investments	6,270	5,646	4,281
Cash paid for acquisitions, net of cash assumed	(5,997)	(2,131)	(1,760)
Purchases of property, equipment and capitalized software	(2,063)	(2,023)	(1,705)
Other, net	(226)	(126)	37
Cash flows used for investing activities	(12,385)	(8,599)	(9,355)
Financing activities			
Common share repurchases	(4,500)	(1,500)	(1,280)
Cash dividends paid	(3,320)	(2,773)	(2,261)
Proceeds from common stock issuances	838	688	429
Repayments of long-term debt	(2,600)	(4,398)	(2,596)
Repayments of commercial paper, net	(201)	(3,508)	(382)
Proceeds from issuance of long-term debt	6,935	5,291	3,968
Customer funds administered	(131)	3,172	1,692
Other, net	(1,386)	(413)	(581)
Cash flows used for financing activities	(4,365)	(3,441)	(1,011)
Effect of exchange rate changes on cash and cash equivalents	(78)	(5)	78
(Decrease) increase in cash and cash equivalents	(1,115)	1,551	(493)
Cash and cash equivalents, beginning of period	11,981	10,430	10,923
Cash and cash equivalents, end of period	$10,866	$11,981	$10,430
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,410	$ 1,133	$ 1,055
Cash paid for income taxes	3,257	4,004	4,726
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ —	$ 2,164	$ —

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets and estimates of other current liabilities and other current receivables. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, that fall below certain targets are required to rebate ratable portions of their premiums annually. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star ratings.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions

premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and compounding pharmacy facilities. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. The customers retain the risk of financing health care costs for their employees and employees' dependents, and the Company administers the payment of customer funds to physicians and other health care professionals from customer-funded bank accounts. As the Company has neither the obligation for funding the health care costs, nor the primary responsibility for providing the medical care, the Company does not recognize premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. OptumHealth's service revenues include net patient service revenues that are recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2018 and 2017, accounts receivables related to products and services were $3.9 billion and $3.7 billion, respectively. In 2018 and 2017, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2018 or 2017.

For the years ended December 31, 2018 and 2017, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts that have an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 13 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2018.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims that have not been received or fully processed, using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (the AARP Program) and to AARP members and non-members under separate Medicare Advantage and Medicare Part D arrangements. The products and services under the AARP Program include supplemental Medicare benefits, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement, AARP Program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable

contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2018 and 2017, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $4.2 billion and $3.8 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. The Company may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

There was no impairment of goodwill during the year ended December 31, 2018.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2018.

Other Current Liabilities

Other current liabilities include health savings account deposits ($7.5 billion and $6.4 billion as of December 31, 2018 and 2017, respectively), deposits under the Medicare Part D program, the RSF associated with the AARP Program, accruals for premium rebate payments under the ACA, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2018 and 2017:

(in millions)	2018	2017
Redeemable noncontrolling interests, beginning of period	$2,189	$2,012
Net earnings	123	71
Acquisitions	102	565
Redemptions	(90)	(309)
Distributions	(53)	(38)
Fair value and other adjustments	(363)	(112)
Redeemable noncontrolling interests, end of period	$1,908	$2,189

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over two to five years and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options and SARs vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Health Insurance Industry Tax

The ACA includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A one year moratorium on the collection of the Health Insurance Industry Tax will occur in 2019.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets.

Recently Issued Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" as modified by ASUs 2018-01, 2018-10, 2018-11 and 2018-20 (collectively, ASU 2016-02). Under ASU 2016-02, an entity is required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, the Company elected to not recognize lease assets and lease liabilities and expense the leases over a straight-line basis for the term of those leases. ASU 2016-02 requires new disclosures that depict the amount, timing and uncertainty of cash flows pertaining to an entity's leases. The Company adopted ASU 2016-02 on January 1, 2019, using the cumulative effect upon adoption approach. The adoption resulted in no material impact to the Company's balance sheet, results of operations, equity or cash flows.

Recently Adopted Accounting Standards

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities" (ASU 2016-01). Most notably, the new guidance requires that equity investments, with certain exemptions, be measured at fair value with changes in fair value recognized in net income as opposed to other comprehensive income. The Company adopted ASU 2016-01 on a prospective basis effective January 1, 2018, as required, and reclassified $24 million from accumulated other comprehensive income to retained earnings.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,434	$ 13	$ (42)	$ 3,405
State and municipal obligations	7,117	61	(57)	7,121
Corporate obligations	15,366	14	(218)	15,162
U.S. agency mortgage-backed securities	4,947	11	(106)	4,852
Non-U.S. agency mortgage-backed securities	1,376	2	(20)	1,358
Total debt securities — available-for-sale	32,240	101	(443)	31,898
Debt securities — held-to-maturity:				
U.S. government and agency obligations	255	1	(2)	254
State and municipal obligations	11	—	—	11
Corporate obligations	355	—	—	355
Total debt securities — held-to-maturity	621	1	(2)	620
Total debt securities	$ 32,861	$ 102	$ (445)	$ 32,518
December 31, 2017				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,673	$ 1	$ (30)	$ 2,644
State and municipal obligations	7,596	99	(35)	7,660
Corporate obligations	13,181	57	(44)	13,194
U.S. agency mortgage-backed securities	3,942	7	(38)	3,911
Non-U.S. agency mortgage-backed securities	1,018	3	(6)	1,015
Total debt securities — available-for-sale	28,410	167	(153)	28,424
Debt securities — held-to-maturity:				
U.S. government and agency obligations	254	1	(1)	254
State and municipal obligations	2	—	—	2
Corporate obligations	280	—	—	280
Total debt securities — held-to-maturity	536	1	(1)	536
Total debt securities	$ 28,946	$ 168	$ (154)	$ 28,960

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2018.

The Company held $2.0 billion of equity securities as of December 31, 2018 and December 31, 2017. The Company's investments in equity securities primarily consist of employee savings plan related investments, Brazilian real denominated fixed-income funds and dividend paying stocks, with readily determinable fair values. Additionally, the Company's investments included $1.5 billion and $0.9 billion of equity method investments in operating businesses in the health care sector, as of December 31, 2018 and 2017, respectively.

The amortized cost and fair value of debt securities as of December 31, 2018, by contractual maturity, were as follows:

(in millions)	Available-for-Sale		Held-to-Maturity	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 3,560	$ 3,551	$ 150	$150
Due after one year through five years	12,432	12,297	213	212
Due after five years through ten years	7,362	7,270	129	129
Due after ten years	2,563	2,570	129	129
U.S. agency mortgage-backed securities	4,947	4,852	—	—
Non-U.S. agency mortgage-backed securities	1,376	1,358	—	—
Total debt securities	$32,240	$31,898	$ 621	$620

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2018						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 998	$ (7)	$ 1,425	$ (35)	$ 2,423	$ (42)
State and municipal obligations	1,334	(11)	2,491	(46)	3,825	(57)
Corporate obligations	8,105	(109)	4,239	(109)	12,344	(218)
U.S. agency mortgage-backed securities	1,296	(22)	2,388	(84)	3,684	(106)
Non-U.S. agency mortgage-backed securities	622	(7)	459	(13)	1,081	(20)
Total debt securities — available-for-sale	$12,355	$ (156)	$11,002	$ (287)	$23,357	$ (443)
December 31, 2017						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 1,249	$ (8)	$ 1,027	$ (22)	$ 2,276	$ (30)
State and municipal obligations	2,599	(21)	866	(14)	3,465	(35)
Corporate obligations	5,901	(23)	1,242	(21)	7,143	(44)
U.S. agency mortgage-backed securities	1,657	(12)	1,162	(26)	2,819	(38)
Non-U.S. agency mortgage-backed securities	411	(3)	144	(3)	555	(6)
Total debt securities — available-for-sale	$11,817	$ (67)	$ 4,441	$ (86)	$16,258	$ (153)

The Company's unrealized losses from all securities as of December 31, 2018 were generated from approximately 19,000 positions out of a total of 31,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of December 31, 2018, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

There was no transfers in or out of Level 3 financial assets or liabilities during the year ended December 31, 2018 or 2017.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the year ended December 31, 2018 or 2017.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company

compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds are estimated using valuation techniques that rely heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2018				
Cash and cash equivalents	$ 10,757	$ 109	$ —	$10,866
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,060	345	—	3,405
State and municipal obligations	—	7,121	—	7,121
Corporate obligations	39	14,950	173	15,162
U.S. agency mortgage-backed securities	—	4,852	—	4,852
Non-U.S. agency mortgage-backed securities	—	1,358	—	1,358
Total debt securities — available-for-sale	3,099	28,626	173	31,898
Equity securities	1,832	13	—	1,845
Assets under management	1,086	1,938	8	3,032
Total assets at fair value	$ 16,774	$ 30,686	$ 181	$47,641
Percentage of total assets at fair value	35%	65%	—%	100%
December 31, 2017				
Cash and cash equivalents	$ 11,718	$ 263	$ —	$11,981
Debt securities — available-for-sale:				
U.S. government and agency obligations	2,428	216	—	2,644
State and municipal obligations	—	7,660	—	7,660
Corporate obligations	65	12,989	140	13,194
U.S. agency mortgage-backed securities	—	3,911	—	3,911
Non-U.S. agency mortgage-backed securities	—	1,015	—	1,015
Total debt securities — available-for-sale	2,493	25,791	140	28,424
Equity securities	1,784	14	194	1,992
Assets under management	1,117	1,984	—	3,101
Total assets at fair value	$ 17,112	$ 28,052	$ 334	$45,498
Percentage of total assets at fair value	38%	61%	1%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2018					
Debt securities — held-to-maturity	$ 260	$ 65	$ 295	$ 620	$ 621
Long-term debt and other financing obligations	$ —	$ 37,944	$ —	$ 37,944	$ 36,554
December 31, 2017					
Debt securities — held-to-maturity	$ 267	$ 4	$ 265	$ 536	$ 536
Long-term debt and other financing obligations	$ —	$ 34,504	$ —	$ 34,504	$ 31,542

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2018	December 31, 2017
Land and improvements	$ 566	$ 405
Buildings and improvements	4,470	3,664
Computer equipment	1,984	1,829
Furniture and fixtures	1,525	1,208
Less accumulated depreciation	(2,787)	(2,488)
Property and equipment, net	5,758	4,618
Capitalized software	4,054	3,601
Less accumulated amortization	(1,354)	(1,206)
Capitalized software, net	2,700	2,395
Total property, equipment and capitalized software, net	$ 8,458	$ 7,013

Depreciation expense for property and equipment for the years ended December 31, 2018, 2017 and 2016 was $924 million, $799 million and $698 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2018, 2017 and 2016 was $606 million, $550 million and $475 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2017	$ 23,854	$ 6,322	$ 4,449	$12,959	$ 47,584
Acquisitions	690	5,189	1,221	—	7,100
Foreign currency effects and adjustments, net	(60)	(23)	4	(49)	(128)
Balance at December 31, 2017	24,484	11,488	5,674	12,910	54,556
Acquisitions	2,723	471	106	1,881	5,181
Foreign currency effects and adjustments, net	(807)	(12)	(8)	—	(827)
Balance at December 31, 2018	$ 26,400	$ 11,947	$ 5,772	$14,791	$ 58,910

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2018			December 31, 2017		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$11,622	$ (3,908)	$7,714	$10,832	$ (3,743)	$7,089
Trademarks and technology	1,122	(512)	610	1,054	(432)	622
Trademarks and other indefinite-lived	745	—	745	561	—	561
Other	428	(172)	256	351	(134)	217
Total	$13,917	$ (4,592)	$9,325	$12,798	$ (4,309)	$8,489

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

(in millions, except years)	2018 Fair Value	2018 Weighted-Average Useful Life	2017 Fair Value	2017 Weighted-Average Useful Life
Customer-related	$1,355	17 years	$324	13 years
Trademarks and technology	122	4 years	367	11 years
Other	97	9 years	82	6 years
Total acquired finite-lived intangible assets	$1,574	16 years	$773	11 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2019	$889
2020	795
2021	724
2022	632
2023	593

Amortization expense relating to intangible assets for the years ended December 31, 2018, 2017 and 2016 was $898 million, $896 million and $882 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2018	2017	2016
Medical costs payable, beginning of period	$ 17,871	$ 16,391	$ 14,330
Acquisitions	339	83	—
Reported medical costs:			
Current year	145,723	130,726	117,258
Prior years	(320)	(690)	(220)
Total reported medical costs	145,403	130,036	117,038
Medical payments:			
Payments for current year	(127,155)	(113,811)	(101,696)
Payments for prior years	(16,567)	(14,828)	(13,281)
Total medical payments	(143,722)	(128,639)	(114,977)
Medical costs payable, end of period	$ 19,891	$ 17,871	$ 16,391

For the years ended December 31, 2018 and 2016, no individual factors significantly impacted medical cost reserve development. For the year ended December 31, 2017, medical cost reserve development was primarily driven by lower than expected health system utilization levels.

Medical costs payable included IBNR of $13.2 billion and $12.3 billion at December 31, 2018 and 2017, respectively. Substantially all of the IBNR balance as of December 31, 2018 relates to the current year. The following is information about incurred and paid medical cost development as of December 31, 2018:

(in millions)	Net Incurred Medical Costs For the Years ended December 31,	
Year	2017	2018
2017	$ 130,726	$ 130,441
2018		145,723
Total		$ 276,164

(in millions)	Net Cumulative Medical Payments For the Years ended December 31,	
Year	2017	2018
2017	$ (113,811)	$ (129,778)
2018		(127,155)
Total		(256,933)
Net remaining outstanding liabilities prior to 2017		660
Total medical costs payable		$ 19,891

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2018			December 31, 2017		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ —	$ —	$ —	$ 150	$ 150	$ 150
6.000% notes due February 2018	—	—	—	1,100	1,101	1,106
1.900% notes due July 2018	—	—	—	1,500	1,499	1,501
1.700% notes due February 2019	750	750	749	750	749	747
1.625% notes due March 2019	500	500	499	500	501	497
2.300% notes due December 2019	500	494	497	500	495	501
2.700% notes due July 2020	1,500	1,498	1,494	1,500	1,496	1,517
Floating rate notes due October 2020	300	299	298	300	299	300
3.875% notes due October 2020	450	443	456	450	446	467
1.950% notes due October 2020	900	897	884	900	895	892
4.700% notes due February 2021	400	398	412	400	403	425
2.125% notes due March 2021	750	747	734	750	746	744
Floating rate notes due June 2021	350	349	347	—	—	—
3.150% notes due June 2021	400	399	400	—	—	—
3.375% notes due November 2021	500	489	503	500	493	516
2.875% notes due December 2021	750	735	748	750	741	760
2.875% notes due March 2022	1,100	1,051	1,091	1,100	1,054	1,114
3.350% notes due July 2022	1,000	997	1,005	1,000	996	1,033
2.375% notes due October 2022	900	894	872	900	893	891
0.000% notes due November 2022	15	12	13	15	12	12
2.750% notes due February 2023	625	602	611	625	606	626
2.875% notes due March 2023	750	750	739	750	762	759
3.500% notes due June 2023	750	746	756	—	—	—
3.500% notes due February 2024	750	745	755	—	—	—
3.750% notes due July 2025	2,000	1,989	2,025	2,000	1,987	2,108
3.700% notes due December 2025	300	298	303	—	—	—
3.100% notes due March 2026	1,000	995	965	1,000	995	1,007
3.450% notes due January 2027	750	746	742	750	745	776
3.375% notes due April 2027	625	619	611	625	618	642
2.950% notes due October 2027	950	938	898	950	937	947
3.850% notes due June 2028	1,150	1,142	1,163	—	—	—
3.875% notes due December 2028	850	842	861	—	—	—
4.625% notes due July 2035	1,000	992	1,060	1,000	991	1,165
5.800% notes due March 2036	850	838	1,003	850	837	1,105
6.500% notes due June 2037	500	492	638	500	491	698
6.625% notes due November 2037	650	641	841	650	641	923
6.875% notes due February 2038	1,100	1,076	1,437	1,100	1,075	1,596
5.700% notes due October 2040	300	296	355	300	296	389
5.950% notes due February 2041	350	345	426	350	345	466
4.625% notes due November 2041	600	588	627	600	588	685
4.375% notes due March 2042	502	484	503	502	483	555
3.950% notes due October 2042	625	607	596	625	607	650
4.250% notes due March 2043	750	734	744	750	734	822
4.750% notes due July 2045	2,000	1,973	2,116	2,000	1,972	2,362
4.200% notes due January 2047	750	738	745	750	738	808
4.250% notes due April 2047	725	717	719	725	717	798
3.750% notes due October 2047	950	933	869	950	933	969
4.250% notes due June 2048	1,350	1,329	1,349	—	—	—
4.450% notes due December 2048	1,100	1,087	1,132	—	—	—
Total commercial paper and long-term debt	$35,667	$35,234	$36,591	$31,417	$31,067	$34,029

The Company's long-term debt obligations also included $1.3 billion and $625 million of other financing obligations, of which $229 million and $107 million were current as of December 31, 2018 and 2017, respectively.

Maturities of long-term debt for the years ending December 31 are as follows:

(in millions)	
2019	$ 1,973
2020	3,350
2021	3,350
2022	3,215
2023	2,325
Thereafter	22,775

Commercial Paper and Revolving Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers.

The Company has $3.5 billion five-year, $3.5 billion three-year and $3.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2023, December 2021 and December 2019, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2018, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2018, annual interest rates would have ranged from 3.2% to 3.6%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2018.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2018	2017	2016
Current Provision:			
Federal	$2,897	$3,597	$4,302
State and local	219	314	312
Foreign	404	254	95
Total current provision	3,520	4,165	4,709
Deferred provision (benefit)	42	(965)	81
Total provision for income taxes	$3,562	$3,200	$4,790

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2018		2017		2016	
Tax provision at the U.S. federal statutory rate	$3,348	21.0%	$4,908	35.0%	$4,152	35.0%
Change in tax law	—	—	(1,199)	(8.6)	—	—
State income taxes, net of federal benefit	168	1.0	197	1.4	205	1.7
Share-based awards — excess tax benefit	(161)	(1.0)	(319)	(2.3)	(158)	(1.3)
Non-deductible compensation	117	0.7	175	1.3	128	1.1
Health insurance industry tax	552	3.5	—	—	645	5.4
Foreign rate differential	(203)	(1.3)	(282)	(2.0)	(105)	(0.9)
Other, net	(259)	(1.6)	(280)	(2.0)	(77)	(0.6)
Provision for income taxes	$3,562	22.3%	$3,200	22.8%	$4,790	40.4%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2018	2017
Deferred income tax assets:		
Accrued expenses and allowances	$ 551	$ 544
U.S. federal and state net operating loss carryforwards	190	216
Share-based compensation	91	97
Nondeductible liabilities	184	169
Non-U.S. tax loss carryforwards	426	445
Other-domestic	306	167
Other-non-U.S.	337	198
Subtotal	2,085	1,836
Less: valuation allowances	(84)	(64)
Total deferred income tax assets	2,001	1,772
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,131)	(1,998)
Non-U.S. goodwill and intangible assets	(709)	(602)
Capitalized software	(603)	(530)
Depreciation and amortization	(266)	(236)
Prepaid expenses	(152)	(223)
Outside basis in partnerships	(300)	(279)
Other-non-U.S.	(314)	(86)
Total deferred income tax liabilities	(4,475)	(3,954)
Net deferred income tax liabilities	$(2,474)	$(2,182)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $99 million expire beginning in 2022 through 2037 and $17 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2019 through 2038. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2018, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2018	2017	2016
Gross unrecognized tax benefits, beginning of period	$ 598	$ 263	$ 224
Gross increases:			
Current year tax positions	487	356	37
Prior year tax positions	87	40	24
Gross decreases:			
Prior year tax positions	(84)	(33)	(4)
Settlements	(20)	(24)	(6)
Statute of limitations lapses	(12)	(4)	(12)
Gross unrecognized tax benefits, end of period	$1,056	$ 598	$ 263

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $118 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2018, 2017 and 2016, the Company recognized $6 million, $14 million and $11 million of interest and penalties, respectively. The Company had $95 million and $84 million of accrued interest and penalties for uncertain tax positions as of December 31, 2018 and 2017, respectively. These amounts are not included in the reconciliation above. As of December 31, 2018, there were $716 million of unrecognized tax benefits that, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2018 and 2017 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2012 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2013 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries in the United States are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For both the years ended December 31, 2018 and 2017, the Company's regulated subsidiaries paid their parent companies dividends of $3.7 billion, including $1.1 billion of extraordinary dividends.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of $23.7 billion as of December 31, 2018. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $10.3 billion as of December 31, 2018.

Optum Bank must meet minimum capital requirements of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2018, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2018, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2018 and 2017 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	2018	2017
Common share repurchases, shares	19	9
Common share repurchases, average price per share	$236.72	$173.54
Common share repurchases, aggregate cost	$ 4,500	$ 1,500
Board authorized shares remaining	94	42

Dividends

In June 2018, the Company's Board of Directors increased the Company's annual dividend rate to shareholders to $3.60 per share compared to $3.00 per share, which the Company had paid since June 2017. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2018, the Company had 42 million shares available for future grants of share-based awards under the Plan. As of December 31, 2018, there were also 7 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2018 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	37	$ 102		
Granted	7	229		
Exercised	(8)	78		
Forfeited	(1)	162		
Outstanding at end of period	35	131	6.5	$ 4,114
Exercisable at end of period	16	87	5.0	2,560
Vested and expected to vest, end of period	34	129	6.5	4,072

Restricted Shares

Restricted share activity for the year ended December 31, 2018 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	7	$ 128
Granted	2	229
Vested	(3)	119
Nonvested at end of period	6	163

Other Share-Based Compensation Data

(in millions, except per share amounts)	For the Years Ended December 31, 2018	2017	2016
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 43	$ 29	$ 20
Total intrinsic value of stock options and SARs exercised	1,431	1,473	595
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	229	163	115
Total fair value of restricted shares vested	$ 521	$ 460	$274
Employee Stock Purchase Plan			
Number of shares purchased	2	2	2
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 638	$ 597	$485
Share-based compensation expense, net of tax effects	587	531	417
Income tax benefit realized from share-based award exercises	239	431	236

(in millions, except years)	December 31, 2018
Unrecognized compensation expense related to share awards	$ 628
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	For the Years Ended December 31,		
	2018	2017	2016
Risk-free interest rate	2.6% - 3.1%	1.9% - 2.1%	1.2% - 1.4%
Expected volatility	18.7% - 19.3%	18.5% - 20.7%	20.8% - 22.5%
Expected dividend yield	1.3% - 1.5%	1.4% - 1.6%	1.8%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.6	5.7	5.6 - 5.9

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2018, 2017 and 2016.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $988 million and $865 million as of December 31, 2018 and 2017, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for the years ended December 31, 2018, 2017 and 2016 was $751 million, $710 million and $608 million, respectively.

As of December 31, 2018, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2019	$ 669
2020	592
2021	511
2022	423
2023	338
Thereafter	1,343

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2018, 2017 or 2016.

As of December 31, 2018, the Company had outstanding, undrawn letters of credit with financial institutions of $83 million and surety bonds outstanding with insurance companies of $1.3 billion, primarily to bond contractual performance.

Pending Acquisition

In December 2017, the Company entered into an agreement to acquire a company in the health care sector for a total of approximately $4.3 billion.

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Similarly, our international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower's complaint, which was unsealed on February 15, 2017, alleges that the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. Those motions were argued in September 2018. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits and health care delivery.
- *OptumHealth* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. OptumHealth serves the physical, emotional and health-related financial needs of individuals, enabling population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* provides services, technology and health care expertise to major participants in the health care industry. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and compounding pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 30%, 28% and 25% for 2018, 2017 and 2016, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 96%, 96% and 97% of consolidated total revenues for 2018, 2017 and 2016, respectively. Long-lived fixed assets located in the United States represented approximately 76% and 77% of the total long-lived fixed assets as of December 31, 2018 and 2017, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum: OptumHealth	Optum: OptumInsight	Optum: OptumRx	Optum: Optum Eliminations	Optum: Optum	Corporate and Eliminations	Consolidated
2018								
Revenues — unaffiliated customers:								
Premiums	$ 174,282	$ 3,805	$ —	$ —	$ —	$ 3,805	$ —	$ 178,087
Products	—	52	111	29,438	—	29,601	—	29,601
Services	8,366	4,925	3,280	612	—	8,817	—	17,183
Total revenues — unaffiliated customers	182,648	8,782	3,391	30,050	—	42,223	—	224,871
Total revenues — affiliated customers	—	14,882	5,596	39,440	(1,409)	58,509	(58,509)	—
Investment and other income	828	481	21	46	—	548	—	1,376
Total revenues	$ 183,476	$ 24,145	$ 9,008	$ 69,536	$ (1,409)	$101,280	$ (58,509)	$ 226,247
Earnings from operations	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ —	$ 17,344
Interest expense	—	—	—	—	—	—	(1,400)	(1,400)
Earnings before income taxes	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ (1,400)	$ 15,944
Total assets	$ 82,938	$ 29,837	$ 11,039	$ 33,912	$ —	$ 74,788	$ (5,505)	$ 152,221
Purchases of property, equipment and capitalized software	761	593	517	192	—	1,302	—	2,063
Depreciation and amortization	845	439	654	490	—	1,583	—	2,428
2017								
Revenues — unaffiliated customers:								
Premiums	$ 154,709	$ 3,744	$ —	$ —	$ —	$ 3,744	$ —	$ 158,453
Products	—	44	106	26,216	—	26,366	—	26,366
Services	7,890	4,013	2,849	565	—	7,427	—	15,317
Total revenues — unaffiliated customers	162,599	7,801	2,955	26,781	—	37,537	—	200,136
Total revenues — affiliated customers	—	12,429	5,127	36,954	(1,227)	53,283	(53,283)	—
Investment and other income	658	340	5	20	—	365	—	1,023
Total revenues	$ 163,257	$ 20,570	$ 8,087	$ 63,755	$ (1,227)	$ 91,185	$ (53,283)	$ 201,159
Earnings from operations	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ —	$ 15,209
Interest expense	—	—	—	—	—	—	(1,186)	(1,186)
Earnings before income taxes	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ (1,186)	$ 14,023
Total assets	$ 76,676	$ 26,931	$ 11,273	$ 29,551	$ —	$ 67,755	$ (5,373)	$ 139,058
Purchases of property, equipment and capitalized software	737	510	588	188	—	1,286	—	2,023
Depreciation and amortization	758	380	614	493	—	1,487	—	2,245
2016								
Revenues — unaffiliated customers:								
Premiums	$ 140,455	$ 3,663	$ —	$ —	$ —	$ 3,663	$ —	$ 144,118
Products	1	48	103	26,506	—	26,657	—	26,658
Services	7,514	2,498	2,670	554	—	5,722	—	13,236
Total revenues — unaffiliated customers	147,970	6,209	2,773	27,060	—	36,042	—	184,012
Total revenues — affiliated customers	—	10,491	4,559	33,372	(1,088)	47,334	(47,334)	—
Investment and other income	611	208	1	8	—	217	—	828
Total revenues	$ 148,581	$ 16,908	$ 7,333	$ 60,440	$ (1,088)	$ 83,593	$ (47,334)	$ 184,840
Earnings from operations	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ —	$ 12,930
Interest expense	—	—	—	—	—	—	(1,067)	(1,067)
Earnings before income taxes	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ (1,067)	$ 11,863
Total assets	$ 70,505	$ 18,656	$ 9,017	$ 29,066	$ —	$ 56,739	$ (4,434)	$ 122,810
Purchases of property, equipment and capitalized software	640	345	571	149	—	1,065	—	1,705
Depreciation and amortization	724	297	559	475	—	1,331	—	2,055

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2018 and 2017 is as follows:

	For the Quarter Ended			
(in millions, except per share data)	March 31	June 30	September 30	December 31
2018				
Revenues	$ 55,188	$ 56,086	$ 56,556	$ 58,417
Operating costs	51,135	51,882	51,966	53,920
Earnings from operations	4,053	4,204	4,590	4,497
Net earnings	2,924	3,010	3,284	3,164
Net earnings attributable to UnitedHealth Group common shareholders	2,836	2,922	3,188	3,040
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.94	3.04	3.31	3.16
Diluted	2.87	2.98	3.24	3.10
2017				
Revenues	$ 48,723	$ 50,053	$ 50,322	$ 52,061
Operating costs	45,310	46,322	46,234	48,084
Earnings from operations	3,413	3,731	4,088	3,977
Net earnings	2,191	2,350	2,561	3,721
Net earnings attributable to UnitedHealth Group common shareholders	2,172	2,284	2,485	3,617
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.28	2.37	2.57	3.73
Diluted	2.23	2.32	2.51	3.65

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2018. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2018.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2018

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2018. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013)*. Based on our assessment and the COSO criteria, we believe that, as of December 31, 2018, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2018, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2018, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control—Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2018, of the Company and our report dated February 12, 2019, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2018. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 12, 2019, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP

Richard T. Burke
Lead Independent Director
UnitedHealth Group

Timothy P. Flynn
Retired Chair
KPMG International

Stephen J. Hemsley
Executive Chair
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council

F. William McNabb III
Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Valerie Montgomery Rice, M.D
President and Dean
Morehouse School of Medicine

Glenn M. Renwick
Chair
Fiserv, Inc.

David S. Wichmann
Chief Executive Officer
UnitedHealth Group

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Proposal 1-Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and

"Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2018, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders [1]	33	$ 135	49[3]
Equity compensation plans not approved by shareholders [2]	—	—	—
Total [2]	33	$ 135	49

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended.

(2) Excludes 1,676,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of $59 and an average remaining term of approximately 5 years. These options are administered pursuant to the terms of the plans under which the options originally were granted. No future awards will be granted under these acquired plans.

(3) Includes 7 million shares of common stock available for future issuance under the 1993 Employee Stock Purchase Plan as of December 31, 2018, and 42 million shares available under the 2011 Stock Incentive Plan as of December 31, 2018. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements and Supplementary Data*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2018 and 2017.
- Consolidated Statements of Operations for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017, and 2016.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1 Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)

3.2 Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on August 16, 2017)

4.1 Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)

4.2 Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)

4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2018
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014)
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)

10.12	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.13	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.16	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.18	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.19	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.20	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.21	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.22	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.23	Sixth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.24	Seventh Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.24 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2016)
*10.25	Eighth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 4.9 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-224254, filed on April 12, 2018)
*10.26	Summary of Non-Management Director Compensation, effective as of October 1, 2018

*10.27 UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)

*10.28 Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)

*10.29 First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)

*10.30 Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)

*10.31 Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)

*10.32 Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)

*10.33 Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)

*10.34 Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)

*10.35 Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)

*10.36 Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)

*10.37 The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)

*10.38 The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)

*10.39 Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)

*10.40 Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)

*10.41	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.42	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.43	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of June 7, 2016, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.44	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.45	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.46	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.47	Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.48	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.49	Amended and Restated Employment Agreement, effective as of March 24, 2015, between United HealthCare Services, Inc. and Steven H. Nelson (incorporated by reference to Exhibit 10.51 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2017)
*10.50	Employment Agreement, effective as of June 3, 2018, between United HealthCare Services, Inc. and Andrew Witty
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data")
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

32.1 Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

101 The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2018, filed on February 12, 2019, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2018 and 2017, and for each of the three years in the period ended December 31, 2018, and the Company's internal control over financial reporting as of December 31, 2018, and have issued our reports thereon dated February 12, 2019; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 434	$ 359
Other current assets	197	575
Total current assets	631	934
Equity in net assets of subsidiaries	83,244	76,231
Long-term notes receivable from subsidiaries	4,461	4,278
Other assets	972	839
Total assets	$ 89,308	$ 82,282
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 618	$ 502
Current portion of notes payable to subsidiaries	714	466
Commercial paper and current maturities of long-term debt	1,744	2,749
Total current liabilities	3,076	3,717
Long-term debt, less current maturities	33,490	28,318
Long-term notes payable to subsidiaries	560	1,518
Other liabilities	486	953
Total liabilities	37,612	34,506
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value -10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 960 and 969 issued and outstanding	10	10
Additional paid-in capital	—	1,703
Retained earnings	55,846	48,730
Accumulated other comprehensive loss	(4,160)	(2,667)
Total UnitedHealth Group shareholders' equity	51,696	47,776
Total liabilities and shareholders' equity	$ 89,308	$ 82,282

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Investment and other income	$ 194	$ 527	$ 522
Total revenues	194	527	522
Operating costs:			
Operating costs	35	—	(22)
Interest expense	1,285	1,114	995
Total operating costs	1,320	1,114	973
Loss before income taxes	(1,126)	(587)	(451)
Benefit for income taxes	251	214	165
Loss of parent company	(875)	(373)	(286)
Equity in undistributed income of subsidiaries	12,861	10,931	7,303
Net earnings	11,986	10,558	7,017
Other comprehensive (loss) income	(1,517)	14	653
Comprehensive income	$10,469	$10,572	$7,670

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2018	2017	2016
Operating activities			
Cash flows from operating activities	$6,099	$ 2,021	$4,294
Investing activities			
Issuances of notes to subsidiaries	(1,420)	—	(824)
Repayments of notes to subsidiaries	1,419	2,071	—
Cash paid for acquisitions	(4,066)	(2,313)	(2,292)
Return of capital to parent company	4,196	3,375	2,143
Capital contributions to subsidiaries	(1,259)	(959)	(765)
Other, net	4	—	168
Cash flows (used for) from investing activities	(1,126)	2,174	(1,570)
Financing activities			
Common stock repurchases	(4,500)	(1,500)	(1,280)
Proceeds from common stock issuances	838	688	429
Cash dividends paid	(3,320)	(2,773)	(2,261)
Repayments of commercial paper, net	(201)	(3,508)	(382)
Proceeds from issuance of long-term debt	6,935	5,291	3,968
Repayments of long-term debt	(2,600)	(3,472)	(2,596)
(Repayments) proceeds of notes from subsidiary	(1,127)	1,704	(30)
Other, net	(923)	(446)	(421)
Cash flows used for financing activities	(4,898)	(4,016)	(2,573)
Increase in cash and cash equivalents	75	179	151
Cash and cash equivalents, beginning of period	359	180	29
Cash and cash equivalents, end of period	$ 434	$ 359	$ 180
Supplemental cash flow disclosures			
Cash paid for interest	$1,294	$ 1,062	$ 974
Cash paid for income taxes	2,379	3,455	4,557
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ —	$ 2,164	$ —
Conversion of note receivable from subsidiaries to equity	—	4,378	—

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.6 billion, $3.4 billion and $3.7 billion in 2018, 2017 and 2016, respectively. Additionally, $4.2 billion, $3.4 billion and $2.1 billion in cash were received as a return of capital to the parent company during 2018, 2017 and 2016, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries that totaled $1.3 billion and $625 million at December 31, 2018 and 2017, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2019	$ 1,750
2020	3,150
2021	3,150
2022	3,015
2023	2,125
Thereafter	22,477

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 12, 2019

UNITEDHEALTH GROUP INCORPORATED

By /s/ DAVID S. WICHMANN

David S. Wichmann
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ DAVID S. WICHMANN **David S. Wichmann**	Director and Chief Executive Officer (principal executive officer)	February 12, 2019
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 12, 2019
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 12, 2019
* **William C. Ballard, Jr.**	Director	February 12, 2019
* **Richard T. Burke**	Director	February 12, 2019
* **Timothy P. Flynn**	Director	February 12, 2019
* **Stephen J. Hemsley**	Director	February 12, 2019
* **Michele J. Hooper**	Director	February 12, 2019
* **F. William McNabb III**	Director	February 12, 2019
* **Valerie Montgomery Rice**	Director	February 12, 2019
* **Glenn M. Renwick**	Director	February 12, 2019
* **Gail R. Wilensky**	Director	February 12, 2019

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

Appendix VI.A.1.h.
Similar Projects Matrix

Appendix VI.A.1.h. - Similar Projects Matrix

We have selected Georgia, Maryland, and Oregon as projects similar to Nebraska for TFN review. While all of our Quitline client states are different, there are many similarities between Nebraska and these three states:

- We serve Medicaid-eligible participants in all four states.
- All four states have adult smoking prevalence rates in the range of 13.8 to 17.5 percent, close to the national average.
- All four states have a percentage of smokers among those who earn less than $25,000 per year, from 24 to 29.4 percent
- The percentage of those with less than a high school diploma who smoke is also similar in all four states, from 24.0 to 26.4 percent
- All four states have a youth cigarette smoking rate (<18 years) of between 7.4 and 8.2 percent
- Nebraska, Georgia and Oregon have a significant number of smokers living in rural communities

(State data rates are taken from https://www.cdc.gov/statesystem/cigaretteuseadult.html , https://www.americashealthrankings.org/explore/annual/measure/Smoking/state/ , https://www.lung.org/our-initiatives/research/monitoring-trends-in-lung-disease/tobacco-trend-brief/rates-by-state.html , and https://www.tobaccofreekids.org/assets/factsheets/0176.pdf)

Additionally, while the services we provide are dependent on our partner states' needs, goals, and funding, we do provide the following services in all four states:

- Reactive and proactive counseling services for residents regardless of health insurance status
- Direct mail order NRT for eligible non-Medicaid residents
- Integrated Web- based services
- Provision of printed materials
- Fax Referral program
- Referrals to community resources
- Tailored service protocols for priority populations

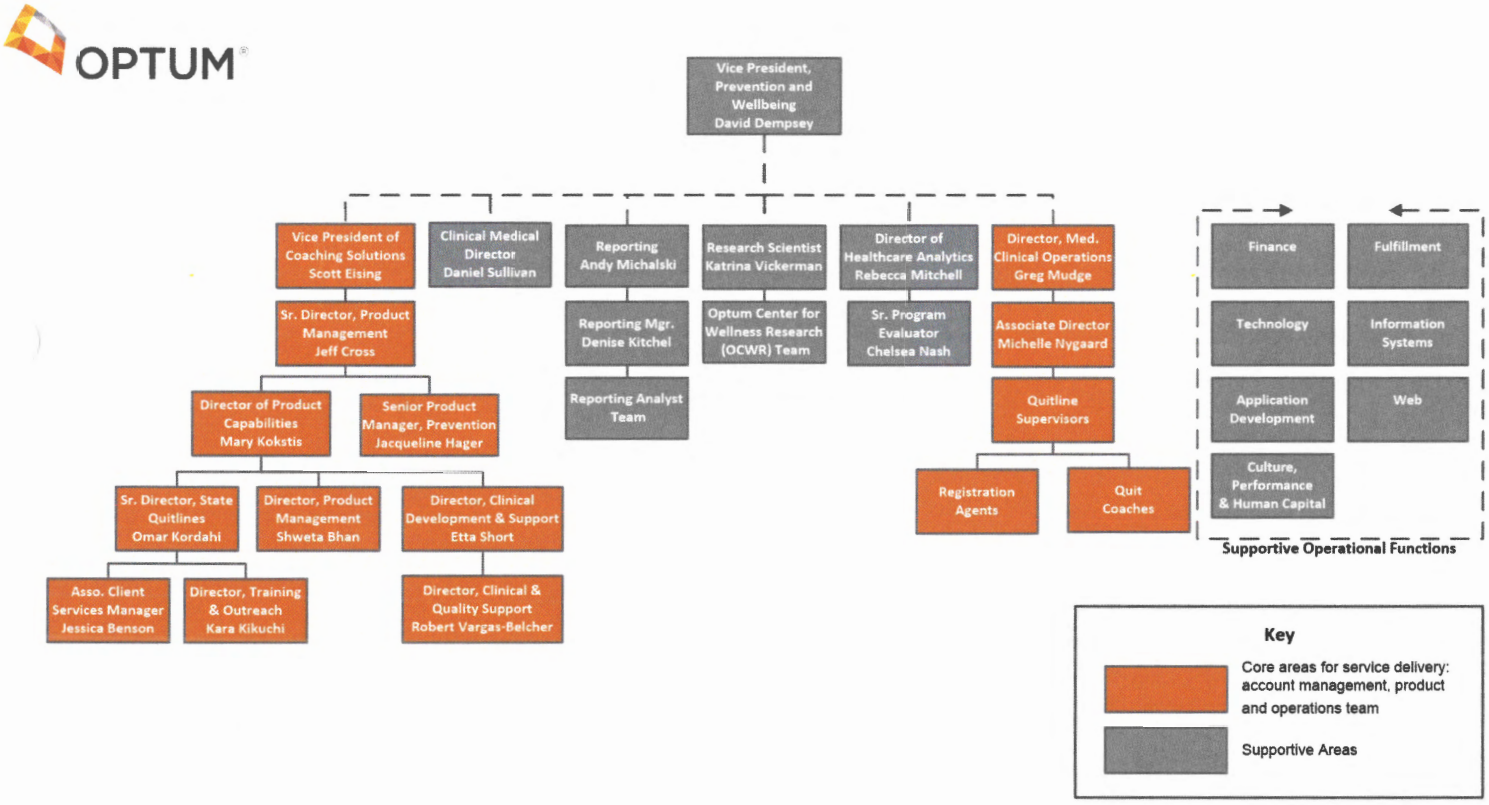
The following summary matrix reflects Optum's previous experience with three projects similar to Nebraska in size, scope, and complexity. It illustrates the following:

- Project Name
- The Time Period of service provision, scheduled and actual completion dates of a previous project (contract cycle), and the scheduled completion date of the current project (contract cycle).
- Optum's responsibilities under the Project
- Reference information
- Our status and Prime Contractor or Subcontractor, with annual revenues for the previous and current contract cycles.

PROJECT:	TIME PERIOD, SCHEDULED AND ACTUAL COMPLETION DATES	OPTUM'S RESPONSIBILITIES AND PROJECT DESCRIPTION	REFERENCE INFORMATION	PRIME CONTRACTOR/ SUBCONTRACTOR AND ORIGINAL BUDGET AND CURRENT BUDGET
Georgia Tobacco Quit Line	Continuous since 10/2001 Prev. Sched.: 6/2019 Prev. Actual: 6/2019 Current Sched.: 6/2020	Services Provided: Reactive and proactive counseling services to all residents 13+ years old; direct mail order NRT to all adults; supportive text messaging; integrated Web Coach; printed materials; referrals to community resources; fax referral and e-referral program	Contact: Colleen Commons Tobacco Cessation Program Manager Georgia Tobacco Quitline Georgia Department of Public Health 2 Peachtree Street, NW, 16th Floor Atlanta, GA 30303 Phone: (404) 657-2491 Email: colleen.commons@dph.ga.gov	Optum worked as Prime Contractor Previous Budget $1,600,000/year Current Budget $1,400,000/year
Maryland Tobacco Quitline	Continuous since 6/2006 Prev. Sched.: 12/2017 Prev. Actual: 12/2017 Current Sched.: 6/2022	Services Provided: Reactive and proactive counseling services for adults regardless of health insurance status; specialized services for tobacco users reporting behavioral health conditions; direct mail order NRT; provision of Medicaid cessation medications; fax referral and e-referral program; Web-only product including direct mail order NRT; text messaging; printed materials; incentives for pregnant tobacco users; referrals to community resources; participation in reach studies; outcomes evaluation	Contact: Sara Wolfe, MS, Chief, Cessation and Health Systems Initiatives Center for Tobacco Prevention & Control Prevention and Health Promotion Admin Maryland Department of Health 201 West Preston Street Baltimore, MD 21201 Phone: (410) 767-1364 Email: sara.wolfe@maryland.gov	Optum worked as Prime Contractor Previous Budget $1,473,933/year Current Budget $2,498,466/year
Oregon Tobacco Quit Line	Continuous since 11/1998 Prev. Sched.: 11/2019 Prev. Actual: 11/2019 Current Sched.: 11/2024	Services Provided: Reactive and proactive counseling services for adults, youth, Medicaid; specialized services for Native Americans; integration with chronic conditions program, direct mail order NRT; fax and e-referral program; integrated Web-based services; Web-only product including direct mail order NRT; printed materials; referral to community resources; participation in reach studies and randomized control trials; cost shares with Medicaid fee-for-service and Medicaid managed care organizations	Contact: J. Hildegard Hinkel, MPH Health Systems Policy Specialist OREGON HEALTH AUTHORITY Public Health Division Health Promotion & Chronic Disease Prevention Office: (971) 673-3182 Cell: (971) 212-1661 Email: janet.h.hinkel@state.or.us	Optum worked as Prime Contractor Previous Budget $716,523/year Current Budget $541,378/year

Appendix VI.A.1.i.a. Organizational Chart

Appendix VI.A.1.i.a. Organizational Chart



Appendix VI.A.1.i.b. Resumes of Key Personnel

Jeff Cross

Senior Director, Product

Experience Summary

Accomplished strategic leader with over 10 years in the medical/insurance industry with a focus on health behavior change and product launch.

- Strategic Planner
- Project Management
- Public Health Strategist

Work Experience

Senior Director, Product, Optum, MN, 2018 - Present

- Responsible for Optum's tobacco cessation product line, Quit for Life
- Manage team of ten product managers and specialists
- Lead product strategy analysis of Optum's State tobacco quit-line product

Service Line Administrator, Mayo Clinic, MN, 2010 - 2016

- Managed Mayo Clinic's commercial Care Management service line, including products for symptom assessment, remote medical support, health behavior change, disease management, and case management.
- Directed the business strategy, product development, and financial performance of the $20M service line
- Managed product development and go-to-market teams while monitoring performance to ensure optimal efficiency.
- Reduced per-unit operating expense and launched high-margin digital and specialized products to improve service line net income by 94% over 3 years, converting businesses from red to black.
- Managed lifecycle for 20+ products, launched 7 new products, and sunset 4 products within 3 years.
- Created standardized product plan template used across the business unit for annual planning, monthly financial performance and product development roadmaps.

Product Manager

- Managed $9M commercial business serving 2.2M covered lives to generate division-leading profitability.
- Developed and launched Ask Mayo Clinic Online (a web-based self-triage application) and the Ask Mayo Clinic
- Critical Illness Support (a specialized medical information service distributed nationally by leading voluntary insurance carriers).
- Interfaced with Mayo Clinic leadership, corporate clients and senior executives to share best practices and insights to drive productivity.
- Facilitated annual project planning, budgeting, pricing, and forecasting for product line to maximize ROI with a focus on zero profit erosion.
- Formulated a partnership with AARP to convert a telephonic product into a digital product for enhanced efficiency.
- Recouped a $4M fledgling product line to break-even.
- Supervised and trained 3 direct reports on best practices and protocol to maximize performance.

Product Manager, American Cancer Society, GA, 2005 – 2009

- Oversaw sales and account team delivery of Workplace Solutions Consulting across 13 divisions nationally while leading consulting engagements with Fortune 1000 clients.
- Conducted financial analyses, program evaluation, and market research to grow product line.
- Directed and oversaw product training certification for 1,000+ staff over 4 years.

Research Coordinator, University of Washington, WA, 2003 – 2005

Education

- Master of Public Health, Epidemiology, University of Washington
- Bachelor of Arts, Anthropology, University of Florida
- Bachelor of Science, Zoology, University of Florida
- Certification, Pragmatic Marketing, Product Management and Marketing
- Certification, Adopting and Adapting Agility, Agile Project Management

Technical Skills

Presentations

- Consumer Health and Wellness Innovation Conference, 2013
- BenefitFocus National Employer Conference, 2012
- 22nd National Conference on Health, Productivity, and Human Capital
- 18th National Conference on Chronic Disease Prevention and Control, 2004

References

- Jeni Klein, Senior Client Services Manager
  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206) -876-2355
  Email: Jeni.Klein@optum.com
- Maria Martin, Senior Client Services Manager
  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206)-876-2117
  Email: Maria.Martin2@optum.com
- Ashley Speight, Client Services Manager
  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206) 876-2151
  Email: Ashley.Speight@optum.com

Mary M. Kokstis

Senior Director, Client Services and Product Management

Experience Summary

Experienced healthcare leader, passionate about improving people's health and wellness. Motivated and capable strategist with the drive and energy required to create positive health centered culture. Creative and inspired to reduce or eliminate measurable, sub-optimal health conditions and behaviors that lead to chronic disease and premature death.

Work Experience

Senior Director, Client Services & Product Management, Optum, WA, 2014 - Present

The leader in population health management, serving the physical, emotional and financial needs of more than 61 million individuals, enabling consumer health management and integrated care delivery through programs offered by employers, payers, government entities and directly through the care delivery system.

- Set strategy and managed product roadmap for innovation
- Monitored the health of the wellness product portfolio, including outcomes and Net Promoter Score
- Collaborated cross-departmentally to develop end to end new products
- Interfaced with the sales and account management teams to understand market needs for three distinct client segments: employer, payer and government

Vice President, Client Services, Alere Wellbeing, WA, 2012 - 2014

Alere Wellbeing's mission is to provide products and services that identify and reduce or eliminate measurable, sub-optimal health conditions and behaviors that lead to chronic disease and premature death. Responsible for the company's client management and retention of 600+ clients. Three client segments employers; government and health plans. 72 of employer accounts in Fortune 500.

- 99% client retention
- Developed strategy, content and sales direction in responding to state RFPs
- Participated in national conversations and partnerships to support the growth, funding and sustainment of quit lines
- Built team and structure supporting three distinct client segments (Employers, Health plans, and State governments) and managing multi-year, complex contracts

Senior Director, Client Services, Alere Wellbeing, WA, 2006 – 2012

- Managed staff of four Client Managers dedicated to serving state quit lines
- Monitored overall performance of quit line clients
- Managed overall budget against utilization and provided recommendations to team in service adjustments or budget justification
- Acted as subject matter expert in the launch of 12 state quit lines
- Implemented enhancements to services including reporting capabilities, MDS recommendations, and digital enhancements including texting and web-based services
- Provided consultation to states on best practices of services, evaluation and promotion

Senior Client Services Manager, Client Services, Free & Clear, Inc., WA, 2003 – 2006

Spun out of Group Health Cooperative, Free & Clear was a venture backed, startup company focused on reducing the tobacco prevalence through evidence based telephonic coaching for employers, health plans and state government.

- Single point of contract for client advocacy within the organization
- Led tactical and strategic in person and telephonic client meetings
- Leveraged data to analyze utilization trends and demographics to make recommendations on promotion, evaluation and service structure
- Participated in the development of proposals for new sales and add-on sales

Registration Supervisor/Implementation Specialist, Operations, Group Health Cooperative, WA, 2002 – 2003

Group Health Cooperative is a member-governed, nonprofit health care system that coordinates care and coverage. Founded in 1947 and based in Seattle, Wash., Group Health and its subsidiary health carrier Group Health Options, Inc. serve more than 600,000 residents of Washington and North Idaho.

- Supervised 20 call center staff to ensure high levels of external and internal customer service, live response expectations through appropriate staffing and accurate data collection.
- Acted as an advocate for registration staff by working with project managers product developers and CRM to enhance products in a manner that successfully meets staff and the client needs.
- Managed business relationship with printing and fulfillment vendors for material reprint and creation with an emphasis of reducing cost for client.
- Owner of corporate initiatives, resulting in implementation of effective internal communication modes and organization of department space needs.
- Began half time development work in April 2001 while in Registration Services.
- Assisted in the development and implementation of four state tobacco quitlines and add on products to already existing services
- Responsibilities included coordination and development of external and internal telecommunication needs, database development and enhancements, development of customized printed materials and training materials for end users.
- Created and conducted training for staff on new products and services.
- Created work plans to ensure timely completion of tasks and communicated frequently with project manager through ad-hoc meetings and conference calls with client to ensure client expectations were met

Lead Registration Agent, Operations, Group Health Cooperative, WA, 2000 – 2002

Began in March 2000 and promoted to Lead in November 2001

- Answered incoming 800# calls from participants seeking tobacco cessation services.
- Point person for staff with questions or to provide immediate coaching/debriefing of calls for staff.
- Assured call center quality standards through excellent customer service, spot checking of files and performing staff evaluations.
- Troubleshoot/problem solve database and voice technology issues effecting staff responsibilities

Education

- BS Degree in fitness and Exercise Science, Western Washington University, Bellingham, WA
- BS Degree in Community Health, Western Washington University, Bellingham, WA

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Omar Kordahi

Associate Director, Client Services

Experience Summary

Strategic, action-oriented client services healthcare leader, with experience managing complex service contracts within state agencies and Fortune 500, mid-market and startup environments.

Work Experience

Associate Director, Client Services, Optum, Seattle, WA, 2020-Present

- Manage staff of Client Service Managers dedicated to serving state quit lines
- Monitor overall performance of state quit line deliverables and overall budget against utilization.
- Collaborate across departments to streamline processes and procedures

Senior Director of Customer Success, American Well, Inc., Seattle, WA, 2017-2020

- Lead a team of 10 customer success managers serving as the voice of the customer.
- Created playbooks around customer churn reduction, net retention and communication.
- Streamlined and clarified the client onboarding process, featuring an interactive end-user Winning Start guide.
- Rolled out customer health score tracking methodology to identify customer risk factors, prompting proactive measures that reduce churn among at-risk clients
- Rolled out a playbook to identify customer segmentation and contact cadence and then leveraged findings to drive proactive customer communication from 18% to 90%; wrote curriculum and delivered playbook training to the success team and the sales director
- Implemented a team culture initiative that raised employee happiness survey scores from 6.8 to 8.4 out of 10, the company's second highest

Director of Customer Success, Avizia, Inc. Seattle, WA, 2015 – 2017

- Lead an account management team that is responsible for maintaining client relationships and achieving revenue objectives by identifying new opportunities and strategic integrations.
- Implemented renewal forecasting and tracking methodology providing insight into customer renewal health, goals, and opportunities and risks.
- Developed processes for scalability and efficiency as well as establish implementation timelines and deliverable schedules for expansion programs.
- Exceeded annual goals with contract renewal rate above 95% for our book of business.
- Created a collaborative environment between internal team by streamlining processes and procedures.

Director of Client Services, Optum, Seattle, WA, 2007 – 2015

- Managed client relationships and overall satisfaction, leading to retention, account growth and profitability.
- Oversaw five direct reports and acts as trainer for new hire Client Services Managers.
- Provided account management support for payers, employers and government accounts, including strategic guidance, complex data analysis and custom reporting, upsell opportunities, support with promotional efforts, and presentations to executives.
- Acts as advocate for clients; coordinates with internal work groups, finance, legal, application development, product and HR to meet or exceed client expectations.

Program Manager, Excell Data (Microsoft Corp. Assignment), Redmond, WA, 2006-2007

- Managed annual plan including schedules, status reports, key performance indicators, and rhythm of project.
- Controlled project performance against plan, deliverables and resource usage.
- Provided support for business process analysis for new systems including data management, change management and incident management solutions for the Client Services Organization.
- Created reference documents, training materials including PowerPoint demos and style guides for model building.

Account Manager, Johnson Controls Inc., Bothell, WA, 2002 – 2006

- Managed day-to-day operations of a $6M service business achieving company goals by coordinating and teaming with field organization.
- Increased contract Gross Margin by 12.5% over a 2-year period through monthly business reviews.
- Achieved 95% customer satisfaction and conducted weekly reviews of asset management to ensure our financial commitments are being met.
- Maintained a 95% contract renewal on existing customers.

Education

- Bachelor of Arts, Business Administration, University of Washington

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Jessica Benson

Client Services Associate, Client Services

Experience Summary

Experienced Associate Account Manager with a demonstrated history of working in health, wellness and tobacco cessation. Skilled in communication and presentation, problem-solving and customer service.

Work Experience

Associate Account Manager, Client Services, Optum, HI, 2019 - Present

Serve as the ultimate advocate for clients within Optum. Responsible for key strategic client relationships by ensuring overall client satisfaction, retention and account growth. Keeping Optum and clients compliant with all contractual agreements, deliverables, timelines and budget management.

- Maintain overall accountability for client satisfaction, retention and growth.
- Provide leadership for state client projects and see through to implementation.
- Use strong industry knowledge to add value to the management of state client's accounts.
- Establish and maintain effective relationships with state clients and business partners.
- Ensure consistent lines of communication and timely follow up with client requests.
- Investigate and manage client issues through root cause analysis and communicate outcomes with clients.
- Maintain client business plan and negotiate contract retention/renewal.
- Collaborate with cross-functional business partners/departments including marketing, service delivery, finance and reporting for client needs.

Client Services Analyst, Client Services, Optum, HI, 2016 - 2019

- Worked in rapidly changing environment that was dynamic and deadline driven.
- Monitored and delivered reporting suite of weekly, monthly and quarterly reports for state clients.
- Provided explanations and interpretations within area of expertise.
- Provided research assistance with data analysis and reporting concerns.
- Assisted in developing client presentations and projects.

Health Coach, Operations, Optum, HI, 2011 - 2016

- Managed a caseload to facilitate successful weight loss, stress management, alcohol reduction and tobacco cessation outcomes over the course of 2 years for National Veteran Administration Pilot Study.
- Flexed between Weight Talk, Florida Weight Management Program, Best Quit Study and Quit for Life Programs while meeting Service Delivery expectations in each program.
- Created tailored planning during each intervention using Cognitive Behavioral Therapy and Motivational Interviewing.
- Adapted to regular changes in call quality and work flow policies in order to best support regularly changing business needs.
- Served as IP Helper/Trainer for Weight Talk and Quit for Life programs.
- Responsible for delivering evidenced-based educational information as it pertains to each participant's health concerns and/or chronic health conditions.
- Participated in Written Communication Project to provide email based support for various programs.
- Provided ongoing feedback on intervention strategies and call structure to increase participant outcome goal success.
- Chosen from peers to participant in facilitation of a Weight-Stress study including 75 participants who reported high stress eating and concentration on stress reduction strategies.

Quit Coach I & Quit Coach II, Operations, Optum, WA, 2010 - 2016

- Provided telephonic tobacco cessation interventions to patients using Motivational Interviewing and

Cognitive Behavioral Therapy counseling techniques.

- Carried out over 5,200 tobacco cessation interventions with an individual quit rate higher than Service Delivery Department average.
- Well versed in FDA-approved pharmacotherapy; aided in APT decision support, provided health screenings and medication dosing using NRT algorithm.
- Completed optional ongoing education opportunities including; Surfacing and Resolving Ambivalence, Professionalism Training, Advanced Experiments, Integrated Practice, Pregnancy Specialized Coaching, Youth Support Program, Mental Health & Tobacco Cessation, and Relapse Prevention Training. Also completed diverse population trainings for Alaska Natives, American Indian, Native American and Native Hawaiian populations.

Senior Merchant Teller & Vault Coordinator, Bank of America, WA, 2001 - 2009

- Demonstrated polished customer service, time management and money management skills.
- Responsible for vault management including: ordering funds, scheduling money deliveries, balancing banking center vault daily and processing ATM transactions.
- Processed customer transactions and recognized sales opportunities.
- Assisted personal bankers with opening 200+ checking and savings accounts monthly.

Receptionist & Conditions Coordinator, Mortgage Investment Lending Associates, WA, 2005 - 2007

- Greeted guests and coordinated meetings with vendors, management and executives.
- Responsible for assigning required loan documentation to client files for underwriter review.

Education

- Bachelor of Arts, University of Washington, Seattle, WA
- Associate of Arts, Seattle Central Community College, Seattle, WA

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Shwetanchla (Shweta) Bhan

Director, Product Management

Experience Summary

Product management leader with demonstrated experience in new product development, marketing analysis, vendor & client management. Technology background with full SDLC experience in multiple domains as part of start-up as well as Fortune 100 organizations.

Work Experience

Director, Product Management, United Health Group, 2009 - Present

- Product Owner for Quit for Life - directing strategy, roadmap and execution for the best tobacco cessation program in the country
- Supervise a team of talented product managers; provide direction to a matrix team of web/app designers, engineers and business analysts
- Launched version 1 mobile app, revamped consumer facing digital tools (QFL Web Coach, Weight Talk) and Next-Gen Wellness Coaching portal

Product Manager, Expedia, Inc., 2008 – 2009

Partner Services Group - Lodging

- Directed product development efforts by defining & prioritizing business requirements and negotiating trade-offs with stakeholders
- Drove new business opportunities for Lodging business impacting Finance and Operations
- Managed delivery of multiple initiatives
- Identified and implemented process improvements enabling the Lodging product management team to work more effectively

Product Manager, Verified Person, Inc., 2008 – 2008

- Managed a new web-based B2C product for a background screening start-up founded by John Scully, former CEO of Apple
- Devised a new Go-To-Market strategy for B2B product with potential to increase customer leads conversion by 15%
- Participated in vendor negotiations, business development and sales planning efforts

Marketing Intern, FedEx Services, 2007 – 2007

- Conducted competitive analysis of FedEx List Rate Surcharges with UPS' and identified $15.7M incremental revenue opportunity
- Created a research platform for pricing business rules, resulting in increased productivity for 20 pricing analysts

Software Engineer, IBM Global Services, 2003 – 2005

- Led the 5 person Quality Review Process Group. Increased productivity of Verticals team by 10%
- Led offshore quality assurance activities for Siebel Medical Verticals group
- Nurtured client-vendor relationship which resulted in increased business for IBM and extension of contract
- Recruited 20 members for the Verticals Team over 6 month period. Mentored new hires and scaled up the team to the target size Facilitated and coordinated meetings such as the Supervisor Support Meeting

Education

- Bachelors of Computer Science and Engineering, Bangalore University, Bangalore, India
- Masters of Business Administration, Marketing, University of Memphis, Memphis, TN

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C. Daniel Sullivan, MS, MD

Sr. Medical Director and Vice President

Experience Summary

Board certified medical executive with extensive experience in development, implementation and operation of Case and Disease Management programs. Successfully executed large scale, information- driven interventions for health management and medical resource management programs to change physician and patient behavior resulting in improved health outcomes.

- In-depth knowledge and management experience in Clinical Informatics including data management, statistical analysis, study design, predictive modeling and outcomes measurement. Skilled in the development of clinical care policies and guidelines, reporting tools and benchmarking. Performed research and analysis in conjunction with major health care organizations, health care industry and academic, governmental and non-governmental service organizations. Performed key roles in the installation and configuration of enterprise-wide information management systems including systems for case management assessment and care management, code set rules for case and disease management and user-specific configuration of care management, case-finding and predictive modeling systems.
- Expert knowledge in utilization management and quality improvement. Thorough knowledge of health care system management, business practices, products and processes, including Pharmacy Benefit Management and Managed Care organizations providing services under Medicare and Medicaid risk arrangements. Achieved accreditation under NCQA, JCAHO, URAC and CARF. Performed HEDIS reporting and successfully completed HCFA and other regulatory audits and instituted processes to meet HIPAA standards.

Work Experience

Sr. Medical Director and Vice President, Optum/Alere, 2006-Present

- Management of the full and part time physicians who provide clinical input and oversight of the Complex and Chronic disease Case Management programs, Oncology Case Management program and the NICU Management and Women's and Children's Heath program physicians.
- Daily medical review of cases in the Complex and Chronic disease Case Management programs, providing medical guidance to RN Care Managers and others involved in cases to ensure improved health status and outcomes. Active case load of approximately 1000 cases.
- Primary clinical support for Disease Management programs and the RN Care Managers located in centers from which these programs are delivered. Provides clinical input on program design, outcomes metrics and program operation. Address specific issues as they arise including those involving outside physicians and other providers of service to the patients participating in our programs.
- Primary clinical support for Case Management information system design and testing including development of documentation standards and other guidelines and procedures. Ongoing participation in system improvement and modification projects.
- Primary clinical support for the Clinical Integrity and Compliance group.
- Primary clinical support for the Wellbeing program.
- Clinical support for case management-related analytics and outcomes assessment services as requested.

Corporate Vice President and Chief of Clinical Informatics Health Care Management, Amerigroup Corporation, VA, 2003 – 2006

Serving over one million members through eleven Health Plans in eight states and the District of Colombia, Amerigroup provides health coverage for women, children and disabled people under Medicaid and SSI programs. Responsible for the establishment of an information-based management strategy including the selection and configuration of a sophisticated corporate-wide patient care and medical resource utilization management system as the cornerstone of the future strategy and vision of the corporation.

- Establishment of the system governing analytic methodology and processes for a wide variety of areas including disease and case management programs, utilization management systems and cost containment initiatives.
- Principle responsibility for selection and configuration of the clinical components of a new corporate-wide information system and clinical rules interface to benefits and procedure and diagnosis coding conventions.
- Complete revision of the overall system of disease and case management program operations and specific service offerings to improve outcomes and efficiency. Enhanced operations to allow for accreditation by

NCQA as an independent disease and case management provider.

- Development of a new, comprehensive program for outpatient medical resource utilization management through a sophisticated analysis of performance and modeling of impact and outcomes.
- Senior member of the team responsible for completely revamping and implementing standardized systems of medical management including inpatient review, discharge planning, authorizations, care coordination and appeals and grievances.
- Senior medical management executive with matrix responsibility for Amerigroup's corporate-wide pharmacy management system, including pharmacy-based care and specialty pharmacy services and supplies.
- Provide direct support to the senior business and medical management of individual health plans to support local operations and address cost, quality and utilization issues.
- Development and distribution of predictive models and case-finding algorithms.
- Clinical support for all corporate-level areas including marketing, provider relations, finance, contracting, legal and regulatory, government relations and associate services.
- Provide clinical performance assessment and other due-diligence functions for the evaluation of potential major acquisitions and business partnerships.
- Management of approximately 50 employees including health professionals and doctoral level researchers in two departments.

Senior Medical Director and Chief of Clinical Informatics, Health Net of Arizona, AZ, 2001 - 2003)

Part of Health Net, Inc., Health Net of Arizona serves nearly 200,000 members providing managed care services under Medicare risk, HMO, PPO and POS plans. As part of a new management team successfully accomplished a major turn-around of medical resource utilization. Key to success was the development of innovative solutions to medical resource utilization problems and re-establishing provider relationships.

- Quantitative analysis of past performance metrics to establish an information-driven approach to care management, network design, utilization management and provider
- Development of performance reporting and tracking to guide medical resource management on a day-to-day and long-term basis.
- Oversight of all medical aspects of inpatient and outpatient utilization management.
- Practice standards development and implementation.
- Evaluation of new medical technologies, therapeutic techniques and pharmaceuticals.
- Development and implementation of disease management and case management programs, including predictive modeling and performance measurement.
- Quality management, including quality improvement programs, provider credentialing and profiling.
- NCQA, JCAHO, URAC, HCFA (CMS) and other certification and regulatory compliance.
- Medical oversight of services performed by delegated providers.
- Research and analytic study design, execution, publication and interpretation.
- Application development for automation of data management, analytic processes and reporting.
- Provider interaction and conflict resolution.
- Support of Provider Services, Member Services, Marketing, Underwriting and Legal Departments.

Education

- Certificate in Medical Management, University of California, Irvine, CA
- Doctor of Medicine (with honors) The Medical College of Wisconsin, Milwaukee, WI
- Master of Science, Mechanical Engineering, Kansas State University, Manhattan, KS
- Bachelor of Science, Mechanical Engineering (with honors) Kansas State University, Manhattan, KS
- Chief Medical Resident, Mount Sinai Medical Center, Milwaukee, WI
- Resident, Internal Medicine, Mount Sinai Medical Center, Milwaukee, WI

Licensure, Board Certification and Professional and Honorary Society Membership

Licensure	• Medicine - Lic. #25079, Arizona • January 1997 - current • Medicine - Lic. #91-372, New Mexico • June 1991 - 1999 • Medicine and Surgery - Lic. #25453, Wisconsin • July 1983 - current • Professional Engineer - Lic. #17761, Wisconsin • June 1978 – retired 11/15/2015
Board Certifications	• Internal Medicine: September 1985 - current • Comprehensive refresher course August, 1997 • SPEX 2002
Professional and Honorary Society Membership	• American College of Physician Executives, Life Member • Association of Medical Directors of Information Systems • Alpha Omega Alpha - Medical Honorary • Bernard M. Baruch Award - 1982 • Tau Beta Pi - Engineering Honorary • Pi Tau Sigma - Mechanical Engineering Honorary
Professional Practice and Other Related Experience	
1991 - 1996	• Consulting Internist and limited outpatient practice FHP of New Mexico, Inc. Albuquerque, NM
1985 - 1991	• Practicing Internist and Vice President United Internists of Milwaukee, SC Milwaukee, WI
1989 - 1991	• President, Professional/Technical Resources Inc. Professional/Technical Resources, Inc. Brookfield, WI • Providing technical consultation for agencies dealing with product liability, persoı legal problem prevention and resolution.
1975 - 1978	• Project Engineer Trane Company, Inc. La Crosse, WI Heat transfer engineering and equipment design for special applications, includir refrigeration, hazardous environment operation and other custom-engineered he
1971 - 1974	• Engineer, Co-op program Caterpillar, Inc. Peoria, IL Small parts manufacturing. Experimental inertia • Welder program. Hydraulic drive and semi-automatic transmission development
References	
	• Jeni Klein, Senior Client Services Manager 11000 Optum Circle Eden Prairie, MN 55344-2503 Phone: (206) -876-2355 Email: Jeni.Klein@optum.com • Maria Martin, Senior Client Services Manager 11000 Optum Circle Eden Prairie, MN 55344-2503 Phone: (206)-876-2117 Email: Maria.Martin2@optum.com • Ashley Speight, Client Services Manager 11000 Optum Circle Eden Prairie, MN 55344-2503 Phone: (206) 876-2151 Email: Ashley.Speight@optum.com

Etta Short, MS

Director, Clinical Development and Support

Experience Summary

High-performing Public Health professional with in-depth experience and knowledge of behavior change models, community organization, project management, instructional design, training delivery, assessment and evaluation. Areas of expertise: Tobacco cessation and prevention, weight management, lifestyle health behavior, cultural competency.

Work Experience

Director, Clinical Development and Support, Optum, Seattle, WA, 2014 - Present

- Provide expertise and leadership for the development and delivery of evidence based, behavior change strategies.
- Provide primary oversight to behavior change aspects of intervention and coach training for tobacco cessation, weight management, and Lifestyle Coaching program

Director, Learning and Development, Optum, Seattle, WA, 2005 –2014

- Establish and maintain company strategy and standards for education, training and development.
- Direct the design, production, evaluation and maintenance of curricula and instructional materials to support staff new hire and ongoing training.

Health Educator, University of Washington Medical Center, Seattle, WA, 1996 - 2005

- Develop, implement and evaluate patient and family education programs and related staff training for UW Medical Center.

Education

- NW Public Health Leadership Institute, University of Washington
- Master of Science, Public Health Education, University of Washington
- Bachelor of Arts, University of California Los Angeles

Consultation/Training Delivery/Project Management

International Quitline Institute, World Health Organization

- Residential Tobacco Quit Counselor Train the Trainer program designed to prepare trainers to train Quitline counselor, Managers and Trainers to deliver services using empirical evidence and best practices. The curriculum is part of the package that supports the World Health Organization's Framework Convention on Tobacco Control (FCTC) Article 14.
- Columbo, Sri Lanka June 12 -16, 2017
- Tekirdag, Turkey April 12 -14, 2016
- Shanghai, China, August 3-7. 2015
- Beijing, China October 20-24, 2014
- Seattle, WA October 9 -12, 2011

Publications

- Short, E., Raskob, M., Nash, C., Carpenter, K., "Tobacco Cessation: Improving Quitline Services for Priority Populations," NCTOH, Minneapolis, August 2019
- Sheffer, C., Cofer, J., Hurst, A., Shumaker, T., Darville, A., MConaha, J., Short, E., "Innovative Strategies for Training Tobacco Treatment Specialists," NCTOH, Minneapolis, August 2019
- Krupski, L., Short, E., Pearson-Collins, S., Johnson, J., Sheffer, C., Webb, M., "The Tobacco Control Workforce: Tobacco Related Disparities and Health Equity," NCTOH, Minneapolis, August 2019
- Short. E., Hurley, S., "Tobacco Cessation and Weight Management Health Coaching: A Strategy for Attaining Broader Lifestyle Behavior Change Benefits" NCTOH, Austin, March 2017
- Short, E.," Effective Health Coaching, "Weight Management Matters, (Weight Management; a dietetic practice group of the Academy of Nutrition and Dietetics, Winter 2017, 16 - 19

- Short, E., *Behavior change key to wellness program success*, Employee Benefits News (EBN) *OCTOBER, 27, 2015*
- Short, E, Wassum, K, "Training for Quit line Tobacco Treatment Specialist: Telephone Counseling," Trainer Manual, Trainee Workbook, World Health Organization 2014, http://apps.who.int/iris/handle/10665/113145
- ISBN 978 92 4 150726 4 (print), ISBN 978 92 4 069280 0 (Epub), (NLM classification: WM 290)
- Wassum K, Short E., Strengthening health systems for treating tobacco dependence in primary care. Chapter 2: smoking cessation; training for primary care providers: brief tobacco interventions; and, Chapter 4: training for future trainers. World Health Organization training package publication, 2013. http://www.who.int/tobacco/publications/building_capacity/training_package/treatingtobaccodependence/en/index.html. Published July 2013. Accessed July 12, 2013. ISBN 978 92 4 150541 3 (NLM classification: HD 9130.6).
- Short, E., Edris, K, Kulas, A, "Using Innovation to Deliver Culturally Sensitive Interventions: The Alaska Experience", Poster) NTCOH, Kansas City, Mo. August 2012.
- Simmons, R., Bennett, E., Schwartz, M., Tung Sharify, D., Short, E., Health Education and Cultural Diversity in the Health Care Setting: Tips for the Practitioner, *Health Promotion Practice*, January 2002, Vol. 3. No.1, 8-11 © 2002 Sage Publications
- S. Abbott, P., Short, E., Dodson, S., Garcia, C., Perkins, J., Wyant, S., Improving Your Cultural Awareness with Culture Clues, *The Nurse Practitioner*, February 2002, Vol. 27, No. 2, 44-47,51.
- Short, E., Michaels, J., and Gray, M., *Managing Every Day Stress*, Group Health Cooperative of Puget Sound, 1984.
- Short, E., *Increasing Self-Efficacy: The Process of Smoking Cessation*, Master's Thesis (unpublished), 1982.

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Michelle Nygaard

Operations Associate Director

Experience Summary

An Associate Director in Operations with more than 15 years of experience in Operations supporting telephonic and email/instant message coaching. Oversees and manages the day-to-day and end-to-end operations and staff of the tobacco cessation, weight management, and wellness programs providing program instruction and guidance to stakeholders and staff. Focuses on building and sustaining a strong and professional team to deliver first-class phone and email-based customer service, effective and efficient work processes (which maximize resources), high quality motivational interviewing techniques and excellent coaching and performance monitoring.

- Operational Excellence
- Employee Engagement
- Strategic Planning

Work Experience

Operations Associate Director, Optum, WA, 2011 – Present

- Oversees and manages the needs of Managers and Supervisors to ensure day to day operations and performance expectations are met and consistent across coaching programs.
- Partners with stakeholders for client and program needs to drive effective and efficient improvements and feature enhancements that maximize resources, as well as positively impacts participant, client, and employee experiences resulting in business growth due to decreased costs and client and employee retention.
- Project experiences includes hiring and staff development; developing and implementing software program and database solutions; managing and implementing changes to support positive client and participant satisfaction results; and developing and executing opportunities for streamlining work processes.

Operations Manager, Optum, WA, 2007 – 2011

- Managed the needs of Supervisors, Enrollment agents, Coaches, and Registered Dietitians to ensure performance and program needs were met and consistent across coaching programs.
- Worked with stakeholders for client and program needs, including technology needs.
- Project experiences includes developing and implementing training programs, creating and implementing staff protocols and processes, and performance management and professional development.

Education

- Masters, Mental Health Counseling, Seattle University, Seattle, WA
- BA, Psychology, University of Minnesota, Moorhead, MN

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  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206) 876-2151
  Email: Ashley.Speight@optum.com

Robert Anthony Vargas-Belcher, MSW, MPH

Manager of Clinical Development and Support

Experience Summary

Effective verbal and written communication skills with special and diverse groups. Lead and Managed several diverse groups of various sizes with 5 years of experience. Experience in public health and promotion. Brief Counseling & Problem solving skills to resolve key challenges. Proficient in health behavior theory, evaluation design, program planning, and curriculum development with 5 years of experience. Worked well with colleagues and inspired them to exceed department goals. Well Developed skills in program analysis and evaluation that have led to development and enhancements of policies and programs.

- Collaborative
- Exceptional Problem Solving Skills
- Strong Analytical Skills

Work Experience

Manager of Clinical Development and Support, Optum, WA, 2017 - Present

Provide day-to-day clinical support and clinical development for all aspects of the delivery of service for the Quality for Life Program, a Telephone Base Smoking Cessation Program.

- Collaborate with the Quit for Life Product Managers to assure the program adheres to the scientific evidence-base and that innovations are grounded in the empirical evidence and best practices.
- Proactive oversight of clinical content focusing on treatment protocols (counseling and pharmacotherapy), Web Portal content, and Quit Guide content for all populations.
- Routine review of tobacco dependence treatment literature, research, and assess potential for inclusion in Quit for Life product;
- Primary contact with Quit for Life Scientific Advisory Board;
- Monitor developments in tobacco control policy and trends in treatment community.
- Partner with research team to assure that studies employ correct protocols in delivering care within RCTs.
- Represent Quit for Life Program/ Quit Tobacco Service in clinical settings; such as, Client Visits, and Scientific, Treatment and Tobacco Control conferences (internal and external).
- Serve as a clinical resource for other departments and stakeholders

Manager, Clinical and Quality Support, Optum, WA, 2011 – 2017

Provide day-to-day clinical support for all aspects of the delivery of service for the Quality for Life Program, a Telephone Base Smoking Cessation Program.

- Provided Analytical and Evaluation Support of the Quit for Life Program to support clinical recommendation for program improvements.
- Identify and make recommendations in areas where additional training or support is needed for development of staff; or related to policies, protocols or client customizations.
- Interface with other departments to ensure integration between contractual client needs and best clinical practices into delivery of service.
- Work closely with Director of Clinical and Quality Support, Vice President of Operations, and Vice President of Client Service to implement coaching center recommendations and continually enhance efficiencies and performance.
- Contributed to research for grant proposals, journal publications, and national conferences.

Social Worker, Virginia Mason Hospital – Emergency/PACE (Observation Unit) Department, 2011 – 2014

As a member of a multi-disciplinary team, responsible for assessing and providing support and intervention for the social and emotional needs of patients and their Families to promote continuity of care and services following hospitalization.

- Performed assessment and evaluation, focusing on the psychosocial needs of the patient and family; facilitates family conferences as appropriate.
- Planned and coordinated interventions; communicated plan to interdisciplinary patient care team and evaluates effectiveness of interventions for identified patients and families.

- Completed documentation responsibilities as identified by department policy and regulatory agencies.
- Provided consultation to staff and physicians on patient issues and provides protocol clarification/guidance.
- Participates in quality assurance and utilization review to enhance patient satisfaction.
- Developed and maintained professional relationships with medical staff, clinical team, community providers and payers to promote effective coordination of care across the continuum of services.

Service Delivery Quit Coach Manager, Optum, WA, 2009 - 2011

Provide day-to-day support of all aspects of the delivery of service, including management of Service Delivery Quit Coach Supervisors and Quit Coaches.

- Mentor direct reports by providing clear direction and motivation to support changes, ensure departmental goals are met, and to increase individual as well as aggregate performance of the Service Delivery staff.
- Provided support to supervisory staff including hiring and termination, assignment of tasks and duties, setting schedules, skills training and performance evaluations
- Participate in daily workflow planning and work closely with Scheduling to identify and address potential service level, workflow and staffing issues.
- Identify and make recommendations in areas where additional training or support is needed for development of staff; or related to policies, protocols or client customizations.
- Interface with other departments to ensure integration between contractual client needs and delivery of service.

Service Delivery Quit Coach Supervisor, Optum, WA, 2007 – 2009

Supervise and monitor a team of 15 Quit Coaches, who provide evidenced based treatment and counseling in the field of tobacco cessation.

- Develop and maintain strong professional relationships with quit coaches, supervisors, managers, and other supporting staff.
- Coach and train current Quit Coaches to improve their overall quality and productivity based upon departmental standards.
- Provide continual growth in the areas of counseling and professional development and devise and follow through on tactical action plans to achieve such growth.
- Worked with quit coaches with special circumstances- such as updating rehired Quit Coaches on missed PODs, trainings, and current expectations.
- Provided day-to-day support for quit coaches.
- Provided weekend support for Quit Coach Supervisors.
- Worked with the Quality Manager implementing an automated survey for participants to provide feedback on completed interventions.
- Facilitated and coordinated meetings such as the Supervisor Support Meeting

Education

- Masters in Public Health, San Diego State University, San Diego, CA
- Masters in Social Work, University of Washington, Seattle, WA
- Bachelors of Arts in Psychology, Seattle University, Seattle, WA

References

- Jeni Klein, Senior Client Services Manager
  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206) -876-2355
  Email: Jeni.Klein@optum.com
- Maria Martin, Senior Client Services Manager
  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206)-876-2117
  Email: Maria.Martin2@optum.com

	• Ashley Speight, Client Services Manager 11000 Optum Circle Eden Prairie, MN 55344-2503 Phone: (206) 876-2151 Email: Ashley.Speight@optum.com

Kara Kikuchi

Manager of Training and Outreach Programs, Client Services

Experience Summary

Experienced supervisor, primary care physician, and educator capitalizing on more than 17 years of experience in health care. Skilled in program design and evaluation, communication and presentation, problem-solving and customer service.

Work Experience

Manager of Training and Outreach Programs, Client Services, Optum, WA, 2015 – Present

The leader in population health management, serving the physical, emotional and financial needs of more than 61 million individuals, enabling consumer health management and integrated care delivery through programs offered by employers, payers, government entities and directly through the care delivery system

- Operationalize health improvement programs by creating and implementing evidence-based solutions for healthcare systems and government agencies to address gaps in their patient treatment systems.
- Plan, lead, organize and control work to meet training and outreach contract requirements and develop new contracts. This includes collecting, analyzing, and presenting data to demonstrate program outcomes.
- Lead a team of 2-8 outreach specialists who provide coaching and technical assistance to health care professionals to improve treatment systems.
- Provide instructional design, project management, and delivery of other health care provider training and systems change projects.
- Serve as client interaction manager, maintaining open communication with clients and ensuring program satisfaction.
- Lead stakeholder meetings, present and gather feedback in SWOT-type analyses.
- Write proposals and Scopes of Work for provider training and outreach projects, including negotiation of budget and services with clients.
- Demonstrate understanding of systems and procedures to provide appropriate information to clients (re: workflows, operational systems, reporting, billing, clinical methodology), representing client internally and coordinating with other functions to implement client systems, complete projects, and address ongoing service needs.
- Identify and resolves operational problems using defined processes, coordination with various teams, expertise and judgment.
- Serve as a dedicated resources and liaison between state tobacco quitline client and internal business leaders to ensure mutual understanding of needs and clear expectations by all stakeholders.
- Manage a tightly-controlled budget, providing spend forecasting, problem-solving, and proposals to extend or spend down budget.
- Lead response to state Request for Proposal, contribute to budget analysis and proposal, and lead contract negotiations.

Program Manager, Training and Outreach, Alere Wellbeing, WA, 2014 – 2015

- Provide project management for training and outreach programs.
- Operationalize health improvement programs by implementing evidence-based practices to drive academic detailing and technical assistance with healthcare providers and administrative champions.
- Serve as client interaction manager, maintaining open communication with clients and ensuring program satisfaction.

Support Line Supervisor, Operations, Alere Wellbeing, WA, 2011 – 2014

Alere Wellbeing's mission is to provide products and services that identify and reduce or eliminate measurable, sub-optimal health conditions and behaviors that lead to chronic disease and premature death. Responsible for the company's client management and retention of 600+ clients. Three client segments employers; government and health plans. 72 of employer accounts in Fortune 500.

- Guided and supervised team of 15 members, providing weekly, quarterly and annual support and feedback.
- Coordinated urgent contact for clinically fragile patients.
- Developed and provided process/procedure training to newly hired team members using adult learning

principles.

- Created and delivered briefing agendas and conducted weekly staff meetings. Maintained staff resource materials and SharePoint site.
- Managed medication reporting, ensuring medication access is in accordance with clinical and contractual obligations.
- Project management: defined scope of weekly projects to address service recovery, identified and collaborated with stakeholders, coordinated with managers to assess work needs/costs, managed risk, evaluated and implemented project by providing trainings and job aids.

Naturopathic Physician, Private Practice, WA, 2007 – 2011

- Diagnosed and treated patients in accordance with the established philosophy of Naturopathic Medicine and Washington State licensure.
- Specialization: Nutrition, Endocrinology, Craniosacral Therapy, Stress Management, Insomnia, Anxiety, Women's Health, Geriatrics.
- Provided health education lectures regarding diabetes and heart disease at West Seattle Senior Center and South Seattle Senior Center.

Support Line Quit Coach I, II, & III, Operations, Free & Clear, Inc., WA, 2008 – 2011

- Participant and Provider Support – resolved service recovery issues, serving as intermediary between tobacco cessation participants & client managers, healthcare providers, & other Service Delivery staff.
- Provided the highest-level tobacco cessation intervention and customer service support.
- Maintained SOAP notes for each patient interaction using an electronic database.
- Worked to ensure services were in compliance with clinical and client expectations.
- Entered tobacco cessation medication overrides in benefit processing websites.

Quit Coach I, Operations, Free & Clear, Inc., WA, 2007 – 2008

Free & Clear was a venture backed, startup company focused on reducing the tobacco prevalence through evidence based telephonic coaching for employers, health plans and state government.

- Provided telephonic tobacco cessation interventions to patients using Motivational Interviewing and Cognitive Behavioral Therapy counseling techniques.
- Maintained SOAP notes for each patient interaction using an electronic database.
- Qualified for employee incentive program, based on high productivity and call quality.

Education

- ND Naturopathic Doctorate, Bastyr University, Kenmore, WA
- BS Degree in Biology, University of Utah, Salt Lake City, UT
- BS Degree in Anthropology, University of Utah, Salt Lake City, UT

References

- Jeni Klein, Senior Client Services Manager
  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206) -876-2355
  Email: Jeni.Klein@optum.com
- Maria Martin, Senior Client Services Manager
  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206)-876-2117
  Email: Maria.Martin2@optum.com
- Ashley Speight, Client Services Manager
  11000 Optum Circle
  Eden Prairie, MN 55344-2503
  Phone: (206) 876-2151
  Email: Ashley.Speight@optum.com

Appendix A.1.12.

Appendix A.1.12. Quarterly Performance Report

Performance Management Report – Q3 2019

Highlights:
- TIPS volume tapering off.
- NRT utilization strong.
- States YTD NPS is 68.
- Portal usage continues to be low; email confirmed turned on for all States.

Key Results	Current Quarter	Target for Quarter	YTD	YTD Target	Insights
Enrollment					
Enrollment Source - % Online (vs. Phone)	27.9%		[illegible]	[illegible]%	
Engagement					
Enrollees signing up for Text2Quit (%)	[illegible]		33.4%	36.9%	
Enrollees with Portal Use (%)	9.[illegible]		10.5%	14.1%	Investigating sharp decline to determine root cause
Eligible Enrollees Ordering NRT (%)	74.9%		79.9%	76.6%	NRT utilization for States have bounced back and consistently strong month over month
Avg. # of Calls Completed per Enrollee	1.75		1.85	1.83	
NPS	66		68	68	

Sample

OPTUM™

Appendix A.1.16.

Appendix A.1.16. Work Plan

This Implementation Work Plan anticipates a contract start date of June 1, 2020. Because Optum is the current service provider for the Nebraska Tobacco Quitline, we are already providing many of the services noted below.

Task	Start Date	End Date	Optum Respon-sibility	Tobacco Free - Nebraska Respon-sibility
PROJECT KICKOFF/CONTRACT IMPLEMENTATION				
Negotiate contract	2/14/2020	3/13/2020	X	X
Execute contract	2/14/2020	3/13/2020	X	X
Schedule call to review required tasks for new contract	2/14/2020	2/20/2020	X	
COMMUNICATION COORDINATION				
Establish primary point of contact that TFN can work with daily, as well as a secondary point of contact in the event the primary contact is unavailable.	Complete	-	X	
Establish meeting schedule with Client Services for coordination and execution of deliverables	Complete	-	X	X
Reiterate goals and Quitline expectations for the contract year; identify additional goals for Quitline and partners	3/14/2020	5/29/2020	X	X
BILLING				
Provide an overview of how to reconcile monthly reports with invoice	6/1/2020	6/30/2020	X	
Set up TFN as a client in Optum's financial system	Complete	-	X	
Send invoices on a monthly basis	7/10/2020	Ongoing	X	
PROGRAM REGISTRATION PROCESS				
Registration (intake calls) meet NAQC Minimal Data Set (MDS) standards	Complete	-	X	
Confirm and review MDS and custom questions asked at registration; discuss any changes	3/14/2020	5/29/2020	X	X
REFERRAL AND MCO INFORMATION				
Establish Medicaid/MCO Process	Complete	-	X	
Review Medicaid/MCO process and flow	6/1/2020	Ongoing	X	X
PROGRAM REPORTING				
Schedule suite of reports to be delivered	Complete	-	X	
Deliver agreed upon weekly reports	6/1/2020	Wednesday of the following week	X	
Deliver agreed upon monthly reports	6/1/2020	10th of the following month	X	
Deliver agreed upon quarterly reports	6/1/2020	Last day of the following month	X	
Deliver agreed upon annual reports	6/1/2020	Ongoing	X	
Review new KPI metrics showing quarterly metrics of engagement	5/1/2020	5/29/2020	X	
TELECOMMUNICATIONS				
Maintain 1-800-QUITNOW and 855-DEJELO-YA to Optum for receipt of calls from Nebraska residents	Complete	Ongoing	X	

Triage callers with employer or health plan benefit	Complete	Ongoing	X	
Establish text telephone (TTY) number, 1-877-777-6534 for callers	Complete	-	X	
Establish live agent availability to callers for both English and Spanish 24/7 with the exception of specific holidays.	Complete	-	X	
Establish third-party translation service	Complete	-	X	
REFERRALS				
Proactively call individuals referred by fax (1-800-483-3078) or secure email submission	Complete	Ongoing	X	
Build web-based provider referral tool, branded for the Nebraska Tobacco Quitline	4/15/2020	5/15/2020	X	
Launch web-based provider referral tool	6/1/2020	Ongoing	X	
Promote web-based provider referral tool to Nebraska-area providers	6/1/2020	Ongoing		X
As approved by TFN, establish needs assessment for Electronic Health Record (EHR) referrals and determine implementation needs	6/1/2020	Ongoing	X	X
As health systems are identified by TFN, build secure connections to support electronic referrals to the Quitline	6/1/2020	Ongoing	X	X
PROGRAM MATERIALS				
Brand Quit Guide for Nebraska Tobacco Quitline	Complete	-	X	
Send tailored materials to Quitline callers	6/1/2020	Ongoing	X	
SERVICES				
Establish eligibility requirements for counseling and medication services	Complete	Ongoing		X
Build eligibility requirements into application; update as needed	Complete	Ongoing	X	
Review eligibility requirements; update as needed	Complete	Ongoing	X	X
Provide one to ten (depending on participant requested services) professional nicotine addiction treatment telephone counseling calls	Complete	Ongoing	X	
Assist callers with developing and executing a personalized quit plan with each of the calls	Complete	Ongoing	X	
Assure protocols for initial and follow up calls are culturally competent and research-based; enforce internal quality control measures regularly for staff	Complete	Ongoing	X	
As approved by TFN, implement tailored counseling for tobacco users reporting behavioral health conditions, Native Americans, tobacco users who are pregnant, planning to become pregnant, breastfeeding or under the age of 18 (and/or others as requested)	6/1/2020	Ongoing	X	X
As approved by TFN, offer Text2Quit to tobacco users who opt-in to text messaging	6/1/2020	Ongoing	X	X
PHARMACOTHERAPY				
Dose and provide guidance for usage of pharmacotherapy, including NRT, based on tobacco user's medical history	Complete	Ongoing	X	

Consult with TFN to determine and authorize changes to service levels and eligibility as appropriate	6/1/2020	Ongoing	X	X
Ship NRT supplies to tobacco users as appropriate per eligibility guidelines	Complete	Ongoing	X	
PROGRAM PORTAL (ONLINE)				
Develop online portal for web enrollment	Complete	-	X	
Ensure online services from quitnow.net/nebraska is fully operational	Complete	Ongoing	X	
As approved by TFN, build stand-alone web program for tobacco users	6/1/2020	Ongoing	X	
QUALITY ASSURANCE OF IMPLEMENTATION ACTIVITIES				
Determine meaningful metrics to monitor quality and engagement for quarterly reporting	5/1/2020	5/29/2020	X	
Counselors (Quit Coaches) will receive at least 200 hours in internal training and evaluation. Assure specific ongoing training of Quit Coaches completed to maintain expertise and keep current with research in the behavioral health/tobacco cessation field	Complete	Ongoing	X	
REGULATORY ISSUES				
Notify participants of rights to privacy per HIPAA	Complete	Ongoing	X	
Obtain consent for evaluation in calls	Complete	Ongoing	X	
EVALUATION				
Develop and discuss evaluation plan; review and approve Evaluation SOW	6/1/2020	6/30/2020	X	X
Conduct evaluation surveying	7/1/2020	As per Evaluation SOW	X	
Deliver evaluation report	7/1/2020	As per Evaluation SOW	X	
ONLINE PROVIDER TRAINING				
Discuss TFN's needs for an online Brief Tobacco Intervention training for Nebraska providers; review and approve Training SOW	6/1/2020	6/30/2020	X	X
Conduct needs assessment and usability review, with participation from TFN-identified stakeholders and providers	7/1/2020	As per Training SOW	X	X
Deliver content outline and build training, incorporating feedback	7/1/2020	As per Training SOW	X	
Launch training	7/1/2020	As per Training SOW	X	
Obtain CME accreditation	7/1/2020	As per Training SOW	X	
Host and maintain training	Training launch date	Ongoing	X	

Appendix A.1.24. Call Recordings (Proprietary Information)

Call recordings are considered proprietary information and are included in a separate package per the RFP instructions

Appendix A.1.30 Self-help and Support Materials

NEBRASKA TOBACCO QUITLINE

You can quit smoking.

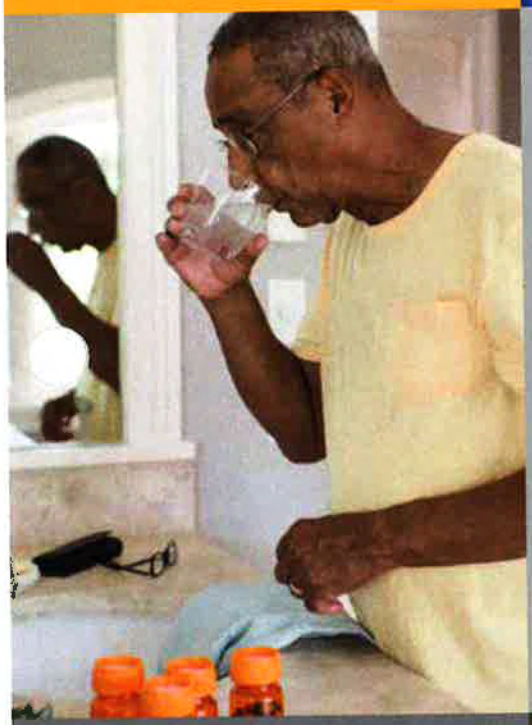
We'll teach you how.

STEP 1

Quit at your own pace

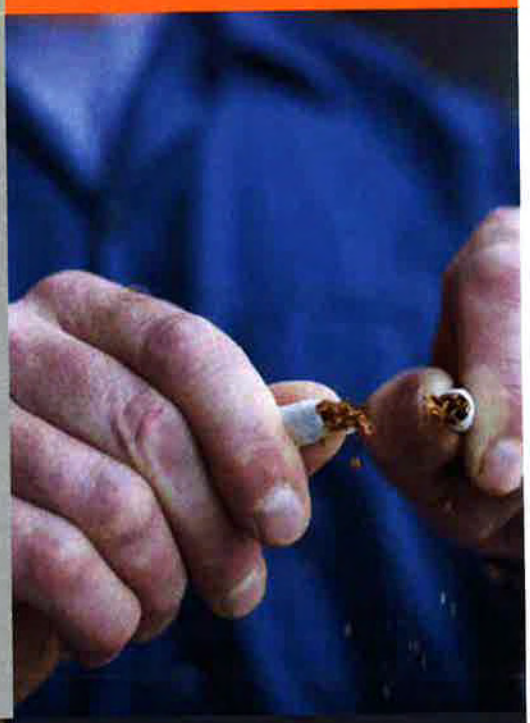
STEP 2

Conquer your urges to smoke



STEP 3

Use quit medicines so they really work



STEP 4

Control your environment

STEP 5

Get social support

You can quit smoking.

We'll teach you how.

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How quitting helps your health 11

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Substitutes and distractions 23

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Mini-quits: A way to practice quitting 28

Ways to cope with stress 29

Ways to cope with stress worksheet 29

Step 3: Use quit medicines so they really work 30

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Welcome to the program

Quitting is the best thing you can do for yourself and the people you love. These five steps, based on 25 years of research, have helped hundreds of thousands of smokers quit and stay quit.

Follow these five steps to make your quit easier and more successful.

Step 1: Quit at your own pace

Quit at your own pace by choosing a quit date (the day you want to quit) that works best for you. Your Quit Coach® will help you prepare and get ready to quit on that date.

Step 2: Conquer your urges to smoke

We'll help you learn how to cope with urges to smoke, no matter when or where you have them. This will help you quit for good. You will also learn how to manage stress without smoking.

Step 3: Use quit medicines so they really work

We'll help you choose a medicine like the patch, gum, Bupropion SR, or Chantix® (Varenicline) that is right for you and teach you how to use it correctly so it helps you quit.

Step 4: Control your environment

Learn why getting rid of all your tobacco, ashtrays and lighters can help you quit and stay quit.

Step 5: Get social support

We'll teach you why it is important to ask your family and friends for the support you want.

"Joining this program was the only thing I did differently this time and it worked. Just knowing you were standing by me made all the difference."

— Danielle, age 34

Your guide to quitting smoking

This guide is for smokers who want to quit and stay quit. Just like you. No matter how many times you have tried to quit and returned to smoking, this guide can help. It has a lot of facts about what to do at each step along the way.

The guide also has worksheets where you can add your own ideas and plans (see page 18). Most people start their quit by filling out the worksheet, **Track your smoking**. Quit Coaches often suggest that people fill out this worksheet for two or three days. This will help you better understand when, where and why you smoke. Your Quit Coach is trained in helping smokers quit and stay quit. You and your Quit Coach will work together as a team. He or she will talk with you by phone and may suggest you complete some of the worksheets in this guide.

The second worksheet most Quit Coaches suggest is **Practice mini-quits**. A mini-quit[1] is a short time when you practice not smoking before you quit for good. Mini-quits help you learn how to cope with urges to smoke. You can learn more about mini-quits on page 28.

There are many ways to use this guide. You can read the whole book from start to finish or just look at those sections you need now. You can also fill out any of the worksheets that interest you.

Track your smoking worksheet

Write down the time of day you smoke, where you are when you smoke, what you are doing when you smoke and how many cigarettes you smoke.

Time of day	Where I am	What I am doing	How many cigarettes
Example: Morning	• Kitchen • Waiting for bus	• Drinking coffee • Reading paper	• 2 cigarettes • 1 cigarette
Morning			
Afternoon			
Evening			
Other			

Thinking about quitting

Good for you for thinking about quitting! Quitting is the most important decision you can make for your health, family and happiness. You have come to the right place for help.

Quitting as a team

In this program, you will work as a team with Quit Coaches. This program has helped hundreds of thousands of smokers quit over the past 25 years.

1. Your coach will help you set a quit date.
2. Learn how to manage urges to smoke.
3. Select a medication and teach you how to use it so it really works.
4. Tobacco-proof your environment.
5. Get support from family and friends.

Maybe you have tried to quit before. This time can be different.
We can help you make this your last quit!

Health problems caused by smoking

Each year smoking kills more people than all traffic accidents, illegal drugs, alcohol, fires, falls and AIDS[2] combined. Smoking also causes many health issues, such as heart disease, cancer, breathing problems, dental problems, eye and ear problems, bone problems, sex and reproductive problems, and skin problems.

If you suffer from a chronic condition such as asthma, COPD, diabetes or heart disease, please see page 57 for more information about how tobacco use and quitting affects these conditions specifically. Smoking can also cause health problems due to "secondhand smoke." This refers to smoke from a burning cigarette, cigar or pipe[3]. Breathing secondhand smoke harms people's health and kills more than 50,000 people each year.

Why is secondhand smoke a problem?

Secondhand smoke has many poisonous chemicals in it that are dangerous to breathe. These chemicals cause heart disease, heart attacks, stroke, lung cancer and blood vessel problems. Secondhand smoke is even more dangerous to children and people who already have breathing problems or heart disease.

When you smoke, your children smoke

Babies exposed to secondhand smoke are three times more likely to die from sudden-infant death syndrome (SIDS or crib death). Children are more likely to get ear infections, asthma, bronchitis, pneumonia and other lung infections when they are near people who smoke. Children of smokers are twice as likely to start smoking themselves.

How can I protect myself and others from secondhand smoke?

Once you have quit:

- Ask smokers not to smoke when around you or your children.
- Make your home and car smoke-free.
- Stay away from places where people smoke. If people smoke where you work, ask your boss to ban smoking at your workplace.

Until you quit, smoke outside so others do not have to breathe your secondhand smoke. Quitting and staying quit is the best thing you can do for yourself and those around you.

How quitting helps your health

Your health will improve no matter when you quit. Your body begins to heal within minutes after you stop smoking. The longer you are free from tobacco smoke, the healthier you will become. You will live up to 10 years longer than if you continued to use tobacco.[4]

Time since quit	Effects on your body
20 Minutes	• Blood pressure and pulse return to a normal rate • Hands and feet feel a normal temperature
8 Hours	• Carbon monoxide level in your blood drops to normal • Oxygen level in your blood goes up to normal
1 Day	• Chance of having and dying from a heart attack goes down
2-3 Days	• Senses of smell and taste improve
2-12 Weeks	• Circulation (blood flow) improves • Breathing is easier • Walking is easier
1-9 Months	• Less coughing and sinus congestion (stuffy nose) • More energy • Less shortness of breath • Less chance of infections
1 Year	• Risk of heart disease is half that of a smoker
5 Years	• Less chance of getting lung cancer or lung problems • Improved health if you have diabetes, asthma, kidney disease or other chronic disease • Chance of getting mouth, throat, esophagus, bladder, kidney or pancreas cancer is cut in half • Risk of having a stroke is the same as a person who never smoked
10 Years	• Risk of lung cancer is cut in half
15 Years	• Risk of heart disease is as low as a person who never smoked

Addiction: Why quitting is hard

Addiction is when you lose control over the use of a drug. Nicotine in tobacco smoke is what causes you to be addicted to smoking. Tobacco companies make cigarettes so the nicotine gets to your brain very quickly. The faster nicotine gets to your brain, the more addictive it is. Nicotine from the patch or gum gets to your brain more slowly. This is why the patch and gum rarely cause addiction.

It can be hard to quit when you are addicted to tobacco. There are three reasons for this. You can think of these as three corners of a triangle.

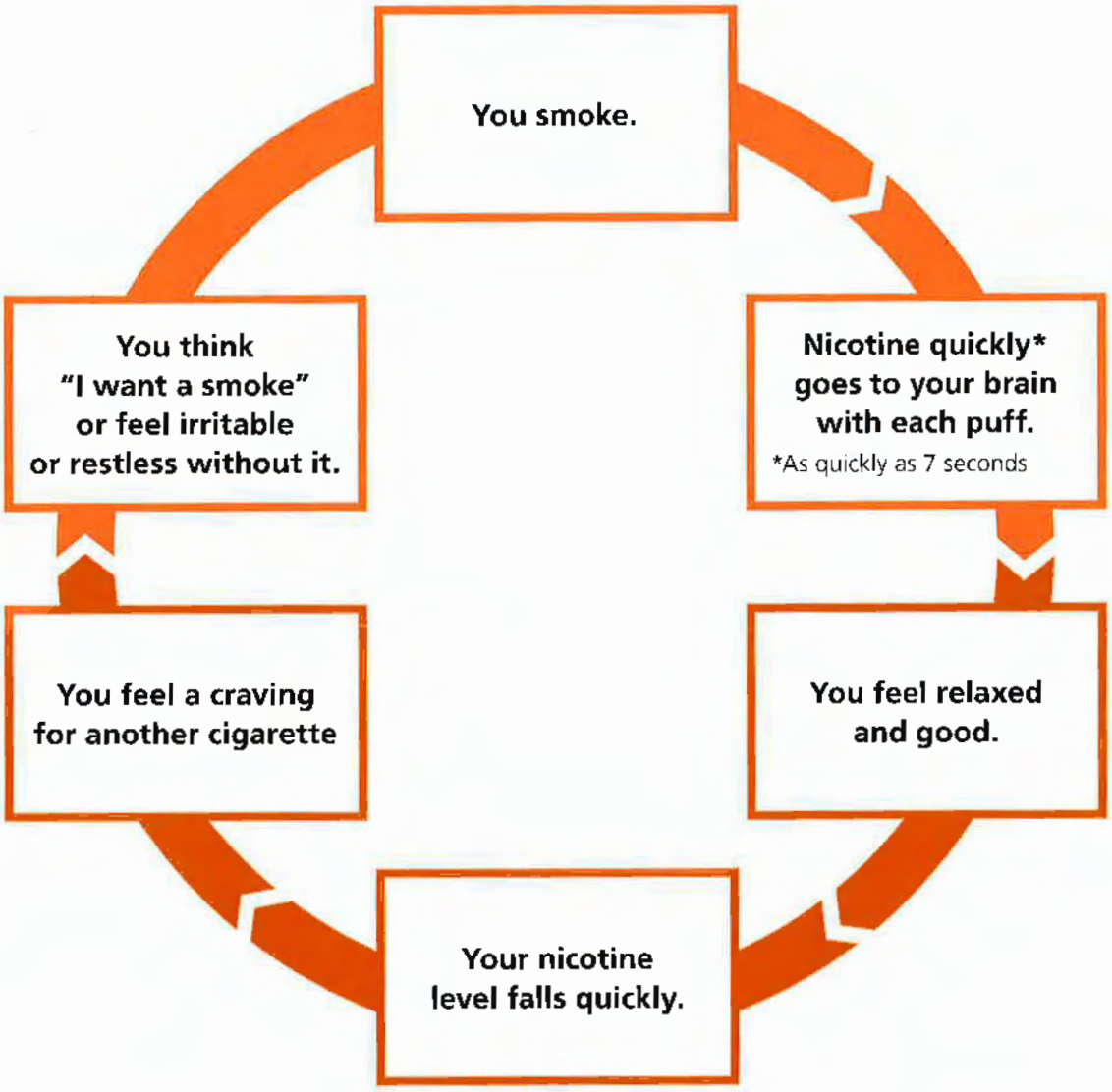
Emotional: How you feel when you use tobacco, what you believe about tobacco use and how you think about tobacco.

Behavioral: How you respond to places and times when you want to smoke, like when you are having a cup of coffee or taking a break from work.

Physical: When your body craves the nicotine in tobacco.

The nicotine cycle happens when your body and mind crave nicotine. It helps to understand this cycle so you can break it. Below is a picture of this cycle.

Your Quit Coach will help you learn ways to fight this nicotine cycle. One way to reduce the craving is to use medicines like nicotine patches, nicotine gum and nicotine lozenges. Varenicline (Chantix) or bupropion SR also can help. You will find information about these medicines starting on page 30. Your Quit Coach can tell you more about these medicines that can help you quit and which may be covered by insurance. Give your Quit Coach a call — he or she is there to help!



What you can do now

It may be helpful to learn how smoking fits with what matters to you. For many people, their health, family and happiness are very important to them. Use the worksheet below to see how smoking affects what matters most to you.

What matters to me worksheet

In each column write down what matters to you, why it matters and how smoking gets in the way. You can add your own ideas at the end of this worksheet. There is an example in the first row for how this works.

What matters to me	Why this matters to me	How smoking gets in the way of what matters to me
Example: Family	• I like spending time with my kids and want to be a good parent.	• I get winded when playing with my kids. • My daughter coughs when I smoke.

Getting ready to quit

Quitting is the best thing you can do for yourself and the people you love. In this section you will learn about the "five essential steps to quit for life." These steps are based on 25 years of research and have helped hundreds of thousands of smokers quit and stay quit. Use these steps to make your quit easier and more successful.

The five key steps to quit for life

Step 1: Quit at your own pace

Quit at your own pace by choosing a quit date (the day you want to quit) that works best for you. Your Quit Coach will help you prepare and get ready to quit on that date.

Step 2: Conquer your urges to smoke

We'll help you learn when and where you have urges to smoke and how to cope with them. This will help you quit for good. You will also learn how to manage stress without smoking.

Step 3: Use quit medicines so they really work

We'll help you choose a medicine (such as the nicotine patch, nicotine gum, nicotine lozenges, bupropion SR or Chantix) that is right for you. We'll teach you how to use the medicine correctly so it helps you quit.

Step 4: Control your environment

Learn why getting rid of all your tobacco, ashtrays and lighters can help you quit and stay quit.

Step 5: Get social support

We'll teach you why it is important to ask your family and friends for the support you want.

Step 1 Quit at your own pace

How many times have you tried to quit? For the average smoker, it takes several attempts to finally quit for good. Think about all the times you've tried to quit but then went back to using tobacco again.

Chances are you weren't really ready, you felt pressured by others or you made a quick decision and didn't prepare at all. Quitting tobacco can be difficult, but creating a plan is half the battle. This section will help you think about your relationship with tobacco, why you want to quit, when to quit and how to prepare for your quit date.

How and why to pick a quit date

It is very important to pick a date to quit smoking. This is called a "quit date." It can be scary to pick a quit date, but a quit date gives you a goal to work toward. When you pick a quit date, you are telling yourself, "I am serious about quitting."

So how do you pick a quit date? It is up to you to decide when you quit smoking, but research shows that those who set a quit date within two weeks are more successful. Here are some things to think about:

- For some people, the work week may be better than the weekend. If you can't smoke at work, you have less opportunity to smoke during the week. Many people pick a Monday morning as their quit date.
- The weekend may be a better time if you have less stress than during the work week. On the weekend, you can plan to spend your first couple of days in enjoyable smoke-free places, such as a movie theater.
- Research shows that those who set a quit date within two weeks are more likely to quit.
- If you plan to use a medicine to help you quit, make sure you have it on hand and know how to use it correctly before quitting. Your Quit Coach can help you learn how to use a quit medicine.
- Do you plan to quit with a friend, spouse, or family member? If so, it's a good idea to sit down with him or her and select a date that works for both of you.

Write your quit date on the calendar

Use a calendar to write down your quit date. Post it in a place you will see often such as on your refrigerator.

The date you plan to quit: _____

The date you start using quit medicines: _____

The date when you will ask friends and family for their support: _____

Healthy habits worksheet

Now is the time to think about healthy habits that will help you quit. Mark what you plan to do and add your own ideas below.

Two weeks before my quit date, I will:

- ☐ Think about things I like to do, other than smoking.
- ☐ Be active at least three times a week. Talk to my doctor if I have health problems or if it has been a while since I last exercised.
- ☐ Fill out the **Track your smoking** worksheet (see page 8).
- ☐ Learn how to cope with urges to smoke (see page 20).

My ideas:

_____

_____

One week before my quit date, I will:

- ☐ Stop smoking in my car and home.
- ☐ Tell other people there is no smoking in my car and home.
- ☐ Practice quitting for a few hours at a time before quitting for good. These are called "mini-quits" (see page 28).
- ☐ Start my quit medicine if using bupropion SR (Zyban® or Wellbutrin®) or varenicline (Chantix).
- ☐ Think of ways to change my daily routine. Some ideas are: to get up later, take a walk or drink tea instead of coffee.

My ideas:

_____

_____

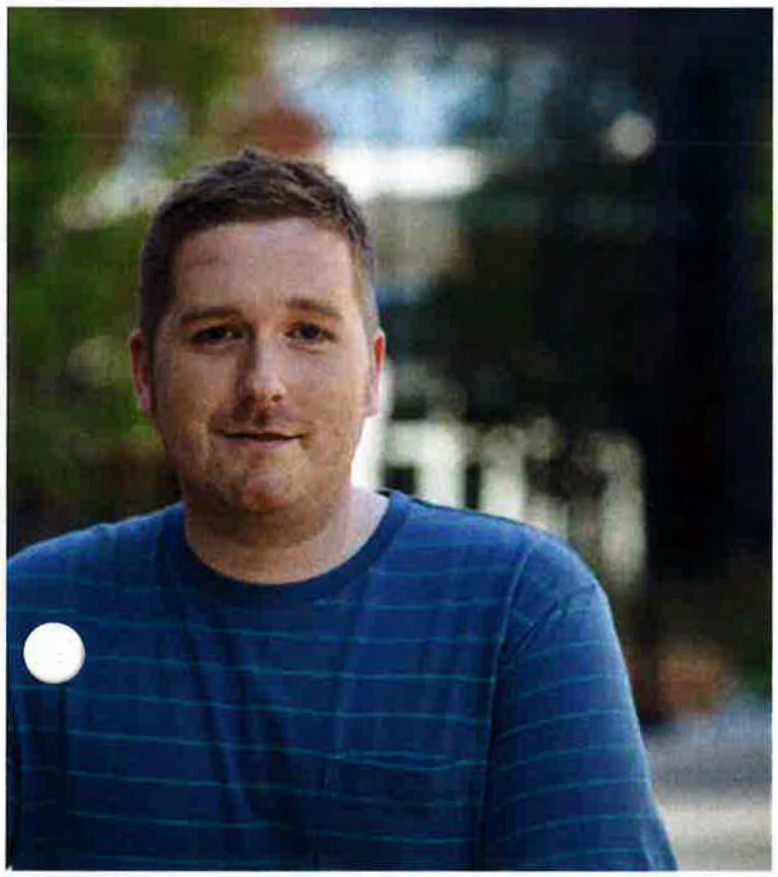
The night before my quit date, I will:

- ☐ Throw away my lighters and cigarettes and put away ashtrays.
- ☐ Wash out the ashtray in my car.
- ☐ Review the right way to use nicotine patches, gum or lozenges, if I plan to use these medications.
- ☐ Practice ways to manage stress, such as deep breathing.
- ☐ Visit Web Coach (if it is part of my program).
- ☐ Call my Quit Coach if I have questions or need support.

My ideas:

_____

_____



"I have tried to quit before, but this time was different. Thank you for taking the time to really listen to me and help me make a successful plan. That's what made a difference."

— Craig, age 27

Step 2

Conquer your urges to smoke

Having an urge or a strong desire to use tobacco after you've quit is normal. Urges can be caused by your body physically craving nicotine or by a trigger such as talking on the phone or finishing a meal.

These urges can be tough, especially in the first two weeks after quitting, so it's important that you have a plan in place for how to conquer these urges and stay on track!

This section will help you understand when, where and why you use tobacco—before you quit. These patterns and triggers are unique to you, so understanding them is essential. You will also learn skills and techniques for how to be ready for urges when they happen.

Urges: What are they?

Ah! It's my first day of living my life smoke-free. I'm feeling great!

Uh-oh. I'm really feeling an urge to smoke a cigarette right now.

Everyone gets urges to smoke when they quit, especially when they are confronted by a trigger. Triggers are the times, places, activities and feelings that give you the urge to smoke. A trigger always comes before the urge to smoke.

Thank goodness my Quit Coach helped me with some ways to conquer my urges to smoke!

Coping skills are ways to make urges to smoke pass much more quickly. They work better than willpower. It is important to know what to do instead of smoking when you are trying to quit. These skills will help you deal with all three corners of the triangle of addiction (see page 12).

Triggers

It helps to learn what triggers your urge to smoke. Many smokers say they have some of the triggers below. Which of these triggers give you the urge to smoke?

Circle them and add more of your own:

- Waking up in the morning
- Finishing a meal
- Driving my car
- Talking on the phone
- Feeling worried or stressed
- Waiting for the bus or train
- Spending time with friends who smoke
- Feeling bored
- Drinking coffee or tea
- Reading the newspaper

My ideas:

_____

_____

_____

_____

"After talking with my Quit Coach, I learned exactly what to do to quit for good. I still think about smoking but now know how to handle my urges like never before."

— José, age 56

Substitutes and distractions

Quitting smoking can be hard. Once they have quit, most smokers face urges, sometimes strong urges, to light up. Some of these urges are triggered by your body craving nicotine. Others can be triggered by certain times of the day or by activities such as driving, finishing a meal, taking a break from work or being where you used to smoke. Your urges may also be triggered by a need to relax and manage stress, maybe as you sit on the couch and watch TV.

But there is a solution. Quitting smoking doesn't have to be about willpower. There are ways to help urges pass without slipping or gritting your teeth. These tools are called substitutes and distractions.

What is a substitute?

Substitutes are things that can be used to keep your mouth and hands busy when you get an urge to smoke. Substitutes can include things such as toothpicks, short straws, cinnamon sticks, gum and hard candies for your mouth. For your hands, you can try pencils, paper clips, worry stones or worry beads.

What is a distraction?

Distractions can include things or activities that take your mind off smoking when an urge hits. These can include taking a walk or getting some exercise, doing a puzzle of some kind, doodling or starting a new hobby — anything to get your mind off smoking for five minutes. The only thing that limits what kind of substitutes and distractions you use is your imagination.

How do I know which tool works best for me?

You may feel that you have to have a cigarette if you get a strong urge to smoke. Getting strong urges is very normal during the first few days after quitting. But you don't have to smoke, even if you want to!

If you are planning to quit soon, put together a list of possible substitutes and distractions, then match your substitutes and distractions to the time of day or activity during which you normally smoke. Write your ideas below.

Substitute/distraction	**Time of day/activity**

Try these out before you quit, but don't give up if the substitute or distraction doesn't work the first time. Practice will help your substitutes and distractions become part of your new pattern.

Notes: (write down which substitutes and distractions worked best for you)

Example: "I learned that my top three triggers to use tobacco were when I finish a meal or watch TV, and when I'm on the computer."

Triggers and coping skills worksheet

Use this worksheet to identify your triggers for using tobacco.

1. Pick the "triggers" below that may give you trouble when you quit.
2. Next, try using different substitutes and distractions INSTEAD of smoking during these situations and times. If you feel like testing your own substitute or distraction, write it down in the "other" section.

Pick the substitutes/distractions that worked best for you and write them in the column titled "What worked for me."

Trigger	Substitutes and distractions	What worked for me
After meals	• Go for a walk. • Do the dishes. • Brush my teeth. • Leave the table. • Have a cup of tea or coffee, a mint or candy. My ideas: _____	
After waking up	• Change my morning routine by showering right away or eating breakfast in a different place. • Have some breakfast. • Brush my teeth as soon as possible. • Take the dog for a walk. My ideas: _____	
When drinking coffee, tea or alcohol	• Try drinking coffee or tea in a different place than usual. • Switch my drink (i.e., tea instead of coffee). • Draw, write or keep my hands busy while drinking coffee or tea. My ideas: _____	

Trigger	Substitutes and distractions	What worked for me
When driving	• Empty the ashtray and fill it with dried flowers or sunflower seeds. • Take a different route to avoid the places in my commute where I normally light up. • Remove all cigarettes from my car or truck. My ideas: _____	
During work breaks	• Take a break in a no-smoking area. • Don't go to my old break area. • Take a break with nonsmokers. • Use substitutes for my hands and mouth if I have to be around other smokers. My ideas: _____	
When watching TV	• Watch TV for shorter periods of time. • Remove ashtrays, cigarettes and lighters from the TV room. • Make the TV room off-limits for smoking. • Play a game. • Post a reminder note on my TV. My ideas: _____	

Trigger	Substitutes and distractions	What worked for me
When stressed	• Talk to a friend/ally. • Try deep breathing. • Remind myself that smoking will not take my anger or stress away. • If you pray, try prayer or meditation. My ideas: _____	
When bored	• Get some exercise. • Walk outside. • Do a crossword puzzle. • Call or visit a friend. • Read a book. • Play video games. • Log into Web Coach or the Quit For Life Facebook® page. My ideas: _____	
When around others	• Spend time with nonsmokers. • Avoid other smokers whenever possible. • Ask others not to smoke around me. • Avoid restaurants and bars where smoking is allowed. • Use toothpicks. My ideas: _____	

Mini-quits: A way to practice quitting

Now is a good time to practice your coping skills. This can make quitting easier and increase your success. Think of it like you are in training. Long-distance runners build strength by taking shorter runs first. In the same way, practicing mini-quits can help you prepare to stay quit for the long term when your quit date arrives.

Tips for mini-quits:

Use the information you entered in the track your smoking worksheet on page 8 to practice your mini-quits.

Practice not smoking during an activity where you usually smoke, like after you finish a meal.

Try practicing mini-quits at different times of the day and during different activities. This is a great time to try the coping skills you wrote down on pages 25-27. Use the coping skills you selected in the coping skills worksheet.

Time of day	Where I am	What I am doing	What helped me not smoke
Example: Morning	• Kitchen • Waiting for bus	• Drinking coffee • Reading paper	• Sucked on coffee stirrer and bent a paper clip • Chewed a piece of regular gum
Morning			
Afternoon			
Evening			

Ways to cope with stress

Stress can get in the way of quitting and staying quit. Stress makes it hard to think clearly and may make you more nervous. Most people have stress from time to time. It helps to learn ways to cope with stress.

Deep breathing is one way to cope with stress.

Here is a deep-breathing exercise you can try, for about five minutes, instead of smoking.

- Go somewhere you can sit and relax, such as on a couch, on your office chair or in your car.
- Turn off your TV, radio, cell phone and any other distractions.
- Take a deep breath through your nose and expand your stomach.
- Hold your breath for five seconds.
- Gently release your breath through your mouth and wait for five seconds.
- Then say the word "relax" out loud.
- Keep breathing deeply for a total of five minutes.

Ways to cope with stress worksheet

Here are some ways to cope with stress. Circle all the ideas you want to try, then add your own. Talk to your friends who have quit smoking and find out how they cope with stress.

For your health

- Get enough sleep.
- Go for a walk.
- Try prayer or meditation.
- Eat healthy, fresh foods.
- Take a nap.

When with others

- Talk to someone who listens to you.
- Read a story to your children.
- Play a game of cards.
- Have dinner with a friend.
- Prepare a meal with your family.

When alone

- Read a book.
- Watch a movie.
- Listen to music.
- Write in your journal.
- Try a relaxation exercise.

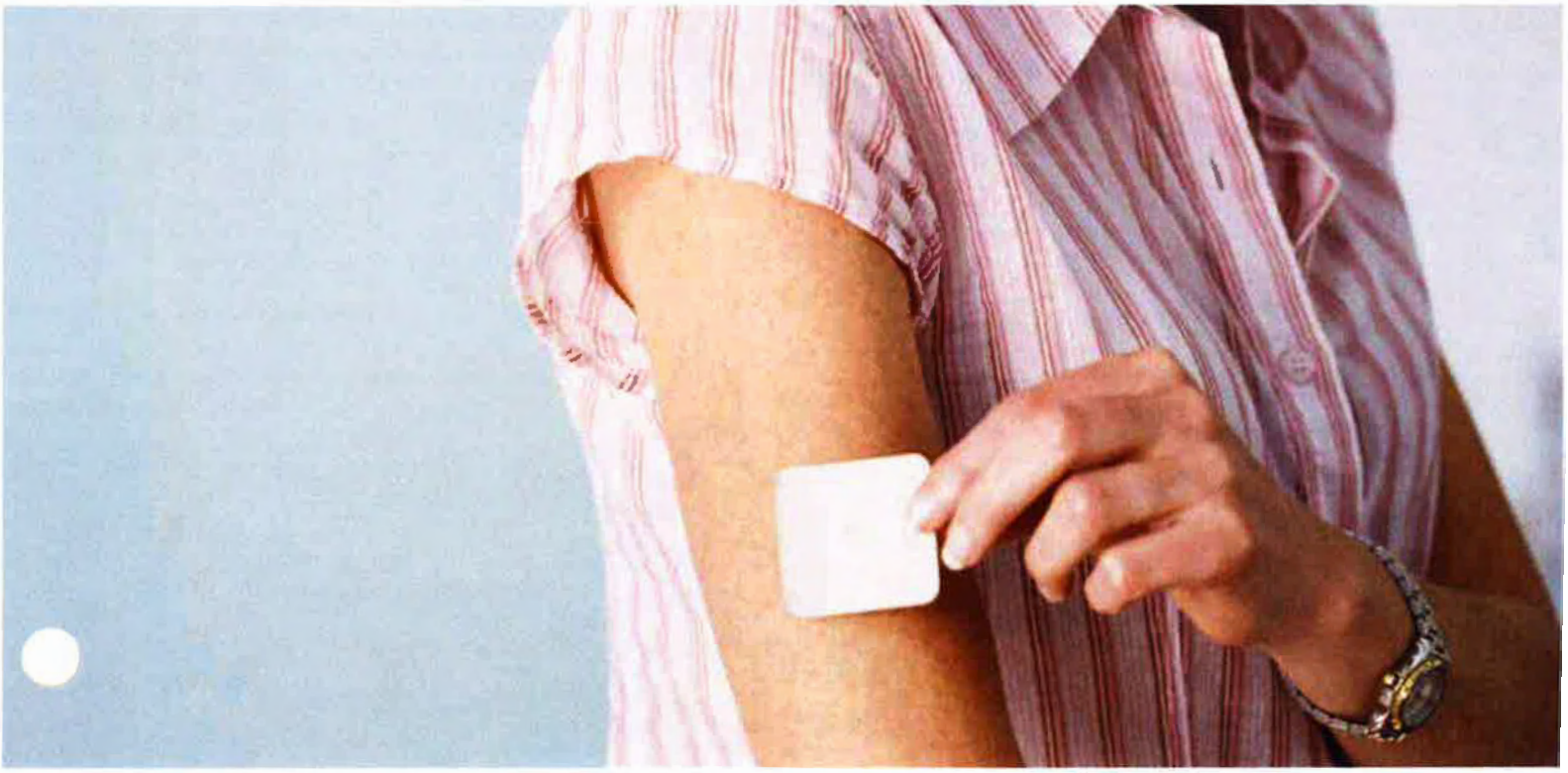
Step 3 Use quit medicines so they really work

There are safe and effective medicines that can make your quit easier. Some have nicotine in them, such as the patch, gum, lozenges, inhaler and nasal spray.

Some have no nicotine, such as bupropion SR (Zyban or Wellbutrin) and varenicline (Chantix). Have you tried to use quit medications in the past only to be frustrated by side effects, or you have stopped because you felt like they weren't working?

It is true that quitting with medicines can double your chances of success, but if you're using them incorrectly or if you're not dealing with your emotional and behavioral ties to tobacco, then you are less likely to succeed. This section will help you understand the difference between all of the quitting medicines out there, how to use each type correctly and how to manage common side effects.

Contact your doctor or your Quit Coach if you have any side effects that concern you or if you have questions about how to use your medicine.



Medicines that can help you quit

Nicotine patch

The nicotine in these patches can help you stop wanting to smoke. Over time you will use patches with less and less nicotine.

How to use

- Put on a new patch each day as soon as you wake up. Make sure to always take off the patch you used the day before.
- Find a place on your body to put the patch — this should be above your waist but below your neck. Put your patch in a new place each day so it does not make your skin sore.
- Press the patch in place by holding it firmly for 10 seconds.

How patches can help

- Easy to use.
- Gives you a steady dose of nicotine all day, to help you not smoke.
- You can find patches at most drug stores and don't need a prescription.
- Costs less per day than a pack of cigarettes!
- Research shows the patch can double your chances of quitting.

Nicotine gum

This is a type of sugarless gum that has nicotine in it. The gum keeps your mouth busy and helps your body take in nicotine slowly, which helps you stop smoking.

How to use

- Must be chewed in a special way to make it work.
- Chew it slowly several times. You may get a "peppery" taste.
- "Park" the gum in the corner of your mouth after several chews.
- When the taste fades, chew and "park" again.
- Spit out the gum after 30 minutes.
- Use a new piece of gum every one to two hours during the first four weeks.

How gum can help

- Gives you a steady dose of nicotine all day, to help you not smoke.
- You can find gum at most drug stores and do not need a prescription.
- Costs less per day than a pack of cigarettes!
- Research shows the gum can double your chances of quitting.

Nicotine lozenge

A nicotine lozenge is used like a throat lozenge for a cold or sore throat. It releases nicotine slowly into your body as it dissolves, which helps you stop wanting to smoke.

How to use

- Put one nicotine lozenge in your mouth.
- Do not chew it.
- Move the lozenge around your mouth from time to time.
- Allow it to dissolve in your mouth.
- Use a new lozenge every one to two hours during the first four weeks.

How lozenges can help

- Easy to use.
- You can use a lozenge as often as you need to help with urges (up to 20 times a day).
- You can find nicotine lozenges at most drug stores and do not need a prescription.
- Costs less per day than a pack of cigarettes!
- Research shows nicotine lozenges can double your chances of quitting.

Nicotine inhaler

The nicotine inhaler looks like a cigarette. You hold it between your fingers and "puff" on it. The inhaler is a prescription medicine, so you will need to see your doctor.

How to use

- Put the nicotine cartridge into the inhaler mouthpiece.
- Puff on the inhaler to take the vapor into your mouth, but do not breathe it into your lungs.
- Use as directed by your doctor.

How inhalers can help

- You can use a nicotine inhaler as often as you need to (read the package instructions).
- Using the inhaler feels like smoking a cigarette.
- The inhaler keeps your hands and mouth busy.
- Research shows the inhaler can double your chances of quitting.

Nicotine nasal spray

You spray this medicine into your nose from a pump bottle. This is a prescription medicine, so you need to first see your doctor.

How to use

- Put the nozzle from the pump bottle into each side of your nose.
- Spray, but do not sniff.
- You can use the spray one to two times each hour.
- Use as directed by your doctor.

How nasal spray can help

- Nasal spray gets nicotine to your brain faster than the patch, gum or lozenge, which helps reduce cravings.
- You can use the nasal spray as often as you need to (read the package instructions).
- Research shows the nasal spray can double your chances of quitting.

Combining the patch and gum or the patch and lozenges

Using the nicotine patch with nicotine gum or lozenges together might make your quit easier and more successful. The patch gives you nicotine slowly while the others work fast and help reduce withdrawal symptoms and cravings before they come up.

Combined patch and gum

How to use the patch and gum together

- Begin using your nicotine patches and gum on the first day you quit.
- Put on one new patch at the start of each day.
- Place the patch somewhere above your waist and below your neck.
- Do not put the patch on exactly the same spot every day because it may make your skin sore.
- You may use a piece of gum every one to two hours. Do not use more than 24 pieces per day.
- Chew each piece of gum several times and then "park" it in the corner of your mouth.
- After five minutes, chew it again a few times and "park" it again.
- Repeat this for 20 to 30 minutes and then spit it out.

How the patch and gum can help

- Using the patch and gum together can help you better manage urges to smoke.
- You decide how much gum to chew in addition to using the patch.
- Research studies show that using the patch with gum can increase your chances of quitting over using the patch or gum alone.
- You can find nicotine gum at most drug stores and do not need a prescription.
- The patch and gum together may cost less per day than a pack of cigarettes!

Combined patch and lozenge

How to use the patch and lozenge together

- Begin using your nicotine patches and lozenges on the first day you quit.
- Put on one new patch at the start of each day.
- Place the patch somewhere above your waist and below your neck.
- Do not put the patch on exactly the same spot every day because it may make your skin sore.
- You may use one lozenge every one to two hours. Do not use more than 20 pieces per day.
- Let the nicotine lozenge slowly dissolve. Do not chew or swallow it.
- Move it to the other side of the mouth every few minutes.
- The lozenge should dissolve completely in about 30 minutes.

How the patch and lozenge can help

- Using the patch and lozenges together can help you better manage urges to smoke.
- You decide how many lozenges to use in addition to using the patch.
- Research studies show that using the patch with lozenges can increase your chances of quitting over using the patch or lozenges alone.
- You can find nicotine lozenges at most drug stores and do not need a prescription.
- The patch and lozenges together may cost less per day than a pack of cigarettes!

Prescription medicines that can help you

Bupropion SR (also known as Zyban or Wellbutrin)

This medicine comes in tablets. It lowers your urge to smoke and reduces cravings, but it does not have any nicotine in it.

How to use it

- Start taking bupropion SR one week before your quit date.
- Limit alcohol, including beer, wine and spirits.
- Let your doctor or nurse know if you want to stop taking this medicine.
- Use as directed by your doctor. If you have questions about how to use bupropion SR, talk to your doctor or pharmacist.

How bupropion SR can help

- It reduces cravings to smoke and lessens nicotine withdrawal.
- Bupropion SR can double your chances of quitting.
- It costs less per day than a pack of cigarettes!

Varenicline (also known as Chantix)

This medicine comes in tablets. It works in the same part of your brain that nicotine does. Most people who use it have fewer urges to smoke. Varenicline does not contain any nicotine.

How to use it

- Start varenicline one week before your quit date.
- Follow the dosage instructions closely.
- Limit alcohol, including beer, wine and spirits.
- Take varenicline with a full glass of water and a meal to reduce the chance of an upset stomach. Having an upset stomach is a common side effect of this medicine.
- Talk to your doctor right away if you have serious mood changes, or feel depressed or angry after starting varenicline.
- Use as directed by your doctor. If you have questions about how to use varenicline, talk to your doctor or pharmacist.

How varenicline can help

- It reduces withdrawal from nicotine.
- If you smoke after you quit, you are less likely to "enjoy" the cigarette. Varenicline blocks the part of the brain that rewards you for smoking.
- It costs less per day than a pack of cigarettes!
- Research shows using varenicline more than doubles your chances of quitting.

If you have certain health conditions, talk to your doctor before using these medicines. Please see below for specific concerns for each type of medicine.

For bupropion SR (Zyban or Wellbutrin), talk to your doctor if you:

- Have kidney disease
- Have liver disease
- Are pregnant, breastfeeding or trying to get pregnant
- Have anorexia or bulimia (eating disorders)
- Get seizures
- Have a prior serious head injury (fainted or lost consciousness)

For varenicline (Chantix), tell your doctor if you:

- Are pregnant, breastfeeding or trying to get pregnant
- Have depression, anxiety, schizophrenia or bipolar disorder, or are suicidal (thoughts of ending your life)
- Have kidney disease

Common questions:

How do I decide which medicines to use?

Your Quit Coach can help you decide which medicines to use. Tell your Quit Coach whether you have used any of these medicines before and if they helped. Tell him or her if you take any other medicines, and if you have any health problems.

Can I use more than one medicine?

Yes. Talk with your Quit Coach or your doctor about which medicines can be combined.

Some of these medicines cost a lot of money. Are there ways to get help paying for them?

Talk with your Quit Coach about ways to pay for these medicines. He or she will help you find out which medicines are covered by insurance.

I have a health problem. Can I still use these medicines?

Tell your doctor, nurse or Quit Coach about your health problem. He or she can help you decide which medicines are safe for you.

Medicines: Side effects and what you can do

Quit medicines may have side effects. Many of these are listed below. Most side effects are minor and go away on their own. Read the information that comes with each medicine to learn about side effects you might have. Contact your doctor or Quit Coach if you have side effects that worry you or do not go away in one to two weeks.

Nicotine patch	
Side effects	**What to do**
Skin irritation (local redness or a rash or hives that are close to the patch site)	Move the patch to a new location each day. Talk to your health care provider or pharmacist about using hydrocortisone cream.
Upset stomach or headache	This can be the result of getting too much or too little nicotine. Call your Quit Coach to discuss the problem.
Strange or vivid dreams	This may be caused by getting nicotine while you sleep. Try taking off the patch one hour before bedtime if vivid dreams are a problem.

Nicotine gum	
Side effects	**What to do**
Upset stomach or headache	Make sure you are using the gum correctly. Nicotine gum is not chewed like regular gum. Go to page 31 to review use instructions. A headache can be the result of getting too much or too little nicotine. Call your Quit Coach to discuss the problem.
Stomach gas	Make sure you're using the gum correctly.
Gum is not working like you think it should	Nicotine gum is not chewed like regular gum. If not chewed correctly it may give you gas and it will not help you quit as well. Go to page 31 to review use instructions.

Nicotine lozenge	
Side effects	**What to do**
Upset stomach or headache	This can be the result of getting too much or too little nicotine. Call your doctor or pharmacist to discuss the problem.
Sore throat	This can be a temporary side effect. Contact your doctor if it does not go away.

Nicotine inhaler	
Side effects	**What to do**
Upset stomach or headache	This can be the result of getting too much or too little nicotine. Call your doctor or pharmacist to discuss the problem.
Sore throat	Try not to inhale into your throat. Hold the nicotine in your mouth only.

Nicotine nasal spray	
Side effects	**What to do**
Upset stomach or headache	This can be the result of getting too much or too little nicotine. Call your doctor or pharmacist to discuss the problem.
Nose is sore	This is a common side effect and often goes away within a week or so. Contact your doctor if your nose irritation does not go away after two weeks.

Bupropion SR	
Side effects	**What to do**
Trouble going to sleep or staying asleep	If taking two pills per day, take the last one at least four hours before bed (and at least eight hours after the first pill). You could also talk to your doctor about taking only one pill per day.
Dry mouth	Sip on water. Suck on hard candies.
Feel nervous	Bupropion SR can increase anxiety for some people. Talk to your doctor if this happens to you.
Think you had a seizure	Stop taking bupropion SR right away and contact your doctor or call 911.

Varenicline (Chantix)	
Side effects	**What to do**
Nausea (an upset stomach so upset you feel you may throw up)	This is the most common side effect. Follow instructions closely and take with a full glass of water and with a meal. If nausea does not go away, contact your doctor or pharmacist to discuss a lower dosage.
Changes in your mood (feeling sad or angry)	Be sure to let your doctor know about this as soon as possible. He or she will help you decide whether to keep using varenicline.
Strange dreams or trouble sleeping	This usually goes away in a week or two. If it lasts longer than a week or two, try reducing your dosage. Your doctor can help you.

Step 4 Control your environment

One of the keys to a successful quit is an environment that helps rather than hinders your progress. Think about how your work, home, car and other places where you spend time can help support you.

Tobacco-proof your home

It is important to get rid of your cigarettes and any other types of tobacco the night before you quit. Soak your tobacco products under water so you cannot smoke them. Look in your purse, car and coat pockets to make sure you don't have any stray cigarettes to tempt you.

The urge to smoke will be stronger and more frequent if you are near tobacco. You will have fewer urges to smoke if you get all tobacco and smoking supplies out of your home and car. Why keep ashtrays and lighters if you don't smoke? Give them away or throw them away.

What to do when others smoke around you

It can be difficult if your friends, co-workers or family members smoke around you. But there are some things you can do to make these situations easier.

Talk to your family, friends and co-workers

The first thing to do is to talk to those around you who smoke and tell them you are planning to quit. Maybe they will want to join you and you can use each other for support. Even if they don't want to quit, they may be willing to help support your quit process. Ask them if they are willing to:

- Smoke outside when you're inside
- Make at least one room tobacco-free at all times
- Only smoke in one part of the house.

Remember — you are in control!

It is important to remember that it is your decision to smoke or not to smoke. You are in control of your own behaviors and the way you think. Next time you are around people who are smoking, think about:

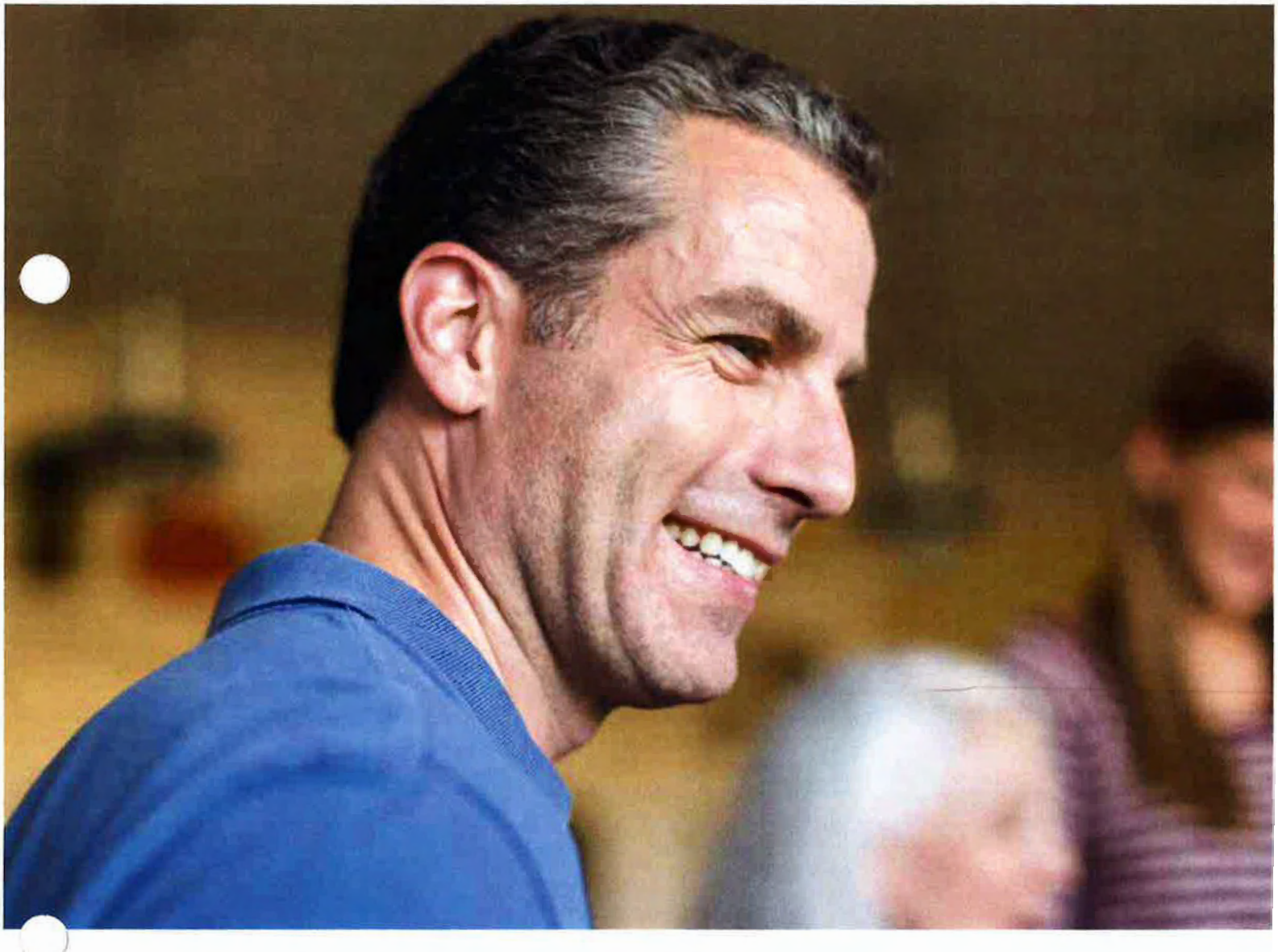
- What you can do to distract yourself from the urge to join them. Can you play with a puzzle, chew on a straw or give yourself a manicure?
- What you can tell yourself that will make your decision to quit stronger than the urge to smoke. You might tell yourself something like "I am tired of spending so much money on cigarettes" or "I promised my daughter I would quit and I don't want to let her down."

One idea for you is to post notes around the home. These remind you of your decision to quit. Here are some ideas to help you come up with your own Post-it reminders:

- "I don't have to smoke, even if I want to."
- "All I have to do is get through today without having a cigarette."
- "No one can make me smoke — I can do it!"

Step 5 Get social support

Support from family members or friends can make your quit attempt go more smoothly. Look at the tips on the next page for ideas on how to ask for support and what kind of support you want.



Choose your allies

Allies are people who can help you quit. They can be anyone you like and trust, such as family members, friends, or people you work with. Think about allies who can best support you when you quit.

It can help to choose allies who have quit smoking themselves since they know what you are going through. But a helpful nonsmoker can support you too! Do not pick allies who still smoke.

Here are some ways allies can help:

- Listening when you need to talk
- Cheering you on and not judging you
- Calling to see how you are doing
- Helping with childcare or errands
- Talking about problems and ways to solve them

Help your allies support you. Here are some ways:

- Tell allies your quit date. Ask them to write your quit date on their calendars so they know when you are quitting.
- Let your allies know if quitting is a secret
- Give them the booklet, "Your allies' guide: Helping someone quit tobacco"
- Plan how often to talk to your allies
- Warn your allies that you may be grouchy after you quit
- Do fun things together, such as cooking, walking, going to the movies or other

Don't just quit, become a nonsmoker

For many people trying to quit tobacco, the hardest part is the first two weeks after they quit.[6] These two weeks can make or break a person's success at quitting.

If you've prepared well and have set a realistic quit date, have figured out how to conquer your urges, and know how to use your medicines correctly, then your chances of success are very high. But you still might be feeling grouchy, nervous and stressed. This is normal. Your body is craving nicotine and you're having to adjust to life without tobacco. The good news is that it all gets easier with time, and the rewards for staying quit are great.

This section helps you recognize the rewards you will gain from quitting. It also teaches you how to stay quit for life using coping strategies for dealing with stress and withdrawal from nicotine.

Quitting gets easier over time

Most people find it helpful to think about quitting one day at a time, or even one hour at a time. The hours and days add up. You have a very high chance of quitting for good after staying quit for two weeks!

Here are some tips from other smokers that may help in the first two weeks after quitting:

- **Avoid other smokers.** You are more likely to smoke if you are around other smokers.
- **Do not smoke** — Not even one puff.
- **Use medicines to help you quit.** Talk with your doctor, nurse or Quit Coach to decide which medicines are right for you.
- **Remove all cigarettes and other tobacco from your home and car.** Throw out ashtrays.
- **Do things in different ways now that you are not smoking.** Go to pages 25-27 to review your coping skills.
- **Ask friends and family for their help and support.** Call your Quit Coach for even more support.
- **Remind yourself why you are quitting.** Make a list of your reasons for quitting and display the list where you often see it.
- **Reward yourself.** Celebrate the benefits of quitting.
- **Avoid alcohol.** Stay out of smoky bars and taverns. If you must drink, please do so moderately. Drinking alcohol too soon after quitting can cause some people to slip back into smoking.
- **Reduce your stress.** Try breathing exercises and stay active.

"Money in the bank" rewards

You will save a lot of money when you quit. Cigarettes cost as much as $11.00 a pack. Think of all the money you can save by not buying cigarettes! The charts below show how much you will save if cigarettes cost $5.00 or $7.00 a pack.

This is your savings if cigarettes cost $5.00 a pack:

Money I will save in	If I smoked:		
	1 pack a day	2 packs a day	3 packs a day
1 Day	$5.00	$10.00	$15.00
1 Week	$35.00	$70.00	$105.00
1 Month	$150.00	$300.00	$450.00
1 Year	$1,825.00	$3,650.00	$5,475.00
5 Years	$9,125.00	$18,250.00	$27,375.00
10 Years	$18,250.00	$36,500.00	$54,750.00

This is your savings if cigarettes cost $7.00 a pack:

Money I will save in	If I smoked:		
	1 pack a day	2 packs a day	3 Packs a day
1 Day	$7.00	$14.00	$21.00
1 Week	$49.00	$98.00	$147.00
1 Month	$210.00	$420.00	$630.00
1 Year	$2,555.00	$5,110.00	$7,665.00
5 Years	$12,775.00	$25,550.00	$38,325.00
10 Years	$25,550.00	$51,100.00	$76,650.00

Nicotine withdrawal

Nicotine withdrawal is when your body misses the nicotine you got from smoking. Nicotine withdrawal usually goes away within two to four weeks after quitting. Using a quit medicine can make quitting easier. Here are some things that can help you feel and be more in control — even if you are also using a medicine.

Withdrawal symptom	What you can do
Strong urge or craving to smoke	• Use a substitute (something that replaces a cigarette), like a toothpick or straw, or find a distraction, like a crossword puzzle. • Drink water or take deep breaths. • Most urges go away in three to five minutes. • If you are using nicotine gum or lozenges, try using them when urges hit.
Feel sleepy during the day	• This is very normal and usually goes away in a couple of weeks. • Go for a walk or be active in other ways. • Take a 15-minute nap.
Feel restless, like you have too much energy and cannot sit still	• Go for a walk or be active in other ways. • Try cutting back on coffee, tea or sodas with caffeine. • Use deep breathing.
Have trouble sleeping	• Exercise can help improve sleep. • Try cutting back on caffeine (in coffee, tea and some sodas), especially in the early afternoon. • Take deep breaths before bedtime to relax. • Talk to your doctor if this continues. • If you are using a medicine to quit smoking, call your Quit Coach or doctor.
Extra hungry, craving sweets or eating too much	• After quitting, it is normal to want to eat more. • Choose healthy foods that are filling but are low in fat and sugar. • You can also use substitutes that are not food. • Look on page 23 for more ideas.

Withdrawal symptom	What you can do
Constipation (trouble having bowel movements)	• Drink lots of water. • Eat more fruits, vegetables and whole grains. • Be active each day.
Have diarrhea (too many bowel movements) or an upset stomach	• Quitting smoking can change the way you digest food for a while. If you are using the patch, gum or lozenges, an upset stomach may mean that you are getting too much nicotine or are not using them the right way. Contact your doctor or nurse. (To learn more about side effects of quit medicines, see page 39).
Trouble thinking clearly or getting things done	• This is very common in the first month or so after quitting. It is a sign of nicotine withdrawal. Go easy on yourself. Ask others to be patient with you. This will get better soon.
Irritable or grouchy	• This is very normal right after quitting. Your body and brain crave nicotine after quitting. Quit medicines like the patch, gum, lozenges, bupropion SR or varenicline can help with these feelings.
Mild headache	• This is common in the first couple of weeks after quitting. If it persists or gets in the way of your daily activities, call your Quit Coach or your doctor.

"My husband and I are so happy with your program. We're here and healthy and going to be around for our grandkids. Your program really helped us!"

— Margaret, age 42

Dealing with strong feelings

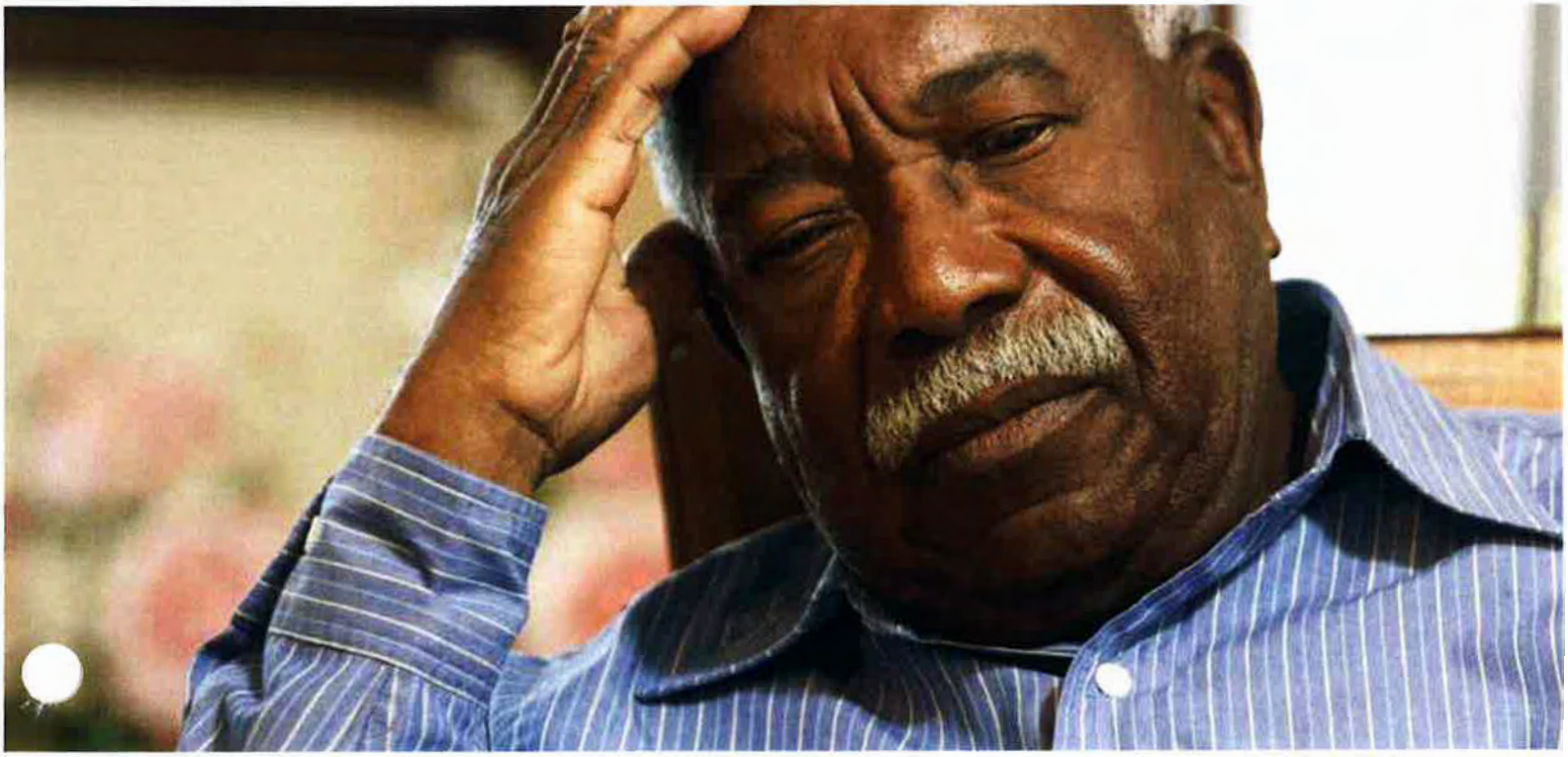
If you've tried to quit tobacco in the past, you may have experienced some strong feelings, such as frustration, anger, sadness, regret and fear. Maybe you found it hard to sleep, focus on your work or get along with other people because of these feelings. These feelings can make it much harder to stick with your plan to quit.

These strong feelings can be tough to cope with, but don't worry — they are common for people quitting tobacco. Strong feelings come and go throughout the day. If you know how, you can deal with them in the moment and turn these feelings into something more positive.

Why do we have such strong feelings after quitting tobacco?

Nicotine leaves your body within two or three days. But you might experience strong feelings for several weeks, months. You may be drinking coffee, trying to meet a work deadline or just watching TV, and suddenly you have a strong feeling that has nothing to do with using tobacco. Why does this happen?

The answer depends on how you used tobacco. Did you use it to relieve stress and calm yourself down when you were feeling angry, frustrated or anxious? If so, your body and mind may be searching for another way to manage these feelings. Think about what you can do instead of smoking. Make sure it is something that's fun, exciting and rewarding.



Frank's story:

Frank used this program and found a great solution. When Frank quit smoking, he was no fun to be around. He was sad all the time and became angry over small things. He told us that he really wanted to smoke during these times, so one day he decided to try something different.

When he started to feel angry, he went to the gym and hit a racquetball against the wall as hard as he could. He couldn't believe how quickly it took away his anger and desire to smoke! From then on, Frank packed his racquet in his backpack and played each day. Can you think of something like this that could work for you?

My ideas:

_____

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Don't ignore your strong feelings — they are telling you something! Just like Frank, you too can turn your strong feelings into something fun and rewarding — and stay quit for life.

A.C.E. model to stay quit

The A.C.E. model is a proven way to avoid having that first smoke after you quit. **Avoid** people and places that may give you an urge to smoke. If you can't avoid them, **Cope** with the situation using the skills you practiced. If the coping skills aren't working, **Escape**. Leave before you have a cigarette.

Now your work is to stay quit for good. Here are some ways to stay on track:

- **Do not smoke — not even one puff.**

  Do not tell yourself "it is okay to have just one." This is not true. If you have a cigarette — even one puff — it is very easy to start smoking again. Everyone who returns to smoking starts with "just one puff."

- **Make staying quit your #1 goal.**

  You have done a lot of work to get this far. Make this your goal so you never have to go through this again!

- **Keep using quit medicines.**

  Use them every day for at least eight weeks. Call your Quit Coach or your doctor if you have questions or concerns.

- **Ask for help and support.**

  Call your allies or your Quit Coach for help if you feel stressed, angry or just plain down, especially in the first few weeks after quitting.

- **Stay away from people who are smoking.**

  Make sure people know you have quit and ask them not to offer you any cigarettes. Use your coping skills to deal with urges to smoke. Stay away from places where people smoke.

- **Keep using your coping skills.**

  You are more likely to stay quit if you use coping skills that work for you.

- **Limit alcohol.**

  Many people go back to smoking when they have a drink. Try to drink as little alcohol as you can for the first month or so. Stay away from smoky bars and taverns at first.[7] If you must drink, know that urges may be stronger. Use your coping skills and the A.C.E. model.

- **Avoid high-risk situations.**

  These are places or people that may give you the urge to smoke. Stay away from them if you can.

- **Learn from the past.**

  Have you tried to quit before? Think about why you started smoking again. Plan what to do if it happens again.

Risky thinking

Here are four kinds of risky thinking that often lead back to smoking. If you find yourself having risky thoughts, try replacing them with more helpful thoughts.

Risky thought

I remember the good old days, when I used to smoke and felt so cool.

Helpful thought

Now that I am free of tobacco, I feel so healthy. I'm so glad I quit smoking!

Risky thought

I should be able to smoke just one cigarette once in a while.

Helpful thought

I know that if I have one cigarette, I will likely have another. It's a slippery slope.

Risky thought

I'm dealing with
a lot right now.
I deserve a cigarette.

Helpful thought

If I smoke a cigarette
now, I'll feel worse
in the long run.
I deserve a healthy life.

Risky thought

I would rather deal
with the consequences
of smoking than
gain weight!

Helpful thought

Smoking harms my
entire body. If I eat
healthy foods, I can
minimize weight gain
and be healthier!

What if I slip?

A slip is when you have a cigarette, cigar, pipe or even a puff after your quit date. Here is what you can do if you slip:

- **Use positive self-talk.**
  Tell yourself, "This is only one slip. I will do things differently next time."
- **Learn from your slip.**
  Figure out what caused the slip and what you can do the next time you have an urge to smoke. Take a look at your list of coping skills (pages 25-27).
- **If you are using a quit medicine, keep using it.**
  Continuing to use a quit medication when slipping will help you get back on track to quit for good.
- **Get support.**
  Call your Quit Coach and talk about ways to keep from having more slips.
- **If you slip, do not give up.**
  Call your Quit Coach for more ideas.

Reward yourself

Some people reward themselves for quitting smoking. Now is the time to start thinking about what kind of reward you would like. Rewards can be small, large, frequent or once in a while. Here are some ideas:

Small rewards

- Dinner out
- Massage
- New pair of shoes
- New music

Large rewards

- Exotic vacation
- New car or truck
- Kitchen or bathroom remodel
- Gym membership

Why you may gain weight

You may worry about gaining weight. And it is true you may gain weight when you quit smoking. Most people gain about 10 pounds. Some do not gain any weight at all. Here are some reasons you may gain weight when you quit smoking:

- **You burn fewer calories each day.**

  Smoking a pack a day burns about 200 calories. After you quit you may burn fewer calories each day.

- **You may be eating more calories than your body needs.**

  Some people eat more after they quit. This is because they eat when they get a craving for a cigarette or want to do something with their hands or mouth.

- **You may not be active enough.**

  You may need to be more active to not gain weight. Being active most days of the week will help you stay at a healthy weight. If you decide to start an exercise program, please talk to your doctor first and follow his or her advice.

Ways to manage your weight

You will likely not gain weight if you are active at least 30 minutes a day, limit how much you eat and eat healthy food. If you are worried about your weight gain, try these ideas:

Stay active!

Walk for 10 minutes, twice a day. This can keep you from gaining 10 pounds a year! Take the stairs instead of the elevator or park farther away so you need to walk a little farther to your job, home or grocery store.

Move around — everything counts

- Light housework
- Slow walks
- Playing with your children
- Working on your car
- Gardening
- Raking leaves

Check with your doctor to see what kinds of activities you can do

Eat healthy snacks

Everyone snacks. People snack because they are hungry, bored or restless. Here are some healthy snack ideas if you are really hungry:

- Apple or banana.
- 1 cup of blueberries or grapes.
- A serving of raw almonds.
- Slices of chilled cucumber.
- Chilled carrots and celery sticks.

Keep weight off with the right foods

Your weight is affected by the foods you eat and how you cook them. Try these ideas to keep your weight gain low:

- Eat nine to twelve servings of fruits and vegetables per day
- Eat two to three servings of low-fat dairy per day
- Eat one to two servings of fish, lean meat, beans or tofu per day
- Eat more whole foods and fewer processed foods per day
- Reduce fat intake to 25 percent of daily calories (or less)

Chronic conditions

If you have any of these conditions, quitting smoking can help.

When you have asthma and smoke:

- You are more likely to have an asthma attack because smoke can trigger these attacks.
- Asthma attacks may be more severe, and you are more likely to be hospitalized because of your asthma.
- Family and friends with asthma are at risk from secondhand smoke (when you smoke and they do not).

When you stop smoking:

- Your lungs and airways are clear of smoke, which is one of the most common triggers of asthma attacks.
- You can better control your asthma symptoms and may need less asthma medicine.
- Your airways are clearer and it is easier for you to breathe.

When you have Chronic Obstructive Pulmonary Disease (COPD) and smoke:

- It gets harder and harder to breathe because the smoke continues to damage your lungs.
- You have higher risk of serious lung infections, such as pneumonia.
- Your COPD will continue to get worse and you are likely to need more oxygen to help you breathe.

When you stop smoking:

- You will stop damaging your lungs and your breathing should get better.
- You will cough less and be less likely to get lung infections.
- You may not need extra oxygen to help you breathe and skin infections.

When you have diabetes and smoke:

- Your risk of diabetes and strokes is very high.
- You are more likely to get cancer of the lung, mouth, throat, esophagus, bladder, kidney, pancreas, and so on.
- You are at risk for breathing problems and lung diseases, such as COPD, asthma and pneumonia.
- Blood sugar medicines and insulin shots may not work as well.

When you stop smoking:

- Your risk of heart disease goes down soon after you quit and continues to go down as long as you stay quit.
- You have less risk of getting cancer and other complications of diabetes, including loss of vision, kidney disease, nerve damage and skin infections.
- You will be able to better control your blood sugar with insulin or other medicines.

When you have heart disease and smoke:

- You have double the risk of getting a heart attack or stroke than people with heart disease who do not smoke.
- Smoking increases blood pressure and heart rate and causes damage (clogging and hardening) in your blood vessels.
- If you are taking birth control pills, you are at even greater risk for heart attacks and strokes.

When you stop smoking:

- Your blood pressure and heart rate go down very soon after you quit, and your risk of having a heart attack or stroke also goes down.
- The damage to your blood vessels caused by smoking starts to repair itself.
- If you have a heart attack, you are less likely to die from it, and if you have had a heart attack before, you are less likely to have another one.

Quit the spit

If you are reading this you probably chew or "dip" tobacco and smoke. You may use moist snuff or chewing tobacco, or both. Maybe you have tried to quit before but found it very hard. The information in this section will help you quit using these types of tobacco for good. We give you a step-by-step plan to quit so that you can become completely free of smoked and chewed tobacco. We will refer to snuff and chewing tobacco as spit tobacco in this section of the guide.

Should I quit smoking and spit tobacco at the same time?

The simple answer is yes. Quitting both at the same time will help you stay quit for good and receive all the health benefits of being totally free of tobacco.

Dangers of spit tobacco

Unlike smoking, spit tobacco does not cause lung cancer or emphysema. But that is where the good news ends. Spit tobacco is known to cause other health problems that can shorten your life and make life less enjoyable. These include cancer of the mouth, tooth decay gum problems that can lead to tooth loss, and some research has shown that spit tobacco is also linked to heart disease and high blood pressure.

Addiction to nicotine

Spit tobacco gives you a lot of nicotine. In fact, someone who uses two tins per week of moist snuff is getting about the same amount of nicotine as a person who smokes 30 cigarettes per day! Most users of spit tobacco take in more nicotine each day than a typical smoker does. This can make it hard to quit spit tobacco.

The top-selling brands of spit tobacco have the most nicotine. In fact, the makers of these products actually treat the tobacco with chemicals (ammonia) to help the nicotine be absorbed into your body more quickly. Also, between 50 and 70 percent of the nicotine is what is called "free nicotine." This is nicotine that is absorbed into your mouth very, very quickly. This makes you more addicted to nicotine.

So, if you smoke and use spit tobacco you may be VERY addicted to nicotine. The information that follows will help you quit for good.

List your reasons to quit

Chewers can have many reasons to quit. Take a minute and think about why you want to quit spit tobacco. It is a good idea to post your reasons somewhere you will see them each day. Doing this will help you stay motivated to quit. Examples may be the following:

- To avoid health problems.
- To prove I can do it.
- I have sores or white patches in my mouth.
- To please someone I care about.
- To set a good example for my kids or other kids.
- To save money.
- I'm tired of the taste.
- I have gum or tooth problems.
- My physician or dentist told me to quit.
- People look at me funny when I spit.
- Because it's banned at work or school.
- I don't want it to control me.
- My girlfriend/boyfriend (or a person I'd like to date) hates it.
- My wife/husband/partner hates it.

My reasons:

_____

_____

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_____

Create your quit plan

Here is a step-by-step plan to stop using spit tobacco.

Set your quit date

Do you have a date to quit smoking? Why not make that same date you quit using spit tobacco? Take a minute and add a note to your quit calendar that you are quitting spit tobacco the same day you quit smoking.

Learn to control your urges to chew before you quit

It is a good idea to track when and where you chew or dip, and what you are doing or feeling at the time. When you do this, you can figure out what you are going to do instead of chewing. You may want to complete the tracking worksheet (page 8) for a couple days. Then pick out some coping strategies below and give them a try.

Use quit medicines

Most people who smoke and chew will have more success quitting if they use a quit medicine[5]. You can choose between a medicine that has nicotine in it and pills that have no nicotine. Many people who both smoke and chew do better if they use two nicotine medicines, such as the patch and gum or the patch and lozenges at the same time.[8] Your Quit Coach can tell you more and help answer your questions.

Once you quit, stay quit for life

Once you quit, you can stay quit by watching out for difficult situations, such as stress or being around other chewers. Don't forget the A.C.E. model:

- **Avoid other chewers and situations where you always chew.**
  If you can't avoid these, then ...
- **Cope using oral substitutes and remembering why you want to quit.**
  If coping is not working, then ...
- **Escape the situation by leaving.**
  Protect your health — you are worth it.

Track your spit tobacco use

On page 8 there is a track your smoking worksheet. You can use this to track your spit tobacco at the same time as you track your smoking. Many smokers and chewers find this exercise helps them see patterns in their smoking and chewing that they didn't notice before.

- Avoid being around other spit tobacco users when you can.
- Use an herbal substitute when you have a craving to take a dip or chew.
- Use other oral substitutes such as hard candy, chewing gum or sunflower seeds.
- Keep reminding yourself why you want to stop chewing or dipping. Try posting reminder notes.
- Mix up your routine to avoid places and activities that give you the urge to chew or dip.

My ideas:

_____

_____

_____

Should I "taper" before quitting?

If you use more than two tins per week, you may want to "taper" or reduce your nicotine intake slowly before you quit for good. There are a couple ways to do that. One is to reduce how much you use over the course of two to three weeks by taking smaller dips or chews and spacing them farther and farther apart. The other way is to use an herbal substitute that you can mix with your spit tobacco before quitting.

Three-week taper method:

Using this method you will reduce your nicotine by at least half (50 percent). If you want to taper down even more, you can take a week or two longer to taper further.

- **Week 1:** Track how many tins or pouches you chew for one week. Write it down.
- **Week 2:** Reduce how much spit tobacco you use by one-quarter. For example: If you found in week 1 that you normally use one tin or one pouch a day, reduce back to three-quarters of a tin or pouch during week 2.
- **Week 3:** This is the week before you quit. Cut back to one-half the amount you used in week 1.
- **Week 4:** This is the week you quit.

Three-week herbal substitute method:

Using this method, you can reduce your nicotine by half (50 percent) or more. If you want to reduce even more, you can take a week or two longer to taper further. Herbal substitutes, such as Mint Chew, BACC OFF, Golden Eagle Herbal Chew or Smoky Mountain Herbal Chew, can be found in many convenience stores or online. Check to make sure the herbal brand you get does not contain any tobacco.

- **Week 1:** Track how many tins or pouches you chew for one week. Write it down.
- **Week 2:** Empty how much tobacco you normally use per day on a plate. Take away one-quarter of the tobacco and mix in some herbal substitute.

Important note: It is very important to mix the tobacco and herbal substitute together very well. "Long-cut" tobacco is harder to mix well than "fine-cut." You may want to switch to a fine-cut brand before you start reducing. If you use Skoal Long Cut, you can switch to Skoal Fine Cut. This will help you mix the tobacco with the herbal substitute so they are blended very well.

- **Week 3:** Repeat what you did for week 2, but instead take away one-half of the tobacco and replace it with an herbal substitute.
- **Week 4:** This is the week you quit.

Remember that your Quit Coach is available seven days a week to help you achieve your goal of being tobacco-free for life. Call if you need help!

Help someone else

Congratulations on quitting for good. You have done what many people are still trying to do — quit their deadly addiction to smoking. Give your support to someone you know who is trying to quit smoking or even thinking about quitting. Helping others is a great way to stay quit.

We are always here to help you stay quit for life. Feel free to call your Quit Coach for help at any time.

Congratulations on quitting for good!

Citations

1 The mini-quit protocol came from 2008 Clinical Practice Guideline Update: Treating Tobacco Use and Dependence, which outlines the STAR model. The "A" is "anticipate challenges ... provide practical counseling including problem solving and skills training; identify and practice coping or problem solving skills." (table 6.19 p 98)

2 American Lung Association, lung.org/associations/states/colorado/tobacco/

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7 Nicotine Tob Res. 2006 Dec;8 Suppl 1:S21-5. Integrated online services for smokers and drinkers? Use of the check your drinking assessment screener by participants of the Stop Smoking Center. Cunningham JA

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Notes

Notes

If you would like more information or have any questions about this guide please contact us:

Nebraska Tobacco Quitline

1-800-QUIT-NOW (1-800-784-8669)

TTY: 1-877-777-6534

QuitNow.ne.gov

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NE-049-0316

Usted puede dejar de fumar.

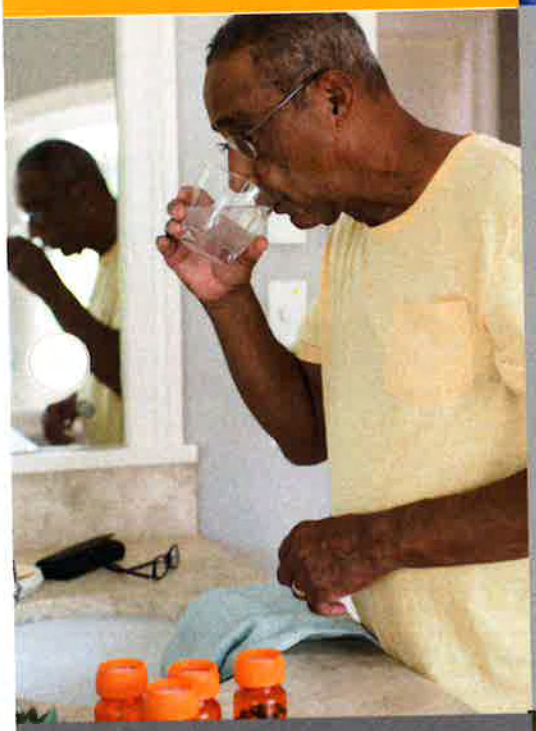
Le enseñaremos cómo.

PASO 1

Deje de fumar a su propio ritmo

PASO 2

Domine el impulso de fumar



PASO 3

Utilice los medicamentos para dejar de fumar de manera que realmente funcionen

PASO 4

Controle su entorno

PASO 5

Obtenga apoyo social

Usted puede dejar de fumar.

Le enseñaremos cómo.

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Bienvenido al programa

Dejar de fumar es lo mejor que puede hacer por su bien y el de las personas que ama. Estos cinco pasos, basados en 25 años de investigación, han ayudado a cientos de miles de fumadores a dejar de fumar para siempre.

Siga estos cinco pasos para que dejar de fumar le resulte más fácil y más exitoso.

Paso 1: Deje de fumar a su propio ritmo

Para dejar de fumar a su propio ritmo, elija la fecha (el día que quiere dejar de fumar) que más le convenga. Su asesor Quit Coach® le ayudará a prepararse y estar listo para dejar de fumar en esa fecha.

Paso 2: Domine el impulso de fumar

Le ayudaremos a aprender cómo manejar el deseo de fumar, sin importar cuándo o dónde lo sienta. Esto le ayudará a dejar de fumar para siempre. También aprenderá cómo manejar el estrés sin fumar.

Paso 3: Utilice los medicamentos para dejar de fumar de manera que realmente funcionen

Le ayudaremos a elegir un medicamento como un parche, goma de mascar, bupropión de liberación prolongada o Chantix® (vareniclina) que sea adecuado para usted y le enseñaremos cómo utilizarlo correctamente para que le sirva para dejar de fumar.

Paso 4: Controle su entorno

Aprenda por qué deshacerse de todo el tabaco, ceniceros y encendedores puede ayudarle a dejar de fumar para siempre.

Paso 5: Obtenga apoyo social

Le enseñaremos por qué es importante que les pida a sus familiares y amigos el apoyo que usted quiere.

"Participar en este programa es lo único que hice diferente esta vez y funcionó. El solo hecho de saber que ustedes estaban a mi lado marcó toda la diferencia".

— Danielle, 34 años

Su guía para dejar de fumar

Esta guía es para fumadores que quieren dejar de fumar sin reincidir. Exactamente como usted. No importa cuántas veces haya tratado de dejar de fumar sin conseguirlo, esta guía puede serle útil. Ofrece mucha información sobre lo que hay que hacer en cada paso del camino.

La guía también tiene hojas de trabajo donde puede anotar sus propias ideas y planes (vea la página 18). La mayoría de la gente cuando empieza a dejar de fumar completa la hoja de trabajo **Registre lo que fuma**. Los asesores Quit Coach suelen sugerir completar esta hoja de trabajo en dos o tres días. Esto le ayuda a entender mejor cuándo, dónde y por qué fuma. Su asesor Quit Coach está entrenado para ayudar a los fumadores a dejar de fumar para siempre. Usted y su asesor Quit Coach trabajarán juntos en equipo. El asesor lo llamará por teléfono y es posible que le sugiera que complete algunas de las hojas de trabajo de esta guía.

La segunda hoja de trabajo que sugiere la mayoría de los asesores Quit Coach es **Tramos de práctica**. Un tramo[1] es un corto período en el cual usted practica no fumar antes de dejar el tabaquismo por completo. Estos tramos sin tabaco le ayudan a aprender cómo enfrentar el impulso de fumar. Puede obtener más información sobre los tramos sin fumar en la página 28.

Hay muchas maneras de utilizar esta guía. Puede leer todo el manual de principio a fin o solo consultar las secciones que necesita ahora. También puede completar cualquiera de las hojas de trabajo que le interese.

Hoja de trabajo Registre lo que fuma

Anote la hora del día en la que fuma, dónde está cuando fuma, qué está haciendo cuando fuma y cuántos cigarrillos fuma.

Hora del día	Dónde estoy	Qué estoy haciendo	Cuántos cigarrillos
Ejemplo: Mañana	• Cocina • Esperando el autobús	• Bebiendo café • Leyendo el periódico	• 2 cigarrillos • 1 cigarrillo
Mañana			
Tarde			
Noche			
Otro momento			

Pensar en dejar de fumar

¡Qué bien que está pensando en dejar de fumar! Dejar de fumar es la decisión más importante que puede tomar por su salud, su familia y su felicidad. Ha llegado al lugar indicado para obtener ayuda.

Dejar de fumar en equipo

En este programa, usted formará un equipo con asesores Quit Coach. Este programa ha ayudado a cientos de miles de fumadores a dejar de fumar en los últimos 25 años.

1. Su asesor le ayudará a fijar una fecha para dejar de fumar.
2. Le enseñará a manejar el impulso de fumar.
3. Seleccionará un medicamento y le enseñará cómo utilizarlo para que realmente funcione.
4. Le indicará cómo crear un ambiente a prueba de tabaco.
5. Lo guiará para recibir el apoyo de familiares y amigos.

Tal vez haya intentado dejar de fumar antes. Esta vez puede ser diferente. ¡Podemos ayudarle a que esta vez sea la definitiva!

Problemas de salud causados por el tabaquismo

Todos los años el tabaquismo mata a más personas que todas las que mueren en accidentes de tránsito, por consumo de drogas ilegales y alcohol, en incendios, por caídas y a causa del SIDA[2] en conjunto. El tabaquismo también causa muchos problemas de salud, como enfermedad cardíaca, cáncer, problemas respiratorios, problemas dentales, problemas en los ojos y oídos, problemas óseos, problemas sexuales y reproductores, y problemas de piel.

Si usted sufre una afección crónica como asma, EPOC, diabetes o enfermedad cardíaca, vea la página 57 para obtener más información sobre cómo el consumo de tabaco y el hecho de dejar de fumar inciden específicamente en estas afecciones. El tabaquismo también causa problemas de salud debido al "humo de segunda mano". Esto se refiere al humo de los cigarrillos, cigarros o pipas que están encendidos[3]. Respirar humo de segunda mano perjudica la salud y mata a más de 50,000 personas por año.

¿Por qué el humo de segunda mano es un problema?

El humo de segunda mano contiene muchas sustancias químicas que son peligrosas al inhalarlas. Estas sustancias químicas causan enfermedad cardíaca, ataque al corazón, accidente cerebrovascular, cáncer de pulmón y problemas en los vasos sanguíneos. El humo de segunda mano es aún más peligroso para los niños y las personas que ya tienen problemas respiratorios o enfermedad cardíaca.

Cuando usted fuma, sus hijos fuman

Los bebés expuestos al humo de segunda mano tienen el triple de probabilidades de morir a causa del síndrome de muerte súbita del lactante (*sudden infant death syndrome*, SIDS) o muerte blanca. Los niños son más propensos a tener infecciones en los oídos, asma, bronquitis, neumonía y otras infecciones pulmonares cuando están cerca de personas que fuman. Los hijos de fumadores tienen el doble de probabilidades de empezar a fumar.

¿Cómo me puedo cuidar y proteger a los demás del humo de segunda mano?

Una vez que haya dejado de fumar:

- Pídales a los fumadores que no fumen cerca de usted o de sus hijos.
- Haga de su casa y su automóvil lugares libres de humo.
- Manténgase alejado de lugares donde la gente fuma. Si donde usted trabaja se fuma, pídale a su jefe que prohíba fumar en su lugar de trabajo.

Hasta tanto deje el cigarrillo, fume en el exterior para que los demás no tengan que respirar el humo de segunda mano que usted genera. Dejar de fumar definitivamente es lo mejor que puede hacer por su bien y el de quienes lo rodean.

Beneficios para la salud cuando se deja de fumar

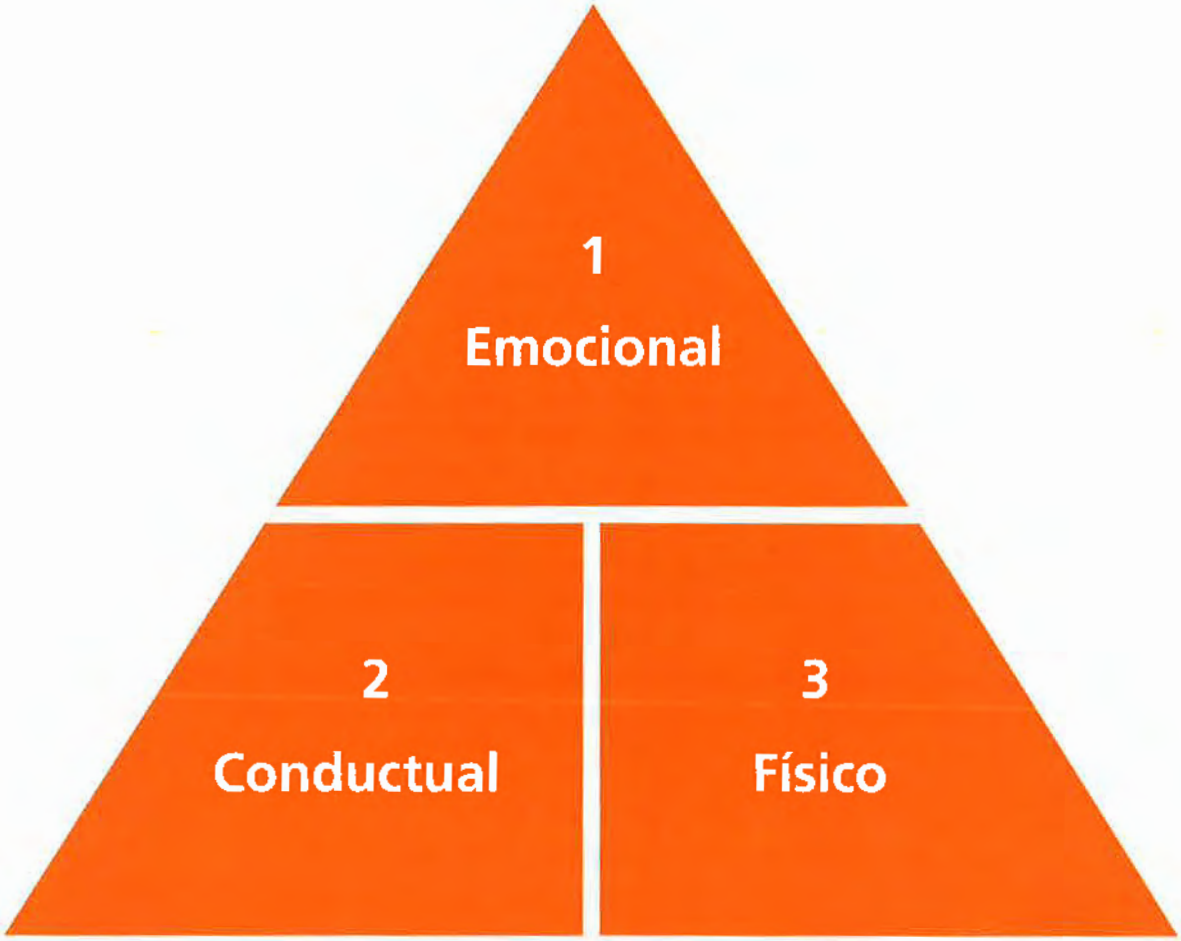
Su salud va a mejorar independientemente de cuándo deje de fumar. El organismo comienza a sanar minutos después de que usted deja de fumar. Cuanto más tiempo pase libre de humo de tabaco, más saludable estará. Vivirá hasta 10 años más que si siguiera consumiendo tabaco.[4]

Tiempo desde que se deja de fumar	Efectos en el organismo
20 minutos	• La presión arterial y el pulso se normalizan • Las manos y los pies tienen temperatura normal
8 horas	• Baja el nivel de monóxido de carbono en la sangre hasta normalizarse • Sube el nivel de oxígeno en la sangre hasta normalizarse
1 día	• Se reducen las probabilidades de tener un ataque al corazón y morir
2-3 días	• Mejoran los sentidos del gusto y del olfato
2-12 semanas	• Mejora la circulación (flujo de la sangre) • Se respira con más facilidad • Se camina con más facilidad
1-9 meses	• Menos tos y congestión sinusal (nariz tapada) • Más energía • Menos falta de aire • Menos probabilidades de infecciones
1 año	• El riesgo de enfermedad cardíaca se reduce a la mitad del de un fumador
5 años	• Menos probabilidades de tener cáncer de pulmón o problemas pulmonares • Mejora la salud si tiene diabetes, asma, enfermedad renal u otra enfermedad crónica • Se reduce a la mitad la probabilidad de tener cáncer de boca, garganta, esófago, vejiga, riñón o páncreas • El riesgo de sufrir un accidente cerebrovascular es el mismo que el de una persona que nunca ha fumado
10 años	• Se reduce a la mitad el riesgo de cáncer de pulmón
15 años	• El riesgo de enfermedad cardíaca es el mismo que el de una persona que nunca ha fumado

Adicción: Por qué es difícil dejar de fumar

Adicción es la pérdida de control en el consumo de una droga. La nicotina del humo del tabaco es lo que determina la adicción al cigarrillo. Las tabacaleras hacen los cigarrillos de manera tal que la nicotina llegue al cerebro con mucha rapidez. Cuanto más rápido llega la nicotina al cerebro, más adictiva es. La nicotina del parche o la goma de mascar llega al cerebro más lentamente. Por este motivo, rara vez el parche o la goma de mascar generan adicción.

Puede ser difícil dejar de fumar cuando se es adicto al tabaco. Los motivos son tres. Puede verlos como los tres vértices de un triángulo.



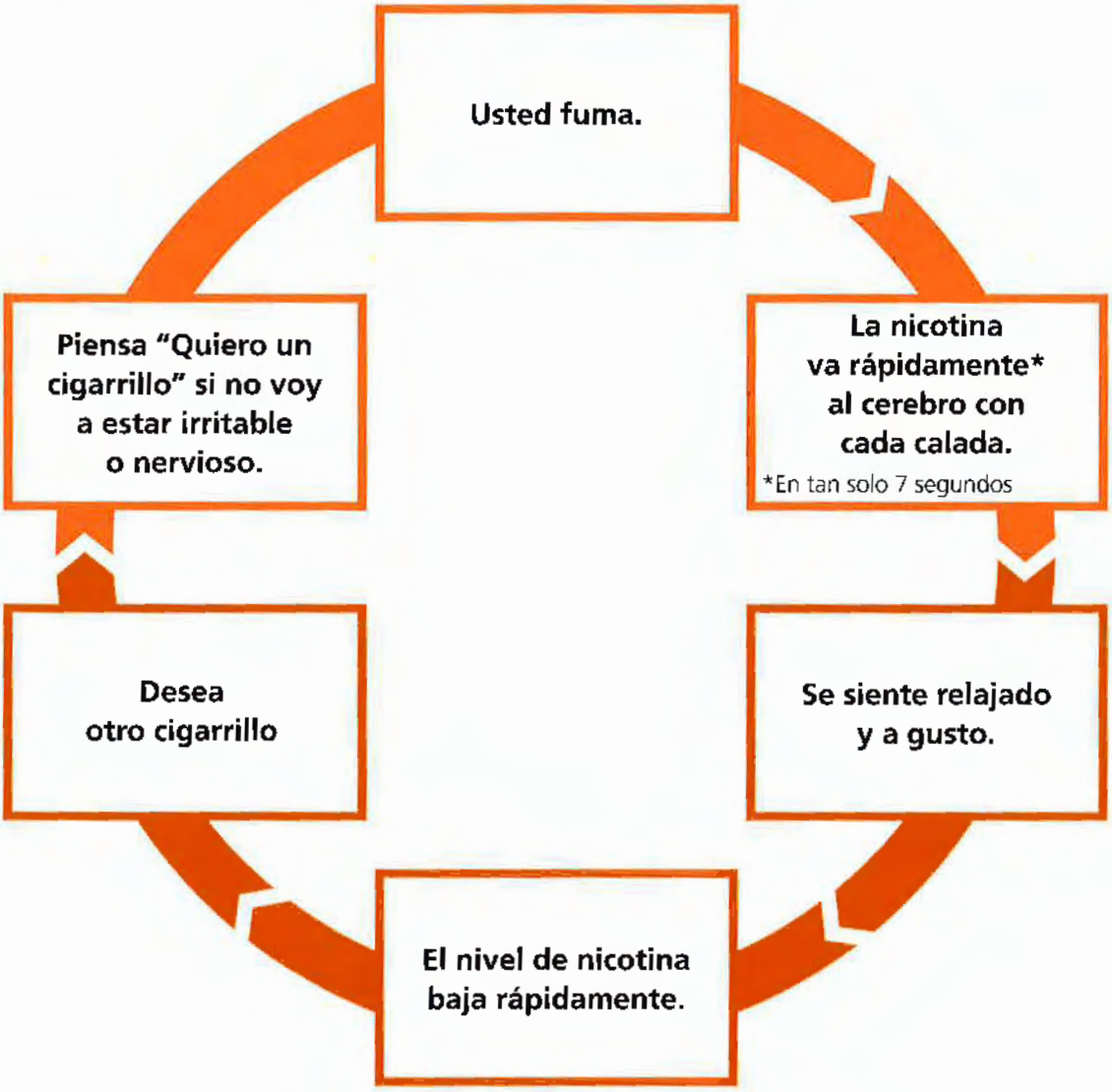
Emocional: lo que siente al consumir tabaco, lo que cree sobre el consumo de tabaco y lo que piensa del tabaco.

Conductual: cómo responde en los lugares y momentos en los que quiere fumar, como cuando está tomando una taza de café o hace una pausa en su trabajo.

Físico: los momentos en los que su organismo ansía la nicotina del tabaco.

El ciclo de nicotina se produce cuando el cuerpo y la mente desean mucho la nicotina. Es bueno entender este ciclo para poder romperlo. A continuación, podemos ver un gráfico de este ciclo.

Su asesor Quit Coach le ayudará a aprender formas de combatir este ciclo de la nicotina. Una forma de reducir las ansias de fumar es con el uso de medicamentos como parches, goma de mascar y pastillas que contienen nicotina. La vareniclina (Chantix) o el bupropión de liberación prolongada también pueden ser de utilidad. Encontrará información sobre estos medicamentos a partir de la página 30. Su asesor Quit Coach puede contarle más sobre estos medicamentos que pueden ayudarle a dejar de fumar y cuáles pueden estar cubiertos por su seguro. Llame a su asesor Quit Coach, ¡está allí para brindarle ayuda!



Qué puede hacer ahora

Puede ser útil saber cómo encaja el tabaquismo con lo que a usted le importa. Para muchas personas, la salud, la familia y la felicidad son importantes. Utilice la hoja de trabajo a continuación para ver cómo el tabaquismo incide en lo que a usted más le importa.

Hoja de trabajo Lo que a mí me importa

En cada columna escriba lo que a usted le importa, por qué le importa y cómo el tabaquismo se interpone. Puede agregar sus propias ideas al final de esta hoja de trabajo. Hay un ejemplo en la primera fila de la consigna a seguir.

Lo que a mí me importa	Por qué esto me importa	Cómo el tabaquismo se interpone en lo que me importa
Ejemplo: Familia	• Me gusta dedicarles tiempo a mis hijos y quiero ser un buen padre.	• Me quedo sin aliento cuando juego con mis hijos. • Mi hija tose cuando fumo.

Prepararse para dejar de fumar

Dejar de fumar es lo mejor que puede hacer por su bien y el de las personas que ama. En esta sección, conocerá los "cinco pasos esenciales para dejar de fumar para siempre". Estos pasos están basados en 25 años de investigación y han ayudado a cientos de miles de fumadores a dejar de fumar y no reincidir. Utilice estos pasos para que dejar de fumar le resulte más fácil y exitoso.

Los cinco pasos claves para dejar de fumar para siempre

Paso 1: Deje de fumar a su propio ritmo

Para dejar de fumar a su propio ritmo, elija la fecha (el día que quiere dejar de fumar) que más le convenga. Su asesor Quit Coach le ayudará a prepararse y estar listo para dejar de fumar en esa fecha.

Paso 2: Domine el impulso de fumar

Le ayudaremos a saber cuándo y dónde tiene ganas de fumar y cómo enfrentar esa situación. Esto le ayudará a dejar de fumar para siempre. También aprenderá cómo manejar el estrés sin fumar.

Paso 3: Utilice los medicamentos para dejar de fumar de manera que realmente funcionen

Le ayudaremos a elegir un medicamento (como un parche, goma de mascar, pastillas de nicotina, bupropión de liberación prolongada o Chantix) que sea adecuado para usted. Le enseñaremos cómo utilizar el medicamento correctamente para que le sirva para dejar de fumar.

Paso 4: Controle su entorno

Aprenda por qué deshacerse de todo el tabaco, ceniceros y encendedores puede ayudarle a dejar de fumar para siempre.

Paso 5: Obtenga apoyo social

Le enseñaremos por qué es importante que les pida a sus familiares y amigos el apoyo que usted quiere.

Paso 1

Deje de fumar a su propio ritmo

¿Cuántas veces intentó dejar de fumar? Para el fumador promedio, se necesitan varios intentos para finalmente dejar de fumar para siempre. Piense en todas las veces que ha intentado dejar de fumar, pero luego volvió a consumir tabaco.

Lo más probable es que no estaba verdaderamente preparado, se sintió presionado por los demás o tomó una decisión a la ligera y no se preparó en absoluto. Dejar el tabaco puede ser difícil, pero crear un plan es la mitad de la batalla. En esta sección, le ayudaremos a pensar en su relación con el tabaco, por qué quiere dejar de fumar, cuándo dejar de fumar y cómo prepararse para su fecha para dejar el tabaco.

Cómo y por qué elegir una fecha para dejar de fumar

Es muy importante elegir una fecha para terminar con el tabaquismo. Se llama "fecha para dejar de fumar". Puede darnos miedo tener que elegir una fecha para dejar de fumar, pero sirve para fijar un objetivo en el cual trabajar. Cuando usted elige una fecha para dejar de fumar, se está diciendo "Me estoy tomando en serio este tema".

¿Entonces cómo se elige una fecha para dejar de fumar? Depende de usted decidir cuándo dejará de fumar, pero las investigaciones indican que quienes fijan una fecha para dejar de fumar en un período de dos semanas tienen más éxito. Estas son algunas cuestiones para tener en cuenta:

- Para algunas personas, los días de semana pueden ser mejores que los fines de semana. Si no puede fumar en el trabajo, tiene menos oportunidades de fumar durante la semana. Muchas personas eligen un lunes en la mañana como fecha para dejar de fumar.
- El fin de semana puede ser un mejor momento si usted tiene menos estrés que durante los días de semana. El fin de semana, puede planificar pasar el primer par de días en lugares agradables libres de humo, como el cine.
- Las investigaciones indican que quienes fijan una fecha para dejar de fumar en un período de dos semanas tienen más probabilidades de lograrlo.
- Si planea utilizar un medicamento que le ayude a dejar de fumar, asegúrese de tenerlo a mano y de saber cómo utilizarlo correctamente antes de dejar de fumar. Su asesor Quit Coach puede enseñarle cómo utilizar un medicamento para dejar de fumar.
- ¿Tiene pensado dejar de fumar con un amigo, su pareja o un familiar? Si es así, es una buena idea sentarse con esa persona y seleccionar una fecha que sea buena para los dos.

Anote la fecha para dejar de fumar en el calendario

Utilice un calendario para escribir la fecha para dejar de fumar. Colóquela en un lugar donde la vea con frecuencia, como el refrigerador.

La fecha en la que tiene planificado dejar de fumar: _____

La fecha en la que comienza a utilizar medicamentos para dejar de fumar: _____

La fecha en la que les va a pedir a amigos y familiares su apoyo: _____

Hoja de trabajo Hábitos saludables

Este es el momento de pensar en los hábitos saludables que le ayudarán a dejar de fumar. Marque lo que planea hacer y agregue sus propias ideas a continuación.

Dos semanas antes de mi fecha para dejar de fumar, voy a:

- ☐ Pensar en las cosas que quiero hacer, que no sea fumar.
- ☐ Hacer actividad física al menos tres veces por semana. Hablar con mi médico si tengo problemas de salud o si ha pasado cierto tiempo desde que hice ejercicio por última vez.
- ☐ Completar la hoja de trabajo **Registre lo que fuma** (página 8).
- ☐ Aprender cómo enfrentar el impulso de fumar (página 20).

Mis ideas:

_____

_____

Una semana antes de mi fecha para dejar de fumar, voy a:

- ☐ Dejar de fumar en el automóvil y en casa.
- ☐ Decirles a los demás que está prohibido fumar en mi automóvil y en mi casa.
- ☐ Practicar el no fumar durante unas horas por vez antes de dejar de fumar definitivamente. Estos son los llamados "tramos sin tabaco" (página 28).
- ☐ Comenzar a utilizar el medicamento para dejar de fumar si debo usar bupropión de liberación prolongada (Zyban® o Wellbutrin®) o vareniclina (Chantix).
- ☐ Pensar en alternativas para cambiar mi rutina diaria. Algunas ideas son: levantarme más tarde, salir a caminar o tomar té en lugar de café.

Mis ideas:

_____

_____

La noche anterior a mi fecha para dejar de fumar, voy a:

- ☐ Tirar a la basura los cigarrillos y encendedores, y guardar los ceniceros.
- ☐ Limpiar el cenicero del automóvil.
- ☐ Repasar la manera correcta de utilizar los parches, goma de mascar y pastillas de nicotina, si tengo pensado usar estos medicamentos.
- ☐ Practicar formas de manejar el estrés, como hacer respiración profunda.
- ☐ Visitar Web Coach (forma parte de mi programa).
- ☐ Llamar a mi asesor Quit Coach si tengo preguntas o necesito apoyo.

Mis ideas:

_____

_____

"Traté de dejar de fumar antes, pero esta vez fue diferente. Gracias por ocuparse de escucharme de verdad y ayudarme a armar un plan exitoso. Eso es lo que marcó la diferencia".

— Craig, 27 años

Paso 2 Domine el impulso de fumar

Tener un impulso de fumar o un gran deseo de consumir tabaco después de haber dejado el cigarrillo es normal. El impulso puede estar causado por una necesidad física del organismo que ansía la nicotina o por un factor desencadenante como hablar por teléfono o terminar de comer.

Este impulso de fumar puede ser fuerte, especialmente en las primeras dos semanas después de haber dejado el tabaco. Por eso, es importante tener un plan en marcha para saber cómo dominar este impulso y ¡no salirse del camino!

Esta sección le ayudará a comprender cuándo, dónde y por qué consume tabaco (antes de dejar de fumar). Estos patrones y factores desencadenantes son exclusivos en cada persona, por eso es fundamental comprenderlos. También aprenderá técnicas y destrezas para saber estar preparado cuando tenga ganas de fumar.

Impulso de fumar: ¿Qué es?

¡Bien! Es el primer día de mi vida sin tabaco. ¡Me siento estupendo!

Mmm. Realmente tengo muchas ganas de fumar un cigarrillo ahora mismo.

Todo el mundo tiene impulsos de fumar cuando deja el cigarrillo, especialmente ante la exposición a un factor desencadenante. Los factores desencadenantes son los momentos, los lugares, las actividades y los sentimientos que generan el impulso de fumar. Un factor desencadenante siempre antecede al impulso de fumar.

¡Gracias a Dios mi asesor Quit Coach me dio algunos recursos para dominar mi impulso de fumar!

Las habilidades para hacer frente al impulso de fumar hacen que esas ganas pasen mucho más rápidamente. Funcionan mejor que la fuerza de voluntad. Cuando se está intentando dejar de fumar, es importante saber qué hacer en lugar de fumar. Estas habilidades le ayudarán a enfrentar los tres vértices del triángulo de la adicción (vea la página 12).

Factores desencadenantes

Es bueno saber qué es lo que activa su impulso de fumar. Muchos fumadores dicen tener algunos de los factores desencadenantes a continuación. ¿Cuáles de estos factores desencadenantes despiertan su impulso de fumar?

Márquelos con un círculo y agregue otros personales:

- Levantarme en la mañana
- Terminar de comer
- Conducir mi automóvil
- Hablar por teléfono
- Estar preocupado o estresado
- Esperar el autobús o el tren
- Estar con amigos que fuman
- Estar aburrido
- Tomar café o té
- Leer el periódico

Mis ideas:

"Después de hablar con mi asesor Quit Coach, supe exactamente qué hacer para dejar de fumar para siempre. Sigo pensando en el cigarrillo, pero ahora sé cómo manejar las ganas de fumar como nunca antes".

— José, 56 años

Sustitutos y distracciones

Dejar de fumar no es nada fácil. Una vez que dejan de fumar, la mayoría de los fumadores se enfrentan al impulso, a veces fuerte, de encender un cigarrillo. Algunos de estos impulsos están activados por la necesidad imperiosa del organismo de nicotina. Otros pueden estar activados por determinados momentos del día o por actividades como conducir, terminar de comer, hacer una pausa en el trabajo o estar en lugares donde se solía fumar. El impulso de fumar también se puede iniciar por la necesidad de relajarse y manejar el estrés, tal vez cuando se sienta en el sofá y mira televisión.

Pero hay una solución. Dejar de fumar no tiene por qué depender de la fuerza de voluntad. Hay formas de ayudar a que los impulsos pasen sin tener traspiés ni comerse las uñas. Estas herramientas se llaman sustitutos y distracciones.

¿Qué es un sustituto?

Los sustitutos son cosas que se pueden utilizar para mantener ocupadas las manos y la boca cuando tiene ganas de fumar. Los sustitutos pueden incluir cosas como escarbadientes, pajillas cortas, palitos de canela, goma de mascar y caramelos duros para la boca. Para las manos, puede probar con lápices, ganchos para papeles, piedras antiestrés o una sarta de cuentas para calmar los nervios.

¿Qué es una distracción?

Las distracciones pueden ser cosas o actividades para poner la mente en otra parte cuando aparece el impulso de fumar. Pueden incluir salir a caminar o hacer un poco de ejercicio, armar un rompecabezas o resolver un crucigrama, dibujar un rato o empezar un pasatiempo nuevo, cualquier cosa que sirva para poner la mente en algo diferente durante cinco minutos. El único límite en cuanto a tipos de sustitutos y distracciones que usted utiliza es su imaginación.

¿Cómo sé qué herramientas son las mejores para mí?

Probablemente sienta que tiene que encender un cigarrillo si tiene muchas ganas de fumar. Tener fuertes impulsos de fumar es muy normal durante los primeros días después de dejar el tabaco. Pero no tiene que fumar, ¡aunque tenga ganas!

Si tiene pensado dejar de fumar en poco tiempo, elabore una lista de posibles sustitutos y distracciones, luego relacione los sustitutos y las distracciones con las actividades o los momentos del día en los que normalmente fuma. Escriba sus ideas a continuación.

Sustituto/distracción	**Momento del día/actividad**

Ponga en práctica estas ideas antes de dejar de fumar, pero no se rinda si el sustituto o la distracción no funcionan la primera vez. Con la práctica, los sustitutos y las distracciones formarán parte de su nuevo patrón.

Notas: (anote qué sustitutos y distracciones le dieron mejores resultados)

Ejemplo: "Me di cuenta de que los principales tres factores desencadenantes para consumir tabaco eran cuando terminaba de comer o miraba televisión, y cuando usaba la computadora".

Hoja de trabajo Factores desencadenantes y habilidades para hacerles frente

Utilice esta hoja de trabajo para identificar sus factores desencadenantes para el consumo de tabaco.

1. Elija los "factores desencadenantes" a continuación que puedan causarle problemas a la hora de dejar de fumar.
2. Luego, trate de utilizar diferentes sustitutos y distracciones para NO fumar en estas situaciones y momentos. Si le interesa incluir sus propios sustitutos o distracciones, escríbalos en la sección "otros".

Elija los sustitutos/distracciones que mejor funcionaron y anótelos en la columna "Lo que me dio resultado".

Factor desencadenante	Sustitutos y distracciones	Lo que me dio resultado
Después de comer	• Salir a caminar. • Lavar los platos. • Cepillarme los dientes. • Irme de la mesa. • Tomar una taza de té o café, comer una pastilla de menta o un caramelo. Mis ideas: _____	
Después de levantarme	• Cambiar mi rutina de la mañana bañándome apenas salgo de la cama o tomando el desayuno en otro lugar. • Desayunar algo. • Lavarme los dientes lo antes posible. • Salir a caminar con el perro. Mis ideas: _____	
Al tomar café, té o alcohol	• Tratar de tomar café o té en un lugar distinto del habitual. • Cambiar de bebida (por ejemplo, té en lugar de café). • Dibujar, escribir o mantener las manos ocupadas mientras tomo café o té. Mis ideas: _____	

Factor desencadenante	Sustitutos y distracciones	Lo que me dio resultado
Al conducir	• Vaciar el cenicero y llenarlo con flores secas o semillas de girasol. • Tomar un camino diferente para evitar los lugares en el recorrido de ida y vuelta al trabajo donde normalmente fumo. • Quitar todos los cigarrillos del automóvil o camioneta. Mis ideas: _____	
Durante los recesos en el trabajo	• Descansar en un área para no fumadores. • No ir a mi área de descanso de antes. • Hacer los recesos con no fumadores. • Utilizar sustitutos para las manos y la boca si tengo que estar cerca de otros fumadores. Mis ideas: _____	
Al mirar televisión	• Mirar televisión durante períodos más cortos. • Quitar los ceniceros, cigarrillos y encendedores de la habitación donde está el televisor. • Impedir que se fume en la habitación donde está el televisor. • Jugar algo. • Colocar un recordatorio en el televisor. Mis ideas: _____	

Factor desencadenante	Sustitutos y distracciones	Lo que me dio resultado
Cuando estoy estresado	• Hablar con un amigo/aliado. • Practicar la respiración profunda. • Recordarme a mí mismo que fumar no va hacer que desaparezca mi enojo o mi estrés. • Si usted reza, intente con una oración o con meditación. Mis ideas:	
Cuando estoy aburrido	• Hacer algo de ejercicio. • Salir a caminar. • Hacer un crucigrama. • Llamar o visitar a un amigo. • Leer un libro. • Jugar videojuegos. • Iniciar sesión en Web Coach o la página de Facebook de Quit For Life®. Mis ideas:	
Cuando estoy con otras personas	• Pasar tiempo con no fumadores. • Evitar a otros fumadores siempre que sea posible. • Pedirles a los demás que no fumen a mi alrededor. • Evitar los restaurantes y bares donde se puede fumar. • Usar escarbadientes. Mis ideas:	

Tramos: una forma de practicar

Este es un buen momento para poner en práctica las habilidades para hacer frente a los desafíos. Así, dejar de fumar puede ser más fácil y usted puede tener más éxito. Piénselo como un entrenamiento deportivo. Los corredores de larga distancia primero corren tramos más cortos para desarrollar su fortaleza. De la misma manera, los tramos sin tabaco de práctica pueden servirle de preparación para dejar de fumar para siempre a largo plazo cuando llegue su fecha para dejar de fumar.

Consejos para los tramos sin tabaco:

Utilice la información que ingresó en la hoja de trabajo Registre lo que fuma, en la página 8, para llevar a cabo estos tramos de práctica.

Practique no fumar durante una actividad en la que normalmente fuma, como cuando termina de comer.

Pruebe realizar tramos sin tabaco de práctica en diferentes momentos del día y durante diferentes actividades. Este es un excelente momento para ejecutar las habilidades para hacer frente a los desafíos que usted escribió en las páginas 25-27. Utilice las destrezas que seleccionó en la hoja de trabajo de habilidades para hacer frente a los factores desencadenantes.

Hora del día	Dónde estoy	Qué estoy haciendo	Qué me ayudó a no fumar
Ejemplo: Mañana	• Cocina • Esperando el autobús	• Bebiendo café • Leyendo el periódico	• Chupé la cucharita del café y deformé un gancho para papel • Mastiqué goma de mascar común
Mañana			
Tarde			
Noche			

Formas de sobrellevar el estrés

El estrés puede interponerse en el camino para dejar de fumar para siempre. El estrés atenta contra la claridad de pensamiento y es posible que incremente el nerviosismo. La mayoría de las personas tiene estrés de vez en cuando. Es bueno aprender distintas maneras de sobrellevar el estrés.

La respiración profunda o abdominal es una forma de hacer frente al estrés.

Este es un ejercicio de respiración profunda que puede probar, durante unos cinco minutos, en lugar de fumar.

- Vaya a algún lugar donde pueda estar sentado y relajarse, como un sofá, o la silla de su escritorio o su automóvil.
- Apague la televisión, la radio, el teléfono celular y cualquier otro dispositivo que lo distraiga.
- Respire profundamente por la nariz e infle el estómago.
- Contenga la respiración durante cinco segundos.
- Exhale suavemente por la boca y espere cinco segundos.
- Luego diga en voz alta la palabra "relajado".
- Siga respirando profundamente durante cinco minutos en total.

Hoja de trabajo Formas de sobrellevar el estrés

Estas son algunas formas de hacer frente al estrés. Marque con un círculo todas las ideas que le gustaría poner en práctica, luego agregue las suyas. Hable con amigos que hayan dejado de fumar y averigüe cómo lidian con el estrés.

Para su salud

- Duerma lo suficiente.
- Salga a caminar.
- Pruebe a rezar o meditar.
- Coma alimentos naturales y saludables.
- Duerma la siesta.

Cuando está con otras personas

- Hable con alguien que lo escuche.
- Léales un cuento a sus hijos.
- Juegue las cartas.
- Cene con un amigo.
- Prepare la comida con su familia.

Cuando está solo

- Lea un libro.
- Mire una película.
- Escuche música.
- Escriba algo en su diario.
- Haga un ejercicio de relajación.

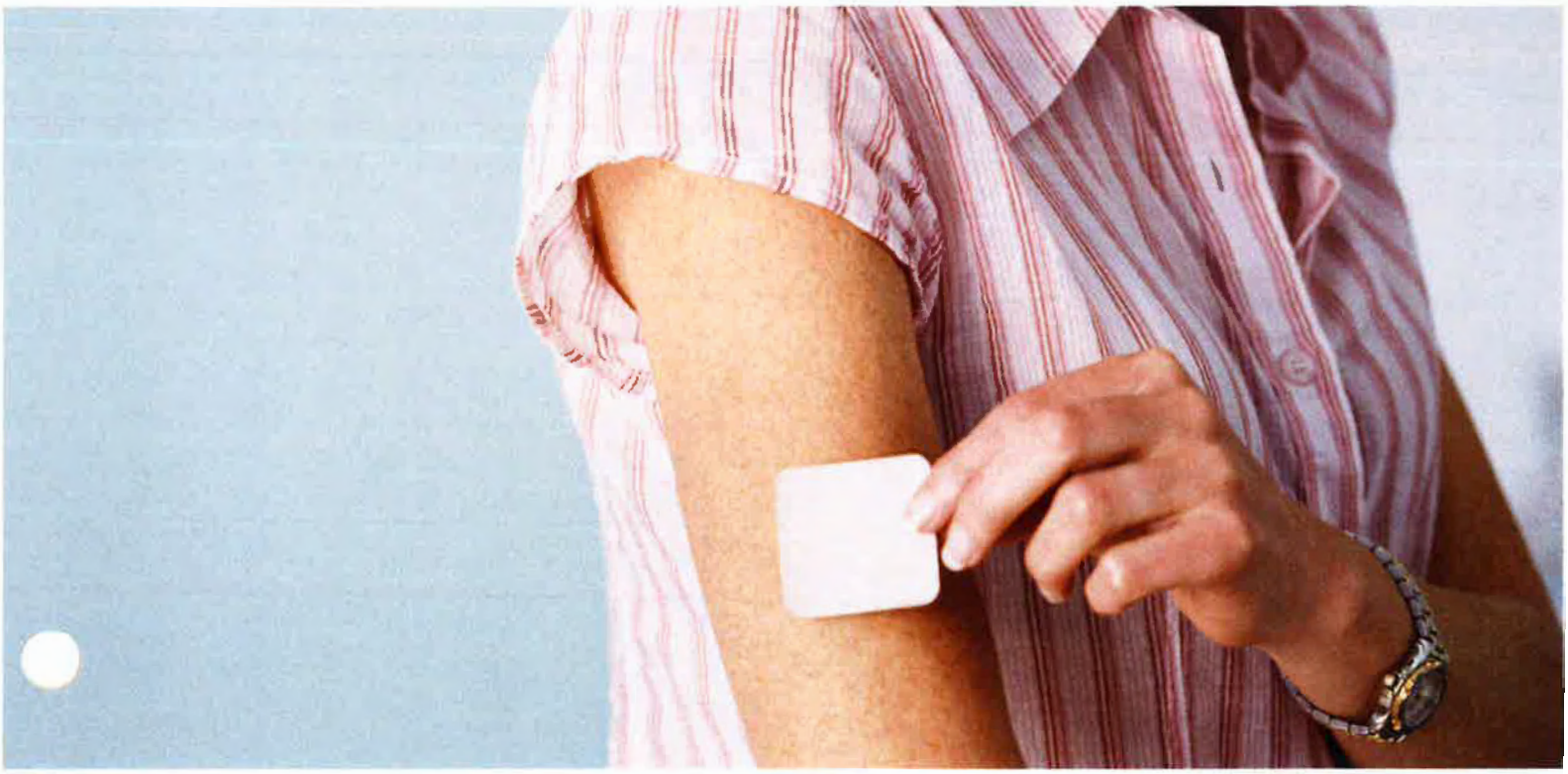
Paso 3 Utilice los medicamentos para dejar de fumar de manera que realmente funcionen

Estos son medicamentos seguros y eficaces con los que dejar de fumar puede ser más fácil. Algunos tienen nicotina, como el parche, la goma de mascar, las pastillas, el inhalador y el aerosol nasal.

Otros no tienen nicotina, como el bupropión de liberación prolongada (Zyban o Wellbutrin) y la vareniclina (Chantix). ¿Anteriormente intentó utilizar medicamentos para dejar de fumar y solo consiguió sentirse frustrado con los efectos secundarios o los dejó de utilizar porque le pareció que no le daban resultado?

Es cierto que dejar de fumar con medicamentos puede duplicar las probabilidades de tener éxito, pero si los utiliza incorrectamente o si no enfrenta los aspectos emocionales y conductuales que lo vinculan con el tabaco, las probabilidades de tener éxito son menores. En esta sección le ayudaremos a comprender la diferencia entre todos los medicamentos disponibles para dejar de fumar, cómo se utiliza cada tipo de medicamento correctamente y cómo se manejan los efectos secundarios comunes.

Comuníquese con su médico o con su asesor Quit Coach si tiene algún efecto secundario que le preocupa o si tiene preguntas sobre la forma de utilizar su medicamento.



Medicamentos que pueden ayudarle a dejar de fumar

Parche de nicotina

La nicotina de estos parches puede ayudarle a dejar de querer fumar. Con el tiempo, usará parches con menos y menos nicotina.

Modo de uso

- Colóquese un parche nuevo todos los días apenas se levante. Siempre asegúrese de retirar el parche que utilizó el día anterior.
- Busque un lugar del cuerpo en el cual colocarse el parche: debe ser por encima de la cintura y por debajo del cuello. Colóquese el parche en un lugar distinto cada día para no lastimarse la piel.
- Presione el parche para fijarlo en su lugar sosteniéndolo con firmeza durante 10 segundos.

Cómo pueden ayudar los parches

- Son fáciles de usar.
- Administran una dosis pareja de nicotina todo el día para ayudarle a no fumar.
- Los parches se venden en la mayoría de las farmacias y no se necesita receta.
- ¡Cuestan menos por día que un paquete de cigarrillos!
- Las investigaciones indican que el parche puede duplicar las probabilidades de dejar de fumar.

Goma de mascar de nicotina

Es un tipo de chicle sin azúcar que contiene nicotina. La goma de mascar mantiene ocupada la boca y ayuda al organismo a incorporar nicotina lentamente, lo cual ayuda a dejar de fumar.

Modo de uso

- Se debe masticar de una forma especial para que dé resultado.
- Mastíquela lentamente varias veces. Tal vez sienta un sabor "picante".
- "Deje quieta" la goma de mascar a un costado de la boca después de masticarla varias veces.
- Cuando el sabor se disipe, vuelva a masticarla y a "dejarla quieta".
- Deseche la goma de mascar después de 30 minutos.
- Utilice una nueva goma de mascar cada una o dos horas en las primeras cuatro semanas.

Cómo puede ayudar la goma de mascar

- Administra una dosis pareja de nicotina todo el día para ayudarle a no fumar.
- La goma de mascar se vende en la mayoría de las farmacias y no se necesita receta.
- ¡Cuesta menos por día que un paquete de cigarrillos!
- Las investigaciones indican que la goma de mascar puede duplicar las probabilidades de dejar de fumar.

Pastilla de nicotina

Una pastilla de nicotina se usa como una pastilla para la garganta en caso de resfriado o dolor de garganta. Libera la nicotina lentamente en el organismo a medida que se disuelve, lo que ayuda a reducir las ganas de fumar.

Modo de uso

- Colóquese una pastilla de nicotina en la boca.
- No la mastique.
- Mueva la pastilla por la boca de vez en cuando.
- Deje que se disuelva en la boca.
- Utilice una nueva pastilla cada una o dos horas en las primeras cuatro semanas.

Cómo pueden ayudar las pastillas

- Son fáciles de usar.
- Puede utilizar las pastillas cuantas veces las necesite para refrenar el impulso de fumar (hasta 20 por día).
- Las pastillas de nicotina se venden en la mayoría de las farmacias y no se necesita receta.
- ¡Cuestan menos por día que un paquete de cigarrillos!
- Las investigaciones indican que las pastillas de nicotina pueden duplicar las probabilidades de dejar de fumar.

Inhalador de nicotina

El inhalador de nicotina se parece a un cigarrillo. Se sostiene con los dedos y se "aspira". El inhalador es un medicamento recetado, de manera que será necesario que vaya al médico.

Modo de uso

- Coloque el cartucho de nicotina en la boquilla del inhalador.
- Aspire en el inhalador para que ingrese el vapor en la boca, pero no lo haga llegar a los pulmones.
- Utilice el inhalador según las indicaciones de su médico.

Cómo pueden ayudar los inhaladores

- Puede utilizar el inhalador de nicotina cuantas veces lo necesite (lea las instrucciones de fábrica).
- Utilizar el inhalador es parecido a fumar un cigarrillo.
- El inhalador mantiene ocupadas las manos y la boca.
- Las investigaciones indican que el inhalador puede duplicar las probabilidades de dejar de fumar.

Aerosol nasal de nicotina

Este medicamento se rocía en la nariz con un vaporizador. Se trata de un medicamento recetado, de manera que será necesario ir primero al médico.

Modo de uso

- Coloque la boquilla del vaporizador en cada fosa nasal.
- Rocíe, pero no inhale.
- Puede utilizar el aerosol una o dos veces por hora.
- Utilice el inhalador según las indicaciones de su médico.

Cómo puede ayudar el aerosol nasal

- El aerosol nasal lleva nicotina al cerebro más rápidamente que el parche, la goma de mascar o las pastillas, lo cual ayuda a disminuir el impulso de fumar.
- Puede utilizar el aerosol nasal cuantas veces lo necesite (lea las instrucciones de fábrica).
- Las investigaciones indican que el aerosol nasal puede duplicar las probabilidades de dejar de fumar.

Combinación del parche y goma de mascar o el parche y pastillas

Con el uso en conjunto del parche de nicotina con goma de mascar o con pastillas es probable que dejar de fumar le resulte más fácil y exitoso. El parche administra la nicotina lentamente mientras que la goma de mascar y las pastillas funcionan con más rapidez y ayudan a reducir los síntomas de abstinencia y el impulso de fumar antes de que aparezcan.

Combinación del parche y goma de mascar

Cómo utilizar el parche y la goma de mascar juntos

- Comience a utilizar los parches y la goma de mascar de nicotina el primer día que deje de fumar.
- Colóquese un parche nuevo al comienzo de cada día.
- Ubique el parche en algún lugar por encima de la cintura y por debajo del cuello.
- No coloque el parche exactamente en el mismo lugar todos los días porque puede lastimarle la piel.
- Puede utilizar la goma de mascar cada una o dos horas. No utilice más de 24 gomas de mascar por día.
- Mastique cada goma de mascar varias veces y luego "déjela quieta" a un costado de la boca.
- Después de unos minutos, vuelva a masticarla unas cuantas veces y "déjela quieta" otra vez.
- Repita este proceso durante 20 o 30 minutos y luego escupa la goma.

Cómo pueden ayudar el parche y la goma de mascar

- El uso combinado del parche y la goma de mascar puede ayudarle a manejar mejor el impulso de fumar.
- Usted decide cuánta goma de mascar va a utilizar además del parche.
- Estudios de investigación indican que el uso del parche con la goma de mascar puede aumentar las probabilidades de dejar de fumar en comparación con el uso solo del parche o de la goma de mascar.
- La goma de mascar de nicotina se vende en la mayoría de las farmacias y no se necesita receta.
- ¡El parche y la goma de mascar juntos pueden costar menos por día que un paquete de cigarrillos!

Combinación del parche y pastillas

Cómo utilizar el parche y las pastillas juntos

- Comience a utilizar los parches y las pastillas de nicotina el primer día que deje de fumar.
- Colóquese un parche nuevo al comienzo de cada día.
- Ubique el parche en algún lugar por encima de la cintura y por debajo del cuello.
- No coloque el parche exactamente en el mismo lugar todos los días porque puede lastimarle la piel.
- Puede utilizar una pastilla cada una o dos horas. No utilice más de 20 pastillas por día.
- Deje que la pastilla de nicotina se disuelva lentamente. No la mastique ni la trague.
- Muévala de un lado de la boca al otro después de unos minutos.
- La pastilla se debe disolver por completo en unos 30 minutos.

Cómo pueden ayudar el parche y las pastillas

- El uso combinado del parche y las pastillas puede ayudarle a manejar mejor el impulso de fumar.
- Usted decide cuántas pastillas va a utilizar además del parche.
- Estudios de investigación indican que el uso del parche con las pastillas puede aumentar las probabilidades de dejar de fumar en comparación con el uso solo del parche o de las pastillas.
- Las pastillas de nicotina se venden en la mayoría de las farmacias y no se necesita receta.
- ¡El parche y las pastillas juntos pueden costar menos por día que un paquete de cigarrillos!

Medicamentos recetados que pueden ser útiles

Bupropión de liberación prolongada (también conocido como Zyban o Wellbutrin)

Este medicamento viene en comprimidos. Disminuye las ganas de fumar y reduce los impulsos, pero no contiene nicotina.

Modo de uso

- Comience a utilizar bupropión de liberación prolongada una semana antes de su fecha para dejar de fumar.
- Limite el consumo de alcohol, lo que incluye cerveza, vino y licores.
- Informe a su médico o enfermero si quiere dejar de tomar este medicamento.
- Utilícelo según las indicaciones de su médico. Si tiene preguntas sobre el modo de uso del bupropión de liberación prolongada, hable con su médico o farmacéutico.

Cómo puede ayudar el bupropión de liberación prolongada

- Disminuye las ganas de fumar y alivia la abstinencia de nicotina.
- El bupropión de liberación prolongada puede duplicar las probabilidades de dejar de fumar.
- ¡Cuesta menos por día que un paquete de cigarrillos!

Vareniclina (también conocida como Chantix)

Este medicamento viene en comprimidos. Actúa en la misma parte del cerebro que la nicotina. La mayoría de las personas que utilizan vareniclina tienen menos impulsos de fumar. La vareniclina no contiene nicotina.

Modo de uso

- Comience a utilizar la vareniclina una semana antes de su fecha para dejar de fumar.
- Siga las instrucciones de dosificación al pie de la letra.
- Limite el consumo de alcohol, lo que incluye cerveza, vino y licores.
- Tome la vareniclina con un vaso lleno de agua y junto con la comida para reducir la probabilidad de malestar estomacal, un efecto secundario común de este medicamento.
- Hable con su médico inmediatamente si tiene cambios significativos en el estado de ánimo, o si se siente deprimido o irascible después de comenzar a utilizar la vareniclina.
- Utilícela según las indicaciones de su médico. Si tiene preguntas sobre el modo de uso de la vareniclina, hable con su médico o farmacéutico.

Cómo puede ayudar la vareniclina

- Alivia la abstinencia de nicotina.
- Si usted fuma después de haber dejado el tabaco, es menos probable que "le guste" el cigarrillo. La vareniclina bloquea la parte del cerebro que "se pone bien" cuando usted fuma.
- ¡Cuesta menos por día que un paquete de cigarrillos!
- Las investigaciones indican que el uso de vareniclina implica más del doble de probabilidades de dejar de fumar.

Si tiene determinadas afecciones de salud, hable con su médico antes de utilizar estos medicamentos. Consulte la información a continuación para ver aspectos específicos de cada tipo de medicamento.

En lo que respecta al bupropión de liberación prolongada (Zyban o Wellbutrin), hable con su médico si:

- Tiene enfermedad renal
- Tiene enfermedad hepática
- Está embarazada, amamanta o intenta quedar embarazada
- Tiene anorexia o bulimia (trastornos de la alimentación)
- Tiene convulsiones
- Ha sufrido una lesión de gravedad en la cabeza anteriormente (se desmayó o perdió el conocimiento)

En lo que respecta a la vareniclina (Chantix), informe al médico si:

- Está embarazada, amamanta o intenta quedar embarazada
- Tiene depresión, ansiedad, esquizofrenia o trastorno bipolar, o tiene tendencias suicidas (pensamientos de terminar con su vida)
- Tiene enfermedad renal

Preguntas frecuentes:

¿Cómo decido qué medicamentos utilizar?

Su asesor Quit Coach puede ayudarle a decidir qué medicamentos utilizar. Dígale a su asesor Quit Coach si utilizó alguno de estos medicamentos anteriormente y si obtuvo algún beneficio. Dígale si toma algún otro medicamento y si tiene algún problema de salud.

¿Puedo utilizar más de un medicamento?

Sí. Hable con su asesor Quit Coach o con su médico sobre los medicamentos que se pueden combinar.

Algunos de estos medicamentos son muy costosos. ¿Hay alguna manera de recibir ayuda para pagarlos?

Hable con su asesor Quit Coach sobre alternativas para pagar estos medicamentos. El asesor puede ayudarle a averiguar qué medicamentos están cubiertos por su seguro.

Tengo un problema de salud. ¿Puedo usar estos medicamentos de todos modos?

Informe a su médico, enfermero o asesor Quit Coach qué problema de salud tiene. Puede ayudarle a determinar qué medicamentos puede utilizar sin correr riesgos.

Medicamentos: efectos secundarios y lo que usted puede hacer

Los medicamentos para dejar de fumar pueden tener efectos secundarios. Muchos de ellos se enuncian a continuación. La mayoría de los efectos secundarios son de menor importancia y desaparecen espontáneamente. Lea la información que viene con cada medicamento para conocer los efectos secundarios que podría tener. Comuníquese con su médico o con su asesor Quit Coach si tiene efectos secundarios que le preocupan o que no desaparecen en una o dos semanas.

Parche de nicotina	
Efectos secundarios	**Qué debe hacer**
Irritación cutánea (enrojecimiento local o sarpullido o urticaria cerca del lugar donde se coloca el parche)	Coloque el parche en un lugar distinto todos los días. Hable con su proveedor de atención médica o farmacéutico sobre el uso de una crema con hidrocortisona.
Malestar estomacal o dolor de cabeza	Puede ser consecuencia de la administración de mucha o poca cantidad de nicotina. Llame a su asesor Quit Coach para hablar del tema.
Sueños extraños o vívidos	Pueden ser causados por la administración de nicotina mientras duerme. Pruebe sacarse el parche una hora antes de irse a dormir si los sueños vívidos son un problema para usted.

Goma de mascar de nicotina	
Efectos secundarios	**Qué debe hacer**
Malestar estomacal o dolor de cabeza	Asegúrese de estar usando la goma de mascar correctamente. La goma de mascar de nicotina no se mastica como un chicle común. Vaya a la página 31 para repasar las instrucciones. El dolor de cabeza puede ser consecuencia de la administración de mucha o poca cantidad de nicotina. Llame a su asesor Quit Coach para hablar del tema.
Meteorismo abdominal	Asegúrese de estar usando la goma de mascar correctamente.
La goma de mascar no está actuando como usted piensa que debería	La goma de mascar de nicotina no se mastica como un chicle común. Si no se mastica correctamente, puede producir gases y tampoco le ayudará a dejar de fumar. Vaya a la página 31 para repasar las instrucciones.

Pastilla de nicotina	
Efectos secundarios	**Qué debe hacer**
Malestar estomacal o dolor de cabeza	Puede ser consecuencia de la administración de mucha o poca cantidad de nicotina. Llame a su médico o farmacéutico para hablar del tema.
Dolor de garganta	Puede ser un efecto secundario pasajero. Comuníquese con su médico si no desaparece.

Inhalador de nicotina	
Efectos secundarios	**Qué debe hacer**
Malestar estomacal o dolor de cabeza	Puede ser consecuencia de la administración de mucha o poca cantidad de nicotina. Llame a su médico o farmacéutico para hablar del tema.
Dolor de garganta	Trate de que la inhalación no llegue a la garganta. Retenga la nicotina solo en la boca.

Aerosol nasal de nicotina	
Efectos secundarios	**Qué debe hacer**
Malestar estomacal o dolor de cabeza	Puede ser consecuencia de la administración de mucha o poca cantidad de nicotina. Llame a su médico o farmacéutico para hablar del tema.
Sensibilidad en la nariz	Es un efecto secundario común y suele desaparecer en una semana aproximadamente. Comuníquese con su médico si la irritación en la nariz no desaparece después de dos semanas.

Bupropión de liberación prolongada	
Efectos secundarios	**Qué debe hacer**
Dificultad para conciliar el sueño o para dormir sin interrupción	Si toma dos pastillas por día, tome la última como mínimo cuatro horas antes de irse a la cama (y como mínimo ocho horas después de la primera pastilla). También podría ver con el médico si puede tomar solo una pastilla por día.
Boca seca	Beba agua a sorbos. Chupe caramelos duros.
Nerviosismo	El bupropión de liberación prolongada puede aumentar la ansiedad en algunas personas. Hable con su médico si esto le pasa.
Piensa que tuvo una convulsión	Deje de tomar bupropión de liberación prolongada de inmediato y comuníquese con su médico o llame al 911.

Vareniclina (Chantix)	
Efectos secundarios	**Qué debe hacer**
Náuseas (malestar estomacal de intensidad suficiente como para sentir que va a vomitar)	Este es el efecto secundario más común. Siga las instrucciones al pie de la letra y tome el medicamento con un vaso lleno de agua junto con una comida. Si las náuseas no desaparecen, comuníquese con su médico o farmacéutico para ver si se puede bajar la dosis.
Cambios en el estado de ánimo (tristeza o irascibilidad)	Informe a su médico lo antes posible si esto le sucede. El médico le ayudará a determinar si puede seguir usando la vareniclina o no.
Sueños extraños o dificultad para dormir	Esto suele desaparecer en una o dos semanas. Si duran más de una o dos semanas, pruebe a reducir la dosis. Su médico puede ayudarle.

Paso 4 Controle su entorno

Una de las claves para tener éxito a la hora de dejar de fumar es un entorno que contribuya a su progreso en lugar de obstaculizarlo. Piense en cómo su trabajo, casa, automóvil y otros lugares donde pasa su tiempo pueden ser un apoyo para usted.

Haga de su casa un lugar a prueba de tabaco

Es importante deshacerse de los cigarrillos y de cualquier otro tipo de tabaco la noche anterior a dejar de fumar. Moje con agua sus productos de tabaco para no poder fumarlos. Busque en los bolsos, el automóvil y los bolsillos de chaquetas o abrigos para corroborar que no le quede ningún cigarrillo con el que se pueda tentar.

El impulso de fumar será más fuerte y frecuente si tiene tabaco al alcance. Tendrá menos impulsos de fumar si saca todo el tabaco y los implementos para fumar de su casa y automóvil. ¿Por qué conservar ceniceros y encendedores si no fuma? Regálelos o tírelos a la basura.

Qué debe hacer cuando otras personas fuman a su alrededor

Puede ser complicado para usted cuando sus amigos, compañeros de trabajo o familiares fumen a su alrededor. Pero hay algunas cosas que puede hacer para que estas situaciones sean más fáciles.

Hable con su familia, amigos y compañeros de trabajo

Lo primero que tiene que hacer es hablar con las personas de su entorno que fuman y decirles que tiene planificado dejar de fumar. Tal vez quieran acompañarlo y puedan brindarse apoyo mutuamente. Aunque no quieran dejar de fumar, quizás estén dispuestos a darle apoyo en su proceso para dejar el tabaco. Pregúnteles si están dispuestos a:

- Fumar afuera cuando usted esté adentro
- Designar al menos una habitación libre de tabaco en todo momento
- Fumar únicamente en una parte de la casa.

Recuerde, ¡usted tiene el control!

Es importante que tenga presente que la decisión de fumar o no fumar es suya. Usted tiene el control de sus propios actos y su manera de pensar. La próxima vez que esté con personas que fuman, piense en lo siguiente:

- Qué puede hacer para distraerse y no seguir el impulso de fumar con los demás. ¿Podría entretenerse con algún juego, masticar una pajilla o hacerse la manicura?
- Qué puede decirse a sí mismo para que su decisión de dejar de fumar sea más fuerte que el impulso de fumar. Podría decirse algo como "Me cansé de gastar tanto dinero en cigarrillos" o "Le prometí a mi hija que iba a dejar de fumar y no quiero decepcionarla".

Una buena idea es colocar notas por toda la casa. Son recordatorios de su decisión de dejar de fumar. Estas son algunas ideas que pueden ayudarle a crear sus propios recordatorios para distribuir en la casa:

- "No tengo que fumar, aunque tenga ganas".
- "Todo lo que tengo que hacer es pasar todo el día sin fumar un cigarrillo".
- "Nadie me puede inducir a fumar. ¡Lo voy a lograr!".

Paso 5 Obtenga apoyo social

El apoyo de familiares o amigos puede facilitarle su intento para dejar de fumar. Lea los consejos en la página siguiente para tener ideas sobre cómo pedir apoyo y la clase de apoyo que desea.

Elija a sus aliados

Los aliados son personas que pueden ayudarle a dejar de fumar. Puede ser cualquier persona de su agrado y en la que usted confíe, como familiares, amigos o compañeros de trabajo. Piense en los aliados que puedan darle más apoyo cuando deje de fumar.

Puede ser bueno elegir aliados que también hayan dejado de fumar porque saben por lo que usted va a pasar. ¡Pero un no fumador colaborador también puede servir de apoyo! No elija aliados que sigan fumando.

Estas son algunas de las formas en las que los aliados pueden ayudar:

- Escuchando cuando usted necesita hablar
- Estimulándolo sin juzgarlo
- Llamando por teléfono para saber cómo le está yendo
- Colaborando con el cuidado de los niños o los mandados
- Charlando sobre los problemas y las formas de resolverlos

Ayude a sus aliados a que le den apoyo. Estas son algunas formas de hacerlo:

- Dígales a los aliados su fecha para dejar de fumar. Pídales que anoten su fecha para dejar de fumar en sus calendarios para que sepan cuándo va a dejar de fumar.
- Hágale saber a sus aliados si el hecho de dejar de fumar es un secreto
- Entrégueles el folleto "Your allies' guide: Helping someone quit tobacco" (Guía para sus aliados: cómo ayudar a alguien a dejar el tabaco)
- Planifique con qué frecuencia va a hablar con sus aliados
- Advierta a sus aliados que es posible que esté irritable cuando deje de fumar
- Hagan cosas divertidas juntos, como cocinar, caminar, ir al cine

No se limite a dejar de fumar, conviértase en no fumador

Para muchas personas que tratan de dejar el tabaco, las primeras dos semanas después de dejar de fumar son las más difíciles.[6] Estas dos semanas pueden definir el éxito o el fracaso de una persona que quiere dejar de fumar.

Si se preparó bien y fijó una fecha realista para dejar de fumar, definió cómo dominar el impulso de fumar y sabe cómo utilizar sus medicamentos correctamente, sus probabilidades de tener éxito son muy altas. Pero, así y todo, es probable que esté irritable, nervioso y estresado. Esto es normal. Su organismo ansía la nicotina y usted está reorganizando su vida sin tabaco. La buena noticia es que todo va siendo más fácil con el tiempo y las recompensas por no volver a fumar son estupendas.

Esta sección le ayuda a reconocer las recompensas que tendrá al dejar de fumar. También le enseña cómo no volver a fumar nunca más con la implementación de estrategias para sobrellevar el estrés y la abstinencia de nicotina.

Dejar de fumar es cada vez más fácil con el tiempo

Para la mayoría de las personas es útil pensar en dejar de fumar un día a la vez, o incluso una hora a la vez. Las horas y los días son granitos de arena. ¡Sus probabilidades de dejar de fumar para siempre son muy altas después de no haber fumado durante dos semanas!

Estos son algunos consejos de otros fumadores que pueden ser de ayuda en las primeras dos semanas después de dejar de fumar:

- **Evite a otros fumadores.** Es más probable que fume si está cerca de otros fumadores.
- **No fume,** ni siquiera una sola calada.
- **Utilice medicamentos que le ayuden a dejar de fumar.** Hable con su médico, enfermero o asesor Quit Coach para determinar qué medicamentos son adecuados para usted.
- **Saque todos los cigarrillos y cualquier otro producto con tabaco de su casa y automóvil.** Tire los ceniceros a la basura.
- **Haga las cosas de un modo diferente ahora que no fuma.** Vaya a las páginas 25-27 para repasar las habilidades para hacer frente a los desafíos.
- **Pídales ayuda y apoyo a sus familiares y amigos.** Llame a su asesor Quit Coach para contar con más apoyo.
- **Recuérdese a sí mismo por qué está dejando de fumar.** Haga una lista de sus motivos para dejar de fumar y colóquela en un lugar donde la vea con frecuencia.
- **Prémiese.** Celebre los beneficios de dejar de fumar.
- **Evite el alcohol.** No vaya a bares y cantinas donde se fuma. Si no puede evitar beber, hágalo con moderación. Beber alcohol muy poco después de dejar el tabaco puede hacer que algunas personas vuelvan a fumar.
- **Disminuya su nivel de estrés.** Pruebe hacer ejercicios de respiración y manténgase activo.

Recompensas "Dinero en el banco"

Va a ahorrar mucho dinero cuando deje de fumar. Un paquete de cigarrillos cuesta unos $11.00. ¡Piense en todo el dinero que puede ahorrar si no compra cigarrillos! En los cuadros a continuación, puede ver cuánto va ahorrar si los cigarrillos cuestan $5.00 o $7.00 por paquete.

Esto es lo que ahorra si el paquete de cigarrillos cuesta $5.00:

Dinero que voy a ahorrar en	Si fumara:		
	1 paquete por día	2 paquetes por día	3 paquetes por día
1 día	$5.00	$10.00	$15.00
1 semana	$35.00	$70.00	$105.00
1 mes	$150.00	$300.00	$450.00
1 año	$1,825.00	$3,650.00	$5,475.00
5 años	$9,125.00	$18,250.00	$27,375.00
10 años	$18,250.00	$36,500.00	$54,750.00

Esto es lo que ahorra si el paquete de cigarrillos cuesta $7.00:

Dinero que voy a ahorrar en	Si fumara:		
	1 paquete por día	2 paquetes por día	3 paquetes por día
1 día	$7.00	$14.00	$21.00
1 semana	$49.00	$98.00	$147.00
1 mes	$210.00	$420.00	$630.00
1 año	$2,555.00	$5,110.00	$7,665.00
5 años	$12,775.00	$25,550.00	$38,325.00
10 años	$25,550.00	$51,100.00	$76,650.00

Abstinencia de nicotina

La abstinencia de nicotina ocurre cuando su organismo extraña la nicotina que obtenía con el cigarrillo. La abstinencia de nicotina suele desaparecer después de dos a cuatro semanas de dejar de fumar. El uso de un medicamento para dejar de fumar puede facilitar el proceso. Estas son algunas cosas que pueden ayudarle a sentir que tiene más dominio de la situación, incluso si también utiliza un medicamento.

Síntoma de abstinencia	Qué puede hacer
Fuerte impulso o ansias de fumar	• Utilice un sustituto (algo que reemplace a un cigarrillo), como un escarbadientes o una pajilla, o busque una distracción, como hacer un crucigrama. • Beba agua o haga respiraciones profundas. • La mayoría de los impulsos de fumar desaparecen en tres a cinco minutos. • Si utiliza goma de mascar o pastillas de nicotina, pruebe usarlas cuando tenga el impulso de fumar.
Somnolencia durante el día	• Es muy normal y suele desaparecer en un par de semanas. • Salga a caminar o haga algún tipo de actividad. • Duerma una siesta de 15 minutos.
Está inquieto, como si tuviera demasiada energía y no se puede quedar sentado tranquilo	• Salga a caminar o haga algún tipo de actividad. • Pruebe tomar menos café, té o gaseosas con cafeína. • Haga respiraciones profundas.
Dificultad para dormir	• El ejercicio puede ayudar a mejorar el sueño. • Pruebe consumir menos cafeína (café, té y algunas gaseosas) especialmente en las primeras horas de la tarde. • Respire profundamente antes de acostarse para relajarse. • Hable con su médico si sigue teniendo dificultad para dormir. • Si utiliza un medicamento para dejar de fumar, llame a su asesor Quit Coach o a su médico.
Tiene más hambre, antojos de dulces o come en exceso	• Después de dejar de fumar, es normal querer comer más. • Elija alimentos saludables que causen saciedad pero que tengan poca grasa y azúcar. • También puede utilizar sustitutos que no sean comida. • Vea más ideas en la página 23.

Síntoma de abstinencia	Qué puede hacer
Estreñimiento (dificultad para tener movimientos intestinales)	• Beba mucha agua. • Coma más frutas, verduras y cereales integrales. • Manténgase activo todos los días.
Tiene diarrea (muchos movimientos intestinales) o malestar estomacal	• Dejar de fumar puede cambiar la forma en la que digiere los alimentos durante un tiempo. Si utiliza el parche, la goma de mascar o las pastillas, el malestar estomacal puede indicar que se está administrando mucha nicotina o que no está usando los medicamentos correctamente. Comuníquese con su médico o enfermero. (Para obtener más información sobre los efectos secundarios de los medicamentos para dejar de fumar, vea la página 39).
Dificultad para pensar con claridad o hacer las cosas	• Es muy común en el primer mes después de dejar de fumar. Es un signo de abstinencia de nicotina. Tranquilícese. Pídales a los demás que le tengan paciencia. Pronto va a notar una mejoría.
Irritabilidad o irascibilidad	• Es muy normal inmediatamente después de dejar de fumar. El organismo y el cerebro ansían la nicotina cuando usted deja el tabaco. Los medicamentos para dejar de fumar como el parche, la goma de mascar, las pastillas, el bupropión de liberación prolongada o la vareniclina pueden ayudar en estos estados.
Dolor de cabeza leve	• Es común durante las primeras dos semanas después de dejar de fumar. Si persiste o interfiere en sus actividades diarias, llame a su asesor Quit Coach o a su médico.

"Mi esposo y yo estamos muy contentos con este programa. Estamos vivos y saludables y vamos a poder disfrutar de nuestros nietos. ¡Su programa realmente nos ayudó!".

— Margaret, 42 años

Lidiar con sentimientos fuertes

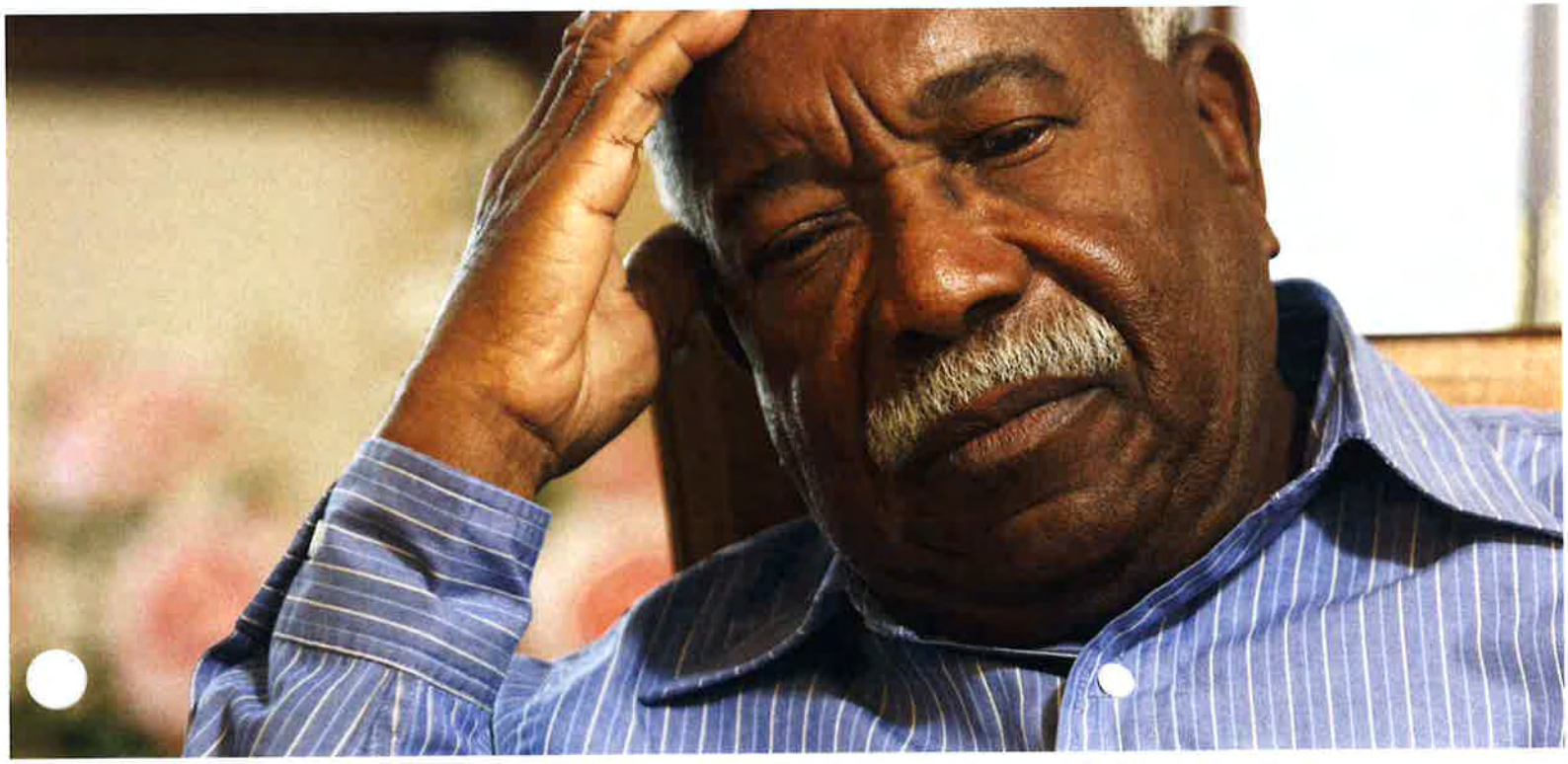
Si en el pasado intentó dejar de fumar, probablemente haya tenido algunos sentimientos negativos, como frustración, enojo, tristeza, pesar y temor. Tal vez le haya costado dormir, concentrarse en su trabajo o llevarse bien con otras personas debido a estos sentimientos, los cuales pueden convertirse en una gran complicación a la hora de seguir adelante con su plan para dejar de fumar.

Puede ser difícil lidiar con estos sentimientos negativos, pero no se preocupe, son una constante en las personas que dejan el tabaco. Los sentimientos negativos van y vienen a lo largo del día. Si sabe cómo, puede enfrentarlos en el momento y transformarlos en algo más positivo.

¿Por qué tenemos estos sentimientos tan fuertes después de dejar el tabaco?

La nicotina se va del organismo en dos o tres días. Pero los sentimientos negativos mencionados pueden durar varias semanas o meses. Es posible que esté tomando café, tratando de cumplir con una fecha límite en el trabajo o simplemente mirando televisión cuando de repente siente algo fuerte que no tiene nada que ver con el consumo de tabaco. ¿Por qué pasa esto?

La respuesta depende de cómo usted utilizó el tabaco. ¿Lo usaba para aliviar el estrés y calmarse cuando estaba enfadado, frustrado o ansioso? Si es así, es posible que su mente y su cuerpo estén buscando otra forma de manejar esos sentimientos. Piense qué puede hacer en lugar de fumar. Asegúrese de que sea algo divertido, interesante y gratificante.



La historia de Frank:

Frank utilizó este programa y encontró una fantástica solución. Cuando Frank dejó de fumar, estar a su lado no era sencillo. Estaba decaído todo el tiempo y se enojaba por tonterías. Nos dijo que realmente tenía ganas de fumar en esos momentos, por eso un día decidió hacer algo distinto.

Cuando se empezaba a poner de mal humor, iba al gimnasio y jugaba al ráquetbol con todas sus fuerzas. ¡No podía creer lo rápido que se iban su enojo y sus ganas de fumar! Así fue que tomó la costumbre de llevar la raqueta en la mochila y jugar todos los días. ¿Se le ocurre algo parecido que podría funcionar para usted?

Mis ideas:

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No ignore sus sentimientos negativos: ¡le están diciendo algo! Al igual que Frank, usted también puede transformar sus sentimientos negativos en algo divertido y gratificante, y nunca más volver a fumar.

Modelo E.E.E. para no volver a fumar

El modelo E.E.E. es un medio comprobado para eludir ese primer cigarrillo después de dejar de fumar (este modelo se denomina A.C.E. en inglés por "Avoid, Cope y Escape"): **evite** a las personas y los lugares que pueden despertar sus ganas de fumar. Si no puede evitarlos, **enfrente** la situación con las habilidades que adquirió. Si las habilidades para hacer frente a los desafíos no funcionan, **escape**. Váyase antes de agarrar un cigarrillo.

Ahora su trabajo es no volver a fumar nunca más. Estas son algunas formas de no salirse del camino:

- **No fume, ni siquiera una sola calada.**

  No se diga a sí mismo: "No pasa nada si solo fumo un cigarrillo". No es cierto. Si fuma un cigarrillo, o tan solo da una calada, es muy fácil volver a fumar. Todos los que vuelven a fumar empiezan con "solo una calada".

- **No volver a fumar debe ser su objetivo número 1.**

  Se esforzó mucho para llegar hasta aquí. ¡Que este sea su objetivo y nunca más tendrá que volver a pasar por esto!

- **Siga utilizando los medicamentos para dejar de fumar.**

  Úselos todos los días durante al menos ocho semanas. Llame a su asesor Quit Coach o a su médico si tiene preguntas o inquietudes.

- **Pida ayuda y apoyo.**

  Llame a sus aliados o a su asesor Quit Coach para pedirles ayuda si está estresado, enojado o simplemente está decaído, en especial las primeras semanas después de dejar de fumar.

- **Manténgase alejado de las personas que fuman.**

  Asegúrese de que los demás sepan que usted dejó de fumar y pídales que no le ofrezcan ningún cigarrillo. Emplee sus habilidades para hacer frente a los impulsos de fumar. Manténgase alejado de los lugares donde la gente fuma.

- **Siga utilizando sus habilidades para hacer frente a los desafíos.**

  Es más probable que pueda seguir sin fumar si utiliza las habilidades que le resultan más útiles.

- **Limite el consumo de alcohol.**

  Muchas personas vuelven a fumar cuando toman un trago. Trate de tomar la menor cantidad de alcohol posible durante el primer mes aproximadamente. Primero, no vaya a bares y cantinas donde se fuma.[7] Si no puede evitar beber, sepa que los impulsos de fumar pueden ser más fuertes. Utilice las habilidades para hacer frente a los desafíos y el modelo E.E.E.

- **Evite las situaciones de alto riesgo.**

  Nos referimos a los lugares o las personas que pueden despertar sus ganas de fumar. Manténgase alejado si puede.

- **Aprenda de la experiencia.**

  ¿Intentó dejar de fumar anteriormente? Analice por qué volvió a fumar. Planifique qué va a hacer si eso vuelve a suceder.

Pensamientos riesgosos

Estas son cuatro clases de pensamientos riesgosos que suelen llevar a volver a fumar.
Si se da cuenta de que tiene pensamientos riesgosos, trate de reemplazarlos por pensamientos más útiles.

Pensamiento riesgoso

Recuerdo los viejos buenos tiempos cuando fumaba y me sentía tan bien.

Pensamiento útil

Ahora que me libré del tabaco, me siento tan sano. ¡Estoy tan feliz de haber dejado de fumar!

Pensamiento riesgoso

Debería poder fumar un cigarrillo de vez en cuando.

Pensamiento útil

Sé que si fumo un cigarrillo, lo más probable es que fume otro. Es un camino sin retorno.

Pensamiento riesgoso

Tengo que hacer y resolver muchas cosas en este momento. Me vendría muy bien un cigarrillo.

Pensamiento útil

Si fumo un cigarrillo ahora, me voy a sentir peor más adelante. Me merezco llevar una vida saludable.

Pensamiento riesgoso

¡Preferiría tener que ocuparme de las consecuencias del cigarrillo que subir de peso!

Pensamiento útil

El cigarrillo le hace mal a todo mi organismo. Si me alimento saludablemente, ¡puedo reducir al mínimo el aumento de peso y estar más sano!

¿Y si tengo un traspié?

Un traspié es cuando usted fuma un cigarrillo, un cigarro, la pipa o incluso una calada después de su fecha para dejar de fumar. Esto es lo que puede hacer si tiene un traspié:

- **Piense en positivo.**

  Dígase a sí mismo "Esto es un tropezón nada más. Voy a hacer las cosas diferentes la próxima vez".

- **Aprenda de lo que hizo mal.**

  Identifique qué hizo que se equivocara y tuviera un traspié, y lo que puede hacer la próxima vez que tenga ganas de fumar. Observe su lista de habilidades para hacer frente a los desafíos (páginas 25-27).

- **Si utiliza un medicamento para dejar de fumar, siga usándolo.**

  Seguir usando los medicamentos para dejar de fumar cuando se tiene un traspié le ayudará a retomar el camino para dejar de fumar para siempre.

- **Obtenga apoyo.**

  Llame a su asesor Quit Coach y analice las distintas maneras de evitar tener más traspiés.

- **Si tiene un traspié, no se rinda.**

  Llame a su asesor Quit Coach para tener más ideas.

Prémiese

Algunas personas se premian a sí mismas por dejar de fumar. Este es el momento de empezar a pensar qué clase de recompensa le gustaría. Las recompensas pueden ser pequeñas, grandes, frecuentes o esporádicas. Estas son algunas ideas:

Pequeñas recompensas

- Salir a comer afuera
- Ir a una sesión de masajes
- Comprarse un par de zapatos nuevos
- Comprarse un nuevo CD de música

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Grandes recompensas

- Vacaciones exóticas
- Comprarse una camioneta o un auto nuevo
- Remodelar la cocina o el baño
- Adquirir la membresía de un gimnasio

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Por qué podría aumentar de peso

Quizás le preocupe subir de peso. Y es cierto que es posible que engorde cuando deja de fumar. La mayoría de la gente sube unas 10 libras. Otros no suben ni un gramo. Estos son algunos motivos por los que es posible que suba de peso cuando deje de fumar:

- **Quema menos calorías por día.**

  Fumar un paquete por día quema unas 200 calorías. Después de dejar de fumar, es posible que queme menos calorías por día.

- **Tal vez ingiera más calorías que las que necesita su cuerpo.**

  Algunas personas comen más después de dejar de fumar. Esto se debe a que comen cuando tienen ganas de fumar un cigarrillo o a que quieren hacer algo con las manos o la boca.

- **Es posible que no esté lo suficientemente activo.**

  Tal vez debería estar más activo para no aumentar de peso. Hacer actividad física la mayoría de los días de la semana le ayudará a mantenerse en un peso saludable. Si decide comenzar un programa de ejercicio, primero hable con su médico y siga sus recomendaciones.

Formas de controlar el peso

Lo más probable es que no aumente de peso si hace actividad física al menos 30 minutos por día, limita la cantidad de comida y consume alimentos saludables. Si le preocupa su aumento de peso, pruebe estas ideas:

¡Manténgase activo!

Camine 10 minutos, dos veces por día. ¡De esta manera puede evitar aumentar 10 libras al año! Suba por las escaleras en lugar de ir en el ascensor o estacione el auto más lejos, de manera de tener que caminar un poco más para llegar al trabajo, su casa o el supermercado.

Muévase todo lo que pueda. Por poco que parezca, todo suma

- Hacer tareas domésticas livianas
- Caminar a ritmo tranquilo
- Jugar con sus hijos
- Hacer trabajos en su automóvil
- Hacer trabajos de jardinería
- Rastrillar las hojas

Consulte a su médico para ver qué clases de actividades puede hacer

Coma refrigerios saludables

Todos comemos cosas fuera de las comidas principales. Lo hacemos porque tenemos hambre, por aburrimiento o porque estamos ansiosos. Estas son algunas ideas de refrigerios saludables que puede consumir si realmente tiene hambre:

- Manzana o banana.
- 1 taza de arándanos o uvas.
- Una porción de almendras al natural.
- Rodajas de pepino bien frío.
- Palitos de zanahoria y apio bien fríos.

Mantenga el peso bajo control con los alimentos adecuados

El peso depende de los alimentos que comemos y cómo los cocinamos. Ponga en práctica estas ideas para no subir mucho de peso:

- Coma entre nueve y doce porciones de frutas y verduras por día
- Coma entre dos y tres porciones de lácteos bajos en grasa por día
- Coma una o dos porciones de pescado, carne de res magra, legumbres o tofu por día
- Coma más cereales integrales y menos alimentos procesados por día
- Reduzca la ingesta de grasa al 25 por ciento de las calorías diarias (o menos)

Afecciones crónicas

Si tiene alguna de estas afecciones, es muy bueno que deje de fumar.

Si tiene asma y fuma:

- Usted es más propenso a tener un ataque de asma porque el cigarrillo puede disparar estos ataques.
- Es posible que los ataques de asma sean más intensos y es más probable que deba hospitalizarse por el asma.
- Los familiares y amigos con asma corren riesgo debido a la exposición al humo de segunda mano (cuando usted fuma y ellos no).

Al dejar de fumar:

- No hay humo en los pulmones y las vías respiratorias, uno de los factores desencadenantes más comunes de los ataques de asma.
- Puede controlar mejor los síntomas del asma y es posible que necesite menos medicamentos para el asma.
- Las vías respiratorias están más despejadas y es más fácil respirar.

Si tiene enfermedad pulmonar obstructiva crónica (EPOC) y fuma:

- Respirar es cada vez más y más difícil porque el humo del cigarrillo sigue dañando los pulmones.
- Corre más riesgo de tener infecciones pulmonares graves, como neumonía.
- La EPOC se seguirá agravando y es probable que necesite más oxígeno que le ayude a respirar.

Al dejar de fumar:

- Dejará de dañarse los pulmones y debería poder respirar mejor.
- Toserá menos y bajarán las probabilidades de tener infecciones pulmonares.
- Posiblemente no necesite oxígeno extra que le ayude a respirar y no tenga infecciones cutáneas.

Si tiene diabetes y fuma:

- Su riesgo de diabetes y accidente cerebrovascular es muy alto.
- Tiene más probabilidades de tener cáncer de pulmón, boca, garganta, esófago, vejiga, riñón, páncreas, entre otros.
- Corre el riesgo de tener problemas respiratorios y enfermedades pulmonares, como EPOC, asma y neumonía.
- También es posible que no actúen los medicamentos para el azúcar en sangre y las inyecciones de insulina.

Al dejar de fumar:

- Baja su riesgo de enfermedad cardíaca poco después de dejar de fumar y sigue disminuyendo siempre y cuando no vuelva a fumar.
- Corre menos riesgo de tener cáncer y otras complicaciones de la diabetes, como pérdida de la visión, enfermedad renal, daño nervioso e infecciones cutáneas.
- Podrá controlar mejor el azúcar en sangre con insulina y otros medicamentos.

Si tiene enfermedad cardíaca y fuma:

- Tiene el doble de riesgo de tener un ataque al corazón o un accidente cerebrovascular que las personas con enfermedad cardíaca que no fuman.
- El tabaquismo aumenta la presión arterial y la frecuencia cardíaca y causa daño en los vasos sanguíneos (obstrucción y endurecimiento).
- Si toma pastillas anticonceptivas, corre incluso más riesgo de ataques al corazón y accidentes cerebrovasculares.

Al dejar de fumar:

- La presión arterial y la frecuencia cardíaca disminuyen muy poco después de dejar de fumar, al igual que el riesgo de tener un ataque al corazón o accidente cerebrovascular.
- El daño en los vasos sanguíneos causado por el tabaco empieza a repararse espontáneamente.
- Si tiene un ataque al corazón, es menos probable que muera. Y si tuvo un ataque al corazón antes, es menos probable que tenga otro.

Deje de mascar

Si está leyendo esto, es probable que masque o "chupe" tabaco. Tal vez use rapé húmedo o tabaco para escupir, o ambos. Quizás haya intentado dejar el tabaco antes, pero le costó mucho. La información en esta sección le ayudará a dejar de usar estos tipos de tabaco para siempre. Le ofrecemos un plan paso a paso para dejar de fumar y liberarse completamente del tabaco para fumar y mascar. En esta sección de la guía, nos vamos a referir al rapé y al tabaco para escupir como tabaco de mascar.

¿Debería dejar de fumar y de utilizar tabaco de mascar al mismo tiempo?

Para ser simples, sí. Dejar ambas cosas a la vez le ayudará a dejar de fumar definitivamente y recibir todos los beneficios de salud que implica estar totalmente sin tabaco.

Peligros del tabaco de mascar

A diferencia del tabaco que se fuma, el tabaco de mascar no causa cáncer de pulmón o enfisema. Pero las buenas noticias se acaban aquí. Se sabe que el tabaco de mascar causa otros problemas de salud que pueden acortarle la vida y hacérsela menos placentera. Entre ellos se incluyen cáncer de boca, caries dentaria y problemas en las encías que pueden conducir a la pérdida de dientes, y algunas investigaciones han demostrado que el tabaco de mascar también está vinculado a enfermedad cardíaca y presión arterial alta.

Adicción a la nicotina

El tabaco de mascar aporta mucha nicotina. En realidad, alguien que usa dos latas por semana de rapé húmedo consume aproximadamente la misma cantidad de nicotina que una persona que fuma 30 cigarrillos por día. La mayoría de los usuarios de tabaco de mascar consumen más nicotina por día que el fumador promedio. Esto puede hacer que sea difícil dejar el tabaco de mascar.

Las marcas más vendidas de tabaco de mascar tienen la mayor cantidad de nicotina. De hecho, los fabricantes de estos productos en realidad tratan el tabaco con sustancias químicas (amoníaco) para que el organismo absorba la nicotina con más rapidez. Además, entre el 50 y el 70 por ciento de la nicotina es lo que se llama "nicotina libre", que se absorbe en la boca muy pero muy rápidamente. En consecuencia, la adicción a la nicotina es mayor.

Por lo tanto, si usted fuma y usa tabaco de mascar posiblemente sea MUY adicto a la nicotina. La información a continuación le ayudará a dejar de fumar para siempre.

Haga una lista de sus motivos para dejar el tabaco

Quienes mastican tabaco pueden tener muchos motivos para dejar este hábito. Tómese un minuto y piense por qué querría dejar de mascar tabaco. Una buena idea es colocar sus motivos en algún lugar en el que los vea a diario. Hacerlo le ayudará a mantener la motivación para dejar de mascar tabaco. Algunos ejemplos podrían ser los siguientes:

- Evitar problemas de salud.
- Demostrar que puedo hacerlo.
- Tengo llagas o aftas blancas en la boca.
- Complacer a alguien que me importa.
- Dar un buen ejemplo a mis hijos u otros niños.
- Ahorrar dinero.
- Me cansé del sabor.
- Tengo problemas en los dientes o las encías.
- Mi médico o dentista me dijeron que lo deje.
- La gente me mira extrañada cuando lo escupo.
- Está prohibido donde estudio o trabajo.
- No quiero que el tabaco me controle.
- Mi novia/novio (o alguien con quien me gustaría tener una relación) lo detesta.
- Mi esposo/esposa/pareja lo detesta.

Mis motivos:

Cree su plan para dejar el tabaco

Este es un plan paso a paso para dejar de usar tabaco de mascar.

Fije su fecha para dejarlo

¿Tiene una fecha para dejar de fumar? ¿Por qué no usar esa misma fecha para dejar de usar tabaco de mascar? Tómese un minuto y agregue una nota en su calendario para indicar que va a dejar el tabaco de mascar el mismo día que deje de fumar.

Aprenda a controlar el impulso de mascar antes de dejar este tabaco

Una buena idea es registrar cuándo y dónde masca o chupa tabaco, y lo que hace o siente en ese momento. Si lo hace, puede definir qué va a hacer en lugar de mascar tabaco. Tal vez le interese completar la hoja de trabajo de registro (página 8) durante un par de días. Luego, elija algunas estrategias para hacer frente a los desafíos a continuación y póngalas en práctica.

Utilice medicamentos para dejar el tabaco

La mayoría de la gente que fuma y masca tendrá más éxito a la hora de dejar el tabaco si utiliza medicamentos[5]. Puede elegir un medicamento que contiene nicotina o bien pastillas sin nicotina. A muchas personas que fuman y mascan les va mejor si utilizan dos medicamentos con nicotina, como el parche y la goma de mascar o el parche y las pastillas al mismo tiempo.[8] Su asesor Quit Coach puede brindarle más información y responder sus preguntas.

Una vez que deje el tabaco, no vuelva a consumirlo nunca más

Una vez que deje el tabaco, puede evitar reincidir en el consumo si está atento a las situaciones difíciles, como el estrés o la cercanía a otros consumidores de tabaco de mascar. No se olvide del modelo E.E.E.:

- **Evite a otros consumidores de tabaco de mascar y situaciones en las que usted siempre masca.**
  Si no los puede evitar, entonces...
- **Enfrente la situación con sustitutos orales y recuerde por qué quiere dejar el tabaco.**
  Si enfrentar la situación no da resultado, entonces...
- **Escape de la situación y váyase.**
  Proteja su salud, usted lo vale.

Registre su uso de tabaco de mascar

En la página 8 encontrará una hoja de trabajo Registre lo que fuma. Puede utilizarla para registrar su uso de tabaco de mascar al mismo tiempo que registra lo que fuma. Para muchos fumadores y consumidores de tabaco de mascar este ejercicio es útil para ver los patrones de consumo de tabaco que se fuma y masca que antes no habían advertido.

- Evite estar cerca de otros consumidores de tabaco de mascar siempre que le sea posible.
- Utilice un sustituto a base de hierbas cuando tenga ganas de mascar o chupar tabaco.
- Emplee otros sustitutos orales como caramelos duros, chicle o semillas de girasol.
- No deje de tener presente por qué quiere dejar de fumar y mascar tabaco. Pruebe colocar notas recordatorias.
- Reorganice su rutina para evitar los lugares y las actividades que despiertan sus ganas de mascar o chupar tabaco.

Mis ideas:

_____

_____

_____

¿Debería disminuirlo gradualmente?

Si consume más de dos latas por semana, tal vez quiera ir disminuyendo su ingesta de nicotina gradualmente antes de dejar el tabaco de mascar para siempre. Hay dos maneras de hacerlo. Una es reducir la cantidad que utiliza en el transcurso de dos o tres semanas, para lo cual lo recomendable es mascar o chupar menos tabaco e ir espaciando el consumo progresivamente. La otra consiste en utilizar un sustituto a base de hierbas que pueda mezclar con el tabaco de mascar antes de dejarlo.

Método de disminución gradual en tres semanas:

Si utiliza este método, reducirá la nicotina que consume en al menos la mitad (50 por ciento). Si quiere disminuir el consumo aún más, puede disponer de una o dos semanas más para afianzar esta reducción gradual.

- **Semana 1:** Cuente cuántas latas o bolsas de tabaco de mascar consume en una semana. Anote.
- **Semana 2:** Reduzca en un cuarto la cantidad de tabaco de mascar que utiliza. Por ejemplo: Si se da cuenta de que en la semana 1 normalmente utiliza una lata o una bolsa por día, baje la cantidad a tres cuartos de la lata o bolsa en la semana 2.
- **Semana 3:** Esta es la semana anterior a dejar el tabaco de mascar. Consuma la mitad de la cantidad que usó en la semana 1.
- **Semana 4:** Esta es la semana en la que va a dejar el tabaco de mascar.

Método de uso de sustituto a base de hierbas en tres semanas:

Si utiliza este método, puede reducir la nicotina que consume a la mitad (50 por ciento) o más. Si quiere reducir el consumo aún más, puede disponer de una o dos semanas más para afianzar esta disminución gradual. Los sustitutos a base de hierbas, como Mint Chew, BACC OFF, Golden Eagle Herbal Chew o Smoky Mountain Herbal Chew, se pueden comprar en muchas tiendas o por Internet. Cerciórese de que la marca del sustituto a base de hierbas que compre no contenga tabaco.

- **Semana 1:** Cuente cuántas latas o bolsas de tabaco de mascar consume en una semana. Anote.
- **Semana 2:** Vacíe la cantidad de tabaco que normalmente usa por día en un plato. Saque un cuarto del tabaco y mezcle el resto con un poco del sustituto a base de hierbas.

Nota importante: Es muy importante mezclar muy bien el tabaco y el sustituto a base de hierbas. Es más difícil mezclar bien el tabaco de "corte grueso" que el de "corte fino". Tal vez le convenga adquirir una marca de corte fino antes de empezar a reducir el consumo de tabaco. Si utiliza Skoal Long Cut, puede cambiar a Skoal Fine Cut. Así le será más fácil mezclar el tabaco con el sustituto a base de hierbas para que quede una mezcla homogénea.

- **Semana 3:** Repita lo que hizo en la semana 2, pero en su lugar saque la mitad del tabaco y reemplácelo con el sustituto a base de hierbas.
- **Semana 4:** Esta es la semana en la que va a dejar el tabaco de mascar.

Recuerde que su asesor Quit Coach está disponible los siete días de la semana para ayudarle a alcanzar su objetivo de llevar una vida sin tabaco. ¡Llame si necesita ayuda!

Ayude a otra persona

Felicitaciones por haber dejado de fumar definitivamente. Hizo lo que muchas personas aún están intentando hacer: dejar su adicción mortal al cigarrillo. Ofrézcale su apoyo a alguien que usted sepa que está intentando dejar de fumar o que recién esté empezando a pensar en dejar de fumar. Ayudar a los demás es una excelente manera de no reincidir en el tabaquismo.

Siempre vamos a estar aquí para ayudarle a seguir llevando una vida sin tabaco. No dude en llamar a su asesor Quit Coach para recibir ayuda en cualquier momento.

¡Felicitaciones por haber dejado de fumar definitivamente!

Citas

1 El protocolo de tramos sin tabaco se extrajo de 2008 Clinical Practice Guideline Update: Treating Tobacco Use and Dependence, donde se esboza el modelo STAR. La "A" remite a "anticipar los desafíos... ofrecer asesoramiento práctico que incluye entrenamiento en destrezas y resolución de problemas; identificación y práctica de habilidades para hacer frente a los desafíos o resolver problemas". (tabla 6.19, pág. 98)

2 American Lung Association, lung.org/associations/states/colorado/tobacco/

3 Informe de Surgeon General, Centros para el Control y la Prevención de Enfermedades (CDC, por sus siglas en inglés), cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/

4 American Lung Association cdc, cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm#benefits

5 US Clinical Practice Guideline 2008 Update: Treating Tobacco Use and Dependence. Strength of Evidence A (pág. 106)

6 Addiction. Enero de 2004;99(1):29-38. Shape of the relapse curve and long-term abstinence among untreated smokers. Hughes JR

7 Nicotine Tob Res. Diciembre de 2006;8 Suppl 1:S21-5. Integrated online services for smokers and drinkers? Use of the check your drinking assessment screener by participants of the Stop Smoking Center. Cunningham JA

8 Clinical Practice Guideline ***Treating tobacco use and dependence. 2008.***

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"At a Glance Outpatient Management Reference for COPD Disease National Jewish Medical Heart, Lung, and Research Center," Chronic Obstructive Pulmonary Disease, 2009. Disponible en Internet.

"COPD: Lifestyle Management," National Jewish Medical and Research Center, 2009. Disponible en Internet.

Notas

Notas

Si le gustaría obtener más información o tiene alguna pregunta sobre esta guía, comuníquese con nosotros:

1-855-DEJELOYA (1-855-335-3569)

TTY: 1-877-777-6534

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WOMEN'S HEALTH CARE PHYSICIANS

409 12th Street, SW
P.O. Box 96920
Washington, DC 20090-6920

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Revised 2012

NEED HELP PUTTING OUT THAT CIGARETTE?

If you are pregnant and you smoke, this guide will help you quit smoking and stay smoke-free.

NEED HELP PUTTING OUT THAT CIGARETTE?

This booklet was developed by a program of The Robert Wood Johnson Foundation, Smoke-Free Families (SFF): Innovations to Stop Smoking During and Beyond Pregnancy, National Dissemination Office at the University of North Carolina at Chapel Hill. The program ended in 2008.

and

American College of Obstetricians and Gynecologists
409 12th Street, SW
P.O. Box 96920
Washington, DC 20090-6920
Fax: (202) 484-3917
Email: smoking@acog.org
Web site: www.acorg.org

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WHY QUIT?

BENEFITS FOR YOUR BABY

Quitting smoking during your pregnancy:

- Increases the amount of oxygen your baby will get
- Increases the chances your baby's lungs will work well
- Lowers the risk that your baby will be born too early
- Increases your chances of having a normal weight, healthy baby
- Increases the chances your baby will come home from the hospital with you

Carbon monoxide and other chemicals from cigarettes get into the baby's blood. They can harm the baby and limit the baby's growth.

"I didn't think it [quitting smoking] was that difficult once I set my mind to it and said 'O.K., I'm going to set them down'. Before I'd never really had a reason, and being pregnant really gave me a reason to want to quit because I didn't want [my son] to be low birth weight and I sure didn't want him to be born early." — Emily, who quit smoking during pregnancy.

WHY QUIT?

BENEFITS FOR YOU

Quitting smoking during pregnancy:

- Gives you more energy and helps you breathe easier
- Saves you money that you can spend on other things
- Makes your clothes, hair, and home smell better
- Makes your food taste better
- Lets you feel good about what you've done for yourself and your baby

Quitting smoking early in pregnancy is best, but quitting at any time will help you and your baby. It's never too late to quit smoking during your pregnancy.

Your prenatal health care team can tell you more about the benefits of quitting for you and your baby. They can also help you use the tips in this booklet as part of an overall quitting plan for you.

FACTS ABOUT QUITTING DURING PREGNANCY

- Many pregnant women are tempted to cut down the number of cigarettes they smoke instead of quitting. Quitting is the best thing you can do for you and your baby.
- After just one day of not smoking, your baby will get more oxygen. Each day that you don't smoke, you are helping your baby grow.
- During the first few weeks after quitting, cravings and withdrawal symptoms may be strongest. You can reduce the length of each craving for a cigarette by distracting yourself (by keeping your hands, mouth, and mind busy).
- Stay away from tobacco products such as electronic cigarettes, snus and chewing tobacco. These are NOT safer choices as they contain nicotine and other chemicals that can cause harm similar to cigarettes.
- Withdrawal symptoms are often signs that your body is healing. They are normal, and will lessen in a couple of weeks.
- Weight gain during pregnancy is normal. If you are worried about gaining weight when you quit smoking, now is an ideal time to quit. The weight you gain is not as bad for you as the risk you take by smoking.

If you are thinking about quitting, it helps to prepare. The next few pages will guide you.

PREPARING TO QUIT

KNOWING YOUR REASONS FOR QUITTING

List your main reasons for quitting smoking here. Keeping them in mind will help you get ready to quit.

1) _____

2) _____

3) _____

4) _____

When you're getting ready to quit, it also helps to think about the times you usually smoke. These are the times you will need to find something else to do instead.

When do you smoke?

1) _____

2) _____

3) _____

4) _____

CHANGING YOUR DAILY HABITS

List 3 daily habits you can change to cut your chances of smoking:

Instead of smoking when I:	**I will try doing this:**
1)	1)
2)	2)
3)	3)

Examples of possible changes:

If you smoke when you:	**Try doing this:**
Drink coffee	Have hot chocolate or herbal tea
Finish a meal	Get right up, take a walk, or go into another room
Watch TV	Do something else with your hands (start a craft) and mouth (chew gum, eat a hard candy)
Need to relax or take a break	Take a nonsmoking break or walk, take a bubble bath, call a friend, do your nails, ask a friend to babysit for 30 minutes – even if you stay home

"I try to do things to keep my mind off smoking. I take my son for a walk, read a book, or find something to work on."
– Florence, who quit smoking during pregnancy.

KEEPING YOUR HANDS AND MOUTH BUSY

List 4 things you can do with your hands and mouth besides smoking:

1)
2)
3)
4)

Examples of ways to keep your hands and mouth busy:

Your hands:	**Your mouth:**
Knit or sew	Chew gum
Play with a rubber band	Eat some fresh fruit
Hold a pen or pencil	Use a straw or toothpick
Draw or doodle	Suck on hard candy
Squeeze a soft rubber ball	Try a cinnamon stick
Work on a craft project	Sip water or juice
Decorate your baby's room	Have a frozen fruit bar
Massage your fingers or hands	Have some popcorn

"I've learned to occupy my hands and mouth with finger foods, carrot sticks, little pieces of apple, popcorn, Tootsie Pops®, and jelly beans... I finger paint with Jonathan, which is very messy, but it's better than holding a cigarette."
– Tamar, who's trying to quit smoking during her pregnancy.

DEALING WITH NEGATIVE FEELINGS

List 3 negative feelings that make you want a cigarette and ways to deal with them instead of smoking:

Instead of smoking when I feel:	**I will try doing this:**
1)	1)
2)	2)
3)	3)

Examples of ways to deal with negative feelings:

If you smoke when you feel:	**Try doing this:**
Stressed or nervous	Go for a walk; take a hard candy break; remind yourself what you do well
Bored or lonely	Talk to a friend; plan a baby project; do something you enjoy; listen to music
Angry or upset	Write down your feelings; take a walk; talk to a friend

"Sometimes I feel like something is missing, and I realize that I'm missing a cigarette. But I recognize it, I talk about it, and I move on."

— Stephanie, who quit smoking during pregnancy.

COPING WITH WITHDRAWAL

Some people have withdrawal symptoms for a few weeks after quitting. They are your body's normal reaction to quitting. Below are common withdrawal symptoms and some ways to cope with them:

Withdrawal symptom:	**Try doing this:**
Feeling grumpy	Tell others it's a withdrawal symptom; be easy on yourself; go for a walk
Cough and sore throat	It's a sign your lungs and throat are clearing; take cough drops; sip warm tea
Hunger	Eat low-fat snacks like fruit, popcorn or pretzels; suck on hard candy; drink lots of water
Dizziness and headaches	Get fresh air; sit when you feel dizzy; take a nap
Hard time paying attention	Take a walk; work in short bursts rather than for long periods; get lots of sleep
Constipation	Eat more fruit, veggies, and bran; drink lots of water

Withdrawal symptom:	Try doing this:
Restlessness	Go for a walk; keep hands busy; avoid caffeine
Trouble sleeping	Avoid caffeine; get more exercise; go to bed only when tired; if you can't sleep, get up and read or do something you enjoy until you feel sleepy

These symptoms are normal and will end soon. Your body is healing, and you are becoming a healthy ex-smoker.

If you are having trouble with withdrawal symptoms, talk with your prenatal care team.

DEALING WITH OTHERS SMOKING AROUND YOU

Being around someone while they are smoking can put you at high risk for having a cigarette. It's a high risk because you see and smell the cigarette and because cigarettes are right there within reach. Think about these ways to handle these times:

- Ask others not to smoke around you. Being in the same space as another person who is smoking is dangerous to your pregnancy.
- Ask friends and family to help by never smoking in the house; if this won't work, make some of the rooms in the house, including the baby's room, off-limits for smoking
- Make your home and cars non-smoking areas; ask smokers to smoke outside your home or car
- Leave the room when others light a cigarette
- Plan ways to distract yourself when someone else is smoking
- Keep your hands and mouth busy
- Spend more time in places that are smoke-free

RALLYING SUPPORT FROM OTHERS

When you quit smoking, it helps to get support from people around you. Here are ways that others might help you:

- Tell your prenatal care team about your quitting plans — they can be a big help
- Ask others to not smoke around you
- Ask others to be patient with you, especially if you are feeling grumpy or tense
- Ask others to help you with your chores during the first few weeks after you quit to ease your stress
- Ask others to remind you how well you are doing not smoking
- Reach out for help and comfort from friends and family who have quit and know what you're going through

List the people you will ask to help you. Tell them how they can help.

Name: **Phone number:**

HELPING YOURSELF FEEL BETTER

List 4 ways you can reward yourself while you are quitting:

1) _____

2) _____

3) _____

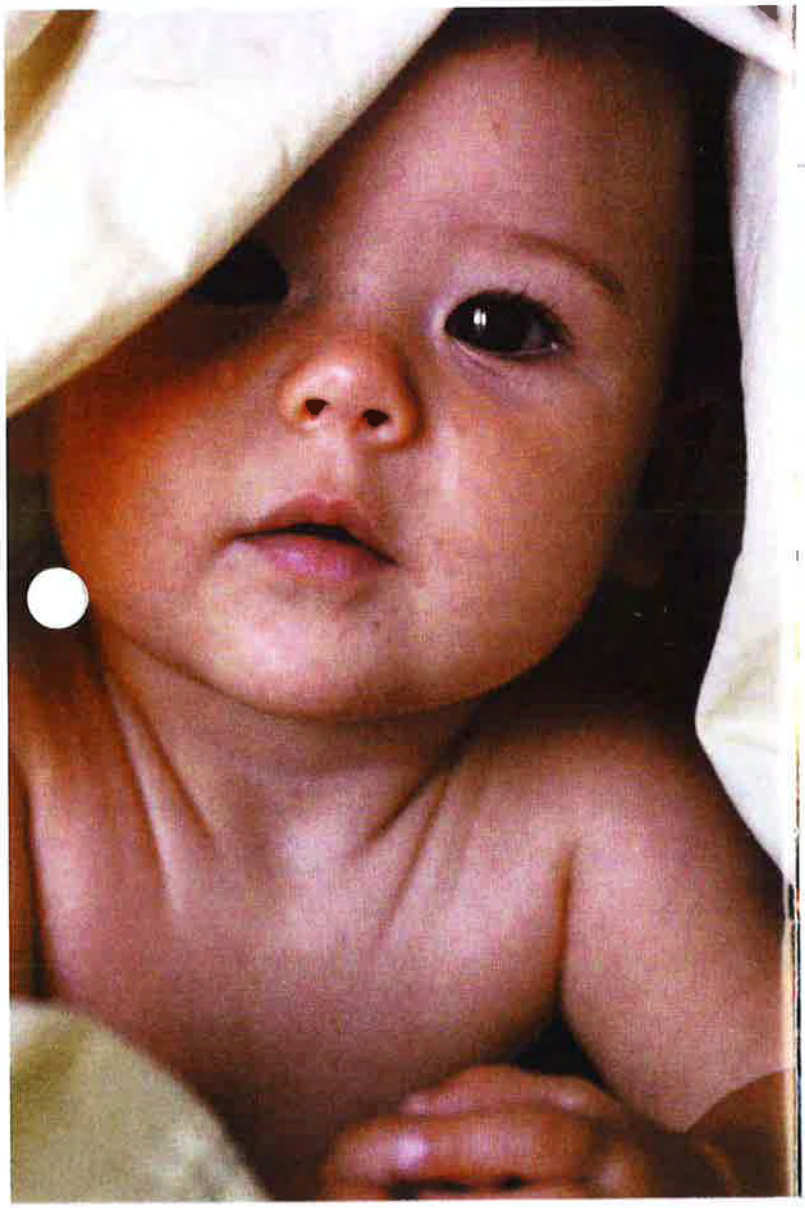
4) _____

Examples of possible rewards:

Go shopping	Go for a walk or bike ride
Ask for a back rub	Get your hair done
Have some frozen yogurt or ice cream	Buy a plant, some flowers or your favorite magazine
Rent a video	Call or visit a friend
Paint your nails	Play a game
Listen to your favorite music	

At this point, you have prepared yourself for quitting. The next step is to set a Quit Date.

"Quitting smoking was hard, but I felt it was the best thing to do. It's the smartest thing for any pregnant woman to do."
— Heather, who quit smoking during pregnancy.



SETTING A QUIT DATE

You are now ready to set a Quit Date. Pick a day coming up soon.

MY QUIT DATE IS: _____

The day before your Quit Date, get rid of your cigarettes and ashtrays. Review your quitting plans in this booklet to remind yourself of:

- Your reasons for quitting
- How you will change your daily habits
- How you will keep your hands and mouth busy
- How you will deal with negative feelings
- How you will cope with withdrawal
- How you will handle others smoking
- How you will reach out for help from your prenatal care team, family and friends
- Who else you have asked to help you
- How you will make yourself feel better, and pamper yourself

Do something fun on your quit day.

HOW TO HANDLE "SLIPS"

- After you quit smoking, it is best not to tempt yourself with even one puff. That's because each time you smoke, you increase the chances of wanting a cigarette in the future.
- If you do "slip" and have a cigarette, don't give up. A "slip" is not a failure.
- Review your reasons for quitting. Think about how you can cope with the craving to smoke in the future.
- Renew your commitment to quitting. Ask for help from others who want to see you succeed.

A "slip" is a mistake, not a failure.

AFTER YOUR BABY IS BORN

Staying smoke-free is the best thing you can do for your baby and yourself.

If you stay quit, your baby will:

- Get fewer chest colds, coughs and ear infections
- Have fewer asthma and wheezing problems
- Be at lower risk for SIDS (crib death)
- Breathe better and grow better
- Be less likely to become a cigarette smoker

You will have more energy, fewer health problems, save money, and feel pride in your success.

Stay in touch with your doctor and talk with your baby's doctor about ways you can stay smoke-free, and the methods that may work best for you after the baby is born.

HOW TO GET MORE HELP

If you need more help, talk with your prenatal care team or your baby's doctor about your smoking and ask for help in quitting. They may be able to provide you with counseling, or refer you to counseling programs in your area.

Nicotine gum and patches and other quit smoking aids are generally not recommended for women who are pregnant or breastfeeding because their safety for your baby is not known. Your prenatal care team can tell you more about what is right for you.

For extra help quitting smoking during pregnancy 24 hours a day 7 days a week, you can call the Smoker's Quitline toll-free at 1-800-QUIT-NOW (1-800-784-8669). At the quitline you will be connected to local resources and understanding counselors.

"Talking to the nurse helped a lot, just hearing the facts about what happens to the baby, what smoking does to it as you get further along – it just didn't feel right to smoke. I set a quit date that day for two weeks out, but quit before I even got there."

— Tammy, who quit smoking during pregnancy with the help of her prenatal care team.

I've quit using commercial tobacco, and now I'm feeling...

Depressed

- Call or visit with friends and family
- Go to a movie, concert, or show with someone
- Use prayer or meditation

Trouble Sleeping (Insomnia)

- Avoid caffeine (coffee, soda, etc.) after 6 pm
- Read before bed
- Allow 10–15 minutes of quiet time before bedtime
- Try calming stretches before bedtime

Irritable, Frustrated, or Angry

- Take a walk or exercise
- Talk to a friend or relative about how you feel
- STOP, and practice deep breathing to stay calm

Difficulty Concentrating

- Take breaks
- Do important tasks when you are most alert
- Avoid sitting in the same position for too long

Restless

- Chew sugarless gum or candy, a carrot, or a toothpick
- Work on a hobby
- Take one day at a time
- Change your routine

Increased Appetite or Weight Gain

- Eat snack like bagels, pretzels, or popcorn
- Eat at least 5 servings of fruits and vegetables every day
- Eat lean cuts of meat and low-fat dairy products
- Avoid "fast foods," convenience foods, and fried foods
- Walk whenever possible, aiming for 20 to 30 minutes a day
- Keep your Survival Bag with you at all times
- Drink lots of water

"There is but one secret to success: *never give up.*"

◆ Ben Nighthorse Campbell

Negative Results of Commercial Tobacco Use

Short-Term Risks:

- Stained teeth and fingers
- Smelly breath, clothes & hair
- Expense of commercial tobacco
- Shortness of breath
- Asthma attacks
- Infertility and impotence

Long-Term Risks:

- Heart attacks and strokes
- Cancer
- Heart & Lung Disease
- Wrinkles, weak bones, ulcers, dental problems

Risks to My Family:

- Newborns have higher risk for Sudden Infant Death Syndrome (SIDS)
- Increased risk of lung cancer in spouse and children
- Increased risk of asthma, middle ear disease, and respiratory infections in children of smokers
- 4,000 chemicals in cigarette smoke, including carbon monoxide, cyanide, acetone, ammonia, formaldehyde, and other poisons

Smoking will take years off your life. But more importantly, *it will reduce the quality of your life.*

Tips and Tools to Help You Quit Commercial Tobacc

Stay Healthy–*Life Matter*

Benefits of Quitting Commercial Tobacco Use

- Improved health for you and your family
- Improved sense of smell and taste
- Home, car, and breath will smell better
- Save money
- More energy and stamina
- Feel better about yourself
- Set a good example for family and friends
- Can stop worrying about quitting
- Healthier heart and lungs
- Normal blood pressure
- Fewer colds and coughs
- Look younger

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www.ihs.gov/MedicalPrograms/tob • www.healthcarepartnership.org

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Respect your culture
Keep tobacco sacred

My Quit Plan

Congratulations *on your choice to quit using commercial tobacco. There is no perfect time to quit, but setting a quit date is the first step to being commercial tobacco-free. You should choose a date that is meaningful to you at a time that will not be too stressful.*

Follow the steps below to make your personal quit plan.

1. My Quit Date:

_____ _____/_____/_____

2. My Support Persons:

_____

_____

_____

3. Problem-Solving Skills:

Ex-tobacco users find these tips useful.

- Practice some suggestions from "Before Quitting."
- Keep "After Quitting" handy after your quit date.
- Always carry your survival bag with you.

4. Medication Information:

Talk to your doctor or pharmacist about medication to help you quit.

5. Referrals to Intensive Services:

For information call

- National Quitline: 1-800-QUIT-NOW
- Other cessation services:

_____

Quitting is a process. Whether this is your **first time** to quit or **fifth**, give yourself permission to go back to your doctor, pharmacist, or counselor if you need to try and quit again.

Before Quitting

Before quitting commercial tobacco, *the best thing you can do is plan ahead for your quit day.*

Tips:

- Remember that tobacco is sacred and should be used for prayer or ceremonial uses
- If you use tobacco ceremonially find an elder or mentor who can guide you during this process while you quit use of commercial tobacco. There may be ways you can continue to use sacred tobacco that do not require you to inhale tobacco smoke.
- Tell your family, friends, and coworkers that you are quitting commercial tobacco
- Clean your house, car, and place of work of any tobacco products or accessories (lighters, ashtrays)
- Wait an extra five to ten minutes before your first commercial tobacco product of the day
- Ask your doctor about starting an exercise plan
- Use prayer and meditation through ceremony to find inner strength and courage
- Spend more time with nonsmoking friends and family
- Prepare yourself for times that you may be tempted to use commercial tobacco and ways you might handle them.
- Make a money jar to collect the money you will save
- Review your self-help materials and make personal notes
- Consider using medication that may help you quit commercial tobacco

Prepare a Survival Bag and carry it with you at all times. Contents can include:

- 3x5 cards with top reasons for being commercial tobacco-free
- A picture of your loved ones
- The phone number of someone you trust
- National Quitline: 1-800-QUIT-NOW
- Sugarless gum or candy, cinnamon sticks, fruit, carrot sticks, straws, and toothpicks

"I see strength, not to be greater than my brother, but to fight my greatest enemy—myself;
So when life fades, as the fading sunset, my spirits may come to you (Great Spirit) without shame".

Anonymous

After Quitting

"I have seen that in any great undertaking it is not enough for a man to depend simply upon himself."

Lone Man (Isna-la-wica), Teton Sioux

After quitting commercial tobacco, *the best thing you can do is plan ahead for tough times. You want to give yourself the best chance of success.*

Triggers

- After meals
- Drinking coffee
- Talking on the telephone
- Boredom
- Driving
- After waking up
- Stressful situations
- Work or lunch breaks
- Enjoying time with friends
- Seeing or smelling commercial tobacco smoke

Other times that may be difficult for you:

_____

_____

_____

Positive Coping Strategies

- Keep busy and try new things
  - Write a letter or work on a hobby
  - Use prayer or meditation
  - Find a support group
  - Visit nonsmoking places
  - Avoid caffeine and alcohol
  - Exercise, if your doctor allows
  - Eat crunchy foods like fruit, vegetables, and popcorn
  - Wash dishes by hand after meals
  - Take a nap
- Practice stress reducers such as the Four D's.
  - Delay
  - Deep breathe
  - Drink lots of water
  - Do something else
- Call or visit a friend or family member to support you
- Do one thing at a time
- Don't put yourself down: if you make a mistake, forgive yourself and learn from it
- Do something special to celebrate your life!

Ally Guide:

A guide to help you help them quit

Dear_____

I am giving you this guide because I want you to be my "ally" (to give me support) while I quit smoking. Quitting will be much easier if I have your help.

Support from people like you is an important part of my quitting plan.

When I have set a quit date, I will let you know. I will also tell you when I want other people to know my quit date.

For now, please read this guide. It will help you to help me quit.

Thanks, _____

Someone you care about has just asked you to help them quit smoking. Your support is important and could play a big part in helping them to quit smoking successfully.

This guide is for you. It explains how you can help your friend or family member make a change that will last a lifetime.

Quitting smoking is hard work. But it is the job of the person quitting to do that work, not you. As their ally, it is your job to be understanding, supportive, and caring.

Your friend or family member is in good hands. This program has helped hundreds of thousands of people quit smoking for more than 25 years. But we need your help to be there when we can't.

Thanks for being part of the team!

How You Can Help

For most people, quitting smoking does not happen overnight. There are many steps that a person will take to get ready to quit. The type of support you give may change with each step. Your friend or family member will tell you what kind of help is needed and when it's needed. Try to be there for them when they need you. Be ready to listen and let them tell you what they need.

Remember, it is the person quitting who makes the rules. Try not to offer advice or tell them what you think is the problem. Don't nag them. **Just ask how you can help.**

Ways You Can Help

You can help take their mind off smoking by keeping them busy. Suggest things you can do together. Take a walk, do chores, go to a movie, go shopping, or have dinner in a smoke-free restaurant.

Ask them to think about things that have helped them keep from smoking in the past. Make a list of those things and try to do them often.

In the first two weeks after quitting, help them with things that may cause stress. You might want to run some errands for them, take care of their kids or help them out at work.

Most people smoke because they are addicted to nicotine and cigarettes are part of their daily routine. Nicotine in tobacco smoke is very addictive, while certain feelings and activities trigger urges to smoke. When people quit smoking, they are learning to live without something that their body wants badly and that they are used to having as part of their daily life. Maybe you were once a smoker and remember how hard it was to quit.

Try to be patient. Be ready for your friend or family member to be grumpy or nervous. Don't take their bad mood personally—it is a normal part of quitting and will soon get better. If you are not sure how to help, just ask.

Triangle of Addiction

People who smoke are addicted physically, behaviorally, and emotionally. That's why it can be so hard to quit smoking.

Tell your friend or family member that you are proud of them for trying. Tell them you will support them no matter how long it takes.

You and Tobacco

If you are an ex-smoker:

- Do let the person quitting know how your life has improved since you quit smoking. Your real-life experiences can help them feel inspired and motivated. Just knowing that you quit yourself will mean a lot to them.
- Don't try to push them to quit the same way you quit. Everyone is different, so what was easy for you may not be easy for them. And what was hard for you may not be hard for them.

If you have never smoked:

- Do think of some other big changes you have made in your life like losing weight or facing a big fear. That will help you to know how hard it is to quit smoking.
- Don't try to give advice or nag the person quitting to do things differently. Just listen and ask how you can help.

If you are a current smoker:

- Do smoke only in places that the person quitting can avoid. Try to smoke outside of the house, car, restaurant, or workplace. Keep your cigarettes and lighter out of sight.
- Don't offer them a cigarette, even if you are only joking! Ask your friend or family member what to do if they ask you for a cigarette.

Slips and Relapses

Many people trying to quit may slip or relapse.

A **slip** is when a person has one or two cigarettes after they quit. A **relapse** is when a person begins to smoke again as they did before they quit.

A slip or relapse usually happens because the person quitting was not ready to deal with a certain situation. It does not mean that the person is weak. A slip or relapse usually teaches a person about how they can do things differently next time they are in a similar situation. Your friend or family member is in a program that will help them see what went wrong and get back on track. You can help too:

- Be positive about slips. Slips can be part of the quitting process and help for next time.
- Tell them that you won't judge them or scold them if they slip.

Stay Quit For Life

The first two weeks after quitting smoking can be the hardest. Give your friend or family member lots of praise if they have stayed quit for this long. But the hard work is not over. Living without tobacco is still very new to the person who has quit. The program they have joined will teach them many new skills for staying away from tobacco for life. Your support over the next weeks and months will help too. It might even be the one thing that keeps them on track.

Quitting smoking is a big deal. Tell your friend or family member how proud you are of them!

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Quitting Smokeless Tobacco

Benefits of quitting

- Cut related health risks
- Stop damaging teeth and gums
- Save money (not spending on tobacco)
- Breath will smell better

What's inside

What is smokeless tobacco? 3

What's in smokeless tobacco? 5

Create a plan to quit 6

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Medicine to help you quit 15

Other ways to quit 18

Quit-plan worksheet 22

How to remain tobacco-free 24

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Here's what you'll learn inside:

- Why smokeless tobacco is bad for your health
- How to plan and carry out a quit strategy
- Medicines that may help you go tobacco-free
- How support can help and where to get it

Welcome to the program

Getting on board

Congratulations. You've taken the first step toward quitting smokeless tobacco and becoming healthier!

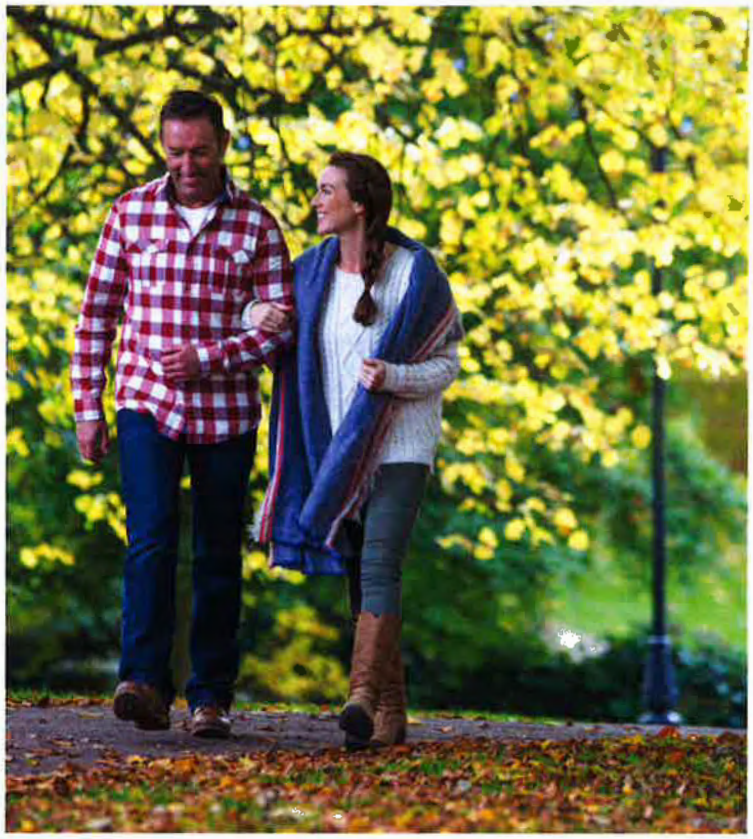
Quitting tips

This guide provides tools to help you quit for *good.* The information included is based on scientific evidence gleaned from over three decades of helping people stop chewing—and *remain* tobacco-free.

Steps to stopping

There are five key steps to kicking the habit:

- Make a plan.
- Set a quit date.
- Ask for support.
- Manage urges to use.
- Curb nicotine withdrawal symptoms.



Create a plan

Follow the steps in this guide to create your own plan to *quit.* You may have discovered other strategies that helped you quit—if only briefly—in the past. Use those and these tips to make this attempt your *last one!*

1 What is smokeless tobacco?

Smokeless tobacco is tobacco that is not burned. You don't smoke it. Instead, you typically chew it and spit out the brown juices (created by the tobacco-saliva mix) every few seconds.

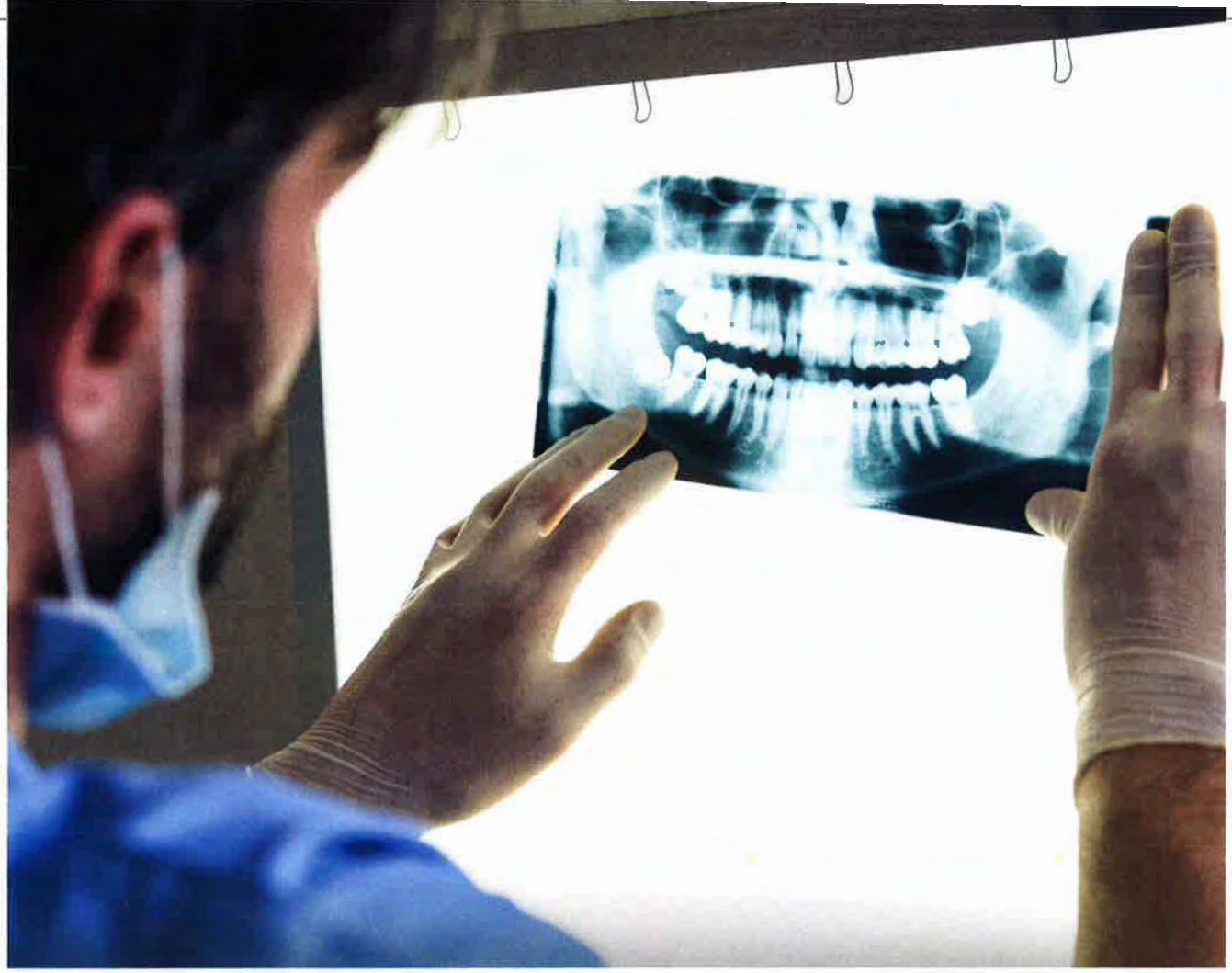
So it must be a safe alternative to *smoking* tobacco. Right? *Wrong!*

Hazardous to your health? All forms of tobacco—whether chewed or smoked—contain harmful ingredients that can cause cancer and other serious health problems, the Centers for Disease Control and Prevention (CDC) warns.

Smokeless tobacco is also called *spit tobacco, chewing tobacco, chew, chaw, dip,* and *plug.* There are two types: *snuff* and *chewing tobacco.*

- Snuff is a fine-grain tobacco. Users "pinch" or "dip" it between their lower lip and gum.
- Chewing tobacco comes in shredded, twisted or "bricked" tobacco leaves. Users put it between their cheek and gums.

Users typically let the tobacco sit in their mouth and spit often to get rid of the saliva that builds up. This allows the nicotine and other ingredients in it to be absorbed into the bloodstream through tissues in the mouth.



Health risks

Chewing tobacco can cause painful mouth sores and bad breath, and stain your teeth a yellowish-brown color. It may also cause:

- Cracking and bleeding lips and gums
- Gum disease and tooth loss
- Increased heart rate and blood pressure

Cancer Smokeless tobacco also increases the risk of mouth (or *oral*) cancer, according to the CDC. This can occur in the lips, tongue, roof and floor of the mouth, the cheeks and gums. Some of its cancer-causing agents can also get into the lining of the stomach, esophagus and bladder, the CDC cautions.

2 What's in smokeless tobacco?

Smokeless tobacco contains many dangerous chemicals, including more than 30 known *carcinogens* or cancer-causing agents, according to the Food and Drug Administration (FDA). It also contains flavorings and sugar that heighten the risk of gum disease and tooth decay and loss, the FDA says.

Nicotine

All types of smokeless, like other tobacco, also contain nicotine. Nicotine is highly addictive and makes it hard to quit. Some types of smokeless tobacco are treated with chemicals that make nicotine even more addictive. This is called "free nicotine." The faster nicotine travels from the tissues in your mouth to your brain, the more addictive and harder it is to quit.

Large doses of nicotine increase blood pressure and heart rate, risk factors for heart attack, stroke and other cardiovascular disease, according to the CDC.

3 Create a plan to quit

List your reasons for quitting

Perhaps you're motivated by the health risks. Or by the money you'd save by stopping. Or the disgust non-chewers display when they see you chew and spit, smell your foul breath or see your tobacco-stained teeth. Maybe it's *all of the above.*

Check the reasons below behind your decision to quit:

- ☐ I want to improve my health and prevent mouth and other cancers, heart disease and high blood pressure linked to chewing.
- ☐ I want to save money. *(Imagine what you could do with the savings!)*
- ☐ I want to prevent related bad breath, gum disease and tooth loss/decay.
- ☐ I want to be a better role model for my kids.
- ☐ I want avoid the disgust of (and rejection by) others.
- ☐ I want to feel better about myself.
- ☐ I want to be free of nicotine addiction.
- ☐ Other reasons: _____

_____

_____

_____

_____

_____

_____

Core values

You may have started chewing at a young age without regard for potential consequences. Over time, you may have learned or changed your views on what's *really* important or a *core value* for you. Core values include things like family, faith, good health, and financial security. Use the chart below to identify your *current* core values—and if smokeless tobacco fits in with them. *(There is an example in first row for how this works.)*

Core value: What matters to me	Why this matters to me	How using smokeless tobacco gets in the way of what matters to me
Example: Family	I like spending time with my kids and want to be a good parent.	My kids say I have real bad breath and they don't want to be close to me and do things together.

Set a quit date

A *quit date* is the day you plan to stop using smokeless tobacco. This date is your choice. But studies show that setting a quit date within two weeks of deciding to stop boosts your chances of success. Circle the date you select on a calendar. Put reminders of your quit date in places where you'll see them every day. This will help you stay on track. Tell friends, family and co-workers about your plans. Ask for their support.

4 Manage urges

It's common to *want* to chew after quitting

Among the reasons:

- Nicotine in tobacco is *highly addictive.* (See *Medicines to help you quit* on page **15** for tips on ways to curb nicotine withdrawal symptoms.)
- You may be used to chewing during certain activities and times of day.
- Being around other smokers or chewers may tempt you.

The good news is that there are many ways to manage urges. It may take a few days, weeks or even months. But you *will* overcome them—and adjust to being *tobacco-free.*

Take your mind off the urge to chew

Some ways to avoid or resist temptation:

- **Workout or take a walk.** *Get your doctor's OK for any new fitness plan.*
- **Change your daily routine,** especially during times you typically chewed.
- **Avoid being around smokers and chewers.** Tell your smoking/smokeless tobacco friends why you're avoiding them.
- **Other ideas:** _____

_____

_____

_____

Choose healthier substitutes

You may miss having something in your mouth after you quit. Use non-tobacco products as a substitute. Some suggestions:

- **Put sugar-free hard candy** or a piece of gum in the corner of your mouth where you held tobacco. Some people find sunflower seeds (in moderation) are a good substitute.
- **Use *non-tobacco* herbal replacement chew.** You can buy this online and in many convenience stores. There's no conclusive scientific evidence this helps. But many of our quitters say it helped them. *Confirm the herbal substitute you use does not contain tobacco.* (Check the *American Cancer Society Guide to Quitting Smokeless Tobacco.*)
- **Chew on a toothpick or short straw.**
- **Other ideas:** _____

_____

_____

_____

_____

_____

_____

_____

Squash risky thoughts

After quitting, you may have thoughts that make it hard to remain tobacco-free. This "stinking thinking" is common and can lead to backsliding. Here are some examples of ways to turn negative into positive or helpful thoughts.

Negative thought	Positive thought
"Man, I really want to chew tobacco right now. I deserve it!"	"Yes, I do want a chew. But it will not help me feel better or quit. I know the urge will pass if I do something to take my mind off of it. Plus, I promised myself I would quit."
"I can't imagine never having a dip again. So I'll have just one now."	"I don't have to quit forever. I just have to stop for today– and I can do that! I should ask my support team for help."

Other ideas for turning negative into positive thinking:

_____

_____

_____

_____

_____

Practice relaxation and coping techniques

Quitting tobacco can be stressful. Relaxation exercises like the following may help ease anxiety.

Deep breathing:

- Go to a place where you can sit and relax.
- Turn off all electronic devices (your computer, mobile phone, TV).
- Take a deep breath through your nose and expand your stomach.
- Hold your breath for five seconds.
- Gently release breath through your mouth. Wait for five seconds.
- Say the word "relax" out loud. Repeat this for five minutes.

Progressive muscle relaxation*:

- Sit in a comfortable place free of distractions. (You may prefer to lie on the floor.) Take off shoes.
- Breathe normally. Note how your body feels from head to toe.
- Tightly curl your toes as if trying to squeeze a small ball between your toes and the bottom of your feet.
- Hold curl for 10 seconds. Release and spread toes.
- Repeat this exercise with your calves, thighs, hands, arms, upper back and face.
- Breathe deeply for a few moments. Notice how all body parts now feel.

**Don't attempt while driving, watching children, operating heavy equipment or doing other things that require your full attention.*

Tobacco-proof your space

Get rid of all tobacco products/reminders. It's key to scrap *all* tobacco products (and reminders) when you decide to quit. Keeping them can make it tougher to quit and *stay* tobacco-free. The night before you quit, run water over any tobacco you have left—and throw it away.

Avoid smokers and other chewers

Ask friends not to chew or smoke around you. It can be harder to quit if you're around other chewers/smokers, especially in the first few days or weeks after quitting. Can't completely avoid them? *Just say "no"*. Or think about other responses if offered chew. Keep substitutes (candies, mints, sunflower seeds) on hand to pop in your mouth instead of tobacco.

Ask for support

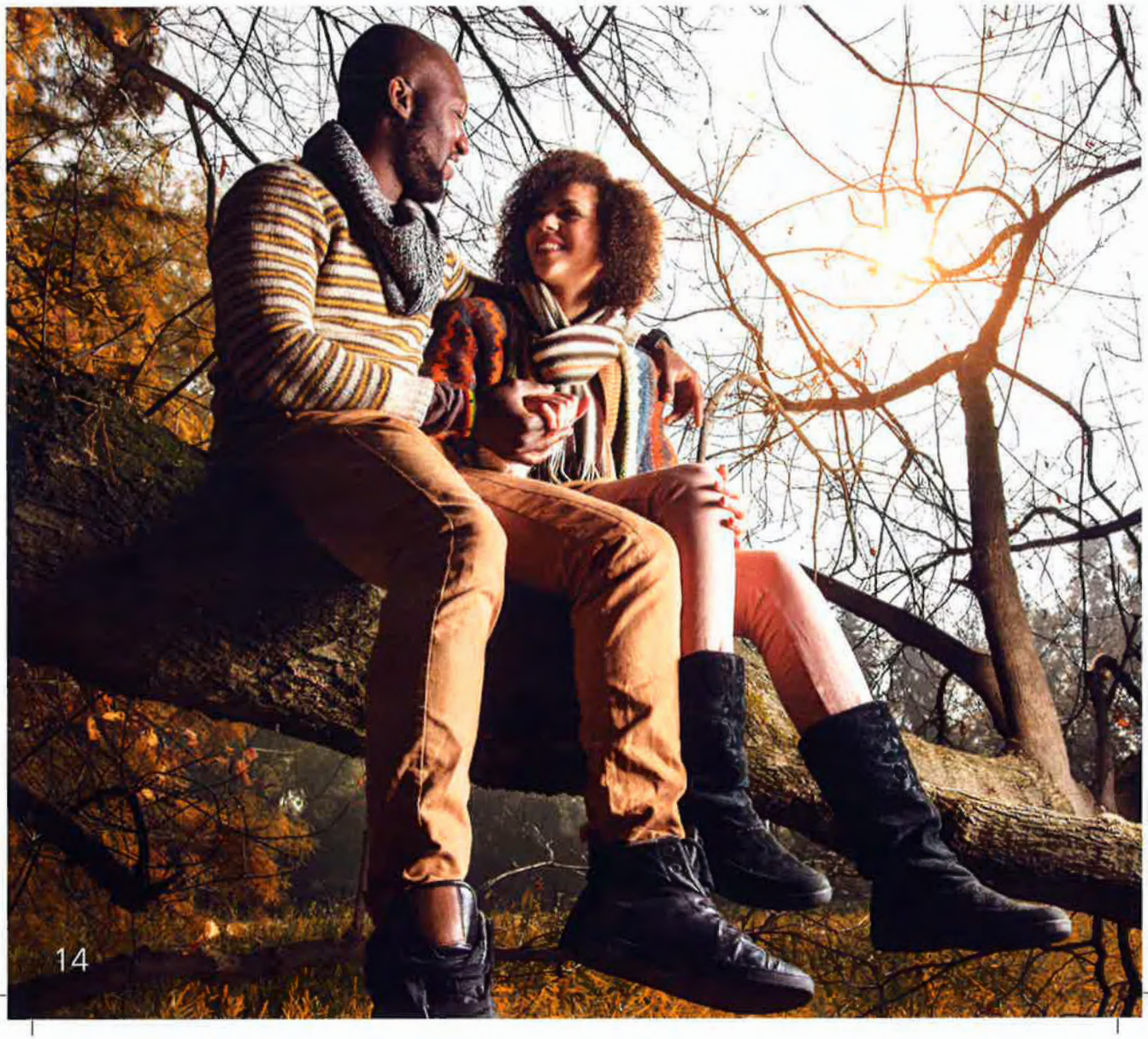
Tell family, friends and co-workers you're planning to quit. This makes quitting easier and increases your chances of success. As you prepare to quit, consider who you can (or want to) lean on most. It could be someone you see every day or reach out to in crises.

A good place to start is with someone who has already quit tobacco and knows what it's like. Not sure? Pick someone you trust to be there for you.

How to ask for support

It may be hard for you to ask for help. You may feel awkward or like you should be able to do this on your own. One way to approach someone is to say something like: "I plan to quit chewing on this date. Would be OK if I turn to you for support if things get hard for me?"

Tell your support person (or team) how they can help. You may want them to check in daily to see how you're doing. Or you may just want your support person/team to be there on an 'as needed' basis. It's up to you. So let your support person/team know in advance how you want them to help you. You can also call your program quit coach *anytime!*



5 Medicine to help you quit

When you stop using smokeless tobacco, your body will likely crave the nicotine in it. This is called *nicotine withdrawal.* Symptoms may include headache, trouble concentrating and/or feeling anxious and grumpy. It's perfectly normal to feel this way. But it's important not to act on these feelings or take them out on others. Try relaxation exercises to control these feelings. Some medicines may also help curb nicotine withdrawal.

Nicotine replacement therapy

NRT helps cut withdrawal symptoms by replacing nicotine without tobacco's other harmful chemicals. The Food and Drug Administration approved its use to help people stop smoking. But studies show it also helps reduce withdrawal symptoms among those trying to quit chewing.

There are five types of NRT. Each delivers what is considered to be safe levels of nicotine—and is typically used for eight to 12 weeks (to replace nicotine in tobacco). Ask your doctor if NRT can help you—and, if so, which type is best for you. *Use only as directed.*

Nicotine patch. This is a patch that sticks to your skin. You apply a patch once a day after waking. It slowly releases nicotine into your body. Patches come in different strengths. They're easy to use. You can buy them over-the-counter (without a prescription) at most pharmacies.

Nicotine gum. This comes in two strengths: 2 milligrams (mg) and 4 mg. It's typically used throughout the day. Nicotine gum is not chewed like regular gum. You put a piece in your mouth and chew it several times. You then move it to a corner of your mouth and leave it there for several minutes. You chew it a few more times—and park it in a corner again. The nicotine in it is released and absorbed by the tissue in your mouth. You throw out the gum after using for 20 to 30 minutes. *Available without a prescription.*

Nicotine lozenge. This also comes in two nicotine doses (2 mg and 4 mg). But you don't chew it. You put it in your mouth and move it around. Nicotine is released and absorbed by the tissues in your mouth. *Available without a prescription.*

Nicotine nasal spray. This is a medicine prescribed by your doctor. It's faster acting than the above therapies and is used throughout the day. It's also pricier than the patch, gum and lozenge.

Nicotine inhaler. This must also be prescribed by your doctor. You puff on it. It delivers small amounts of nicotine with each puff. You should not inhale the nicotine from this device. It can irritate your throat and lungs. The nicotine in this is absorbed by the tissues in the mouth. Your doctor will tell you how often to use it. It costs more than the patch, gum or lozenge.

Combinations of NRT. You can use the nicotine patch with other quit medicines to provide extra relief. The patch provides a steady dose of nicotine. Other types of NRT can be used regularly (throughout the day) or 'as needed' to help combat strong urges to use tobacco.

Two other Rx's used to combat tobacco urges are *varenicline* (Chantix®) and *bupropion SR* (Zyban®). They do not contain nicotine.

Your doctor or pharmacist can tell you more about all of these medicines. Give your doctor a list of all the medicines you take, including prescription and over-the-counter meds, vitamins and supplements. Learn the potential side effects of all medicines.

Check to see if your health benefits cover any/all of these therapies.

The right way to use quit meds

Some people say quit meds did not help them. In many cases, this is because they failed to use them the right way. Always follow directions *exactly*. Have questions? Ask your pharmacist or doctor. Other tips:

- Use every day or as recommended by your doctor.
- Nicotine gum, lozenge, inhaler, and nasal spray are most effective when used *every one to two hours daily* during the first four weeks of use.
- Use the gum as directed. Remember: This is *not* chewed like regular gum. *If you chew it like chewing gum it will not work well and may give you an upset stomach.*
- Use the patch every day. Rotate it to a different site each day to avoid itchy or sore skin.
- Varenicline and bupropion SR should typically be taken starting a week or two *before* you quit. It's key to follow instructions from your doctor or pharmacist.

(See pages 15 to 16 for more info on NRT.)

6 Other ways to quit

Switch to lower-nicotine chew

Some types of smokeless tobacco contain more nicotine than others. If you're using a fine-cut type of tobacco, you may try switching to a long-cut variety a few weeks before quitting. Doing this may make it easier to quit because your body will get accustomed to less nicotine.

If you choose this option, it's important *not* to use it as an excuse to take more or *bigger* dips or chews. *Reminder: Less nicotine does not make smokeless tobacco safer. It just means it contains less nicotine per dip.*

Reduce chews

Cutting the number of dips or chews you take is another way to prepare to quit. Keep track of the chews you take each day, and start skipping a few. This will add up as you get closer to your quit date. If you use this method, it's important not to take *bigger* dips or chews. That will defeat your purpose.

Two-week taper method

This helps reduce nicotine intake *before* you quit. To taper more, take an extra week or two longer.

Step 1: Track how many dips or chews you take each day for a few days. Record the time of day, what you're doing/feeling, and who you're with when you imbibe.

Step 2: Cut your dips by one or two a day. For example, if you normally use 15 dips a day, cut out one of them. By the end of two weeks, you'll ideally be down zero.

Step 3: Start using your coping skills and quit meds (if you opt to use one) on your quit date (unless instructed to begin earlier). Call your quit coach as needed. Lean on family/friends for support.

Use herbal substitutes

Herbal "spit tobacco" tastes like but doesn't contain tobacco. You can buy it online or in most convenience stores. (Some brand names: Mint Chew, Golden Eagle® Herbal Chew and Smoky Mountain® Herbal Chew.) *Confirm any herbal substitutes you get do not contain tobacco.*

How to cut back with herbal substitutes:

Week 1: Record number of tins/pouches of smokeless tobacco you use in one week on calendar on next page.

Week 2: Empty the weekly amount of tobacco you typically use on a plate. Remove one-quarter of the tobacco. Mix herbal substitute into remainder. *Refrigerate the mix in a sealed container to keep it fresh.* ***Note: It's key to mix tobacco and herbal substitutes together very well.***

FYI: "Long-cut" tobacco mixes better with long-cut herbal substitutes; fine-cut tobacco with fine-cut substitutes.

Week 3: Repeat what you did during week 2 only this time take away half of the tobacco and replace with an herbal substitute. *Refrigerate in a sealed container. Take out a fresh supply daily.*

Week 4: This is the week you take the plunge—and *quit!*

	Four week 'cut-back' with herbal substitutes calendar						
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Wk #1							
Wk #2							
Wk #3							
Wk #4							

Abrupt method (Cold Turkey)

Some people prefer to quit abruptly. If you take this approach, you may have more nicotine cravings in the first few days or weeks after quitting.

Types of smokeless tobacco	
Moist Snuff	The most popular form of spit tobacco. This fine-cut snuff typically delivers *more* nicotine than long-cut tobacco. Some brands of moist snuff have more nicotine than others.
Snus	This is inserted under the upper lip. There's no spitting because there are no salivary glands in the upper mouth (and, so, no saliva buildup). Most American snus contains more cancer-causing agents (than imported snus).
Chewing tobacco	Spit tobacco that often has added sweeteners and is flavored with licorice. Users usually put large wads in their mouth. They chew it. Tuck it in a corner of their mouth. Then spit out the tobacco-saliva juice.

Types of smokeless tobacco *(continued)*	
Dissolvable tobacco	Comes in pellets, twisted sticks (the size of toothpicks), thin tongue strips, and other dissolvable products. Made from finely milled tobacco. Comes in flavors like wintergreen. Slowly dissolves in five to 20 minutes. No spitting required.
Blocks, plugs and braids/twists	All but twist varieties are typically mixed with molasses or other sweeteners and tightly pressed together into square blocks or plugs. Users break or bite off a chunk, chew it and spit out tobacco juices
Iq'mik	A mix of tobacco leaves and ash (from a birch tree fungus) most commonly used by Alaskan Natives. Can be purchased at stores in rural Alaska. The ash/leaf combination makes the nicotine easier to absorb when in the mouth. May be pre-chewed into individual "doses" and saved in a tin for later use.
Gutkha, khaini and pan masala	Originated in Africa, India and Asia and available in the U.S. Contains either cut, shredded or powdered tobacco. May be mixed with slaked-lime, ash or other flavorings to boost the nicotine and improve the taste. Often marketed as "natural" or "traditional," but carries the same health risks as other tobacco.
Dry Snuff	Dry powdered form of tobacco. Users place a small amount between their thumb and forefinger and hold it under their nose. They inhale it. It causes some to sneeze. Users may also put a pinch their mouth between their lip and gum. Less popular today.

For more info on types of/ nicotine content in smokeless tobacco, check out: *http://www.fda.gov/TobaccoProducts/Labeling/ProductsIngredientsComponents/ucm482582.htm*

7 Quit-plan worksheet

Set a quit date:

My planned *quit date* is _____

Circle this date on your calendar. Set a date within the next two to three weeks. Post your quit date on your mobile phone as a reminder. You can also put reminders on your fridge and give friends a heads-up on *Facebook* or *Twitter.*

Pick a med to help reduce nicotine cravings (if you opt to use one):

Using a quit medicine can make the process go more smoothly. Plan to use a med? Ask your doctor about over-the-counter and prescription options.

I plan to use _____

_____

as my quit medication.

How I will cope with urges to dip or chew:

☐ **Distractions.** I will do these activities to temper urges to chew:

_____

_____

_____

_____

☐ **Substitutes.** I will keep these substitutes on hand.

_____

_____

_____

☐ **Risky thinking.** Post where you can see this every day (like on your fridge or bathroom mirror).

Negative/risky thoughts: _____

_____

_____

_____

_____

Positive/helpful thoughts: _____

_____

_____

_____

_____

_____

_____

_____

I will create a tobacco-free area by:

☐ Tossing all of my tobacco and related products.

☐ Avoiding other chewers and smokers.

☐ Removing all reminders of smokeless tobacco at home and work.

My support team:

Family _____

_____

_____

Friends _____

_____

8 How to remain tobacco-free

Some people find it easy to quit and stick with the program. Others have more trouble. If you've previously tried but failed, you may know things that tripped you up. Think back to when and where you started using tobacco again—and what you can do differently to prevent backsliding. Talk to your quit coach. He/she will help you stay tobacco-free for *good*.

It's normal to think "just one dip or chew" would be OK after quitting. Keep reminding yourself *why* you quit. *Commit* to not using tobacco one day at a time. Successes will add up. Soon you'll find you're going days—and then weeks—without even thinking about using tobacco.

The ACE model

The *ACE model* is one tool you can use to stay tobacco-free. The "A" stands for *avoid*, the "C" for *cope*, and "E" for *escape*. The key is to *avoid risky situations*. If you can't, *use your "coping" skills* (including your support system, distractions and substitutes). If your coping skills fail, try to *escape the situation*. Leave wherever you are and try to get your mind off your desire to have a dip or chew. Get busy doing something else. The urge *will* pass.

Other tips to help you stay tobacco-free:

- Do not take a dip, no matter the temptation.
- Avoid other chewers/smokers, especially right after you quit.
- Use your quit medicine every day as directed.
- Change up your routine. Avoid all tobacco triggers.

- Use your support system.
- Regularly reward yourself for ditching tobacco. Replace tobacco with other fun, healthy activities to remind yourself this isn't only about giving something up!
- Avoid or limit alcohol especially during the early stages of quitting.
- Learn to manage stress without tobacco. This will become easier over time.

We're here to help

It's not easy to quit tobacco for good. But we know you can do it. Thousands of smokeless tobacco users have put on the breaks using this program. Need more help? *Call your quit coach any time. We're here to help you!*

Questions?

Remember: As part of this program, you can contact a quit coach if you have questions or concerns. *So call—anytime!*

See resources below for more information.

Resources

American Cancer Society
http://www.cancer.org

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov

National Cancer Institute
http://cancer.gov

National Institutes of Health
http://nidcr.nih.gov

The Oral Cancer Foundation
http://oralcancerfoundation.org/tobacco/tobacco-forms-types.php

References

American Cancer Society: http://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/smokeless-fact-sheet and http://www.cancer.org/cancer/cancercauses/tobaccocancer/smokeless-tobacco

National Cancer Institute: http://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/smokeless-fact-sheet

Centers for Disease Control and Prevention: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/health_effects/) and http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/products_marketing/index.htm

Patricia Richter, Knachelle Hodge, Stephen Stanfill, Liquin Ahang, Clifford Watson. Surveillance of moist snuff: total nicotine, moisture, pH, un-ionized nicotine, and tobacco-specific nitrosamines. March 2008

Food and Drug Administration: http://www.fda.gov/TobaccoProducts/Labeling/ProductsIngredientsComponents/ucm482582.htm

National Institutes of Health: http://nidcr.nih.gov/oralhealth/topics/smokelesstobacco/smokelesstobaccoaguideforquitting.htm#Introduction

The Quit For Life® Program provides information regarding tobacco cessation methods and related well-being support. Any health information provided by you is kept confidential in accordance with the law. The Quit For Life® program does not provide clinical treatment or medical services and should not be considered a substitute for your doctor's care. Participation in this program is voluntary. If you have specific health care needs or questions, consult an appropriate health care professional. This service should not be used for emergency or urgent care needs. *In an emergency, call 911 or go to the nearest emergency room.*

Notes

Notes

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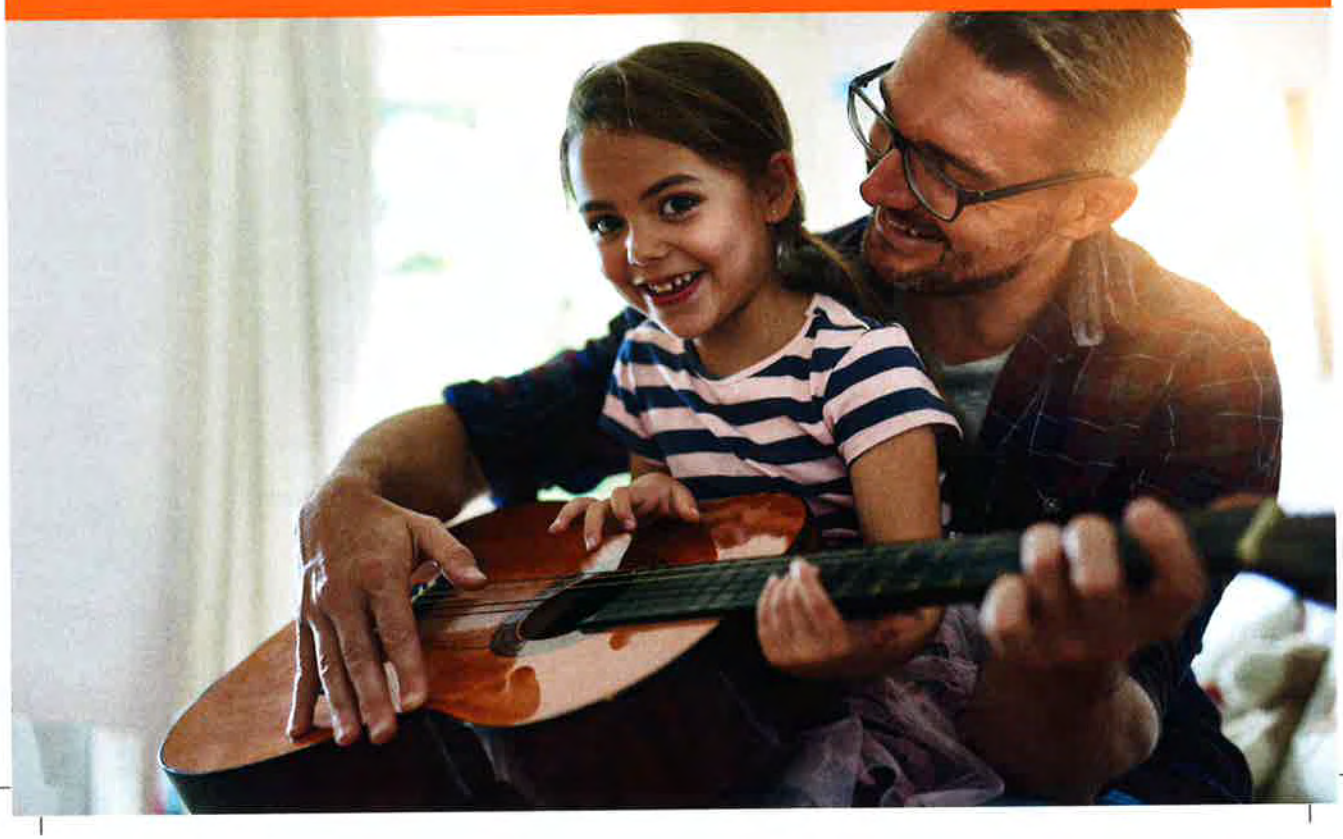
Dejar el consumo de tabaco sin humo

Beneficios de dejar de consumir tabaco

- Elimine los riesgos de salud relacionados
- Deje de producir daño a dientes y encías
- Ahorre dinero (al no gastar en tabaco)
- Tenga un mejor aliento



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Esto es lo que aprenderá:

- Por qué el tabaco sin humo es malo para su salud
- Cómo planificar y llevar adelante una estrategia para dejar de consumir tabaco
- Medicamentos que pueden ayudarle a dejar de consumir tabaco
- Maneras en que el apoyo puede ayudar y dónde obtenerlo

Bienvenido al programa

Ya está a bordo

¡Felicitaciones! Ha dado el primer paso en su recorrido para dejar de consumir tabaco sin humo y mejorar su salud.

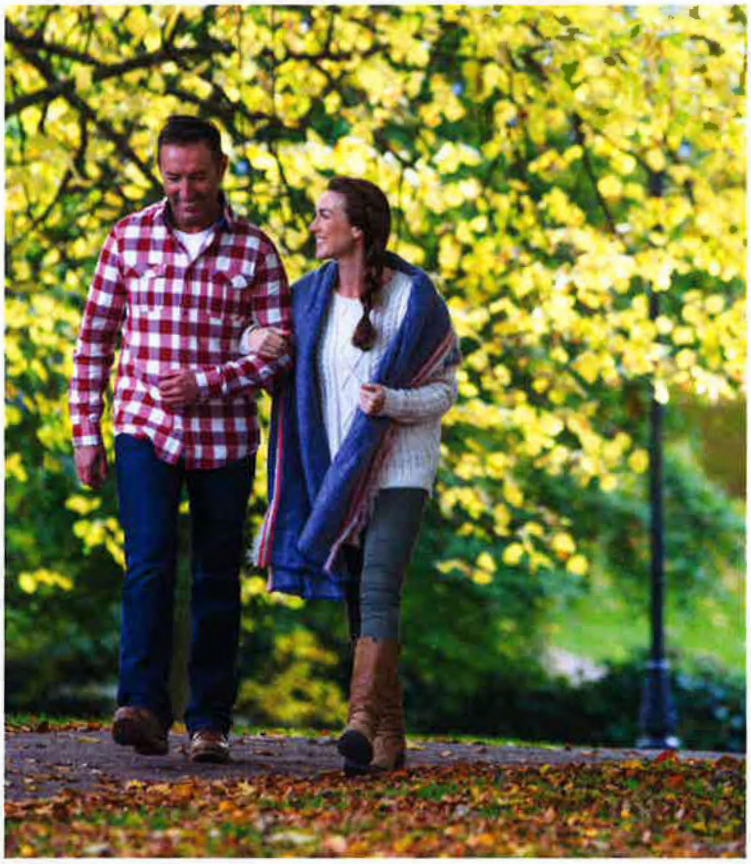
Consejos para dejar de consumir tabaco

Esta guía ofrece herramientas que le ayudarán a dejar de consumir tabaco *para siempre.* La información incluida se basa en evidencia científica recabada durante más de tres décadas de ayudar a las personas a dejar de masticar y a *mantenerse* libres de tabaco.

Pasos para dejar de consumir tabaco

Hay cinco pasos clave para abandonar el hábito:

- Haga un plan.
- Fije una fecha para dejar de consumir tabaco.
- Pida ayuda.
- Controle sus impulsos de consumir tabaco.
- Frene los síntomas de abstinencia de nicotina.



Cree un plan

Siga los pasos en esta guía para crear su propio plan para *dejar de consumir tabaco.* Es posible que en el pasado haya descubierto otras estrategias que le ayudaron a dejar de consumir tabaco, aunque solo por poco tiempo. Use esas ideas y estas recomendaciones para que este sea su *último intento.*

1 ¿Qué es el tabaco sin humo?

El tabaco sin humo es tabaco que no se quema. No se fuma. En cambio, por lo general se mastica y se escupe el jugo marrón que produce (creado por la mezcla de tabaco y saliva) cada pocos segundos.

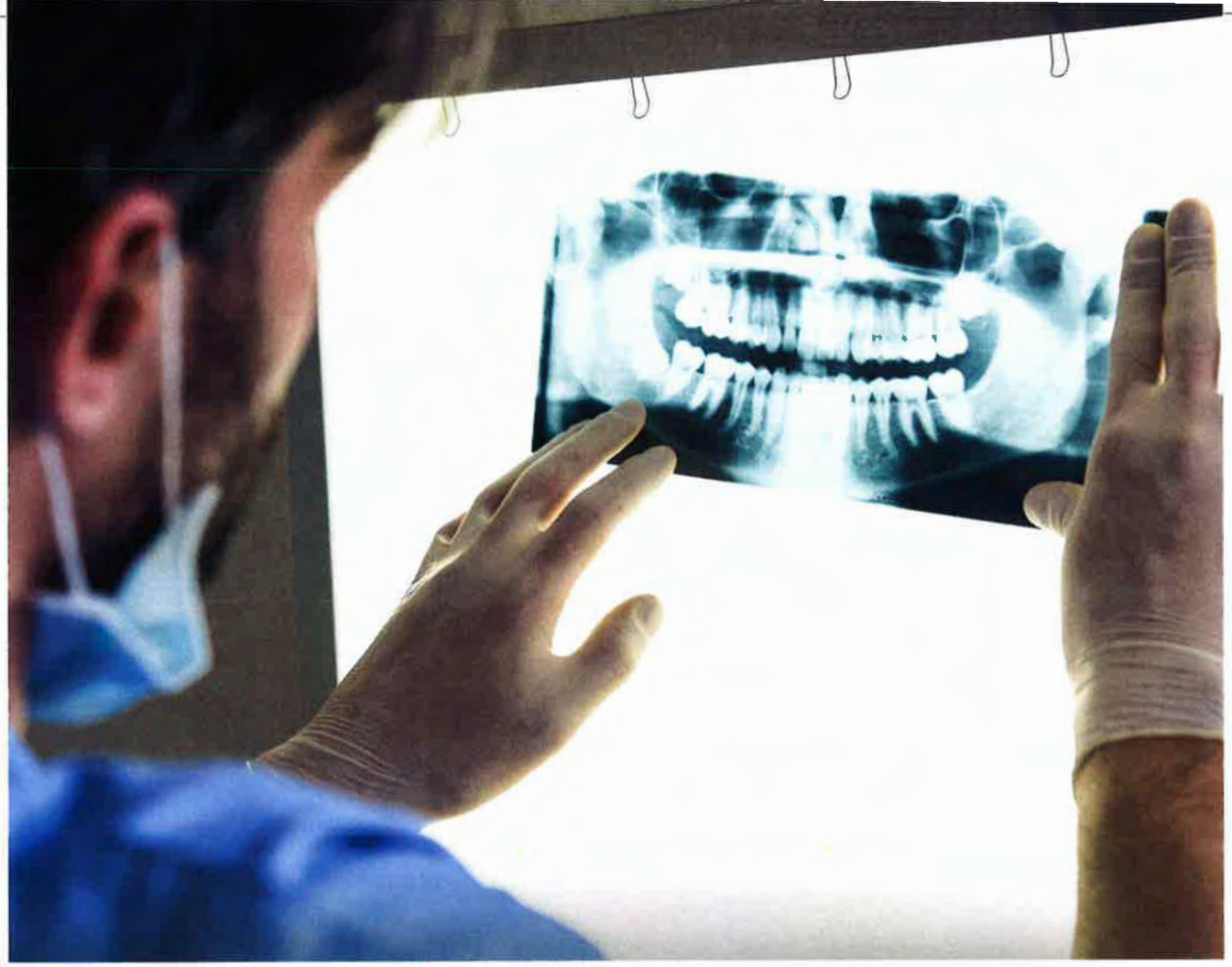
Por lo tanto, parece ser una alternativa segura a *fumar* tabaco. ¿Correcto? *¡Incorrecto!*

¿Peligroso para la salud? Todas las formas de tabaco, incluso masticado o fumado, contienen ingredientes dañinos que pueden causar cáncer y otros problemas de salud graves, advierten los Centros para el Control y la Prevención de Enfermedades (CDC).

El tabaco sin humo también se denomina *tabaco para escupir, tabaco de mascar, chew, chaw, dip* y *plug.* Existen dos tipos: *rapé* y *tabaco de mascar.*

- El rapé es un tabaco de grano fino. Los usuarios "aprietan" o "hunden" el tabaco entre el labio inferior y la encía.
- El tabaco de mascar viene en forma de hojas de tabaco trituradas, retorcidas o "compactadas". Los usuarios lo colocan entre la mejilla y la encía.

Los usuarios por lo general dejan que el tabaco se asiente en la boca y escupen con frecuencia para eliminar la saliva que se acumula. Esto permite que la nicotina y otros ingredientes incluidos ingresen en el torrente sanguíneo a través de los tejidos de la boca.



Riesgos para la salud

Mascar tabaco puede provocar llagas dolorosas en la boca y mal aliento, y además puede teñir los dientes con un color marrón amarillento. También puede causar:

- Resquebrajamiento y sangrado de labios y encías
- Enfermedad de las encías y pérdida de dientes
- Aumento de la frecuencia cardíaca y la presión arterial

Cáncer El tabaco sin humo también aumenta el riesgo de cáncer de la boca (también llamado *oral*), según los CDC. Puede afectar los labios, la lengua, las paredes superiores y las paredes inferiores, las mejillas y las encías. Algunos de los agentes causantes de cáncer también pueden llegar hasta el recubrimiento del estómago, el esófago y la vejiga, advierten los CDC.

2 ¿Qué hay en el tabaco sin humo?

El tabaco sin humo contiene muchas sustancias químicas peligrosas, entre ellas más de 30 *carcinógenos* o agentes causantes de cáncer, según la Administración de Alimentos y Medicamentos (Food and Drug Administration, FDA). También contiene saborizantes y azúcar que aumentan el riesgo de enfermedad de las encías, caries dentarias y pérdida de dientes, expresa la FDA.

Nicotina

Todos los tipos de tabaco sin humo, al igual que el otro tabaco, también contienen nicotina. La nicotina es altamente adictiva y hace que sea más complicado dejar de consumir tabaco. Algunos tipos de tabaco sin humo son tratados con sustancias químicas que hacen a la nicotina incluso más adictiva. Esto se denomina "nicotina libre". Cuanto más rápido viaja la nicotina desde los tejidos de la boca hacia el cerebro, más adictiva será y más difícil resultará abandonar el hábito.

Grandes dosis de nicotina aumentan la presión sanguínea y la frecuencia cardíaca, que son factores de riesgo para ataques cardíacos, accidentes cerebrovasculares y otras enfermedades cardiovasculares, según los CDC.

3 Crear un plan para dejar de consumir tabaco

Haga una lista de sus razones para dejar de consumir tabaco

Tal vez esté motivado por los riesgos para la salud. O por el dinero que ahorra al abandonar el hábito. O bien a causa del disgusto que las personas que no mastican demuestran cuando le ven masticar y escupir, sienten su mal aliento o ven sus dientes manchados con tabaco. Posiblemente sea por *todas estas razones.*

Marque las razones a continuación que justifican su decisión de dejar de consumir tabaco:

☐ Deseo mejorar mi salud y prevenir el cáncer de boca y de otro tipo, las enfermedades cardíacas y la presión arterial alta relacionados con masticar nicotina.

☐ Quiero ahorrar dinero. *(¡Imagine lo que podría hacer con ese ahorro!)*

☐ Quiero evitar el consecuente mal aliento, la enfermedad de las encías y la pérdida de dientes y las caries.

☐ Quiero ser un mejor ejemplo para mis hijos.

☐ Quiero evitar el disgusto (y el rechazo) de otros.

☐ Me quiero sentir mejor conmigo mismo.

☐ Quiero liberarme de la adicción a la nicotina.

☐ Otras razones: _____

_____

_____

_____

_____

_____

_____

Valores fundamentales

Es posible que haya comenzado a masticar tabaco a una edad temprana sin prestar atención a las posibles consecuencias. Con el tiempo, probablemente haya aprendido o cambiado sus puntos de vista con respecto a lo que es *realmente* importante o un *valor fundamental* para usted. Los valores fundamentales incluyen cosas como la familia, la fe, la buena salud y la seguridad financiera. Use el cuadro a continuación para identificar sus valores fundamentales *actuales* y si el tabaco sin humo tiene algo que ver con ellos. *(Hay un ejemplo en la primera fila que le puede orientar).*

Valor fundamental: Lo que es importante para mí	Por qué esto es importante para mí	Cómo el uso del tabaco sin humo se interpone en lo que es importante para mí
Ejemplo: Familia	Me gusta dedicarle tiempo a mis hijos y quiero ser un buen padre.	Mis hijos dicen que tengo muy mal aliento y no quieren estar cerca de mí y hacer cosas conmigo.

Fije una fecha para dejar de consumir tabaco

La fecha para *dejar de consumir tabaco* es el día en que planifica dejar de usar tabaco sin humo. A esta fecha la elije usted. Pero los estudios muestran que establecer una fecha para dejar de consumir tabaco dentro de las dos semanas posteriores a tomar la decisión de dejar de consumir aumenta ampliamente las probabilidades de éxito. Marque con un círculo la fecha seleccionada en un calendario. Coloque recordatorios de su fecha para dejar de consumir tabaco en lugares en donde los vea todos los días. Esto le ayudará a mantener el rumbo. Cuénteles a sus amigos, familiares y compañeros de trabajo su plan. Pídales ayuda.

4 Controlar el impulso de consumir tabaco

Es común *desear* masticar tabaco después de dejar de consumir

Algunos motivos son:

- La nicotina que contiene el tabaco es *altamente adictiva*. (Consulte *Medicamentos que ayudan a dejar de consumir tabaco* en la página **15** para ver recomendaciones sobre maneras de frenar los síntomas de abstinencia de nicotina).
- Es posible que esté acostumbrado a masticar durante ciertas actividades y horas del día.
- Estar cerca de otros fumadores o consumidores de tabaco sin humo puede despertar la tentación.

La buena noticia es que hay muchas maneras de controlar los impulsos. Es posible que le lleve días, semanas o incluso meses. Pero *definitivamente* los superará, y se adaptará a vivir *sin consumir tabaco.*

Aparte su mente del impulso de masticar tabaco

Para prevenir o resistir la tentación:

- **Haga ejercicio o camine.** *Haga ejercicio o camine. Obtenga la aprobación de su médico antes de comenzar un nuevo plan de acondicionamiento físico.*
- **Cambie su rutina diaria,** especialmente en los momentos en los que por lo general masticaba tabaco.
- **Evite estar cerca de fumadores o personas que mastican tabaco.** Dígales a sus amigos fumadores o consumidores de tabaco sin humo que los está evitando.
- **Otras ideas:** _____

_____

_____

_____

Elija sustitutos más saludables

Es posible que extrañe tener algo en la boca después de abandonar el hábito de consumir tabaco. Use productos sin tabaco como sustituto. Algunas sugerencias:

- **Coloque caramelos duros sin azúcar** o goma de mascar en el lugar de la boca donde solía colocar el tabaco. Algunas personas afirman que consumir semillas de girasol (moderadamente) es un buen sustituto.
- **Use una mezcla de hierbas *sin tabaco* de reemplazo.** Se puede comprar en línea y en muchas tiendas de autoservicio. No hay evidencia científica concluyente que indique que esto ayuda. Pero muchos de nuestros exconsumidores dicen que los ayudó. *Confirme que el sustituto de hierbas que use no contenga tabaco.* (Consulte la *Guía para dejar de consumir tabaco sin humo de la Sociedad Estadounidense del Cáncer*).
- **Mastique un escarbadientes o una pajilla corta.**

- **Otras ideas:** _____

_____

_____

_____

_____

_____

_____

_____

Derrote los pensamientos riesgosos

Después de dejar de consumir, es posible que tenga pensamientos que hagan que resulte más complicado permanecer libre de tabaco. Esos "pensamientos derrotistas" son comunes y pueden causar una reincidencia. Los siguientes son algunos ejemplos de cómo transformar los pensamientos negativos en pensamientos positivos o útiles.

Pensamiento negativo	Pensamiento positivo
"Está bien, quiero masticar tabaco ahora mismo. ¡Me lo merezco!"	Sí, realmente quiero masticar. Pero no me ayudará a sentirme mejor o a abandonar el hábito. Sé que el impulso pasará si hago algo para alejar mi mente del deseo de consumir. Además, me prometí a mí mismo que dejaría de consumir".
"No puedo imaginar no meterme una pizca de tabaco en la boca nunca más. Así que solo será una ahora".	"No es necesario que deje de consumir para siempre. Solo debo parar por hoy, ¡y puedo hacerlo! Debo pedir ayuda a mi equipo de apoyo".

Otras ideas para convertir pensamientos negativos en pensamientos positivos:

_____

_____

_____

_____

_____

Practique técnicas de relajación y para enfrentar desafíos

Dejar de consumir tabaco puede resultar estresante. Los ejercicios de relajación como los siguientes pueden ayudar a aliviar la ansiedad.

Respiración profunda:

- Vaya a un lugar donde pueda sentarse y relajarse.
- Desconecte todos los dispositivos electrónicos (computadora, teléfono móvil, televisor).
- Respire profundamente por la nariz e infle el estómago.
- Contenga la respiración durante cinco segundos.
- Exhale lentamente por la boca. Espere cinco segundos.
- Diga en voz alta la palabra "relajación". Repita este ejercicio durante 5 minutos.

Relajación muscular progresiva*:

- Siéntese en un lugar cómodo en el que no haya distracciones. (Tal vez desee recostarse en el piso). Quítese los zapatos.
- Respire normalmente. Perciba cómo se siente el cuerpo de pies a cabeza.
- Contraiga los dedos de los pies fuertemente como si tratara de apretar una pelota pequeña entre los dedos y la parte inferior del pie.
- Sostenga esta contracción durante 10 segundos. Afloje y extienda los dedos.
- Repita este ejercicio con las pantorrillas, las manos, los brazos, la parte superior de la espalda y la cara.
- Respire profundo durante algunos segundos. Perciba cómo se sienten ahora todas las partes del cuerpo.

* *No intente esta práctica mientras conduce, cuida niños, opera equipos pesados o hace otras actividades que requieran su atención completa.*

Asegúrese de que no haya tabaco en su espacio

Deshágase de todos los productos de tabaco o cosas que le recuerden su consumo. Es clave desechar *todos* los productos de tabaco (y las cosas que le recuerdan el consumo) cuando decida abandonar el hábito. Mantenerlos a la vista puede hacer que resulte más difícil abandonar el hábito y *permanecer* libre de tabaco. La noche antes de dejar de consumir, haga correr agua sobre todo el tabaco que le haya quedado y deséchelo.

Evite estar cerca de fumadores y otras personas que mastican tabaco

Pídales a sus amigos que no fumen ni mastiquen tabaco a su alrededor. Puede resultar más difícil dejar de consumir si uno se encuentra cerca de otras personas que mastican o fuman tabaco, especialmente en los primeros días o semanas después de abandonar el hábito. ¿No puede evitar completamente estar cerca de ellos? *Simplemente diga "no".* O piense en otras respuestas si le ofrecen mezcla para masticar. Tenga a mano sustitutos (caramelos, pastillas de menta, semillas de girasol) para ponerse en la boca en lugar de tabaco.

Pida ayuda

Informe a sus familiares, amigos y compañeros de trabajo que está pensando en dejar de consumir tabaco. Así, dejar de consumir puede ser más fácil y usted puede aumentar sus posibilidades de éxito. A medida que se prepara para dejar el hábito, considere en quién puede (o en quién desea) apoyarse más. Podría ser alguien a quien ve a diario o con quien puede comunicarse en momentos de crisis.

Una buena idea para comenzar es elegir a alguien que ya haya dejado de consumir tabaco y sepa de qué se trata. ¿No está seguro? Elija a alguien que usted sabe que estará presente en los momentos en que usted lo necesite.

Cómo pedir ayuda

Es posible que le resulte difícil pedir ayuda. Tal vez se sienta incómodo o piense que debería poder hacer esto por su cuenta. Una manera de acercarse a alguien es decir algo como lo siguiente: "Tengo pensado dejar de masticar tabaco en esta fecha. ¿Podría recurrir a ti en busca de ayuda si las cosas se complican para mí

Dígale a su persona (o equipo) de apoyo de qué manera puede ayudar. Posiblemente quiera que esta persona se comunique con usted a diario para ver cómo lo está haciendo. O tal vez solo desee contar con una persona o un equipo de apoyo para recurrir a ellos cuando le parece que es necesario. Como usted desee. Permita que su persona o equipo de apoyo sepa de antemano de qué manera usted desea que ellos ayuden. También puede llamar a su asesor para dejar de consumir *en cualquier momento.*

5 Medicamentos que ayudan a dejar de consumir tabaco

Cuando deje de usar tabaco sin humo, el cuerpo probablemente anhelará los efectos de la nicotina. Esto se denomina *abstinencia de nicotina.* Los síntomas incluyen dolor de cabeza, dificultad para concentrarse y/o sensación de ansiedad y enojo. Sentirse triste a veces es perfectamente normal. Pero es importante no reaccionar ante estas sensaciones ni descargarse con otras personas. Intente hacer ejercicios de relajación para controlar estas sensaciones. Algunos medicamentos también pueden ayudar a frenar los síntomas de abstinencia de nicotina.

Tratamiento de reemplazo de la nicotina (TRN)

El TRN ayuda a frenar los síntomas de abstinencia reemplazando la nicotina sin otras sustancias químicas dañinas del tabaco. La Administración de Alimentos y Medicamentos (FDA) aprobó su uso para ayudar a las personas a dejar de fumar. Pero los estudios demuestran que también ayudan a reducir los síntomas de abstinencia entre las personas que tratan de dejar de masticar tabaco.

Existen cinco tipos de TRN. Cada uno libera lo que se considera niveles seguros de nicotina, y por lo general se los usa durante 8 a 12 semanas (para reemplazar la nicotina del tabaco). Pregunte a su médico si el TRN puede ayudarle y si es así, qué tipo es el mejor en su caso. *Úselo solamente de la manera en que se le indicó.*

Parche de nicotina. Se trata de un parche que se adhiere a la piel. El parche se aplica una vez al día después de despertarse. Libera lentamente la nicotina en el cuerpo. Los parches vienen en diferentes potencias. Son fáciles de usar. Son de venta libre (sin receta) y se los puede comprar en la mayoría de las farmacias.

Goma de mascar de nicotina. Viene en dos potencias: 2 miligramos (mg) y 4 mg. Por lo general se usa durante todo el día. La goma de mascar de nicotina no se mastica como un chicle común. Se coloca un trozo en la boca y se lo mastica varias veces. Luego se lo coloca en un ángulo de la boca y se lo deja allí durante varios minutos. Se lo mastica unas veces más, y nuevamente se lo deja en un ángulo de la boca. La nicotina que libera la goma de mascar es absorbida por los tejidos de la boca. La goma de mascar se desecha luego de usarla durante 20 a 30 minutos. *Disponible sin receta.*

Pastilla de nicotina. Estas también vienen en dos dosis de nicotina (2 mg y 4 mg). Pero no se mastican. Se colocan en la boca y se las mueve de un lado a otro. La nicotina que libera la pastilla es absorbida por los tejidos de la boca. *Disponible sin receta.*

Aerosol nasal de nicotina. Ese medicamento debe ser recetado por un médico. Actúa más rápidamente que las terapias anteriores y se usa durante todo el día. Además, es más costoso que el parche, la goma de mascar y las pastillas.

Inhalador de nicotina. Debe ser recetado por un médico. Se aplica mediante disparo. Libera pequeñas cantidades de nicotina con cada disparo. No debe inhalar la nicotina desde este dispositivo. Puede irritar la garganta y los pulmones. La nicotina que libera el dispositivo es absorbida por los tejidos de la boca. Su médico le dirá con qué frecuencia puede usarlo. Cuesta más que el parche, la goma de mascar y las pastillas.

Combinaciones de TRN. Puede usar el parche de nicotina con otro medicamento para dejar el consumo para proporcionar alivio adicional. El parche ofrece una dosis uniforme de nicotina. Otros tipos de TRN se pueden usar con regularidad (durante todo el día) o según sea necesario, para ayudar a combatir el impulso de consumir tabaco. Otros dos medicamentos recetados que se usan para combatir los impulsos de consumir tabaco son la *vareniclina* (Chantix®) y el *bupropión de liberación prolongada* (Zyban®). Estos medicamentos *no* contienen nicotina.

Su médico o farmacéutico pueden ofrecerle más información acerca

de todos estos medicamentos. Entregue a su médico una lista de todos los medicamentos que toma, incluidos los medicamentos recetados y de venta libre, vitaminas y suplementos. Aprenda cuáles son los efectos secundarios posibles de todos los medicamentos.

Averigüe si sus beneficios de salud cubren alguna de estas terapias o todas.

La forma correcta de usar medicamentos para dejar de consumir tabaco

Algunas personas dicen que los medicamentos para dejar de consumir tabaco no les sirvieron de ayuda. En muchos casos, esto se debe a que no lograron usarlos de la forma correcta. Siempre siga las indicaciones de manera *exacta*. ¿Tiene preguntas? Hable con su médico o farmacéutico. Otros consejos:

- Úselos todos los días o según las recomendaciones de su médico.
- La goma de mascar de nicotina, el inhalador y el aerosol nasal son más efectivos cuando se los usa *cada una o dos horas todos los días* durante las primeras cuatro semanas de uso.
- Use la goma de mascar según las indicaciones. Recuerde: *No* se mastica como un chicle común. *Si la mastica como un chicle común no funcionará bien y probablemente le cause malestar estomacal.*
- Use el parche todos los días. Cámbielo de lugar todos los días para evitar picazón o irritación de la piel.
- La vareniclina y el bupropión de liberación prolongada deben comenzar a tomarse preferentemente una o dos semanas *antes* de dejar de consumir. Es clave seguir las instrucciones del médico o farmacéutico.

(Consulte las páginas 15 y 16 para obtener más información sobre TRN).

6 Otras formas de dejar de consumir tabaco

Cambie a una mezcla con menor contenido de nicotina

Algunos tipos de tabaco sin humo contienen más nicotina que otros. Si está usando un tipo de tabaco cortado fino, intente cambiar a una variedad de corte más largo unas semanas antes de comenzar con el proceso de dejar de consumir. Hacer esto puede hacer que abandonar el hábito resulte más fácil debido a que el cuerpo se acostumbrará a menos nicotina.

Si elige esta opción, es importante *no* usarla como excusa para consumir trozos o pizcas *más grandes. Recordatorio: Menos nicotina no hace que el tabaco sin humo sea más seguro. Solo significa que contiene menos nicotina por trozo.*

Reduzca las pizcas

Reducir la cantidad de trozos o pizcas que consume es otra manera de prepararse para dejar de consumir. Lleve un registro de las pizcas que usa cada día, y comience a saltear algunas. Esto ayudará a medida que se acerca a su fecha para dejar de consumir. Si usa este método, es importante no usar trozos o pizcas *más grandes.* Eso derrotará su propósito.

Método de disminución gradual en dos semanas

Esto ayuda a reducir la ingesta de nicotina *antes* de dejar de consumir. Para disminuir gradualmente aun más, sume una semana o dos más al proceso.

Paso 1: Lleve un registro de la cantidad de trozos o pizcas que usa cada día durante algunos días. Registre la hora del día, lo que estaba haciendo o sintiendo y con quién estaba en el momento de consumir.

Paso 2: Reduzca la cantidad de pizcas a una o dos por día. Por ejemplo, si normalmente usa 15 pizcas al día, elimine una de ellas.

Al final de la semana, idealmente habrá reducido la cantidad a cero.

Paso 3: Comience a usar su capacidad de soportar situaciones y los medicamentos para dejar de consumir tabaco (si opta por usar uno) en su fecha para dejar de consumir (a menos que se le indique comenzar antes). Llame a su asesor para dejar de consumir según sea necesario. Busque el apoyo de familiares y amigos.

Use sustitutos a base de hierbas

El "tabaco para escupir" de hierbas tiene un sabor similar al tabaco común pero no contiene tabaco. Se puede comprar en línea y en la mayoría de las tiendas de autoservicio. (Algunas marcas: Mint Chew, Golden Eagle® Herbal Chew y Smoky Mountain® Herbal Chew).
Confirme que el sustituto de hierbas que use no contenga tabaco.

Cómo reducir el consumo con sustitutos a base de hierbas:

Semana 1: Registre la cantidad de latas o bolsas de tabaco sin humo que usa en una semana en el calendario de la página siguiente.

Semana 2: Vacíe en un plato la cantidad de tabaco semanal que habitualmente consume. Retire un cuarto del tabaco. Mezcle el sustituto a base de hierbas con el tabaco remanente. *Refrigere la mezcla en un contenedor sellado para mantenerla fresca.* ***Nota: Es muy importante mezclar muy bien el tabaco y el sustituto a base de hierbas.***

Nota: El tabaco de "corte largo" se mezcla bien con los sustitutos a base de hierbas de corte largo, y el tabaco de corte fino con los sustitutos de corte fino.

Semana 3: Repita lo que hizo en la semana 2, pero esta vez saque la mitad del tabaco y reemplácelo con el sustituto a base de hierbas. *Refrigere en un contenedor sellado. Tome un suministro fresco diariamente.*

Semana 4: Esta es la semana en la que va por todo ¡y deja el tabaco de mascar!

Semana:	Calendario de reducción en cuatro semanas con sustitutos a base de hierbas						
	Dom	Lun	Mar	Mié	Jue	Vie	Sáb
1							
2							
3							
4							

Método abrupto *("Cold Turkey")*

Algunas personas prefieren dejar de consumir en forma abrupta. Si opta por este método, es posible que tenga más síntomas de abstinencia de nicotina en los primeros días o semanas después de dejar.

Tipos de tabaco sin humo	
Rapé húmedo	La forma más popular de tabaco para escupir. Este rapé cortado fino en general libera más nicotina que el tabaco de corte más largo. Algunas marcas de rapé húmedo contienen más nicotina que otras.
Snus	Se inserta bajo el labio superior. No se escupe porque no hay glándulas salivales en la parte superior de la boca (y por lo tanto no se produce saliva). La mayoría de los snus estadounidenses contienen mayor cantidad de agentes cancerígenos (que los snus importados).
Tabaco de mascar	Tabaco para escupir que frecuentemente contiene edulcorantes y está saborizado con regaliz. Los consumidores generalmente colocan un trozo grande en la boca. Lo mascan. Lo colocan en un ángulo de la boca. Y después escupen la saliva con tabaco.

Tipos de tabaco sin humo *(continuación)*

Tabaco soluble	Viene en gránulos, rollos (del tamaño de un mondadientes), tiras delgadas para la lengua y otros productos solubles. Se hace con tabaco finamente molido. Viene en diversos sabores como *wintergreen* Se disuelve lentamente entre cinco y 20 minutos. No es necesario escupir.
Bloques, pastillas y trenzas/ rollos	Todas las variedades (salvo el tabaco enrollado) en general se mezclan con melaza u otros edulcorantes y se prensan en pastillas o bloques cuadrados. Los usuarios rompen o muerden un trozo, lo mascan y escupen el jugo de tabaco.
Iq'mik	Una mezcla de hojas de tabaco y ceniza (de un hongo del abedul) usada más comúnmente por los nativos de Alaska. Se puede comprar en tiendas en las zonas rurales de Alaska. La combinación de ceniza y hojas hace que la nicotina se absorba con más facilidad en la boca. Este tipo de tabaco puede venir precortado en "dosis" individuales y guardarse en una lata para uso posterior.
Gutkha, khaini y pan masala	Productos originarios de África, India y Asia, disponibles en los EE.UU. Contienen tabaco cortado, triturado o en polvo. El tabaco puede estar mezclado con cal muerta, ceniza u otros saborizantes para aumentar el efecto de la nicotina y mejorar el sabor. Con frecuencia se comercializan como producto "natural" o "tradicional", pero causan los mismos riesgos para la salud que el tabaco.
Rapé seco	Forma de tabaco seco en polvo. Los usuarios toman una pequeña cantidad entre los dedos pulgar e índice y lo colocan bajo la nariz. Lo inhalan. A algunas personas les causa estornudos. Algunos usuarios también colocan una pizca entre el labio y la encía. Esta forma es menos popular en la actualidad.

Para obtener más información sobre los tipos de tabaco sin humo y su contenido de nicotina, visite el sitio: *http://www.fda.gov/TobaccoProducts/Labeling/ProductsIngredientsComponents/ucm482582.htm*

7 Hoja de trabajo del plan para dejar de consumir tabaco

Fije una fecha para dejar de consumir tabaco:

Mi *fecha planificada para dejar de consumir* es el _____

Marque esta fecha en su calendario. Fije una fecha dentro de las próximas dos o tres semanas. Coloque en su teléfono móvil un recordatorio de la fecha para dejar de consumir. También puede poner recordatorios en la puerta del refrigerador y avisar a sus amigos a través de *Facebook* o *Twitter*.

Elija un medicamento para reducir el deseo de consumir nicotina (si desea utilizar alguno):

Usar un medicamento para dejar de consumir tabaco puede facilitar el proceso. ¿Piensa usar un medicamento? Pregunte a su médico sobre las diferentes opciones con y sin receta.

Pienso usar _____

_____

como medicación de apoyo para dejar de consumir tabaco.

¿Cómo puedo manejar los síntomas de abstinencia de tabaco?

☐ **Distracciones.** Voy a hacer estas actividades para mitigar el deseo de mascar tabaco:

_____

_____

_____

_____

☐ **Sustitutos.** Voy a tener estos sustitutos a la mano.

_____

_____

_____

☐ **Pensamientos riesgosos.** Coloque esto donde pueda verlo todos los días (en la puerta del refrigerador o en el espejo del baño).

Pensamientos negativos/riesgosos: _____

_____

_____

_____

_____

Pensamientos positivos/útiles: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Voy a crear un área libre de tabaco:

☐ Desechando todo mi tabaco y los productos relacionados.

☐ Evitando a otros mascadores y fumadores.

☐ Eliminado todos los recordatorios del tabaco sin humo del hogar y el lugar de trabajo.

Mi equipo de apoyo:

Familia _____

_____

_____

_____

Amigos _____

_____

8 Cómo evitar volver a consumir tabaco

A algunas personas les resulta fácil dejar de consumir y mantenerse firmes con el programa. Otras pueden tener más problemas. Si ya una vez lo intentó y falló, posiblemente sepa qué fue lo que le impidió tener éxito. Trate de recordar cómo y cuándo comenzó otra vez a consumir tabaco y qué puede cambiar para evitar una nueva recaída. Hable con su asesor para dejar de consumir. Esta persona le ayudará a liberarse del tabaco *para siempre*.

Es normal pensar que está bien consumir "solo un trocito o una pizca" después de dejar. Repítase siempre *por qué* quiso dejar de consumir. *Comprométase* a no consumir tabaco, un día por vez. Los éxitos se acumularán. Pronto verá que transcurren días —y después semanas— sin ni siquiera pensar en consumir tabaco.

El modelo ACE

El *modelo ACE* es una herramienta que puede utilizar para mantenerse libre de tabaco. La "A" significa *avoid (evitar)*, la "C" *cope (soportar)* y la "E" *escape (escapar)*. La clave es *evitar situaciones riesgosas*. Si no logra evitarlas, *use su capacidad de "soportar"* (lo que incluye su sistema de apoyo, distracciones y sustitutos). Si su capacidad de soportar falla, intente *escapar de la situación*. Salga de donde esté e intente desviar su mente del deseo de consumir un trozo o una pizca de tabaco. Ocúpese con otra cosa. La urgencia *seguro* pasará.

Otras recomendaciones para mantenerse libre de tabaco:

- No tome una pizca, no importa lo fuerte que sea la tentación.
- Evite estar con otros mascadores o fumadores, especialmente en los primeros tiempos después de dejar de consumir.
- Tome todos los días el medicamento para dejar de consumir, según las indicaciones.

- Cambie su rutina. Evite los disparadores del consumo de tabaco.
- Use su sistema de apoyo.
- Prémiese por dejar de consumir tabaco. Sustituya el tabaco con otras actividades recreativas o saludables para recordarse a sí mismo que no solo se trata de hacer sacrificios.
- Evite o limite el consumo de alcohol, especialmente durante las primeras etapas después de dejar el tabaco.
- Aprenda a manejar el estrés sin el tabaco. Esto le resultará más fácil con el transcurso del tiempo.

Estamos aquí para ayudarle

No es fácil dejar de consumir tabaco para siempre. Pero sabemos que puede lograrlo. Miles de usuarios de tabaco sin humo han logrado dejar de consumir usando este programa. ¿Necesita más ayuda? *Llame a su asesor para dejar de consumir en cualquier momento. ¡Estamos aquí para ayudarle!*

¿Preguntas?

Recuerde: Como parte del programa puede contactar a un asesor para dejar de consumir si tiene preguntas o inquietudes. *¡Llame en cualquier momento!*

Consulte los Recursos a continuación para obtener más información.

Recursos

American Cancer Society
(Sociedad Americana contra el Cáncer)
http://www.cancer.org

Centers for Disease Control and Prevention (CDC)
(Centros para el Control y la Prevención de las Enfermedades)
http://www.cdc.gov

National Cancer Institute
(Instituto Nacional del Cáncer)
http://cancer.gov

National Institutes of Health
(Institutos Nacionales de Salud)
http://nidcr.nih.gov

The Oral Cancer Foundation
(Fundación contra del Cáncer Oral)
http://oralcancerfoundation.org/tobacco/tobacco-forms-types.php

Referencias

American Cancer Society (Sociedad Americana contra el Cáncer): http://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/smokeless-fact-sheet y http://www.cancer.org/cancer/cancercauses/tobaccocancer/smokeless-tobacco

National Cancer Institute (Instituto Nacional del Cáncer): http://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/smokeless-fact-sheet

Centers for Disease Control and Prevention (Centros para el Control y la Prevención de Enfermedades): https://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/health_effects/) y http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/products_marketing/index.htm

Patricia Richter, Knachelle Hodge, Stephen Stanfill, Liquin Ahang, Clifford Watson. Surveillance of moist snuff: total nicotine, moisture, pH, un-ionized nicotine, and tobacco-specific nitrosamines. Marzo de 2008

Food and Drug Administration: http://www.fda.gov/TobaccoProducts/Labeling/ProductsIngredientsComponents/ucm482582.htm

National Institutes of Health: http://nidcr.nih.gov/oralhealth/topics/smokelesstobacco/smokelesstobaccoaguideforquitting.htm#Introduction

El programa Quit For Life® ofrece información relacionada con métodos para dejar el tabaco y apoyo de bienestar relacionado. Toda información médica que usted proporcione se mantendrá de manera confidencial de conformidad con la ley. El programa Quit For Life® no ofrece tratamiento clínico ni servicios médicos y no se debe considerar como un sustituto de atención médica. La participación en este programa es voluntaria. Si tiene preguntas o necesidades de atención médica específicas, consulte a un profesional de atención médica apropiado. Este servicio no debe usarse en caso de necesidad de atención de emergencia o urgencia. *En caso de emergencia, llame al 911 o diríjase a la sala de emergencias más cercana.*

Notas

Notas

Smoking & Cancer

What you should know and why you should quit

Cancer is an uncontrolled growth of cells. It can happen in many parts of the body and can spread to other parts of the body. Cigarette smoking causes 87% of lung cancer deaths and is the leading cause of cancer death in both men and women.

Smoking is also responsible for most cancers of the throat, mouth, esophagus, stomach, and bladder. It is a risk factor for cancers of the cervix, colon and rectum, kidney, pancreas, stomach and acute myeloid leukemia.

Your chance of getting cancer begins to decrease as soon as you quit smoking – even if you have been a heavy smoker for many years. Even if you already have cancer, quitting now may help you feel better and live longer. Quitting now also protects the health of those around you.

When you have Cancer and smoke:

- Smoking may make the side effects of cancer treatment worse and continuing to smoke makes it harder for your body to heal.
- Smoking while receiving radiation therapy, chemotherapy, or surgery for cancer makes these treatments less effective.
- Smoking can cause mutations in genes, damaging the way your lungs work and causing your immune system to not work as well as it should.
- If you continue to smoke, you are more likely to develop a second cancer in the same place or another type of cancer.

When you stop smoking:

- You are more likely to survive the cancer long term than if you keep smoking.
- You have less chance of developing other cancers.
- Complications from surgery are reduced and wounds heal faster.
- Your body heals from cancer treatment more easily.
- You are less likely to develop other diseases associated with smoking such as heart disease and stroke.
- Your family and friends breathe cleaner air, which protects them from increased risk of cancer. They can also worry less about you and your health.

330-001 (REV 08/16)

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Appendix A.1.37.a. Samples of Monthly Reports

OPTUM

Nebraska Tobacco Quitline
NRT Shipments

From 8/1/2019 through 8/31/2019

Registration ID	Participant ID	Ship #	Ship Date	Billable	Patch Weeks	Gum Boxes	Gum 2mg	Gum 4mg	Lozenge Boxes	Lozenge 2mg	Lozenge 4mg	Service Type	Status	Program
		1	8/1/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true		1	1					Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/1/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	4							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/2/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/5/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true					2		2	Integrated Help Line	Active	Quit For Life

OPTUM

Nebraska Tobacco Quitline
NRT Shipments

From 8/1/2019 through 8/31/2019

		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/6/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/7/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	No Calls	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/8/2019	true	2							Integrated Help Line	Active	Quit For Life

OPTUM

Nebraska Tobacco Quitline
NRT Shipments

From 8/1/2019 through 8/31/2019

		1	8/9/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/9/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/9/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/9/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/9/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/9/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/9/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/9/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/12/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/13/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/14/2019	true	2							Integrated Help Line	Active	Quit For Life - P
		1	8/14/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/14/2019	true					2	2		Integrated Help Line	Active	Quit For Life - P
		1	8/14/2019	true		1	1					Integrated Help Line	Active	Quit For Life
		1	8/14/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/14/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/14/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/14/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/14/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life

OPTUM

Nebraska Tobacco Quitline
NRT Shipments

From 8/1/2019 through 8/31/2019

		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/15/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/16/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/19/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/19/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/19/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/19/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/19/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/19/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/19/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/20/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true		1		1				Integrated Help Line	Active	Quit For Life

OPTUM

Nebraska Tobacco Quitline
NRT Shipments

From 8/1/2019 through 8/31/2019

		1	8/21/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/21/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true		1	1					Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true		1	1					Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/22/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/23/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/27/2019	true	4							Integrated Help Line	Active	Quit For Life
		1	8/27/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/27/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/27/2019	true		1		1				Integrated Help Line	Active	Quit For Life

OPTUM

Nebraska Tobacco Quitline
NRT Shipments

From 8/1/2019 through 8/31/2019

		1	8/28/2019	true		2		2				Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	4							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/28/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true	4							Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true		1		1				Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/29/2019	true		1	1					Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	4							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true					2		2	Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true					2	2		Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true	2							Integrated Help Line	Active	Quit For Life
		1	8/30/2019	true		1		1				Integrated Help Line	Active	Quit For Life

OPTUM

Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed & Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid/Nebraska Total Care	8/1/2019												
Medicaid/Nebraska Total Care	7/8/2019												
Medicaid Other	7/31/2019												
Medicaid Other	8/25/2019												
Medicaid/Nebraska Total Care	7/8/2019												
Medicaid/Nebraska Total Care	8/7/2019												
Medicaid/United Healthcare Community	8/13/2019												
Medicaid/United Healthcare Community	7/1/2019												
Medicaid/United Healthcare Community	8/22/2019												
Medicaid/WellCare of Nebraska	8/26/2019												
Medicaid/Nebraska Total Care	7/15/2019												
Medicaid Other	8/14/2019												
Medicaid/Nebraska Total Care	7/30/2019												
Medicaid/WellCare of Nebraska	8/8/2019												
Medicaid Other	6/22/2019												
Medicaid/WellCare of Nebraska	8/26/2019												
M[illegible] United Healthcare Community	8/2/2019												
M[illegible] Nebraska Total Care	8/22/2019												
Medicaid/Nebraska Total Care	8/1/2019												
Medicaid/Nebraska Total Care	6/7/2019												
Medicaid/Nebraska Total Care	8/23/2019												
Medicaid/WellCare of Nebraska	8/1/2019												
Medicaid/United Healthcare Community	8/6/2019												
Medicaid/Nebraska Total Care	1/26/2019												
Medicaid/Nebraska Total Care	8/7/2019												
Medicaid/Nebraska Total Care	8/22/2019												
Medicaid/Nebraska Total Care	1/19/2018												
Medicaid/Nebraska Total Care	8/5/2019												
Medicaid/Nebraska Total Care	8/29/2019												
Medicaid/Nebraska Total Care	8/6/2019												
Medicaid/Nebraska Total Care	4/9/2019												
Medicaid Other	8/24/2019												
Medicaid/Nebraska Total Care	7/3/2019												
Medicaid/United Healthcare Community	3/22/2019												
Medicaid/United Healthcare Community	8/8/2019												
Medicaid/United Healthcare Community	7/8/2019												
Medicaid/United Healthcare Community	8/7/2019												
Medicaid/United Healthcare Community	4/3/2019												
Medicaid Other	8/9/2019												
Medicaid/WellCare of Nebraska	7/31/2019												
Medicaid/United Healthcare Community	7/31/2019												
Medicaid/WellCare of Nebraska	6/20/2019												

OPTUM

Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed & Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid Other	6/13/2019												
Medicaid/Nebraska Total Care	8/19/2019												
Medicaid/Nebraska Total Care	7/16/2019												
Medicaid Other	8/11/2019												
Medicaid/Nebraska Total Care	7/9/2019												
Medicaid/United Healthcare Community	7/27/2019												
Medicaid/Nebraska Total Care	8/19/2019												
Medicaid/Nebraska Total Care	8/5/2019												
Medicaid/United Healthcare Community	8/2/2019												
Medicaid/Nebraska Total Care	7/17/2019												
Medicaid Other	7/31/2019												
Medicaid/Nebraska Total Care	8/12/2019												
Medicaid/United Healthcare Community	7/13/2019												
Medicaid/WellCare of Nebraska	8/24/2019												
Medicaid Other	8/21/2019												
Medicaid/United Healthcare Community	8/27/2019												
M[illegible] United Healthcare Community	6/25/2019												
M[illegible] United Healthcare Community	8/3/2019												
Medicaid Other	8/27/2019												
Medicaid/Nebraska Total Care	5/20/2019												
Medicaid/United Healthcare Community	8/15/2019												
Medicaid Other	7/30/2019												
Medicaid/Nebraska Total Care	6/12/2019												
Medicaid/Nebraska Total Care	4/24/2019												
Medicaid/WellCare of Nebraska	8/5/2019												
Medicaid Other	8/20/2019												
Medicaid/WellCare of Nebraska	8/20/2019												
Medicaid Other	7/5/2019												
Medicaid/WellCare of Nebraska	8/26/2019												
Medicaid/United Healthcare Community	8/2/2019												
Medicaid/Nebraska Total Care	5/28/2019												
Medicaid/United Healthcare Community	8/27/2019												
Medicaid/WellCare of Nebraska	8/20/2019												
Medicaid/United Healthcare Community	8/30/2019												
Medicaid/Nebraska Total Care	8/6/2019												
Medicaid/United Healthcare Community	7/1/2019												
Medicaid/United Healthcare Community	8/8/2019												
Medicaid/WellCare of Nebraska	8/5/2019												
Medicaid/United Healthcare Community	7/30/2019												
Medicaid/United Healthcare Community	8/22/2019												
Medicaid/Nebraska Total Care	7/22/2019												
Medicaid/Nebraska Total Care	8/18/2019												

OPTUM

Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed at Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid/United Healthcare Community	3/28/2019												
Medicaid Other	8/15/2019												
Medicaid/Nebraska Total Care	8/2/2019												
Medicaid/WellCare of Nebraska	7/22/2019												
Medicaid/WellCare of Nebraska	7/12/2019												
Medicaid/WellCare of Nebraska	8/18/2019												
Medicaid/WellCare of Nebraska	8/8/2019												
Medicaid/Nebraska Total Care	8/14/2019												
Medicaid/Nebraska Total Care	8/10/2018												
Medicaid/Nebraska Total Care	8/2/2019												
Medicaid/WellCare of Nebraska	7/8/2019												
Medicaid/WellCare of Nebraska	8/31/2019												
Medicaid/Nebraska Total Care	7/31/2019												
Medicaid/Nebraska Total Care	8/20/2019												
Medicaid/Nebraska Total Care	2/4/2019												
Medicaid/Nebraska Total Care	8/26/2019												
M[illegible]nited Healthcare Community	8/19/2019												
M[illegible]nited Healthcare Community	7/31/2019												
Medicaid/Nebraska Total Care	6/20/2019												
Medicaid/United Healthcare Community	7/24/2019												
Medicaid/United Healthcare Community	6/5/2019												
Medicaid/United Healthcare Community	8/1/2019												
Medicaid/Nebraska Total Care	8/29/2019												
Medicaid/United Healthcare Community	8/12/2019												
Medicaid/United Healthcare Community	6/11/2019												
Medicaid/United Healthcare Community	8/29/2019												
Medicaid/Nebraska Total Care	7/19/2019												
Medicaid/WellCare of Nebraska	8/26/2019												
Medicaid/United Healthcare Community	6/13/2019												
Medicaid/United Healthcare Community	8/16/2019												
Medicaid/United Healthcare Community	5/15/2019												
Medicaid/United Healthcare Community	8/21/2019												
Medicaid Other	8/12/2019												
Medicaid/United Healthcare Community	7/23/2019												
Medicaid/WellCare of Nebraska	7/24/2019												
Medicaid/WellCare of Nebraska	8/15/2019												
Medicaid/United Healthcare Community	7/31/2019												
Medicaid/United Healthcare Community	8/30/2019												
Medicaid/United Healthcare Community	7/19/2019												
Medicaid/United Healthcare Community	8/25/2019												
Medicaid/United Healthcare Community	7/2/2019												
Medicaid/Nebraska Total Care	5/1/2019												

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Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed & Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid/United Healthcare Community	2/26/2019												
Medicaid/WellCare of Nebraska	8/22/2019												
Medicaid/United Healthcare Community	7/29/2019												
Medicaid/Nebraska Total Care	8/28/2019												
Medicaid/United Healthcare Community	6/19/2019												
Medicaid/WellCare of Nebraska	8/27/2019												
Medicaid/Nebraska Total Care	8/16/2019												
Medicaid/United Healthcare Community	9/25/2018												
Medicaid/WellCare of Nebraska	8/26/2019												
Medicaid/Nebraska Total Care	7/9/2019												
Medicaid/Nebraska Total Care	7/2/2019												
Medicaid/United Healthcare Community	8/27/2019												
Medicaid/United Healthcare Community	8/13/2019												
Medicaid/Nebraska Total Care	7/25/2019												
Medicaid/United Healthcare Community	8/22/2019												
Medicaid/United Healthcare Community	7/2/2019												
M[redacted]United Healthcare Community	5/31/2018												
N[redacted]United Healthcare Community	8/28/2019												
Medicaid/WellCare of Nebraska	8/21/2019												
Medicaid/United Healthcare Community	6/12/2019												
Medicaid/United Healthcare Community	8/13/2019												
Medicaid Other	8/5/2019												
Medicaid/United Healthcare Community	6/11/2019												
Medicaid/WellCare of Nebraska	6/12/2019												
Medicaid/WellCare of Nebraska	8/19/2019												
Medicaid/WellCare of Nebraska	8/21/2019												
Medicaid/Nebraska Total Care	8/12/2019												
Medicaid/United Healthcare Community	8/28/2019												
Medicaid/United Healthcare Community	5/15/2019												
Medicaid/United Healthcare Community	8/9/2019												
Medicaid/Nebraska Total Care	7/30/2019												
Medicaid Other	7/31/2019												
Medicaid/United Healthcare Community	7/30/2019												
Medicaid/Nebraska Total Care	8/2/2019												
Medicaid/Nebraska Total Care	5/30/2019												
Medicaid/Nebraska Total Care	8/7/2019												
Medicaid/WellCare of Nebraska	8/16/2019												
Medicaid Other	7/29/2019												
Medicaid/Nebraska Total Care	7/11/2019												
Medicaid/United Healthcare Community	8/2/2019												
Medicaid/Nebraska Total Care	8/2/2019												
Medicaid Other	7/30/2019												

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Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed & Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid Other	8/19/2019												
Medicaid/Nebraska Total Care	6/11/2019												
Medicaid/Nebraska Total Care	8/10/2019												
Medicaid/United Healthcare Community	5/31/2019												
Medicaid/United Healthcare Community	9/6/2018												
Medicaid/Nebraska Total Care	8/30/2019												
Medicaid Other	7/8/2019												
Medicaid Other	8/16/2019												
Medicaid/United Healthcare Community	8/12/2019												
Medicaid/United Healthcare Community	8/19/2019												
Medicaid Other	8/30/2019												
Medicaid/United Healthcare Community	8/24/2019												
Medicaid/United Healthcare Community	6/20/2019												
Medicaid/United Healthcare Community	8/21/2019												
Medicaid/Nebraska Total Care	7/30/2019												
Medicaid/United Healthcare Community	7/15/2019												
M[illegible]nited Healthcare Community	8/27/2019												
M[illegible]VellCare of Nebraska	4/2/2019												
Medicaid/United Healthcare Community	7/18/2019												
Medicaid/United Healthcare Community	7/24/2019												
Medicaid Other	6/14/2019												
Medicaid Other	8/2/2019												
Medicaid/Nebraska Total Care	4/8/2019												
Medicaid/United Healthcare Community	8/20/2019												
Medicaid Other	8/13/2019												
Medicaid Other	7/26/2019												
Medicaid/WellCare of Nebraska	7/24/2019												
Medicaid/Nebraska Total Care	8/1/2019												
Medicaid/United Healthcare Community	6/12/2019												
Medicaid/United Healthcare Community	2/16/2019												
Medicaid/United Healthcare Community	8/19/2019												
Medicaid/Nebraska Total Care	8/22/2019												
Medicaid/Nebraska Total Care	3/21/2019												
Medicaid/United Healthcare Community	8/20/2019												
Medicaid Other	8/26/2019												
Medicaid Other	7/21/2019												
Medicaid/United Healthcare Community	7/18/2019												
Medicaid/United Healthcare Community	7/14/2019												
Medicaid/United Healthcare Community	8/1/2019												
Medicaid/WellCare of Nebraska	3/21/2019												
Medicaid/WellCare of Nebraska	7/21/2019												
Medicaid/WellCare of Nebraska	8/28/2019												

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Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed & Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid/WellCare of Nebraska	7/29/2019												
Medicaid/WellCare of Nebraska	8/14/2019												
Medicaid/United Healthcare Community	7/26/2019												
Medicaid/WellCare of Nebraska	8/14/2019												
WellCare of Nebraska	6/27/2019												
Medicaid/United Healthcare Community	8/28/2019												
Medicaid/United Healthcare Community	6/27/2019												
Medicaid Other	8/31/2019												
Medicaid/WellCare of Nebraska	8/22/2019												
Medicaid/Nebraska Total Care	8/29/2019												
Medicaid/Nebraska Total Care	7/9/2019												
Medicaid/United Healthcare Community	4/15/2019												
Medicaid/United Healthcare Community	4/16/2019												
Medicaid/WellCare of Nebraska	8/13/2019												
Medicaid/Nebraska Total Care	7/29/2019												
Medicaid/United Healthcare Community	7/31/2019												
M[illegible]nited Healthcare Community	8/8/2019												
M[illegible]Nebraska Total Care	8/27/2019												
Medicaid/Nebraska Total Care	8/12/2019												
Medicaid/United Healthcare Community	4/23/2019												
Medicaid/United Healthcare Community	8/28/2019												
Medicaid/Nebraska Total Care	1/17/2019												
Medicaid/Nebraska Total Care	7/5/2019												
Medicaid/United Healthcare Community	7/25/2019												
Medicaid Other	7/22/2019												
Medicaid/Nebraska Total Care	7/22/2019												
Medicaid/Nebraska Total Care	8/17/2019												
Medicaid Other	7/15/2019												
Medicaid/United Healthcare Community	7/2/2019												
Medicaid/United Healthcare Community	6/15/2019												
Medicaid/WellCare of Nebraska	6/26/2019												
Medicaid/WellCare of Nebraska	8/7/2019												
Medicaid/Nebraska Total Care	8/9/2019												
Medicaid/WellCare of Nebraska	7/15/2019												
Medicaid Other	8/7/2019												
Medicaid/WellCare of Nebraska	8/9/2019												
Medicaid/United Healthcare Community	8/15/2019												
Medicaid/United Healthcare Community	8/25/2019												
Medicaid/United Healthcare Community	7/9/2019												
Medicaid/Nebraska Total Care	8/21/2019												
Medicaid/WellCare of Nebraska	8/13/2019												
Medicaid/United Healthcare Community	7/18/2019												

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Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed in Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid/Nebraska Total Care	7/1/2019												
Medicaid/United Healthcare Community	8/20/2019												
Medicaid/Nebraska Total Care	8/9/2019												
Medicaid/United Healthcare Community	7/17/2019												
Medicaid/Nebraska Total Care	7/23/2019												
Medicaid/United Healthcare Community	8/23/2019												
Medicaid/United Healthcare Community	8/23/2019												
Medicaid/WellCare of Nebraska	6/20/2019												
Medicaid/WellCare of Nebraska	7/31/2019												
Medicaid/WellCare of Nebraska	8/29/2019												
Medicaid/WellCare of Nebraska	8/28/2019												
Medicaid Other	8/2/2019												
Medicaid/Nebraska Total Care	8/15/2019												
Medicaid/Nebraska Total Care	7/12/2019												
Medicaid/Nebraska Total Care	8/16/2019												
Medicaid/WellCare of Nebraska	8/26/2019												
M[redacted]VellCare of Nebraska	8/7/2019												
M[redacted]United Healthcare Community	7/12/2019												
Medicaid/Nebraska Total Care	6/26/2019												
Medicaid/Nebraska Total Care	8/14/2019												
Medicaid/Nebraska Total Care	8/5/2019												
Medicaid/Nebraska Total Care	8/20/2019												
Medicaid/Nebraska Total Care	8/16/2019												
Medicaid/United Healthcare Community	7/15/2019												
Medicaid/United Healthcare Community	8/8/2019												
Medicaid/WellCare of Nebraska	6/14/2019												
Medicaid/United Healthcare Community	7/24/2019												
Medicaid/WellCare of Nebraska	7/29/2019												
Medicaid/Nebraska Total Care	8/20/2019												
Medicaid/WellCare of Nebraska	8/28/2019												
Medicaid/United Healthcare Community	7/7/2019												
Medicaid/Nebraska Total Care	8/21/2019												
Medicaid Other	7/29/2019												
Medicaid/United Healthcare Community	8/2/2019												
Medicaid Other	7/24/2019												
Medicaid Other	7/16/2019												
Medicaid Other	7/18/2019												
Medicaid Other	8/10/2019												
Medicaid/WellCare of Nebraska	8/6/2019												
Medicaid/United Healthcare Community	4/29/2019												
Medicaid/Nebraska Total Care	6/26/2019												
Medicaid/United Healthcare Community	6/26/2019												

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Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed & Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid/United Healthcare Community	8/16/2019												
Medicaid/United Healthcare Community	8/1/2019												
Medicaid/United Healthcare Community	7/31/2019												
Medicaid/WellCare of Nebraska	6/9/2019												
Medicaid Other	5/23/2019												
Medicaid/WellCare of Nebraska	8/6/2019												
Medicaid/Nebraska Total Care	7/16/2019												
Medicaid Other	7/30/2019												
Medicaid Other	8/14/2019												
Medicaid/Nebraska Total Care	8/14/2019												
Medicaid/Nebraska Total Care	8/28/2019												
Medicaid/United Healthcare Community	8/20/2019												
Medicaid/Nebraska Total Care	8/2/2019												
Medicaid/United Healthcare Community	6/13/2019												
Medicaid/United Healthcare Community	8/17/2019												
Medicaid/Nebraska Total Care	7/23/2019												
M[illegible]ther	8/27/2019												
M[illegible]ebraska Total Care	7/18/2019												
Medicaid/WellCare of Nebraska	3/19/2019												
Medicaid/Nebraska Total Care	7/2/2019												
Medicaid/Nebraska Total Care	5/23/2019												
Medicaid/Nebraska Total Care	8/22/2019												
Medicaid/United Healthcare Community	7/5/2019												
Medicaid/United Healthcare Community	8/13/2019												
Medicaid/United Healthcare Community	8/23/2019												
Medicaid/Nebraska Total Care	8/15/2019												
Medicaid/United Healthcare Community	7/25/2019												
Medicaid/United Healthcare Community	8/20/2019												
Medicaid/Nebraska Total Care	6/3/2019												
Medicaid/Nebraska Total Care	8/4/2019												
Medicaid Other	7/22/2019												
Medicaid/United Healthcare Community	7/10/2019												
Medicaid/Nebraska Total Care	7/31/2019												
Medicaid/Nebraska Total Care	7/24/2019												
Medicaid/United Healthcare Community	7/26/2019												
Medicaid/United Healthcare Community	7/17/2019												
Medicaid/Nebraska Total Care	6/3/2019												
Medicaid/Nebraska Total Care	8/7/2019												
Medicaid/WellCare of Nebraska	8/19/2019												
Medicaid Other	1/11/2019												
Medicaid/WellCare of Nebraska	7/16/2019												
Medicaid/WellCare of Nebraska	6/28/2019												

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Nebraska Dept Of Health
Medicaid Billing Report
From 2019-8-1 Through 2019-08-31

Health Plan	Registration Date	Call 1's completed & Initial Registration - 1 Call	Completed Call 1	Completed Call 2	Completed Call 3	Completed Call 4	Completed Call 5	Completed Call 6-10	AdHoc	Patches	NRT - Gum	NRT - Lozenge	Total
Medicaid/WellCare of Nebraska	8/16/2019												
Medicaid/United Healthcare Community	8/28/2019												
Total													

Nebraska Tobacco Quitline

Tobacco Users by Health Plan Report

From 8/1/2019 through 8/31/2019
Contract Dates from 7/1/2019 through 8/31/2019

Execution Date/Time: 9/5/2019 11:52:59 AM

The purpose of this report is to display self-reported answers to the question about health insurance coverage during time of registration.

NOTE: Some participants may not know the name of their health plan. These participants fall into the 'Doesn't Know' category. If the health plan is not listed as an option, these participants fall in the 'Other' category. Percentage of total does not include 'Not Collected' and 'Refused'. It only includes those who have answered the question. Report includes Tobacco Users whose service is Intervention Requested, Materials Only or Transferred To (their health plan cessation benefit).

Commercial

Commercially Insured	Previous Month	Previous Month %	Contract YTD	Current YTD %
Blue Cross Blue Shield of Nebraska	13	31.7 %	23	27.7 %
Other (a health plan that is not Medicaid or Medicare)	24	58.5 %	42	50.6 %
UnitedHealthcare	4	9.8 %	18	21.7 %
Total	**41**	**12.9 %**	**83**	**13.0 %**
Total Commercial	**41**	**12.9 %**	**83**	**13.0 %**

Medicaid

Medicaid	Previous Month	Previous Month %	Contract YTD	Contract YTD %

Medicaid Insured	Previous Month	Previous Month %	Contract YTD	Current YTD %
Medicaid Other	23	13.3 %	56	15.9 %
Medicaid/Nebraska Total Care	53	30.6 %	108	30.6 %
Medicaid/United Healthcare Community	58	33.5 %	123	34.8 %
Medicaid/WellCare of Nebraska	39	22.5 %	66	18.7 %
Total	**173**	**54.2 %**	**353**	**55.2 %**
Total Medicaid	**173**	**54.2 %**	**353**	**55.2 %**

Medicare

Medicare	Previous Month	Previous Month %	Contract YTD	Contract YTD %

Medicare Insured	Previous Month	Previous Month %	Contract YTD	Current YTD %
Medicare Other	40	100.0 %	88	100.0 %
Total	**40**	**12.5 %**	**88**	**13.8 %**
Total Medicare	**40**	**12.5 %**	**88**	**13.8 %**

Uninsured	Previous Month	Previous Month %	Contract YTD	Contract YTD %
Uninsured	61	100.0 %	109	100.0 %
Total Uninsured	**61**	**19.1 %**	**109**	**17.1 %**

Other	Previous Month	Previous Month %	Contract YTD	Contract YTD %
Doesn't Know	4	50.0 %	6	37.5 %
Not Collected	2		5	
Refused	2		5	
Total Other	**8**	**1.3 %**	**16**	**0.9 %**

Total excluding Refused and Not Collected	**319**		**639**	
Grand Total	**323**		**649**	

Account Name Nebraska Tobacco Quit Inc AltName Nebraska Tobacco Quitline-Report Name State Tobacco Users by Health Plan-AutoDateSelect 12-Mo Age 18-Max Age 255 - Access Type Phone/Integrated Web - RDL Name Tobacco Users by Health Plan.rdl

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Report Execution Date/Time: 9/5/2019 12:20:51 PM

Nebraska Tobacco Quitline

Services Report - Pregnant Program

From 8/1/2019 through 8/31/2019

Contract Dates From 7/1/2019 through 8/31/2019

Summary of Services - Total Registered Callers

Note: The following section is based on the date that the caller registered for services.

	Period	Period %	Year	Year %
Integrated Help Line	4	100.0%	17	100.0%
Total	**4**		**17**	

Services By Caller Type

Tobacco User	Period	Period %	Year	Year %
Integrated Help Line - Pregnant	4	100.0%	17	100.0%
Total	**4**		**17**	

Summary of Services Provided

Note: Re-enrollments includes participants who have registered within the previous 12 months and who have opted for additional services.

Pregnant Tobacco User	Period	Period %	Year	Year %
Multiple Call Program	4	100.0%	16	94.1%
Registered This Period	4		15	
Registered Prior Period	-		1	
One Call Program	-	-	1	5.9%
Closed With Attempt	-		1	
Total	**4**		**17**	

Calls Completed

Includes Tobacco Users who have enrolled in the Multiple Call Program.

	Period	Period %	Year	Year %
Call 1 Completed with an Intervention	4	6.3%	13	9.9%
Call 2 Completed with an Intervention	3	4.8%	7	5.3%
Call 3 Completed with an Intervention	4	6.3%	7	5.3%
Call 4 Completed with an Intervention	2	3.2%	4	3.1%
Call 5 Completed with an Intervention	2	3.2%	3	2.3%
Call 6 Completed with an Intervention	1	1.6%	1	0.8%
Call 7 Completed with an Intervention	1	1.6%	1	0.8%
Call 8 Completed with an Intervention	1	1.6%	1	0.8%
Call 1 Completed with an Attempt	-	-	4	3.1%
Call 2 Completed with an Attempt	5	7.9%	13	9.9%
Call 3 Completed with an Attempt	8	12.7%	14	10.7%
Call 4 Completed with an Attempt	9	14.3%	16	12.2%
Call 5 Completed with an Attempt	4	6.3%	8	6.1%

Call 6 Completed with an Attempt	6	9.5%	6	4.6%
Call 7 Completed with an Attempt	-	-	4	3.1%
Call 8 Completed with an Attempt	3	4.8%	7	5.3%
Call 9 Completed with an Attempt	3	4.8%	6	4.6%
Call 10 Completed with an Attempt	5	7.9%	12	9.2%
Ad Hoc Calls with an Intervention	2	3.2%	4	3.1%

Pharmacotherapy - Participant Shipments

Includes Tobacco Users only.

Patch Only	**Period**	**Period %**	**Year**	**Year %**
Shipment 1	1	50.0%	5	55.6%
Total	**1**		**5**	
Lozenge Only	**Period**	**Period %**	**Year**	**Year %**
Shipment 1 - 2mg	1	50.0%	1	11.1%
Shipment 1 - 4mg	-	-	3	33.3%
Total	**1**		**4**	

Pharmacotherapy - Boxes Sent

Lozenge	**Period**	**Period %**	**Year**	**Year %**
2mg	2	100.0%	2	25.0%
4mg	-	-	6	75.0%
Total	**2**		**8**	

Quit Materials Sent

Includes all Caller Types. Note: The number of kits reflected on the report include kits that have a sent date within this period.

	Period	**Period %**	**Year**	**Year %**
Q4L Welcome Packet (Standard)	4	-	13	-
Total	**4**		**13**	

Web Coach Participant Summary

	Period	**Period %**	**Year**	**Year %**
Enrolled individuals with web accounts	2	-	8	-
Individuals with web accounts logging in for the first time	-	-	1	-
Logins - Average per Participant	1.0	-	1.0	-
Session Duration (Average Minutes)	-	-	0.0	-

Email Message Summary

	Period	Period %	Year	Year %
Total automated emails sent to participants	7	-	25	-
Total coaching emails sent to participants	-	-	0	-

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Report Execution Date/Time: 9/5/2019 12:53:03 PM

Nebraska Tobacco Quitline

Services Report

From 8/1/2019 through 8/31/2019

Contract Dates From 7/1/2019 through 8/31/2019

Summary of Services - Total Registered Callers

Note: The following section is based on the date that the caller registered for services.

	Period	Period %	Year	Year %
Integrated Help Line	322	92.3%	648	92.8%
Materials Only	1	0.3%	2	0.3%
General Questions	26	7.4%	48	6.9%
Total	**349**		**698**	

Services By Caller Type

Tobacco User	**Period**	**Period %**	**Year**	**Year %**
Integrated Help Line - Non-Pregnant	318	88.8%	631	88.7%
Integrated Help Line - Pregnant	4	1.1%	17	2.4%
Materials Only	1	0.3%	1	0.1%
General Questions	16	4.5%	31	4.4%
Total	**339**		**680**	
Family	**Period**	**Period %**	**Year**	**Year %**
Materials Only	-	-	1	0.1%
General Questions	2	0.6%	3	0.4%
Total	**2**		**4**	
Provider	**Period**	**Period %**	**Year**	**Year %**
General Questions	5	1.4%	8	1.1%
Total	**5**		**8**	
General Public	**Period**	**Period %**	**Year**	**Year %**
General Questions	2	0.6%	5	0.7%
Total	**2**		**5**	
Hang Up	**Period**	**Period %**	**Year**	**Year %**
General Questions	1	0.3%	1	0.1%
Total	**1**		**1**	
Other Calls Handled	**Period**	**Period %**	**Year**	**Year %**
Hang Up	5	1.4%	7	1.0%
Wrong Number	4	1.1%	6	0.8%
Total	**9**		**13**	

Summary of Services Provided

Note: Re-enrollments includes participants who have registered within the previous 12 months and who have opted for additional services.

Tobacco User (excluding programs below)	Period	Period %	Year	Year %
Multiple Call Program	301	92.6%	600	91.7%
Registered This Period	301		598	
Registered Prior Period	-		2	
One Call Program	20	6.2%	37	5.7%
Completed With Intervention	9		13	
Closed With Attempt	6		16	
In Process	5		8	
Total	**321**		**637**	
Pregnant Tobacco User	**Period**	**Period %**	**Year**	**Year %**
Multiple Call Program	4	1.2%	16	2.4%
Registered This Period	4		15	
Registered Prior Period	-		1	
One Call Program	-	-	1	0.2%
Closed With Attempt	-		1	
Total	**4**		**17**	

Calls Completed

Includes Tobacco Users who have enrolled in the Multiple Call Program.

	Period	Period %	Year	Year %
Call 1 Completed with an Intervention	279	20.2%	563	19.3%
Call 2 Completed with an Intervention	125	9.1%	258	8.8%
Call 3 Completed with an Intervention	95	6.9%	214	7.3%
Call 4 Completed with an Intervention	109	7.9%	210	7.2%
Call 5 Completed with an Intervention	2	0.1%	3	0.1%
Call 6 Completed with an Intervention	1	0.1%	1	0.0%
Call 7 Completed with an Intervention	1	0.1%	1	0.0%
Call 8 Completed with an Intervention	1	0.1%	1	0.0%
Call 1 Completed with an Attempt	25	1.8%	66	2.3%
Call 2 Completed with an Attempt	173	12.5%	374	12.8%
Call 3 Completed with an Attempt	175	12.7%	368	12.6%
Call 4 Completed with an Attempt	314	22.8%	691	23.7%
Call 5 Completed with an Attempt	5	0.4%	9	0.3%
Call 6 Completed with an Attempt	6	0.4%	6	0.2%
Call 7 Completed with an Attempt	-	-	4	0.1%

Call 8 Completed with an Attempt	3	0.2%	7	0.2%
Call 9 Completed with an Attempt	3	0.2%	6	0.2%
Call 10 Completed with an Attempt	5	0.4%	12	0.4%
Ad Hoc Calls with an Intervention	56	4.1%	113	3.9%
Ad Hoc Calls with an Attempt	1	0.1%	10	0.3%

Pharmacotherapy - Participant Shipments

Includes Tobacco Users only.

Patch Only	**Period**	**Period %**	**Year**	**Year %**
Shipment 1	177	68.3%	350	68.1%
Total	**177**		**350**	
Gum Only	**Period**	**Period %**	**Year**	**Year %**
Shipment 1 - 2mg	5	1.9%	14	2.7%
Shipment 1 - 4mg	28	10.8%	56	10.9%
Total	**33**		**70**	
Lozenge Only	**Period**	**Period %**	**Year**	**Year %**
Shipment 1 - 2mg	10	3.9%	22	4.3%
Shipment 1 - 4mg	39	15.1%	72	14.0%
Total	**49**		**94**	

Pharmacotherapy - Boxes Sent

Gum	**Period**	**Period %**	**Year**	**Year %**
2mg	5	3.8%	15	5.5%
4mg	29	22.0%	62	22.5%
Total	**34**		**77**	
Lozenge	**Period**	**Period %**	**Year**	**Year %**
2mg	20	15.2%	48	17.5%
4mg	78	59.1%	150	54.5%
Total	**98**		**198**	

Quit Materials Sent

Includes all Caller Types. Note: The number of kits reflected on the report include kits that have a sent date within this period.

	Period	**Period %**	**Year**	**Year %**
Q4L Materials Only Fulfillment	1	-	2	-
L Welcome Packet (SLT)	4	-	6	-

Q4L Welcome Packet (Standard)	258	-	534	-
Total	**263**		**542**	

Web Coach Participant Summary

	Period	Period %	Year	Year %
Enrolled individuals with web accounts	141	-	279	-
Individuals with web accounts logging in for the first time	37	-	53	-
Logins - Average per Participant	2.0	-	2.1	-
Session Duration (Average Minutes)	5.9	-	4.9	-

Email Message Summary

	Period	Period %	Year	Year %
Total automated emails sent to participants	609	-	1658	-
Total coaching emails sent to participants	-	-	0	-

Nebraska Tobacco Quitline
Referral Report

From 8/1/2019 through 8/31/2019
Contract Dates from 7/1/2019 through 8/31/2019

The purpose of this report is to provide results by recruitment source. Reported results reflect the current status of all referrals processed during the indicated reporting period as well as Year to Date enrollments by recruitment source.

NOTE: This report is based on the date the fax referral is received by Optum, Inc. and the current disposition for that participant. Pending reflects participants who Optum, Inc. is still attempting to reach. Clinics that are located outside of this state, but refer participants who reside in this state will be displayed on this report.

Fax Referral

Clinic

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
ADAM, TYLER	-	1	-	-	-	1	0.69 %	1	0.37 %
ADRIANNA SHUEY	1	-	-	-	-	1	0.69 %	2	0.74 %
AERTS, ANDREA PAC	-	-	-	-	-	-	-	1	0.37 %
ALLEN, JEAN APRN	-	-	-	-	-	-	-	1	0.37 %
ALVAREZ RAMIREZ, HORACIO	-	-	-	-	1	1	0.69 %	2	0.74 %
ANDRADE, FERKINANDO DR	-	-	-	1	-	1	0.69 %	1	0.37 %
ANTHONY COX, PA-C\C KRESHIL, MD	-	1	-	-	-	1	0.69 %	1	0.37 %
BARSOOM, MICHAEL DR - IAM	-	-	-	-	-	-	-	1	0.37 %
BATTERMAN, MICHELLE PA	1	-	-	-	-	1	0.69 %	1	0.37 %
BEAN, KELLY ARNP	-	-	-	-	-	-	-	1	0.37 %
BELLEVUE PRIMARY CARE - DR PATRICK ANDERL	1	-	-	-	-	1	0.69 %	1	0.37 %
BERGAN MERCY HOSPITAL - DR JASON LAMBRECHT	1	-	-	-	-	1	0.69 %	1	0.37 %
BERNEY, JEFF	-	-	-	-	-	-	-	1	0.37 %
BERNEY, JEFFREY MD	-	-	-	-	-	-	-	1	0.37 %
BERUMEN, BARRY	-	-	-	-	-	-	-	1	0.37 %
Bohaly, Karen	1	1	-	-	-	2	1.39 %	3	1.10 %
BORG, DR	1	-	-	-	-	1	0.69 %	1	0.37 %
BREWER, CAMILLE A-PRN - IAM	-	-	-	-	-	-	-	1	0.37 %
BROCKMAN, TYLER DR	1	-	-	-	-	1	0.69 %	1	0.37 %
BRYAN HEALTH - DR SIDDIQUI	1	-	-	-	-	1	0.69 %	3	1.10 %
BRYNER, SALLY APRN	-	-	-	-	1	1	0.69 %	1	0.37 %
BYINGTON, ROBERT	-	-	-	-	-	-	-	1	0.37 %
BYRD, JOHN MATT	-	-	-	-	-	-	-	1	0.37 %
CAMERON, SARAH	1	-	-	-	-	1	0.69 %	1	0.37 %

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Nebraska Tobacco Quitline
Referral Report

From 8/1/2019 through 8/31/2019
Contract Dates from 7/1/2019 through 8/31/2019

Clinic

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
CAMMACK, MARY	-	-	-	-	1	1	0.69 %	1	0.37 %
CAMMACK, MARY APRN	1	-	-	-	-	1	0.69 %	1	0.37 %
CATHY LAFLAN	-	-	-	-	1	1	0.69 %	1	0.37 %
CHI HEALTH CLINIC - DR DANIEL DESJARDINS	-	-	-	-	-	-	-	1	0.37 %
CHI HEALTH UNIV CAMPUS - DR EVANGELOS GIAKOUMATOS	-	-	-	-	1	1	0.69 %	1	0.37 %
CHI IMMANUEL WOMEN'S SPECIALISTS - DR MICHAEL REED	-	-	-	-	1	1	0.69 %	1	0.37 %
CHILDREN'S PHYSICIANS WEST VILLAGE POINTE - STEPHANIE CLARK	-	-	-	-	1	1	0.69 %	1	0.37 %
CHRISTENSEN, KECIA APRN	-	-	1	-	-	1	0.69 %	1	0.37 %
CHRISTIANSEN, HANNAH DR	-	-	-	-	1	1	0.69 %	2	0.74 %
CLARKSON FAMILY MEDICINE	-	-	-	-	1	1	0.69 %	1	0.37 %
COOK, LEIGH APRN	-	-	-	1	-	1	0.69 %	1	0.37 %
CORNELIUS, BLAINE	-	-	-	-	-	-	-	1	0.37 %
CRAIG, CADE MD	-	-	-	-	1	1	0.69 %	1	0.37 %
CRAIG, JOHN AE MD	-	-	-	-	-	-	-	1	0.37 %
CROCKETT, LIBBY	-	-	-	-	-	-	-	1	0.37 %
DAILEY, MARY	1	-	-	-	-	1	0.69 %	1	0.37 %
DANIEL, CONNIE APRN	2	-	-	-	-	2	1.39 %	4	1.47 %
DAVIS, JOSEPHINE DR	-	-	-	-	-	-	-	1	0.37 %
DESJARKINS, DANIEL DR	1	-	-	-	-	1	0.69 %	2	0.74 %
DIECKMANN, TRACI DO	1	-	-	-	-	1	0.69 %	1	0.37 %
DINSMOOR, JASON DR	-	-	-	-	-	-	-	1	0.37 %
DORN, ERIN	1	-	-	-	1	2	1.39 %	2	0.74 %
DR NASEEM	2	-	-	-	-	2	1.39 %	4	1.47 %
EBERLE, TODD	-	-	-	-	1	1	0.69 %	1	0.37 %
ERICKSON, TERI	-	-	-	-	-	-	-	1	0.37 %
ESTERAICH, ROCKY DR	-	-	-	-	-	-	-	1	0.37 %
FAHMY, LYLIA DR	-	-	-	-	-	-	-	2	0.74 %
FAMILY PRACTICE OF GRAND ISLAND - DR STEVEN HUSEN	-	-	-	-	-	-	-	1	0.37 %
FELBER, MATTHEW DR	-	1	-	-	-	1	0.69 %	1	0.37 %
FELDER, TIFFANY APRN	1	-	-	-	-	1	0.69 %	1	0.37 %
FERRIS, LETISHA	-	-	-	-	-	-	-	2	0.74 %

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Clinic

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
FICKENSCHER, BRADY DR	1	-	-	-	-	1	0.69 %	1	0.37 %
FITZGERALD, AMANDA DR	-	-	-	-	-	-	-	1	0.37 %
FITZGERALD, ANN	-	-	-	-	-	-	-	1	0.37 %
FREY, ZACH DR	1	-	-	-	-	1	0.69 %	1	0.37 %
FYNBU EGGERT, CLARA APRN	1	-	-	-	-	1	0.69 %	1	0.37 %
GESELL, ARIANNE	2	-	-	-	-	2	1.39 %	3	1.10 %
GOLD, KURT DR	1	-	-	-	-	1	0.69 %	1	0.37 %
GOODMAN, MARK	-	-	-	-	1	1	0.69 %	1	0.37 %
GRACE, MICHAEL DR	-	-	-	-	1	1	0.69 %	2	0.74 %
GRACE, SO YUN	-	-	-	-	-	-	-	1	0.37 %
GRACE, SO YUN P	-	1	-	-	-	1	0.69 %	1	0.37 %
HAAKE, ERICA DR	-	-	-	-	-	-	-	2	0.74 %
HAGEMAN, TRAVIS MD	-	-	-	-	-	-	-	1	0.37 %
HALFAR, MATTHEW	-	1	-	-	-	1	0.69 %	1	0.37 %
HARDY, TATIA MD	-	-	-	-	1	1	0.69 %	1	0.37 %
HATCH, JESSICA MD	1	-	-	-	-	1	0.69 %	1	0.37 %
HERNANDEZ, MELISSA DR	-	-	-	-	-	-	-	1	0.37 %
HERRERA, EDUARDO DR	-	1	-	-	-	1	0.69 %	1	0.37 %
HIERGIS, RICK MD	-	-	-	-	-	-	-	1	0.37 %
HO, CO THI	1	-	-	-	-	1	0.69 %	1	0.37 %
HOUGHTON, BRUCE - IAM	1	-	-	-	-	1	0.69 %	1	0.37 %
HUSEN, DR	1	-	-	-	-	1	0.69 %	1	0.37 %
IFTIKHAR, AHSAN DR	-	-	-	-	-	-	-	1	0.37 %
JAGAN, NIKHIL DR	-	-	-	-	-	-	-	1	0.37 %
JANSSEN, MISTY MD	-	-	-	-	-	-	-	2	0.74 %
JENSEN, CHRISTOPHER	1	-	-	-	-	1	0.69 %	1	0.37 %
JOACHIMSEN, TONYA	1	1	-	-	-	2	1.39 %	2	0.74 %
JOHNSON, AMBER	-	-	-	-	-	-	-	1	0.37 %
JOHNSON, MICHAEL	-	-	-	-	-	-	-	3	1.10 %
JOHNSON, RACHEL	-	-	-	-	-	-	-	1	0.37 %
JOHNSON, SCOTT MD	1	-	-	-	-	1	0.69 %	1	0.37 %
JONES, ANDREA DR	-	-	-	-	-	-	-	1	0.37 %

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Clinic

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
JOURNEY, GWEN	1	-	-	-	-	1	0.69 %	1	0.37 %
JULIE A LINDSTROM, DO	1	-	-	-	-	1	0.69 %	1	0.37 %
KADER, LAQUEL	-	-	-	-	-	-	-	1	0.37 %
KADER, LAQUEL DR	-	-	-	-	-	-	-	1	0.37 %
KARRE, BRIAN MD	-	-	-	-	-	-	-	1	0.37 %
KEIM, LAUREN	1	-	-	-	-	1	0.69 %	1	0.37 %
KING, AFOMA	-	-	-	-	-	-	-	2	0.74 %
KLINGEMANN, THOMAS	1	-	-	-	-	1	0.69 %	1	0.37 %
KOLL, KELSEY PAC	-	1	-	-	-	1	0.69 %	2	0.74 %
KOLLASCH, DANIELLE PAC	-	-	-	-	1	1	0.69 %	2	0.74 %
LAFFERTY, FRANCES DR	-	-	-	-	-	-	-	1	0.37 %
LAUER - SILVA, KAREN DR	-	-	-	-	-	-	-	1	0.37 %
LAWANDY, DALIA	-	-	-	-	-	-	-	1	0.37 %
LE, HUY T. MD	1	-	-	-	-	1	0.69 %	1	0.37 %
LEWANDOWSKI, KELLI	-	1	-	-	-	1	0.69 %	1	0.37 %
LINCOLN FAMILY MEDICINE CENTER	1	-	-	-	-	1	0.69 %	1	0.37 %
LINDA CIHACEK, PAC	-	-	-	-	1	1	0.69 %	1	0.37 %
LOEWENS, LAURA APRN	-	-	-	-	-	-	-	1	0.37 %
LUCKER, ALYSSA DR	1	-	-	-	-	1	0.69 %	1	0.37 %
LUCKER, DR	-	-	-	-	1	1	0.69 %	1	0.37 %
LUCKEY, DARBY	-	-	-	-	1	1	0.69 %	1	0.37 %
LUCKEY, DARBY DO	-	1	-	-	-	1	0.69 %	2	0.74 %
MACKENZIE HEMJE, MD	-	-	-	-	-	-	-	1	0.37 %
MALCHOW, BRETT MD	-	-	-	-	-	-	-	1	0.37 %
MALOLEY, PETER MD	-	-	-	-	-	-	-	1	0.37 %
MARK JOBMAN MD	-	-	-	-	1	1	0.69 %	1	0.37 %
MARK MCCORKINDALE	1	-	-	-	-	1	0.69 %	1	0.37 %
MARTIN, BENJAMIN	-	-	-	1	-	1	0.69 %	1	0.37 %
MCGILL, KATIE	-	-	-	-	-	-	-	1	0.37 %
MCKNIGHT,THOMAS DR	-	-	-	-	-	-	-	2	0.74 %
MCMINN, C TODD MD	-	-	-	-	-	-	-	1	0.37 %
MCPHERSON, SCOTT DR	1	-	-	-	-	1	0.69 %	2	0.74 %

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Nebraska Tobacco Quitline
Referral Report

From 8/1/2019 through 8/31/2019
Contract Dates from 7/1/2019 through 8/31/2019

Clinic

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
MEYERS, PATRICK DR	-	-	-	-	-	-	-	1	0.37 %
MICHELLE MULLIGAN WITT	-	1	-	-	-	1	0.69 %	1	0.37 %
MICHELLE TYSER, PA-C	-	1	-	-	-	1	0.69 %	1	0.37 %
MOHRING, STEPHEN MD	-	-	-	-	1	1	0.69 %	1	0.37 %
MOORE, SUSAN APRN	1	-	-	-	-	1	0.69 %	1	0.37 %
MUILENBURG, JEFFREY DR	-	-	-	-	1	1	0.69 %	1	0.37 %
MULKEY, JOSELYN	1	-	-	-	-	1	0.69 %	1	0.37 %
MULLENDORE, SEAN DR	-	1	-	-	-	1	0.69 %	1	0.37 %
NASEEM, DR	-	-	-	-	-	-	-	1	0.37 %
NEBRASKA MED CTR - SHAHBAZ MALIK	1	-	-	-	-	1	0.69 %	1	0.37 %
NEBRASKA PULMONARY SPECIALTIES LLC	-	-	-	-	1	1	0.69 %	1	0.37 %
NGUYEN, CUN APRN	-	-	-	-	-	-	-	2	0.74 %
NGUYEN, CUU DR	-	-	-	-	-	-	-	1	0.37 %
OAKESON, DACIA	-	-	-	-	-	-	-	2	0.74 %
ONE WORLD COMMUNITY HEALTH CENTER - DR DEEPTHI SAMINDLA	1	-	-	-	-	1	0.69 %	1	0.37 %
OPP, ANDREW DR	-	-	-	-	-	-	-	1	0.37 %
OSTERHOLM, RICHARD	1	-	-	-	-	1	0.69 %	1	0.37 %
OTT, JESSICA, MD	-	-	-	1	-	1	0.69 %	1	0.37 %
PAKNIKAR, JAYASHREE DR	-	-	-	-	-	-	-	1	0.37 %
PEARSON, JENNIFER APRN	-	-	-	-	1	1	0.69 %	1	0.37 %
PENDER MEDICAL CLINIC - JEFF MUNDERLOH PA-C	-	-	-	-	-	-	-	1	0.37 %
PETERSON, KELSEY PAC	1	1	-	-	-	2	1.39 %	3	1.10 %
PLOG, PAULA PAC	-	-	-	-	1	1	0.69 %	1	0.37 %
POLYNICE, MARIE MD	-	-	-	-	1	1	0.69 %	1	0.37 %
POTTER, VANESSA	-	-	-	-	-	-	-	1	0.37 %
QUALITY HEALTH CLINIC	-	-	-	-	-	-	-	1	0.37 %
RAFIQ, NAUREEN	1	-	-	-	1	2	1.39 %	2	0.74 %
RAPP, JEFFREY DR	1	-	-	-	-	1	0.69 %	1	0.37 %
RENEE A GRAMS, APRN	1	-	-	-	-	1	0.69 %	1	0.37 %
RIDDER, JOSH PAC	-	-	-	-	1	1	0.69 %	1	0.37 %
RODRIGUEZ, WOLFGANG	1	-	-	-	-	1	0.69 %	1	0.37 %

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Nebraska Tobacco Quitline
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Clinic

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
RORIE, ANDREW DR	-	-	-	-	-	-	-	1	0.37 %
ROTHLISBERGER JULIE MD	-	-	-	-	-	-	-	1	0.37 %
ROUSER, RINA APRN	1	-	-	-	-	1	0.69 %	1	0.37 %
RYSTROM, KATHERINE APRN	-	-	-	1	-	1	0.69 %	1	0.37 %
SAKOWSKI, HENRY	-	-	-	-	-	-	-	1	0.37 %
SCHERLING, MARY APRN	1	2	-	-	1	4	2.78 %	5	1.84 %
SCHOOFF, MICHAEL MD	-	-	-	-	-	-	-	1	0.37 %
SCHROER, KYLENE	1	1	1	-	-	3	2.08 %	5	1.84 %
SCHULTE, RAYMOND	1	-	-	-	-	1	0.69 %	1	0.37 %
SCHULTZ, RACHAEL DR	-	-	-	-	-	-	-	1	0.37 %
SCHULTZ, RACHEL	1	-	-	-	-	1	0.69 %	1	0.37 %
SCHUTTE, LINDSEY PAC	-	-	-	-	-	-	-	1	0.37 %
SHAW, DANELLE	-	-	-	1	-	1	0.69 %	1	0.37 %
SIDDIQUI, DR	2	1	-	-	-	3	2.08 %	7	2.57 %
SMITH, SARAH	-	-	-	-	-	-	-	1	0.37 %
SMITH, STEPHEN J	1	-	-	-	-	1	0.69 %	1	0.37 %
SNYDER, CHRISTOPHER MD	1	-	-	-	-	1	0.69 %	2	0.74 %
SPANEL, AJ	1	-	-	-	-	1	0.69 %	1	0.37 %
SPIVEY, E. APRN	-	1	-	-	1	2	1.39 %	2	0.74 %
SPIVEY, EMI APRN	1	-	-	-	-	1	0.69 %	2	0.74 %
STACIE GILROY, PA-C	-	1	-	-	-	1	0.69 %	1	0.37 %
STEIER, NICHOLAS	-	-	-	-	-	-	-	1	0.37 %
STEPHENSON, TYLER DR	-	1	-	-	-	1	0.69 %	1	0.37 %
STODDEN, JENNIFER PAC	-	-	-	1	-	1	0.69 %	2	0.74 %
STRAWMIER, THOMAS	1	-	-	-	-	1	0.69 %	1	0.37 %
SUMMA, JASON DR	-	-	-	-	1	1	0.69 %	1	0.37 %
TAYLOR, ADAM APRN	-	-	-	-	-	-	-	1	0.37 %
THIELEN, PAULA DR	1	-	-	-	1	2	1.39 %	2	0.74 %
THOMAS STRAWMIER MD / CHI HEALTH	-	-	-	-	-	-	-	1	0.37 %
TINCHER, RACHEL PAC	1	-	-	-	-	1	0.69 %	4	1.47 %
TRAMP, ALLAN MD	-	1	-	-	-	1	0.69 %	1	0.37 %
TREU, BODO DR	1	-	-	-	-	1	0.69 %	1	0.37 %

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Nebraska Tobacco Quitline
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Clinic

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
TYSER, MICHELLE	-	-	-	-	-	-	-	1	0.37 %
ULEN, MICHAEL DR	-	-	-	-	-	-	-	1	0.37 %
UNKNOWN CLINIC - NE	3	-	-	-	2	5	3.47 %	13	4.78 %
UNMC MIDTOWN CLINIC - DR ALEXANDER PRAUS	1	-	-	-	-	1	0.69 %	1	0.37 %
VICKIE PETERSON TRUKSA APRN	-	1	-	-	-	1	0.69 %	1	0.37 %
VINTON, THOMAS MD	1	-	-	-	-	1	0.69 %	1	0.37 %
WAGONER, JILL	-	-	-	-	-	-	-	1	0.37 %
WEEDER, T APRN	-	-	-	-	1	1	0.69 %	1	0.37 %
WENZL, JOSEPH MD	-	-	-	-	1	1	0.69 %	3	1.10 %
WERGIN, BRETT MD	-	1	-	-	-	1	0.69 %	1	0.37 %
WESTENGAARD, DR	-	-	-	-	-	-	-	1	0.37 %
WILFORD, NICOLE	-	-	-	-	-	-	-	1	0.37 %
WOLTHEMAN, KELLI	-	-	-	-	1	1	0.69 %	1	0.37 %
WORNER, AMANDA APRN	-	1	-	-	1	2	1.39 %	2	0.74 %
ZAWAIDEH, ZIAD MD - IAM	-	-	-	-	-	-	-	1	0.37 %
ZILLIG KIELIAN, JAMIE	-	-	-	-	-	-	-	1	0.37 %
Total	71	26	2	7	38	144	100.00 %	271	100.00 %

Physician

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
CHUGHTAI	-	-	-	-	-	-	-	1	0.37 %
Total	-	-	-	-	-	-	-	1	100.00 %
Grand Total	71	26	2	7	38	144	100.00%	272	100.00%

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Nebraska Tobacco Quitline
Referral - Service Requested at Registration

From 8/1/2019 through 8/31/2019
Contract Dates from 7/1/2019 through 8/31/2019

The purpose of this report is to provide a breakdown of service requested at registration.

NOTE: Clinics that are located outside of this state, but refer participants who reside in this state will be displayed on this report.

Fax Referral

Clinic

Clinic/Provider	Intervention Requested		Materials	General	All Transfer	Web
	1-call	Multiple Call	Only	Questions	Type	Only
ADAM, TYLER	-	-	-	-	-	-
ADRIANNA SHUEY	-	-	-	-	-	-
AERTS, ANDREA PAC	-	-	-	-	-	-
ALLEN, JEAN APRN	-	-	-	-	-	-
ALVAREZ RAMIREZ, HORACIO	-	1	-	-	-	-
ANDRADE, FERKINANDO DR	-	-	-	-	-	-
ANTHONY COX, PA-C\C KRESHIL, MD	-	-	-	-	-	-
BARSOOM, MICHAEL DR - IAM	-	-	-	-	-	-
BATTERMAN, MICHELLE PA	-	-	-	-	-	-
BEAN, KELLY ARNP	-	-	-	-	-	-
BELLEVUE PRIMARY CARE - DR PATRICK ANDERL	-	-	-	-	-	-
BERGAN MERCY HOSPITAL - DR JASON LAMBRECHT	-	-	-	-	-	-
BERNEY, JEFF	-	-	-	-	-	-
BERNEY, JEFFREY MD	-	-	-	-	-	-
BERUMEN, BARRY	-	-	-	-	-	-
Bohaty, Karen	-	-	-	-	-	-
BORG, DR	-	-	-	-	-	-
BREWER, CAMILLE A-PRN - IAM	-	-	-	-	-	-
BROCKMAN, TYLER DR	-	-	-	-	-	-
BRYAN HEALTH - DR SIDDIQUI	-	-	-	-	-	-
BRYNER, SALLY APRN	-	1	-	-	-	-
BYINGTON, ROBERT	-	-	-	-	-	-
BYRD, JOHN MATT	-	-	-	-	-	-
CAMERON, SARAH	-	-	-	-	-	-
CAMMACK, MARY	-	1	-	-	-	-
CAMMACK, MARY APRN	-	-	-	-	-	-

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Clinic

Clinic/Provider	Intervention Requested		Materials	General	All Transfer	Web
	1-call	Multiple Call	Only	Questions	Type	Only
CATHY LAFLAN	-	1	-	-	-	-
CHI HEALTH CLINIC - DR DANIEL DESJARDINS	-	-	-	-	-	-
CHI HEALTH UNIV CAMPUS - DR EVANGELOS GIAKOUMATOS	-	1	-	-	-	-
CHI IMMANUEL WOMEN'S SPECIALISTS - DR MICHAEL REED	-	1	-	-	-	-
CHILDREN'S PHYSICIANS WEST VILLAGE POINTE - STEPHANIE CLARK	-	1	-	-	-	-
CHRISTENSEN, KECIA APRN	-	-	-	-	-	-
CHRISTIANSEN, HANNAH DR	-	1	-	-	-	-
CLARKSON FAMILY MEDICINE	-	1	-	-	-	-
COOK, LEIGH APRN	-	-	-	-	-	-
CORNELIUS, BLAINE	-	-	-	-	-	-
CRAIG, CADE MD	-	1	-	-	-	-
CRAIG, JOHN AE MD	-	-	-	-	-	-
CROCKETT, LIBBY	-	-	-	-	-	-
DAILEY, MARY	-	-	-	-	-	-
DANIEL, CONNIE APRN	-	-	-	-	-	-
DAVIS, JOSEPHINE DR	-	-	-	-	-	-
DESJARKINS, DANIEL DR	-	-	-	-	-	-
DIECKMANN, TRACI DO	-	-	-	-	-	-
DINSMOOR, JASON DR	-	-	-	-	-	-
DORN, ERIN	-	1	-	-	-	-
DR NASEEM	-	-	-	-	-	-
EBERLE, TODD	-	1	-	-	-	-
ERICKSON, TERI	-	-	-	-	-	-
ESTERAICH, ROCKY DR	-	-	-	-	-	-
FAHMY, LYLIA DR	-	-	-	-	-	-
FAMILY PRACTICE OF GRAND ISLAND - DR STEVEN HUSEN	-	-	-	-	-	-
FELBER, MATTHEW DR	-	-	-	-	-	-

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Nebraska Tobacco Quitline
Referral - Service Requested at Registration

From 8/1/2019 through 8/31/2019
Contract Dates from 7/1/2019 through 8/31/2019

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Clinic

Clinic/Provider	Intervention Requested		Materials	General	All Transfer	Web
	1-call	Multiple Call	Only	Questions	Type	Only
FELDER, TIFFANY APRN	-	-	-	-	-	-
FERRIS, LETISHA	-	-	-	-	-	-
FICKENSCHER, BRADY DR	-	-	-	-	-	-
FITZGERALD, AMANDA DR	-	-	-	-	-	-
FITZGERALD, ANN	-	-	-	-	-	-
FREY, ZACH DR	-	-	-	-	-	-
FYNBU EGGERT, CLARA APRN	-	-	-	-	-	-
GESELL, ARIANNE	-	-	-	-	-	-
GOLD, KURT DR	-	-	-	-	-	-
GOODMAN, MARK	-	1	-	-	-	-
GRACE, MICHAEL DR	-	1	-	-	-	-
GRACE, SO YUN	-	-	-	-	-	-
GRACE, SO YUN P	-	-	-	-	-	-
HAAKE, ERICA DR	-	-	-	-	-	-
HAGEMAN, TRAVIS MD	-	-	-	-	-	-
HALFAR, MATTHEW	-	-	-	-	-	-
HARDY, TATIA MD	-	1	-	-	-	-
HATCH, JESSICA MD	-	-	-	-	-	-
HERNANDEZ, MELISSA DR	-	-	-	-	-	-
HERRERA, EDUARDO DR	-	-	-	-	-	-
HIERGIS, RICK MD	-	-	-	-	-	-
HO, CO THI	-	-	-	-	-	-
HOUGHTON, BRUCE - IAM	-	-	-	-	-	-
HUSEN, DR	-	-	-	-	-	-
IFTIKHAR, AHSAN DR	-	-	-	-	-	-
JAGAN, NIKHIL DR	-	-	-	-	-	-
JANSSEN, MISTY MD	-	-	-	-	-	-
JENSEN, CHRISTOPHER	-	-	-	-	-	-

Report Name: MonthlyFacReferralReport-DetailRow, D-AllDataSelect, B

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Clinic

Clinic/Provider	Intervention Requested		Materials	General	All Transfer	Web
	1-call	Multiple Call	Only	Questions	Type	Only
JOACHIMSEN, TONYA	-	-	-	-	-	-
JOHNSON, AMBER	-	-	-	-	-	-
JOHNSON, MICHAEL	-	-	-	-	-	-
JOHNSON, RACHEL	-	-	-	-	-	-
JOHNSON, SCOTT MD	-	-	-	-	-	-
JONES, ANDREA DR	-	-	-	-	-	-
JOURNEY, GWEN	-	-	-	-	-	-
JULIE A LINDSTROM, DO	-	-	-	-	-	-
KADER, LAOUEL	-	-	-	-	-	-
KADER, LAOUEL DR	-	-	-	-	-	-
KARRE, BRIAN MD	-	-	-	-	-	-
KEIM, LAUREN	-	-	-	-	-	-
KING, AFOMA	-	-	-	-	-	-
KLINGEMANN, THOMAS	-	-	-	-	-	-
KOLL, KELSEY PAC	-	-	-	-	-	-
KOLLASCH, DANIELLE PAC	-	1	-	-	-	-
LAFFERTY, FRANCES DR	-	-	-	-	-	-
LAUER - SILVA, KAREN DR	-	-	-	-	-	-
LAWANDY, DALIA	-	-	-	-	-	-
LE, HUY T. MD	-	-	-	-	-	-
LEWANDOWSKI, KELLI	-	-	-	-	-	-
LINCOLN FAMILY MEDICINE CENTER	-	-	-	-	-	-
LINDA CIHACEK, PAC	-	1	-	-	-	-
LOEWENS, LAURA APRN	-	-	-	-	-	-
LUCKER, ALYSSA DR	-	-	-	-	-	-
LUCKER, DR	-	1	-	-	-	-
LUCKEY, DARBY	-	1	-	-	-	-
LUCKEY, DARBY DO	-	-	-	-	-	-

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Nebraska Tobacco Quitline
Referral - Service Requested at Registration

From 8/1/2019 through 8/31/2019
Contract Dates from 7/1/2019 through 8/31/2019

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Clinic

Clinic/Provider	Intervention Requested		Materials	General	All Transfer	Web
	1-call	Multiple Call	Only	Questions	Type	Only
MACKENZIE HEMJE, MD	-	-	-	-	-	-
MALCHOW, BRETT MD	-	-	-	-	-	-
MALOLEY, PETER MD	-	-	-	-	-	-
MARK JOBMAN MD	-	1	-	-	-	-
MARK MCCORKINDALE	-	-	-	-	-	-
MARTIN, BENJAMIN	-	-	-	-	-	-
MCGILL, KATIE	-	-	-	-	-	-
MCKNIGHT,THOMAS DR	-	-	-	-	-	-
MCMINN, C TODD MD	-	-	-	-	-	-
MCPHERSON, SCOTT DR	-	-	-	-	-	-
MEYERS, PATRICK DR	-	-	-	-	-	-
MICHELLE MULLIGAN WITT	-	-	-	-	-	-
MICHELLE TYSER, PA-C	-	-	-	-	-	-
MOHRING, STEPHEN MD	-	1	-	-	-	-
MOORE, SUSAN APRN	-	-	-	-	-	-
MUILENBURG, JEFFREY DR	-	1	-	-	-	-
MULKEY, JOSELYN	-	-	-	-	-	-
MULLENDORE, SEAN DR	-	-	-	-	-	-
NASEEM, DR	-	-	-	-	-	-
NEBRASKA MED CTR - SHAHBAZ MALIK	-	-	-	-	-	-
NEBRASKA PULMONARY SPECIALTIES LLC	-	1	-	-	-	-
NGUYEN, CUN APRN	-	-	-	-	-	-
NGUYEN, CUU DR	-	-	-	-	-	-
OAKESON, DACIA	-	-	-	-	-	-
ONE WORLD COMMUNITY HEALTH CENTER - DR DEEPTHI SAMINDLA	-	-	-	-	-	-
OPP, ANDREW DR	-	-	-	-	-	-
OSTERHOLM, RICHARD	-	-	-	-	-	-
OTT, JESSICA, MD	-	-	-	-	-	-

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Clinic

Clinic/Provider	Intervention Requested		Materials	General	All Transfer	Web
	1-call	Multiple Call	Only	Questions	Type	Only
PAKNIKAR, JAYASHREE DR	-	-	-	-	-	-
PEARSON, JENNIFER APRN	-	1	-	-	-	-
PENDER MEDICAL CLINIC - JEFF MUNDERLOH PA-C	-	-	-	-	-	-
PETERSON, KELSEY PAC	-	-	-	-	-	-
PLOG, PAULA PAC	-	1	-	-	-	-
POLYNICE, MARIE MD	-	1	-	-	-	-
POTTER, VANESSA	-	-	-	-	-	-
QUALITY HEALTH CLINIC	-	-	-	-	-	-
RAFIQ, NAUREEN	-	1	-	-	-	-
RAPP, JEFFREY DR	-	-	-	-	-	-
RENEE A GRAMS, APRN	-	-	-	-	-	-
RIDDER, JOSH PAC	-	1	-	-	-	-
RODRIGUEZ, WOLFGANG	-	-	-	-	-	-
RORIE, ANDREW DR	-	-	-	-	-	-
ROTHLISBERGER JULIE MD	-	-	-	-	-	-
ROUSER, RINA APRN	-	-	-	-	-	-
RYSTROM, KATHERINE APRN	-	-	-	-	-	-
SAKOWSKI, HENRY	-	-	-	-	-	-
SCHERLING, MARY APRN	-	1	-	-	-	-
SCHOOFF, MICHAEL MD	-	-	-	-	-	-
SCHROER, KYLENE	-	-	-	-	-	-
SCHULTE, RAYMOND	-	-	-	-	-	-
SCHULTZ, RACHAEL DR	-	-	-	-	-	-
SCHULTZ, RACHEL	-	-	-	-	-	-
SCHUTTE, LINDSEY PAC	-	-	-	-	-	-
SHAW, DANELLE	-	-	-	-	-	-
SIDDIQUI, DR	-	-	-	-	-	-
SMITH, SARAH	-	-	-	-	-	-

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Clinic

Clinic/Provider	Intervention Requested		Materials	General	All Transfer	Web
	1-call	Multiple Call	Only	Questions	Type	Only
SMITH, STEPHEN J	-	-	-	-	-	-
SNYDER, CHRISTOPHER MD	-	-	-	-	-	-
SPANEL, AJ	-	-	-	-	-	-
SPIVEY, E. APRN	-	1	-	-	-	-
SPIVEY, EMI APRN	-	-	-	-	-	-
STACIE GILROY, PA-C	-	-	-	-	-	-
STEIER, NICHOLAS	-	-	-	-	-	-
STEPHENSON, TYLER DR	-	-	-	-	-	-
STODDEN, JENNIFER PAC	-	-	-	-	-	-
STRAWMIER, THOMAS	-	-	-	-	-	-
SUMMA, JASON DR	-	1	-	-	-	-
TAYLOR, ADAM APRN	-	-	-	-	-	-
THIELEN, PAULA DR	-	1	-	-	-	-
THOMAS STRAWMIER MD / CHI HEALTH	-	-	-	-	-	-
TINCHER, RACHEL PAC	-	-	-	-	-	-
TRAMP, ALLAN MD	-	-	-	-	-	-
TREU, BODO DR	-	-	-	-	-	-
TYSER, MICHELLE	-	-	-	-	-	-
ULEN, MICHAEL DR	-	-	-	-	-	-
UNKNOWN CLINIC - NE	-	2	-	-	-	-
UNMC MIDTOWN CLINIC - DR ALEXANDER PRAUS	-	-	-	-	-	-
VICKIE PETERSON TRUKSA APRN	-	-	-	-	-	-
VINTON, THOMAS MD	-	-	-	-	-	-
WAGONER, JILL	-	-	-	-	-	-
WEEDER, T APRN	1	-	-	-	-	-
WENZL, JOSEPH MD	-	1	-	-	-	-
WERGIN, BRETT MD	-	-	-	-	-	-
WESTENGAARD, DR	-	-	-	-	-	-

Account Name:11NKHS8-AllVoice -ContactID: Scope: A, Report Name: Monthly Fax Referral Report, Detail Row ID=AnyDateSelect 12

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Nebraska Tobacco Quitline
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Clinic

Clinic/Provider	Intervention Requested		Materials Only	General Questions	All Transfer Type	Web Only
	1-call	Multiple Call				
WILFORD, NICOLE	-	-	-	-	-	-
WOLTHEMAN, KELLI	-	1	-	-	-	-
WORNER, AMANDA APRN	-	1	-	-	-	-
ZAWAIDEH, ZIAD MD - IAM	-	-	-	-	-	-
ZILLIG KIELIAN, JAMIE	-	-	-	-	-	-
Total	1	37	-	-	-	-

Physician

Clinic/Provider	Intervention Requested		Materials Only	General Questions	All Transfer Type	Web Only
	1-call	Multiple Call				
CHUGHTAI	-	-	-	-	-	-
Total	-	-	-	-	-	-
Grand Total	1	37	-	-	-	-

Account Name 1120018-AtNama -DomainID Scope A Report Name Monthly Fax Referral Report -Detail Form D AutoDateSelect 12

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Nebraska Tobacco Quitline

NRT Shipments

From 8/1/2019 through 8/31/2019

Billable	true

Patch Weeks	Count of Service Type
2	172
4	5
Grand Total	**177**

Billable	true

Gum Boxes	Count of Service Type
1	32
2	1
Grand Total	**33**

Billable	true

Lozenge Boxes	Count of Service Type
2	49
Grand Total	**49**

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Nebraska Tobacco Quitline

Mental Health SUD Report

From 8/1/2019 through 8/31/2019

Contract Dates from 7/1/2019 through 8/31/2019

Time 9/5/2018 1:51:24 AM

This section details responses to the question "Do you currently have any mental health conditions, such as:" Note that a participant can respond Yes to more than one condition.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Attention Deficit Hyperactivity Disorder (ADHD)	39	5.3 %	88	5.9 %
Bi-Polar	90	12.2 %	182	12.2 %
Depression	165	22.4 %	323	21.6 %
Drug Or Alcohol Abuse Disorder	50	6.8 %	93	6.2 %
Generalized Anxiety Disorder	149	20.2 %	295	19.8 %
Post Traumatic Stress Disorder (PTSD)	101	13.7 %	192	12.9 %
Schizophrenia	33	4.5 %	77	5.2 %
None	105	14.2 %	228	15.3 %
Does Not Know	-	0.0 %	-	0.0 %
Refused	6		14	
Total	**738**	**100 %**	**1492**	**100 %**

's section details responses to a follow-up question. If any of the conditions above are selected, the participant is asked "Do you think that ıse mental health conditions or emotional challenges might interfere with your ability to quit?"

	Current Month	Current Month %	Contract YTD	Contract YTD %
Yes	72	32.4 %	144	34.4 %
No	129	58.1 %	226	54.1 %
Does Not Know	21	9.5 %	48	11.5 %
Refused	-		-	
Total	**222**	**100 %**	**418**	**100 %**

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Nebraska Tobacco Quitline

How Heard About By Day

Phone Counseling

From 8/1/2019 through 8/31/2019

The purpose of this report is to provide a count of self reported answers associated with the question, 'How did you hear about the program?' asked at Registration, per day.

How Heard About	8/1	8/2	8/3	8/4	8/5	8/6	8/7	8/8	8/9	8/10	8/11	8/12	8/13	8/14	8/15	8/16	8/17	8/18	8/19	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30	8/31	Total
Brochure/Flyer	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Brochure/Newsletter/Flyer	-	1	-	1	-	-	-	1	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4
Bus Ad	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	3
Community Organization	-	1	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Co-Worker	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Customer/Member Service	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	2
Does Not Know	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-	-	-	4
E /Worksite	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	3
Every Woman Matters (EWM)	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Family/Friend	-	-	-	-	-	-	2	-	-	-	-	-	-	1	1	2	-	-	1	-	3	1	1	-	-	2	-	2	-	1	1	18
Health Department	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Health Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	-	1	-	-	-	3
Health Professional	6	12	-	1	5	4	3	4	4	1	-	1	1	3	3	6	2	1	3	4	4	6	2	3	-	2	6	5	6	1	1	134
Outdoor Ad	1	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	3
Radio	-	-	-	-	-	1	1	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	5
TV/Commercial	1	1	-	-	7	2	6	6	3	1	1	4	9	3	4	3	2	2	2	8	3	3	1	-	2	4	1	3	3	3	-	88
Website	-	-	-	1	-	-	1	-	-	-	-	1	1	-	-	-	-	1	-	1	-	-	-	-	-	1	-	-	1	3	-	11
Other	1	2	1	-	-	1	2	1	-	2	1	3	1	1	2	1	-	-	1	-	1	1	-	1	-	3	1	2	1	-	-	30
Not Collected	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-	1	-	-	1	-	1	-	1	-	-	-	-	-	-	-	-	6
Total	**13**	**22**	**2**	**3**	**16**	**10**	**18**	**14**	**7**	**4**	**2**	**12**	**13**	**11**	**13**	**14**	**5**	**4**	**10**	**18**	**16**	**15**	**6**	**5**	**5**	**14**	**10**	**17**	**13**	**8**	**2**	**322**

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Nebraska Tobacco Quitline

E-Cigarette/Vapor Summary Report

From 8/1/2019 through 8/31/2019

Contract Dates from 7/1/2019 through 8/31/2019

Report Execution Date/Time 9/5/2019 11:54:30 AM

NOTE: Tobacco Users whose service is intervention requested or web only are reflected in this report.

Used E-Cigarettes Past 30 Days

Have you used an e-cigarette or other electronic vaping product in the past 30 days?				
	Current Period	Current Period %	Contract YTD	Contract YTD %
No	271	86.03%	526	85.25%
Yes	41	13.02%	87	14.10%
Don't know	1	0.32%	1	0.16%
Refused	2	0.63%	3	0.49%

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Print Date/Time 9/5/2019 1:28:37 PM

Nebraska Tobacco Quitline
Demographic Report
Pregnant Program

From 8/1/2019 through 8/31/2019

Contract Dates from 7/1/2019 through 8/31/2019

The purpose of this report is to display summary demographic information of program participants. This information is aggregated based on the date that the participant registers to receive services.

Method of Entry

NOTE: Includes Tobacco User, Proxy, Provider and General Public.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Fax Referral	1	25.0 %	6	35.3 %
Phone English	3	75.0 %	10	58.8 %
Re-enrollment Recruitment	-	-	1	5.9 %
Total	**4**	**100 %**	**17**	**100 %**

Caller Type

	Current Period	Current Period %	Contract YTD	Contract YTD %
Tobacco User	4	100.0 %	17	100.0 %
Total	**4**	**100 %**	**17**	**100 %**

How Heard About

Displays a count of self-reported answers associated with the question asked by Registration, 'How did you hear about the program?'.

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Brochure/Flyer	-	-	1	6.3 %
Community Organization	-	-	1	6.3 %
Family/Friend	-	-	1	6.3 %
Health Department	-	-	1	6.3 %
Health Professional	3	75.0 %	10	62.5 %
Health Care Provider	*2*	*50.0 %*	*6*	*37.5 %*
Mental Health Provider	-	-	*1*	*6.3 %*
OB/GYN Specialist	*1*	*25.0 %*	*2*	*12.5 %*
Pharmacist	-	-	*1*	*6.3 %*
Sub Total	*3*	*75.0 %*	*10*	*62.5 %*
TV/Commercial	1	25.0 %	1	6.3 %
Other	-	-	1	6.3 %
Not Collected	-		1	
Total	**4**	**100 %**	**17**	**100 %**

Tobacco Users by Gender

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Female	4	100.0 %	17	100.0 %
Total	**4**	**100 %**	**17**	**100 %**

Tobacco Users by Language Spoken

	Current Period	Current Period %	Contract YTD	Contract YTD %
English	4	100.0 %	17	100.0 %
Total	**4**	**100 %**	**17**	**100 %**

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Nebraska Tobacco Quitline
Demographic Report
Pregnant Program

Print Date/Time 9/5/2019 1:28:37 PM

From 8/1/2019 through 8/31/2019

Contract Dates from 7/1/2019 through 8/31/2019

Tobacco Users by Age

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
20 to 24	1	25.0 %	2	11.8 %
25 to 30	1	25.0 %	6	35.3 %
31 to 40	2	50.0 %	8	47.1 %
41 to 50	-	-	1	5.9 %
Total	**4**	**100 %**	**17**	**100 %**

Tobacco Users by Tobacco Type

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Cigarette	3	75.0 %	15	68.2 %
Cigar	1	25.0 %	2	9.1 %
Pipe	-	-	1	4.5 %
Smokeless Tobacco	-	-	1	4.5 %
E-Cigarette	-	-	2	9.1 %
Other	-	-	1	4.5 %
Total	**4**	**100 %**	**22**	**100 %**

Tobacco Users by Education

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Less than grade 9	-	-	1	5.9 %
Grade 9-11 no degree	-	-	4	23.5 %
GED	1	25.0 %	1	5.9 %
High School Degree	-	-	5	29.4 %
Some College or University	2	50.0 %	3	17.6 %
College or University Degree	1	25.0 %	2	11.8 %
Technical Trade School degree	-	-	1	5.9 %
Total	**4**	**100 %**	**17**	**100 %**

Female Tobacco Users by Pregnancy Status

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Not Pregnant	-	-	1	5.9 %
Currently Pregnant	2	50.0 %	8	47.1 %
Planning	-	-	5	29.4 %
Currently Breastfeeding	2	50.0 %	3	17.6 %
Total	**4**	**100 %**	**17**	**100 %**

Tobacco Users by Chronic Condition

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
ma	1	25.0 %	4	28.6 %
er	-	-	1	7.1 %
Type 2 Diabetes	-	-	1	7.1 %
None	3	75.0 %	8	57.1 %

Tobacco Users by Chronic Condition

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Not Collected	-		5	
Total	**4**	**100 %**	**19**	**100 %**

Tobacco Users by Mental Health Conditions

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
ADHD	1	9.1 %	7	13.7 %
Anxiety	3	27.3 %	11	21.6 %
Bi-Polar	1	9.1 %	7	13.7 %
Depression	3	27.3 %	10	19.6 %
Drug or Alcohol Abuse	-	-	1	2.0 %
PTSD	2	18.2 %	10	19.6 %
Schizophrenia	-	-	2	3.9 %
None	1	9.1 %	3	5.9 %
Total	**11**	**100 %**	**51**	**100 %**

Tobacco Users by Stage at Registration

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Preparation	4	100.0 %	16	94.1 %
Action - 24 hours to less than 7 days	-	-	1	5.9 %
Total	**4**	**100 %**	**17**	**100 %**

Tobacco Users by Race

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Black or African American	-	-	2	11.8 %
White	3	75.0 %	13	76.5 %
Other	1	25.0 %	2	11.8 %
Total	**4**	**100 %**	**17**	**100 %**

Tobacco Users by Ethnicity

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Non-Hispanic	4	100.0 %	17	100.0 %
Total	**4**	**100 %**	**17**	**100 %**

Tobacco Users by Income Level

	Current Period	Current Period %	Contract YTD	Contract YTD %
Less than $10,000	1	25.0 %	9	52.9 %
Less than $15,000 ($10,000 to less than $15,000)	1	25.0 %	4	23.5 %
Less than $20,000 ($15,000 to less than $20,000)	-	-	1	5.9 %
Less than $25,000 ($20,000 to less than $25,000)	1	25.0 %	1	5.9 %

Tobacco Users by Income Level

	Current Period	Current Period %	Contract YTD	Contract YTD %
Does Not Know	1	25.0 %	2	11.8 %
Total	**4**	**100 %**	**17**	**100 %**

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Nebraska Tobacco Quitline
Demographic Report
Integrated Web

Print Date/Time 9/5/2019 12:50:38 PM

From 8/1/2019 through 8/31/2019

Contract Dates from 7/1/2019 through 8/31/2019

The purpose of this report is to display summary demographic information of program participants. This information is aggregated based on the date that the participant registers to receive services.

Method of Entry

NOTE: Includes Tobacco User, Proxy, Provider and General Public.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Phone English	113	80.1 %	213	76.3 %
Fax Referral	19	13.5 %	32	11.5 %
Other	1	0.7 %	3	1.1 %
Re-enrollment Recruitment	2	1.4 %	14	5.0 %
Web Enroll	6	4.3 %	17	6.1 %
Total	**141**	**100 %**	**279**	**100 %**

Caller Type

	Current Period	Current Period %	Contract YTD	Contract YTD %
Tobacco User	141	100.0 %	279	100.0 %
Total	**141**	**100 %**	**279**	**100 %**

Heard About

Displays a count of self-reported answers associated with the question asked by Registration, 'How did you hear about the program?'.
NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Brochure/Flyer	2	1.4 %	6	2.2 %
Bus Ad	3	2.2 %	3	1.1 %
Community Organization	1	0.7 %	4	1.5 %
Co-Worker	1	0.7 %	1	0.4 %
Customer/Member Service	2	1.4 %	3	1.1 %
Employer/Worksite	3	2.2 %	5	1.8 %
Every Woman Matters (EWM)	1	0.7 %	1	0.4 %
Family/Friend	7	5.0 %	20	7.3 %
Health Department	1	0.7 %	2	0.7 %
Health Insurance	3	2.2 %	8	2.9 %
Health Professional	57	41.0 %	104	37.8 %
Health Care Provider	*44*	*31.7 %*	*78*	*28.4 %*
Mental Health Provider	*2*	*1.4 %*	*4*	*1.5 %*
Nurse	*-*	*-*	*2*	*0.7 %*
Other	*1*	*0.7 %*	*2*	*0.7 %*
Other Specialist	*1*	*0.7 %*	*4*	*1.5 %*
Pharmacist	*5*	*3.6 %*	*9*	*3.3 %*
Social Worker	*4*	*2.9 %*	*4*	*1.5 %*
Substance Abuse Provider	*-*	*-*	*1*	*0.4 %*
Sub Total	*57*	*41.0 %*	*104*	*37.8 %*
Poor Ad	1	0.7 %	3	1.1 %
Billboard	*1*	*0.7 %*	*3*	*1.1 %*
Sub Total	*1*	*0.7 %*	*3*	*1.1 %*
Radio	3	2.2 %	4	1.5 %

How Heard About

Displays a count of self-reported answers associated with the question asked by Registration, 'How did you hear about the program?'.
NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
TV/Commercial	37	26.6 %	75	27.3 %
TV/News	-	-	1	0.4 %
Website	10	7.2 %	15	5.5 %
Does not know/remember	1	0.7 %	2	0.7 %
Other	6	4.3 %	18	6.5 %
Not Collected	2		4	
Total	**141**	**100 %**	**279**	**100 %**

Tobacco Users by Gender

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Male	43	30.5 %	81	29.0 %
Female	98	69.5 %	198	71.0 %
Total	**141**	**100 %**	**279**	**100 %**

Tobacco Users by Language Spoken

	Current Period	Current Period %	Contract YTD	Contract YTD %
sh	141	100.0 %	279	100.0 %
Total	**141**	**100 %**	**279**	**100 %**

Tobacco Users by Age

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
18	1	0.7 %	1	0.4 %
20 to 24	3	2.1 %	8	2.9 %
25 to 30	16	11.3 %	28	10.0 %
31 to 40	38	27.0 %	63	22.6 %
41 to 50	27	19.1 %	63	22.6 %
51 to 60	37	26.2 %	76	27.2 %
61 to 70	18	12.8 %	37	13.3 %
71 to 80	-	-	2	0.7 %
Over 80	1	0.7 %	1	0.4 %
Total	**141**	**100 %**	**279**	**100 %**

Tobacco Users by Tobacco Type

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Cigarette	130	74.3 %	254	74.9 %
Cigar	13	7.4 %	17	5.0 %
Pipe	1	0.6 %	3	0.9 %
keless Tobacco	4	2.3 %	7	2.1 %
arette	23	13.1 %	43	12.7 %
Other	4	2.3 %	15	4.4 %
Total	**175**	**100 %**	**339**	**100 %**

Tobacco Users by Education

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Less than grade 9	4	2.9 %	6	2.2 %
Grade 9-11 no degree	12	8.8 %	26	9.6 %
GED	10	7.3 %	19	7.0 %
High School Degree	22	16.1 %	52	19.3 %
Some College or University	55	40.1 %	95	35.2 %
College or University Degree	32	23.4 %	66	24.4 %
Some Technical / Trade School	1	0.7 %	1	0.4 %
Technical Trade School degree	1	0.7 %	5	1.9 %
Refused	2		6	
Not Collected	2		3	
Total	**141**	**100 %**	**279**	**100 %**

Female Tobacco Users by Pregnancy Status

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Not Pregnant	96	98.0 %	191	96.5 %
Currently Pregnant	-	-	2	1.0 %
[illegible]ning	-	-	2	1.0 %
[illegible]ntly Breastfeeding	2	2.0 %	3	1.5 %
Total	**98**	**100 %**	**198**	**100 %**

Tobacco Users by Chronic Condition

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Asthma	35	17.4 %	61	16.2 %
CAD	10	5.0 %	18	4.8 %
Cancer	9	4.5 %	19	5.1 %
Heart Failure (CHF)	6	3.0 %	11	2.9 %
COPD	30	14.9 %	54	14.4 %
Type 1 Diabetes	4	2.0 %	5	1.3 %
Type 2 Diabetes	18	9.0 %	38	10.1 %
None	89	44.3 %	169	44.9 %
Does Not Know	-	-	1	0.3 %
Refused	2		7	
Not Collected	-		19	
Total	**203**	**100 %**	**402**	**100 %**

Tobacco Users by Mental Health Conditions

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
ADHD	15	5.2 %	32	5.6 %
[illegible]ty	62	21.3 %	119	20.9 %
[illegible]olar	33	11.3 %	69	12.1 %
Depression	71	24.4 %	131	23.0 %
Drug or Alcohol Abuse	14	4.8 %	31	5.4 %
PTSD	46	15.8 %	85	14.9 %

Tobacco Users by Mental Health Conditions

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Schizophrenia	9	3.1 %	20	3.5 %
None	41	14.1 %	83	14.6 %
Refused	2		4	
Not Collected	4		17	
Total	**297**	**100 %**	**591**	**100 %**

Tobacco Users by Stage at Registration

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Precontemplation	-	-	1	0.4 %
Contemplation	3	2.1 %	4	1.4 %
Preparation	125	88.7 %	240	86.0 %
Action - Less than 24 hours	7	5.0 %	11	3.9 %
Action - 24 hours to less than 7 days	4	2.8 %	9	3.2 %
Action - 7 days to less than 1 month	-	-	6	2.2 %
Maintenance - 6 months OR more	2	1.4 %	8	2.9 %
Total	**141**	**100 %**	**279**	**100 %**

ıcco Users by Race

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
American Indian or Alaskan Native	3	2.2 %	5	1.8 %
Arab or Arab American	-	-	1	0.4 %
Black or African American	18	13.1 %	34	12.5 %
White	106	77.4 %	213	78.3 %
Other	10	7.3 %	19	7.0 %
Not Collected	2		3	
Refused	2		4	
Total	**141**	**100 %**	**279**	**100 %**

Tobacco Users by Ethnicity

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Hispanic	11	8.1 %	17	6.3 %
Non-Hispanic	125	91.9 %	255	93.8 %
Refused	2		4	
Not Collected	3		3	
Total	**141**	**100 %**	**279**	**100 %**

Tobacco Users by Income Level

	Current Period	Current Period %	Contract YTD	Contract YTD %
ıhan $10,000	38	27.9 %	77	28.6 %
Less than $15,000 ($10,000 to less than $15,000)	28	20.6 %	52	19.3 %
Less than $20,000 ($15,000 to less than $20,000)	14	10.3 %	30	11.2 %
Less than $25,000 ($20,000 to less than $25,000)	16	11.8 %	27	10.0 %

Tobacco Users by Income Level

	Current Period	Current Period %	Contract YTD	Contract YTD %
Less than $35,000 ($25,000 to less than $35,000)	13	9.6 %	27	10.0 %
Less than $50,000 ($35,000 to less than $50,000)	11	8.1 %	19	7.1 %
Less than $75,000 ($50,000 to less than $75,000)	7	5.1 %	14	5.2 %
$75,000 or More	7	5.1 %	17	6.3 %
Does Not Know	2	1.5 %	6	2.2 %
Refused	3		8	
Not Collected	2		2	
Total	**141**	**100 %**	**279**	**100 %**

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Nebraska Tobacco Quitline
Demographic Report

Print Date/Time 9/5/2019 12:50:45 PM

From 8/1/2019 through 8/31/2019

Contract Dates from 7/1/2019 through 8/31/2019

The purpose of this report is to display summary demographic information of program participants. This information is aggregated based on the date that the participant registers to receive services.

Method of Entry

NOTE: Includes Tobacco User, Proxy, Provider and General Public.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Phone English	283	81.3 %	534	76.6 %
Fax Referral	50	14.4 %	103	14.8 %
Other	3	0.9 %	9	1.3 %
Re-enrollment Recruitment	6	1.7 %	34	4.9 %
Web Enroll	6	1.7 %	17	2.4 %
Total	**348**	**100 %**	**697**	**100 %**

Caller Type

	Current Period	Current Period %	Contract YTD	Contract YTD %
Tobacco User	339	97.4 %	680	97.6 %
Proxy	2	0.6 %	4	0.6 %
[illegible]der	5	1.4 %	8	1.1 %
[illegible]ral Public	2	0.6 %	5	0.7 %
Total	**348**	**100 %**	**697**	**100 %**

How Heard About

Displays a count of self-reported answers associated with the question asked by Registration, 'How did you hear about the program?'.
NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Brochure/Flyer	5	0.8 %	13	1.0 %
Bus Ad	3	0.9 %	3	0.5 %
Community Organization	2	0.6 %	7	1.1 %
Co-Worker	2	0.6 %	2	0.3 %
Customer/Member Service	2	0.6 %	3	0.5 %
Employer/Worksite	3	0.9 %	5	0.8 %
Every Woman Matters (EWM)	1	0.3 %	1	0.2 %
Family/Friend	21	6.5 %	51	7.8 %
Health Department	2	0.6 %	6	0.9 %
Health Insurance	3	0.9 %	17	2.6 %
Health Professional	135	41.5 %	278	42.6 %
Health Care Provider	*96*	*29.5 %*	*198*	*30.4 %*
Health Educator	*5*	*1.5 %*	*6*	*0.9 %*
Mental Health Provider	*4*	*1.2 %*	*9*	*1.4 %*
Nurse	*4*	*1.2 %*	*12*	*1.8 %*
OB/GYN Specialist	*1*	*0.3 %*	*2*	*0.3 %*
Other	*1*	*0.3 %*	*3*	*0.5 %*
Other Specialist	*9*	*2.8 %*	*13*	*2.0 %*
Pharmacist	*6*	*1.8 %*	*21*	*3.2 %*
Respiratory Therapist	*1*	*0.3 %*	*1*	*0.2 %*
Social Worker	*4*	*1.2 %*	*4*	*0.6 %*

How Heard About

Displays a count of self-reported answers associated with the question asked by Registration, 'How did you hear about the program?'.
NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Substance Abuse Provider	*4*	*1.2 %*	*9*	*1.4 %*
Sub Total	*135*	*41.5 %*	*278*	*42.6 %*
Mailed Information	-	-	1	0.2 %
Open enrollment/New hire	1	0.3 %	1	0.2 %
Outdoor Ad	3	0.9 %	5	0.8 %
Billboard	*3*	*0.9 %*	*5*	*0.8 %*
Sub Total	*3*	*0.9 %*	*5*	*0.8 %*
Radio	5	1.5 %	7	1.1 %
State Quit Line/Help Line	-	-	1	0.2 %
TV/Commercial	89	27.4 %	172	26.4 %
TV/News	-	-	1	0.2 %
Website	11	3.4 %	18	2.8 %
Does not know/remember	4	1.2 %	7	1.1 %
Other	33	10.2 %	53	8.1 %
Not Collected	23		45	
Total	**348**	**99 %**	**697**	**99 %**

Tobacco Users by Gender

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Male	101	31.4 %	204	31.5 %
Female	221	68.6 %	444	68.5 %
Not Collected	26		49	
Total	**348**	**100 %**	**697**	**100 %**

Tobacco Users by Language Spoken

	Current Period	Current Period %	Contract YTD	Contract YTD %
English	321	99.7 %	646	99.7 %
Spanish	1	0.3 %	2	0.3 %
Not Collected	26		49	
Total	**348**	**100 %**	**697**	**100 %**

Tobacco Users by Age

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
18	1	0.3 %	2	0.3 %
20 to 24	10	3.1 %	19	2.9 %
25 to 30	23	7.1 %	52	8.0 %
31 to 40	78	24.2 %	132	20.4 %
41 to 50	51	15.8 %	122	18.8 %
60	83	25.8 %	180	27.8 %
70	57	17.7 %	113	17.4 %
71 to 80	15	4.7 %	23	3.5 %
Over 80	4	1.2 %	5	0.8 %

Tobacco Users by Age

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Not Collected	26		49	
Total	**348**	**100 %**	**697**	**100 %**

Tobacco Users by Tobacco Type

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Cigarette	295	77.2 %	587	76.3 %
Cigar	25	6.5 %	39	5.1 %
Pipe	2	0.5 %	5	0.7 %
Smokeless Tobacco	8	2.1 %	17	2.2 %
E-Cigarette	41	10.7 %	89	11.6 %
Other	11	2.9 %	32	4.2 %
Not Collected	26		49	
Total	**408**	**100 %**	**818**	**100 %**

Tobacco Users by Education

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
[illegible]han grade 9	14	4.5 %	26	4.1 %
Grade 9-11 no degree	41	13.1 %	84	13.3 %
GED	21	6.7 %	48	7.6 %
High School Degree	76	24.3 %	160	25.4 %
Some College or University	95	30.4 %	176	27.9 %
College or University Degree	56	17.9 %	114	18.1 %
Some Technical / Trade School	1	0.3 %	3	0.5 %
Technical Trade School degree	9	2.9 %	20	3.2 %
Refused	5		12	
Not Collected	30		54	
Total	**348**	**100 %**	**697**	**100 %**

Female Tobacco Users by Pregnancy Status

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Not Pregnant	217	98.2 %	428	96.4 %
Currently Pregnant	2	0.9 %	8	1.8 %
Planning	-	-	5	1.1 %
Currently Breastfeeding	2	0.9 %	3	0.7 %
Total	**221**	**100 %**	**444**	**100 %**

Tobacco Users by Chronic Condition

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
[illegible]na	75	15.2 %	128	14.3 %
CAD	27	5.5 %	47	5.2 %

Tobacco Users by Chronic Condition

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Cancer	25	5.1 %	48	5.3 %
Heart Failure (CHF)	19	3.8 %	36	4.0 %
COPD	82	16.6 %	142	15.8 %
Type 1 Diabetes	11	2.2 %	15	1.7 %
Type 2 Diabetes	49	9.9 %	85	9.5 %
None	205	41.5 %	392	43.7 %
Does Not Know	1	0.2 %	5	0.6 %
Refused	6		15	
Not Collected	26		117	
Total	**526**	**100 %**	**1,030**	**100 %**

Tobacco Users by Mental Health Conditions

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Period	Current Period %	Contract YTD	Contract YTD %
ADHD	32	5.0 %	74	5.8 %
Anxiety	129	20.1 %	252	19.9 %
Bi-Polar	83	12.9 %	159	12.5 %
[illegible]ession	147	22.9 %	278	21.9 %
[illegible]or Alcohol Abuse	39	6.1 %	71	5.6 %
PTSD	88	13.7 %	164	12.9 %
Schizophrenia	26	4.1 %	63	5.0 %
None	97	15.1 %	207	16.3 %
Refused	4		9	
Not Collected	35		82	
Total	**660**	**100 %**	**1,359**	**100 %**

Tobacco Users by Stage at Registration

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Precontemplation	-	-	1	0.2 %
Contemplation	6	1.9 %	11	1.7 %
Preparation	281	87.3 %	566	87.3 %
Action - Less than 24 hours	13	4.0 %	20	3.1 %
Action - 24 hours to less than 7 days	10	3.1 %	18	2.8 %
Action - 7 days to less than 1 month	4	1.2 %	13	2.0 %
Maintenance - 6 months OR more	8	2.5 %	19	2.9 %
Not Collected	26		49	
Total	**348**	**100 %**	**697**	**100 %**

Tobacco Users by Race

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
[illegible]rican Indian or Alaskan Native	11	3.5 %	16	2.5 %
Arab or Arab American	-	-	2	0.3 %
Black or African American	39	12.5 %	83	13.2 %

Tobacco Users by Race

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Native Hawaiian/Other Pacific Islander	-	-	2	0.3 %
Guamanian/Chamorro	-	-	*1*	*0.2 %*
Other Pacific Islander	-	-	*1*	*0.2 %*
Sub Total	-	-	*2*	*0.3 %*
White	239	76.8 %	487	77.4 %
Other	22	7.1 %	38	6.0 %
Does Not Know	-	-	1	0.2 %
Not Collected	31		55	
Refused	6		13	
Total	**348**	**100 %**	**697**	**100 %**

Tobacco Users by Ethnicity

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Period	Current Period %	Contract YTD	Contract YTD %
Hispanic	18	5.8 %	32	5.1 %
Non-Hispanic	292	94.2 %	597	94.9 %
Refused	6		12	
Collected	32		56	
	348	**100 %**	**697**	**100 %**

Tobacco Users by Income Level

	Current Period	Current Period %	Contract YTD	Contract YTD %
Less than $10,000	119	38.5 %	247	39.5 %
Less than $15,000 ($10,000 to less than $15,000)	63	20.4 %	128	20.5 %
Less than $20,000 ($15,000 to less than $20,000)	28	9.1 %	60	9.6 %
Less than $25,000 ($20,000 to less than $25,000)	24	7.8 %	47	7.5 %
Less than $35,000 ($25,000 to less than $35,000)	26	8.4 %	47	7.5 %
Less than $50,000 ($35,000 to less than $50,000)	20	6.5 %	33	5.3 %
Less than $75,000 ($50,000 to less than $75,000)	13	4.2 %	23	3.7 %
$75,000 or More	8	2.6 %	20	3.2 %
Does Not Know	8	2.6 %	20	3.2 %
Refused	9		19	
Not Collected	30		53	
Total	**348**	**100 %**	**697**	**100 %**

Nebraska Tobacco Quitline

Custom Questions Report

From 8/1/2019 through 8/31/2019

Contract dates 7/1/2019 through 8/31/2019

Do you currently live in public housing (sometimes called subsidized housing)?

	Period	Period %	YTD	YTD %
Yes	87	27.02%	159	24.57%
No	231	71.74%	476	73.57%
Does Not Know	1	0.31%	3	0.46%
Rather Not Answer	3	0.93%	9	1.39%
Total	**322**	**100 %**	**647**	**100 %**

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Nebraska Tobacco Quitline

Caller Types By County

*All

From 8/1/2019 through 8/31/2019

Contract Dates From 7/1/2019 through 8/31/2019

The purpose of this report is to provide a breakdown of callers by type, by geographical region.

	Tobacco User	Proxy	Provider	General Public	Other	Report Period	Report Year
ADAMS	12	-	-	-	-	12	24
ANTELOPE	-	-	-	-	-	0	0
ARTHUR	-	-	-	-	-	0	0
BANNER	-	-	-	-	-	0	0
BLAINE	-	-	-	-	-	0	0
BOONE	-	-	-	-	-	0	1
BOX BUTTE	2	-	-	-	-	2	2
BOYD	-	-	-	-	-	0	0
BROWN	-	-	-	-	-	0	0
BUFFALO	1	-	-	-	-	1	8
BURT	3	-	-	-	-	3	3
BUTLER	1	-	-	-	-	1	3
CASS	3	-	-	-	-	3	4
CEDAR	1	-	-	-	-	1	3
[illegible]	-	-	-	-	-	0	1
CHERRY	1	-	-	-	-	1	4
CHEYENNE	-	-	-	-	-	0	2
CLAY	1	-	-	-	-	1	1
COLFAX	-	-	-	-	-	0	0
CUMING	1	-	-	-	-	1	3
CUSTER	1	-	-	-	-	1	1
DAKOTA	1	-	-	-	-	1	2
DAWES	-	-	-	-	-	0	1
DAWSON	2	-	-	-	-	2	4
DEUEL	-	-	-	-	-	0	0
DIXON	-	-	-	-	-	0	1
DODGE	14	-	-	-	-	14	23
DOUGLAS	124	-	-	-	-	124	244
DUNDY	1	-	-	-	-	1	1
FILLMORE	-	-	-	-	-	0	0
FRANKLIN	1	-	-	-	-	1	3
FRONTIER	-	-	-	-	-	0	0
FURNAS	1	-	-	-	-	1	1
GAGE	9	-	-	-	-	9	14
GARDEN	2	-	-	-	-	2	3
GARFIELD	-	-	-	-	-	0	0
GOSPER	-	-	-	-	-	0	0
GRANT	-	-	-	-	-	0	0
GREELEY	-	-	-	-	-	0	1
[illegible]	11	-	-	-	-	11	22
[illegible]TON	1	-	-	-	-	1	1
HARLAN	1	-	-	-	-	1	1
HAYES	-	-	-	-	-	0	0
HITCHCOCK	-	-	-	-	-	0	0
HOLT	1	-	-	-	-	1	1

Nebraska Tobacco Quitline

Caller Types By County

*All

From 8/1/2019 through 8/31/2019

Contract Dates From 7/1/2019 through 8/31/2019

HOOKER	-	-	-	-	-	0	0
HOWARD	-	-	-	-	-	0	0
JEFFERSON	1	-	-	-	-	1	3
JOHNSON	-	-	-	-	-	0	0
KEARNEY	1	-	-	-	-	1	3
KEITH	-	-	-	-	-	0	2
KEYA PAHA	-	-	-	-	-	0	0
KIMBALL	1	-	-	-	-	1	4
KNOX	-	-	-	-	-	0	0
LANCASTER	54	-	-	-	-	54	117
LINCOLN	11	-	-	-	-	11	17
LOGAN	-	-	-	-	-	0	0
LOUP	-	-	-	-	-	0	0
MADISON	10	-	-	-	-	10	14
MCPHERSON	-	-	-	-	-	0	0
MERRICK	-	-	-	-	-	0	1
MORRILL	-	-	-	-	-	0	3
NANCE	1	-	-	-	-	1	1
NEMAHA	-	-	-	-	-	0	0
NUCKOLLS	-	-	-	-	-	0	0
OTOE	1	-	-	-	-	1	4
PAWNEE	1	-	-	-	-	1	2
PERKINS	-	-	-	-	-	0	0
PHELPS	1	-	-	-	-	1	5
[illegible]E	-	-	-	-	-	0	2
PLATTE	4	-	-	-	-	4	5
POLK	-	-	-	-	-	0	0
RED WILLOW	2	-	-	-	-	2	6
RICHARDSON	1	-	-	-	-	1	2
ROCK	-	-	-	-	-	0	0
SALINE	1	-	-	-	-	1	3
SARPY	17	-	-	-	-	17	36
SAUNDERS	2	-	-	-	-	2	6
SCOTTS BLUFF	8	-	-	-	-	8	12
SEWARD	-	-	-	-	-	0	1
SHERIDAN	-	-	-	-	-	0	0
SHERMAN	1	-	-	-	-	1	1
SIOUX	-	-	-	-	-	0	0
STANTON	-	-	-	-	-	0	1
THAYER	2	-	-	-	-	2	4
THOMAS	-	-	-	-	-	0	0
THURSTON	1	-	-	-	-	1	2
VALLEY	-	-	-	-	-	0	0
WASHINGTON	3	-	-	-	-	3	5
WAYNE	-	-	-	-	-	0	0
WEBSTER	1	-	-	-	-	1	1
WHEELER	-	-	-	-	-	0	0
YORK	1	-	-	-	-	1	3
Not Collected	17	2	5	2	10	36	62
Total	339	2	5	2	10	358	711

Nebraska Tobacco Quitline
NRT Shipments

From 8/1/2019 through 8/31/2019

Billable	true

Patch Weeks	Count of Service Type
2	172
4	5
Grand Total	**177**

Billable	true

Gum Boxes	Count of Service Type
1	32
2	1
Grand Total	**33**

Billable	true

Lozenge Boxes	Count of Service Type
2	49
Grand Total	**49**

Summary

Appendix A.1.37.b.
Data Dictionary
(Proprietary Information)

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