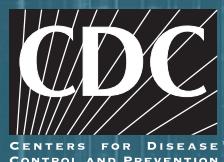




# A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**Centers for Disease Control and Prevention**

# **A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention



## Ordering Information

**To order a copy of this publication, contact:**

Centers for Disease Control and Prevention  
Office on Smoking and Health  
Mail Stop K-50, Publications  
4770 Buford Highway, NE  
Atlanta GA 30341-3717

Phone: 1-800-CDC-1311 (800-232-1311)

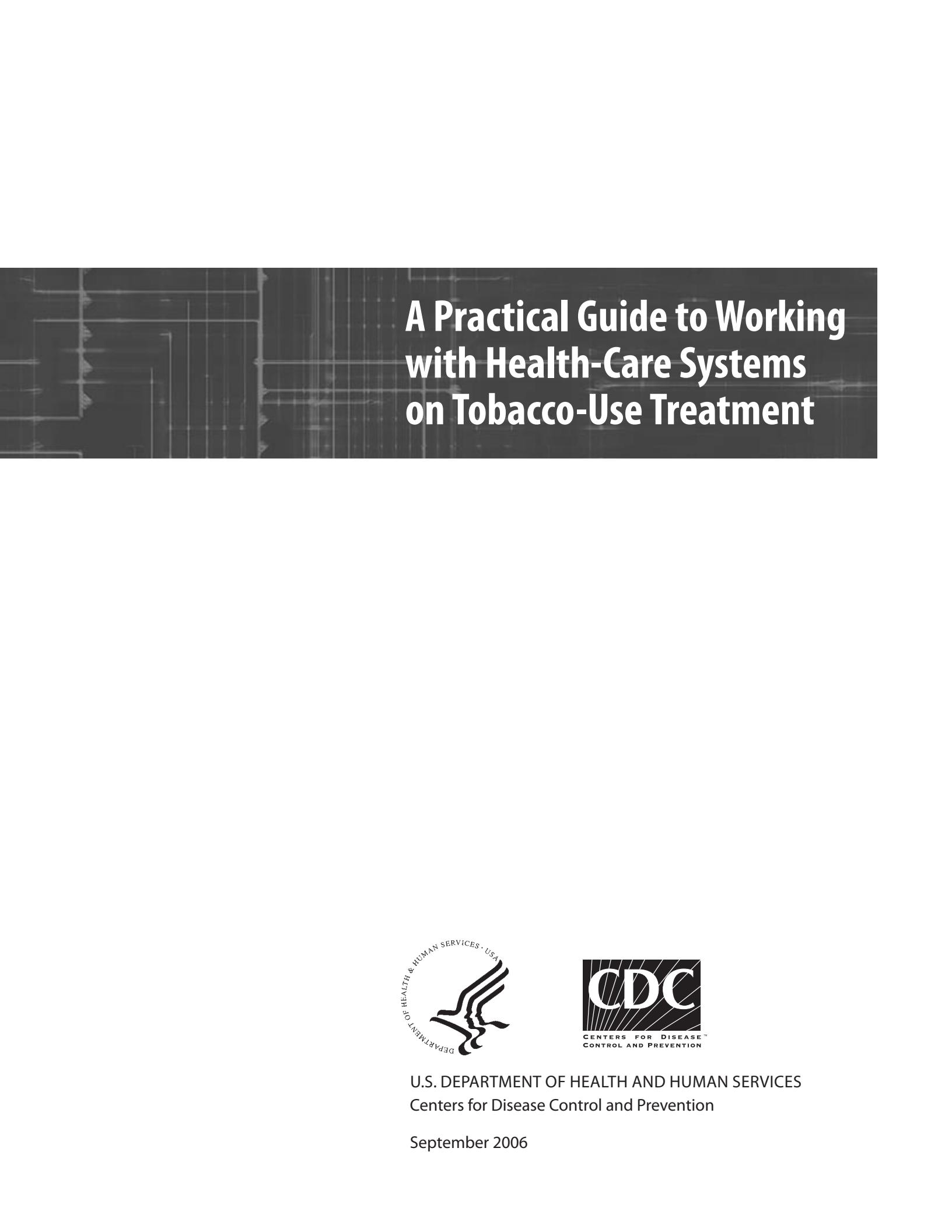
FAX Information Services: 1-888-CDC-FAXX (888-232-3299)

<http://www.cdc.gov/tobacco/pubs.htm>

### **Suggested Citation**

Centers for Disease Control and Prevention. *A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006.





# A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention

September 2006



# Table of Contents

<b>Acknowledgments.....</b>	iii
<b>Introduction.....</b>	1
<b>Health-Care Systems Primer.....</b>	7
Ambulatory Care .....	7
Government as Health-Care Clinician .....	8
Hospitals .....	11
Health Plans .....	13
Purchasers of Insurance .....	17
<b>Effective Tobacco-Control Interventions and the Health-Care System's Role.....</b>	21
Individual Treatment.....	21
Clinicians.....	25
Systems Changes to Support Clinician Intervention.....	32
Reducing Patient Out-of-Pocket Costs for Tobacco-Use Treatment.....	37
Community Policy and Mass Media .....	40
<b>Building Relationships Within Health-Care Systems .....</b>	43
Reasons to Collaborate.....	43
Keys to Successful Collaboration .....	43
Beginning a Collaboration.....	44
Roles Within the Collaboration.....	44
The Public Health Contribution .....	45
<b>Implementation Strategies.....</b>	47
Lessons Learned.....	47
Measuring Progress.....	48
Increasing Systems-Change Effectiveness .....	48
Case Studies.....	51
<b>Conclusion .....</b>	69
<b>References.....</b>	71
<b>Appendices.....</b>	77
A. Glossary of Terms.....	78
B. Essential Elements of an Effective Practice-Based Tobacco-Cessation System .....	80
C. Essential Elements of an Effective Pediatric Practice-Based Tobacco-Control System .....	81

D. Making the Business Case for Tobacco Control.....	83
E. For More Information.....	84
F. Practice Assessment Document .....	90
G. Coverage for Tobacco-Use Cessation Treatments .....	95
H. Reducing the Burden of Smoking on Employee Health and Productivity .....	101
I. Tobacco Quitlines .....	109
J. QuitWorks .....	113
K. Minimal Data Set Intake Questions.....	115
L. Medicaid Model Language .....	125
M. Promotion of Tobacco Cessation in the Health-Care System: Suggested Strategies .....	127

# Acknowledgments

## **Abby C. Rosenthal, M.P.H.**

Cessation Strategic Coordinator  
Office on Smoking and Health  
Centers for Disease Control  
and Prevention  
Atlanta, Georgia

## **Corinne G. Husten, M.D., M.P.H.**

Acting Director  
Office on Smoking and Health  
Centers for Disease Control  
and Prevention  
Atlanta, Georgia

---

We thank the following individuals who served as members of the Health-Care Systems Workgroup and who contributed their expertise and experience in developing and reviewing this document.

### **Marc W. Manley, M.D., M.P.H.**

#### **Workgroup Chair**

Executive Director  
Center for Tobacco Reduction and  
Health Improvement  
BlueCross and BlueShield of Minnesota  
St. Paul, Minnesota

### **Anna Berkowitz, M.P.H.**

Program Consultant  
Office on Smoking and Health  
Centers for Disease Control and Prevention  
Atlanta, Georgia

### **Wendy Bjornson, M.P.H.**

Smoking Cessation Center  
Oregon Health & Science University  
Portland, Oregon

### **Nancy G. Clarke**

Health System Liaison  
Oregon Department of Human Services,  
Health Promotion, and Chronic  
Disease Prevention  
Portland, Oregon

### **Jack F. Hollis, Ph.D.**

Associate Director  
Kaiser Permanente Center for Health Research  
Portland, Oregon

### **Carolyn C. Link, M.P.H.**

#### **Workgroup Lead Writer**

Center for Tobacco Reduction and  
Health Improvement  
BlueCross and BlueShield of Minnesota  
St. Paul, Minnesota

### **Nicola Majchrzak, M.P.H., M.S.W.**

Project Director  
Massachusetts General Hospital Tobacco  
Research and Treatment Center  
Boston, Massachusetts

### **Tim McAfee, M.D., M.P.H.**

Chief Medical Officer  
Free and Clear, Inc.  
Seattle, Washington

### **Cathy Melvin, Ph.D., M.P.H.**

Director, Smoke-Free Families  
National Dissemination Office  
Cecil G. Sheps Center for Health  
Services Research  
University of North Carolina at Chapel Hill  
Chapel Hill, North Carolina

### **Nancy Rigotti, M.D.**

Director, Tobacco Research and  
Treatment Center  
Massachusetts General Hospital  
Boston, Massachusetts

**Leif Solberg, M.D.**

Associate Medical Director for  
Care Improvement Research  
Health Partners Research Foundation  
Minneapolis, Minnesota

**Jessica Spraggins, M.P.H.**

ORISE Fellow  
Office on Smoking and Health  
Centers for Disease Control and Prevention  
Atlanta, Georgia

**Tracey Strader, M.S.W.**

Executive Director  
Oklahoma Tobacco Settlement  
Endowment Trust Fund  
Oklahoma City, Oklahoma

**Susan Swartz, M.D.**

Medical Director  
Center for Tobacco Independence  
Maine Medical Center  
Portland, Maine

**Jonathan P. Winickoff, M.D., M.P.H.**

Chair, American Academy of Pediatrics  
Tobacco Consortium  
Assistant Professor of Pediatrics  
Harvard Medical School  
Boston, Massachusetts

---

## Reviewers

**Christopher M. Anderson, B.A.**

Program Director  
California Smoker's Helpline  
Dept. of Family and Preventive Medicine  
University of California, San Diego  
La Jolla, California

**Donna Warner, M.B.A., M.A., C.A.C.**

Director, Planning and Program  
Development  
Massachusetts Tobacco Control Program  
Massachusetts Department of Public Health  
Boston, Massachusetts

**Scott Sherman, M.D., M.P.H.**

Smoking Cessation Coordinator  
VA Greater Los Angeles Health-  
Care System  
Professor of Medicine  
UCLA/San Fernando Valley Program  
Sepulveda, California

---

## Case Study Contributors

Charles J. Bentz, M.D., F.A.C.P.  
Wendy Bjornson, M.P.H.  
Nancy Clarke  
Sally Carter, M.S.W.  
D'Anne Gilmore  
Joy L. Leuthard, M.S., L.S.W.A.  
Nicola Majchrzak, M.P.H., M.S.W.  
Tim McAfee, M.D., M.P.H.

Lynn Mitchell, M.D., M.P.H.  
Lezli Redmond, M.P.H.  
Dawn Robbins  
Tracey Strader, M.S.W.  
Susan Swartz, M.D.  
Judith Van Osdol, B.S.N., R.N., M.H.S.A.  
Donna Warner, M.B.A., M.A., C.A.C.

We also acknowledge the contributions of the following Northrop Grumman IT contractor staff:  
**Maxine Forrest**, Technical Writer; **Jody Gan**, Research Associate; **Samantha Helfert**, Medical Librarian; and **Jeffrey Roussel** and **Catherine Ignacio**, Graphic Designers.

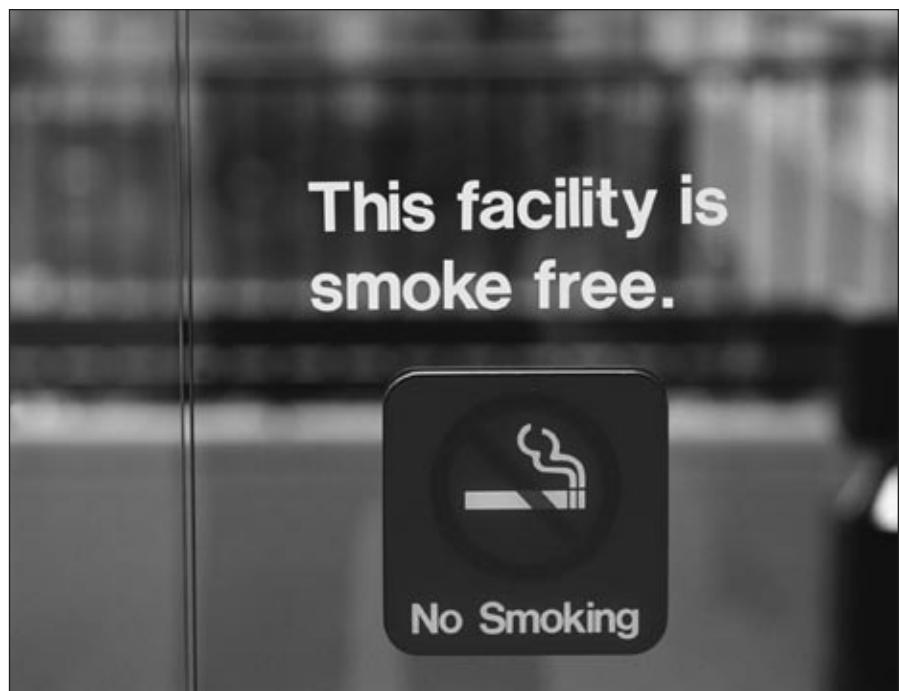
# Introduction

**T**obacco dependence shows many features of a chronic disease. Although a minority of tobacco users achieves permanent abstinence in an initial quit attempt, the majority persist in tobacco use for many years and typically cycle through multiple periods of relapse and remission. A failure to appreciate the chronic nature of tobacco dependence may undercut clinicians' motivation to treat tobacco use consistently (Fiore et al., 2000).

Treating Tobacco Use and Dependence:  
Clinical Practice Guideline

Promoting widespread use of treatment for tobacco dependence is one of the primary goals in improving public health (U.S. Department of Health and Human Services, 2000). Tobacco use, and smoking in particular, causes many of the chronic and debilitating diseases that affect the population and stress the health-care system. Such diseases include heart disease, stroke, multiple cancers, and respiratory diseases, as well as complications of pregnancy such as preterm delivery and low infant birth weight (U.S. Department of Health and Human Services, 1989, 2001, and 2004; National Cancer Institute, 1999).

State health departments and businesses are uniquely positioned to expand the provision of tobacco-dependence treatment through partnerships and purchasing strategies. Insurance coverage can be expanded for state employees and Medicaid recipients. Business partnerships can be developed to initiate or expand coverage for self-insured or indemnity populations. Comprehensive benefits must be appropriately promoted, and their use should be monitored.



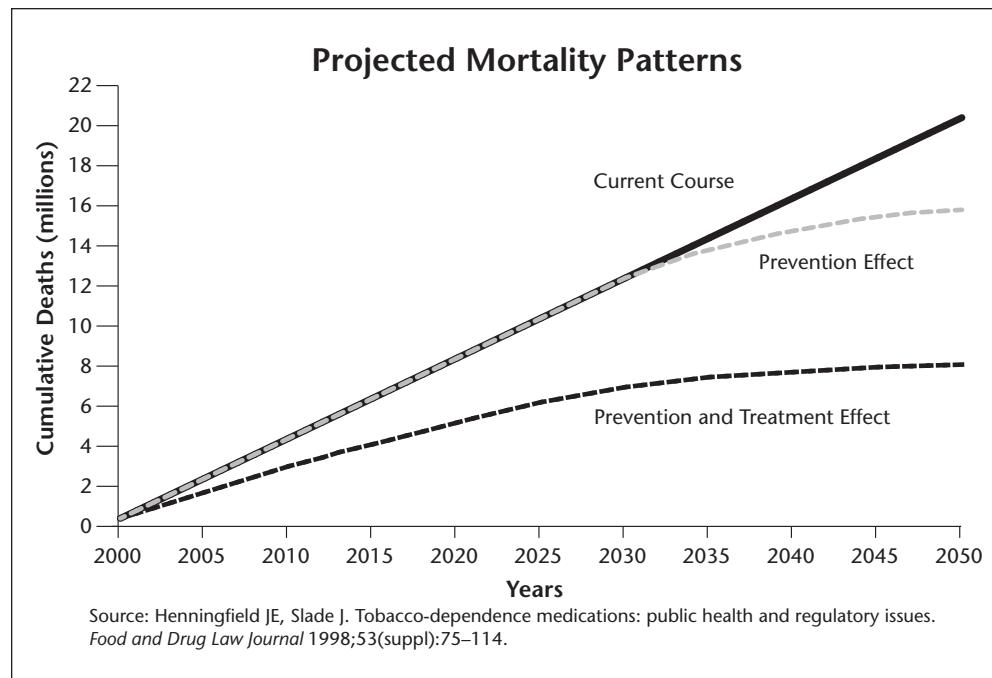
This guide will review what is known about implementing comprehensive tobacco-control and treatment strategies within health-care systems. Provided within are examples of effective partnerships between public health agencies, health-care systems, and the business community. Also included is a primer designed to promote a better understanding of health care for those not familiar with systems operations. The reader should be aware that this guide uses the term “patient” in the broadest sense—therefore, users of this guide should not exclude opportunities for providers to treat tobacco use among relatives, such as parents of infant, child, and adolescent patients; other patient family members; and any other individuals with whom providers have contact through interactions with patients.

Approximately 28% of adolescents in this country currently use tobacco, 22% of whom are smokers (Centers for Disease Control and Prevention [CDC], 2005a). Additionally, more than one in five adults in this country currently smoke (CDC, 2004b), but most want to quit. In 2002, 70% of smokers reported that they wanted to quit, and 41% attempted to quit for at least 24 hours in the past year. However, only about 5% of smokers maintained abstinence for 3 to 12 months (CDC, 2005b).

Safe and effective tobacco-use treatments that greatly enhance success in quitting are available, but many smokers do not or cannot access these treatments (Fiore et al., 2000). Most who try to quit may not be successful because they do not use effective treatments (American Cancer Society, 2003; Zhu et al., 2000).

In terms of efficacy, cost effectiveness, and impact, tobacco-use treatment has been ranked in the top three preventive services and has been specified as cost saving (Maciosek et al., 2006). Experts agree that reducing the number of new smokers and helping current smokers quit plays a critical role in improving public health (Peto et al., 2000). Reducing tobacco use is a key component of *Healthy People 2010*—the nation’s action plan for improving public health in the first decade of the 21st century. This plan includes 21 objectives related to tobacco and a goal to reduce smoking prevalence by more than half (to 12%) by 2010. Current smoking prevalence in the United States is 20.8% (CDC, 2005b).

The chart below illustrates the importance of including cessation in primary tobacco-control efforts.



Promoting quitting among tobacco users is one of the key recommendations in several recent major reports. The CDC recommends the following comprehensive tobacco-control strategies:

### **U.S. Public Health Service (PHS) Guideline for Treating Tobacco Use and Dependence**

- Ensure that all smokers are offered effective tobacco-use treatment at all clinical encounters.
- Increase access to and participation in effective tobacco-use counseling.
- Increase access to and appropriate use of effective tobacco-treatment medications.
- Reduce patient out-of-pocket costs for tobacco-use treatment.
- Create a social and economic environment that promotes quitting (Fiore et al., 2000).

### ***Guide to Community Preventive Services***

- Increase the unit price for tobacco products.
- Implement sustained mass media campaigns.

- Implement provider reminder systems in health-care settings.
- Reduce patient out-of-pocket costs for tobacco-use treatment.
- Initiate multicomponent interventions that include patient telephone support (Hopkins et al., 2001).

### **Interagency Committee on Smoking and Health, Cessation Subcommittee Goals, 2003**

- Mobilize health insurers, employers, and others to foster evidence-based tobacco-dependence coverage for all covered lives.
- Mobilize health systems to implement system-level changes to foster effective utilization of tobacco-dependence treatments.
- Mobilize national quality assurance and accreditation organizations, clinicians, health systems, and others to establish and measure the treatment of tobacco dependence as part of the standard of care ([www.cdc.gov/tobacco/ICHS](http://www.cdc.gov/tobacco/ICHS)).
- Mobilize communities to ensure that policies and programs are in place to increase demand for services and to ensure access to such services, especially for underserved populations (Fiore et al., 2004).

### **The Cochrane Collaboration, 2005**

- Health insurance that pays the full cost of smoking-cessation treatments can increase quit rates compared to benefit plans that only partially cover cessation treatment or that offer no cessation benefits (Cochrane Collaboration, 2005).
- Programs to stop smoking delivered during hospitalization that include a 1-month follow-up are most effective (Cochrane Collaboration, 2005).
- Proactive telephone counseling can be effective compared to an intervention without personal contact. Successful interventions generally involve multiple contacts timed around a quit attempt (Cochrane Collaboration, 2005).
- All of the commercially available forms of nicotine replacement therapy (gum, transdermal patch, nasal spray, inhaler, and sublingual tablets/lozenges) are effective as part of a strategy to promote smoking cessation (Cochrane Collaboration, 2005).
- Standard self-help materials may increase quit rates compared to no intervention, but the effect is likely to be small (Cochrane Collaboration, 2005).

Establishing new relationships, particularly with people in health-care systems and the business community, is essential to achieving success. By themselves, public health agencies have insufficient funding and capacity to deliver tobacco-use treatment services, create an environment that supports tobacco-use treatment, and manage other aspects of a comprehensive tobacco-use treatment program. These tobacco-use treatment objectives may be best achieved by developing new partnerships.

The primary purpose of this guide is to increase public health professionals' (in state and local health departments) comfort with and skill in establishing collaborative relationships with leaders in health-care systems and working with these partners on activities to promote effective system-wide tobacco-use treatment. The goal is to provide key information and practical advice that will help public health professionals improve their understanding of health-care systems and develop better skills in building relationships and working with health-care professionals.

This guide is also intended as a vehicle for public health agencies to assist health-care systems in increasing their use of effective tobacco-dependence treatments. The guide can also serve as a resource for the business/employer sector, which is adversely affected by tobacco use through absenteeism, loss of productivity, and higher health-care costs. Businesses and employers also have a vested interest in encouraging and supporting health-care systems to promote and implement effective tobacco-dependence treatment and cessation services.

Two primary sources of evidence inform this guide: the PHS clinical practice guidelines, *Treating Tobacco Use and Dependence*, and the CDC's *Guide to Community Preventive Services* (the Community Guide). The evidence base from those resources is supplemented by the opinions and experiences of a national panel of experts who contributed to this effort and served as technical reviewers.

This guide includes four major sections:

- **Health-Care Systems Primer** provides an overview of the major organizations that make up the health-care system and summarizes the challenges that each component faces for implementing effective tobacco-cessation initiatives. As noted above, public health professionals and members of the business/employer sector who are less familiar with these organizations should review this section before reading the next sections.

- **Effective Tobacco-Control Interventions and the Health-Care System's Role** discusses effective tobacco-use treatments and strategies for increasing access to these treatments. Professionals from each part of the public and private health-care system—clinics, hospitals, health plans, insurers, insurance purchasers, and the public health community—have roles to play in implementing these strategies. Some of their key roles are described in this section. Because the section presumes a working knowledge of health-care systems, readers who are less familiar with these organizations should first review the Health-Care Systems Primer, which begins on page 7. Case studies of successful partnerships between public health agencies and health-care systems are integrated throughout the document.
- **Building Relationships Within Health-Care Systems** describes strategies for collaboration on achieving tobacco-treatment-related objectives and how different agencies have used collaborative efforts to achieve specific goals.
- **Implementation Strategies** describes initiatives for incorporating recommended evidence-based strategies into practice.

The appendixes provide additional resources, such as detailed information on selected topics and sample materials that can be adapted or duplicated by clinics and clinicians. A listing of additional sources of information (e.g., publications, Web sites) is also included.

# Health-Care Systems Primer

**T**he influence of health-care system administrators, insurers, and purchasers could, in theory, be used to encourage and support the consistent and effective identification and treatment of tobacco users. These agents could craft and implement supportive systems, policies, and environmental prompts that render tobacco-use treatment an integral part of the health-care system. Indeed, research clearly shows that systems-level change can reduce smoking prevalence among enrollees of managed health-care plans (Fiore et al., 2000).

Treating Tobacco Use and Dependence:  
Clinical Practice Guideline

In a very simplified view of the health-care system, there are four major components:

- Service delivery (inpatient through hospitals and outpatient/ambulatory through clinics or providers' offices).
- Administration (via health plans or insurers).
- Finance (through commercial and governmental purchasers).
- Quality care (compliance with quality-assurance standards).

It is useful to understand the basic organizational forms and concerns of ambulatory care, hospitals, health plans, and purchasers before approaching these organizations with a tobacco-use treatment agenda. This knowledge can increase confidence, help identify opportunities, and demonstrate a commitment to understanding potential partners' capabilities and constraints.

## Ambulatory Care

Providers' offices are the main point of contact between tobacco users and the health-care system because 70% of smokers visit a clinician each year (Tomar et al., 1996). (In this document we use the term clinic to describe all sites where patients receive outpatient ambulatory care. We use the term clinician to refer to all health-care providers, including physicians; nurses; physical, occupational, and respiratory therapists; pharmacists; etc.) Clinics range in size and focus, from solo practices to small- and large-group practices or medical groups, and from specialty to multispecialty clinics and outpatient surgery centers.

Increasingly, clinics and practices are joining together to form larger medical groups. An organization that includes services like home health care or physical therapy as well as clinic and hospital services is referred to as an **integrated delivery system**. In some communities these large systems also are major employers that play a significant role in the local business community.

While autonomy has always been important to clinicians, aggregation provides certain advantages, such as greater leverage when negotiating contracts with health plans, joint marketing opportunities, resource sharing, and financial stability for smaller practices.

Tobacco-use treatment efforts have traditionally targeted **primary care** clinics, but in recent years these efforts have been expanded to reach specialty clinics and inpatient settings.

## Government as Health-Care Clinician

Government-funded and -operated clinics are an important part of the health-care safety net. These include county health departments, clinics, and hospitals; Women, Infants, and Children (WIC) clinics; Federally Qualified Health Centers (FQHC); the Veterans' Administration hospitals and clinics; and the Department of Defense and Indian Health Service community health clinics and centers. In each of these settings, clinicians should be encouraged to deliver treatments that are recommended in the Public Health Service (PHS) guidelines. Strategies described in the *Guide to Community Preventive Services* should be supported as systems-change initiatives (Hopkins et al., 2001). These clinical settings provide an excellent opportunity for reaching low-income populations, which have the highest smoking rates.

### *Challenges Clinics Face*

Public health professionals should be aware of typical concerns affecting the energy, interest, and capacity of clinicians in integrating tobacco-use treatment strategies into regular practice.

#### **Change pressures**

In one study of clinical quality improvement in the mid-1990s, researchers noted that during a single year, 64% of 44 participating clinics underwent a change in ownership or affiliation, 77% experienced a major change in internal systems, and almost every clinic experienced personnel turnover among managers or key clinicians (Magnan et al., 1997). While clinicians may value tobacco-use treatment, such turmoil makes it difficult for clinic staff and management to focus on new or non-acute issues.

### Economic pressures

Health plan or Medicaid reimbursement may be absent or insufficient to adequately reimburse providers for services, which can be a disincentive for providing “free service.” This adds to time pressures. Health plan cost increases have also added economic pressures.

### Clinician time and stress

A standard 12- to 15-minute office visit actually involves about 10 minutes of clinician–patient time. The priority for clinicians is to address patient concerns as well as potential acute medical needs during this limited time. Clinicians are also under pressure to provide patients with a wide range of preventive services and comprehensive care for an increasing number of chronic medical conditions. So although clinicians generally want their patients to stop smoking, they often believe that they do not have the time or expertise to address this issue, or they may not consider tobacco-use treatment to be a top priority for the time-limited office visit. Patients rarely make an appointment specifically for or request assistance with quitting smoking. To address the time constraints, referrals can be made to telephone counseling/quitlines, which are present in almost every state, or to community-based cessation programs to provide ongoing counseling and support for quitting.

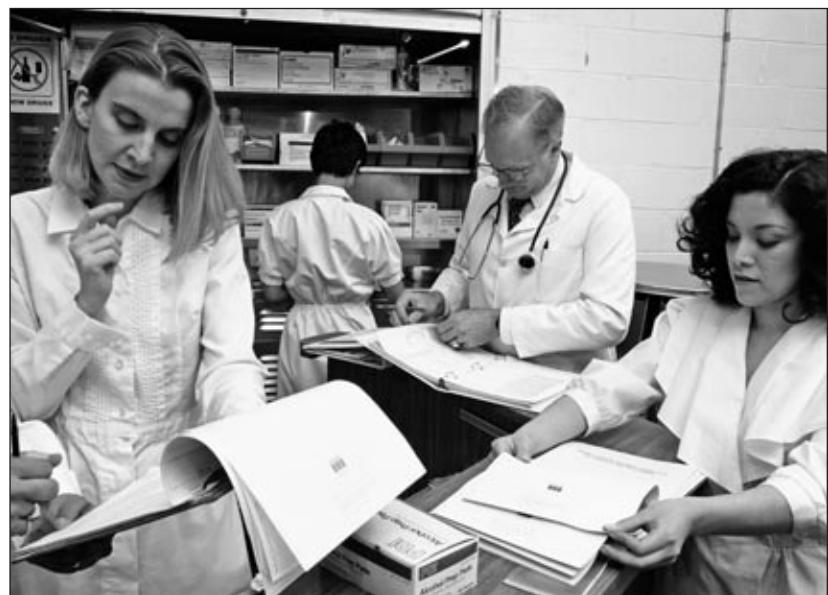
### Reimbursement

Although there are effective evidence-based treatments for smokers, clinicians usually are not reimbursed for providing these services. The lack of reimbursement, while not the main driver of care delivery, may negatively affect treatment patterns (Fiore et al., 2000; Manley et al., 2003).

Payment methods are shifting back to **fee-for-service** arrangements and away from **capitation**. Under **fee-for-service** reimbursement systems, the incentives point more toward procedures and tests and away from services that are harder to quantify (and bill), such as intensive tobacco-use treatment counseling (Fiore et al., 2000; Manley et al., 2003).

### Staffing

Clinic staffs vary widely in their number, capacity, skill level, and expertise. However, clinics can



improve their tobacco-cessation efforts for patients who use tobacco. The important factors in successfully implementing interventions are (a) any staff member can be involved, (b) assigning specific roles and tasks makes it happen, and (c) making referrals to state quitlines may reduce the counseling burden.

### **Quality of care**

Clinicians in all settings are concerned with delivering high-quality care, and many employ quality improvement (QI) techniques to plan, implement, measure, and improve care strategies. Many clinics emphasize the use of evidence-based care guidelines, which are readily available for tobacco-use treatment (Fiore et al., 2000). This may be a challenge if the PHS guideline was not used to develop the QI measures or if the measures are not being monitored.

Clinicians who have limited access to information technology may use a paper-based system, which limits system-wide data collection and affects their ability to measure quality improvement. A number of health systems have or are moving toward electronic medical records, which will enable them to collect more comprehensive information.

2002 HEDIS  
measures related  
to smoking report  
three rates:

- Advising smokers to quit (as in prior years).
- Offer of smoking cessation medications.
- Offer of strategies for support and assistance with quitting.

About 90% of the nation's health plans use the Health Employer Data Information Set (HEDIS) measures to assess their performance. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA), a nonprofit organization that assesses and measures the quality of health plans. NCQA assesses health plans in three ways:

1. Accreditation through an on-site review of key clinical and administrative processes.
2. Use of HEDIS to measure performance in key areas.
3. A comprehensive satisfaction survey of plan members.

Prior to 2002, the HEDIS measure related to tobacco use was called "Advising Smokers to Quit" and one rate was reported: the percentage of health plan members 18 and older who were continuously enrolled during the measurement year, were either current smokers or recent quitters, were seen by a managed care organization (MCO) practitioner during the measurement year, and received advice to quit smoking.

In 2002, rates were added for discussion or recommendation of tobacco-use treatment medications and support or assistance with quitting. The measure was renamed "Medical Assistance with Smoking Cessation" (NCQA, 2003a).

HEDIS data are collected using a mailed patient-satisfaction survey developed by the Consumer Assessment of Health Plans (CAHPS®), a 5-year project funded by the Agency for Healthcare Research and Quality (AHRQ) to help consumers identify the best health plans and services to meet their needs (AHRQ, 1998). Information on tobacco use is collected as part of a general patient-satisfaction survey of randomly selected health plan members. Respondents who report recent smoking and a visit to the doctor during the previous year are asked whether their clinician advised them to quit, offered medication, or provided assistance with quitting during the visit. The most recent survey found the mean for medication and assistance to be 35%. Plans in the top 90th percentile were providing medications and assistance in the 46% range.

HEDIS data can be used as a rough estimate of smoking prevalence in the health plan population. If a health plan mails 1,500 surveys and receives 500 returned surveys, and 100 respondents report being smokers, it is reasonable to estimate a 20% smoking prevalence rate among plan members. However, because smokers are somewhat less likely to respond to surveys, the estimate may be somewhat low (Solberg et al., 2003). These data can be compared to state prevalence data to validate the estimate.

## Hospitals

Like clinics, hospitals can operate as independent entities, as part of a system, or as part of a network of hospitals. Also like clinics, the trend is toward greater integration and affiliation with other parts of the health-care system.

There are four major types of hospitals:

- General medical and surgical.
- Specialty (specialty hospitals treat a specific population like children or mothers or specialize in the treatment of certain conditions, such as heart disease).
- Psychiatric.
- Rehabilitation and chronic disease.

Each of the major types of hospitals also can be characterized by their tax status (for-profit or not-for-profit), affiliation with a health professional training school or teaching hospital, and the range of services provided (Pacific Business Group on Health, 2004). Teaching hospitals and those receiving public funding may be more willing to initiate tobacco-control programming (Conroy et al., 2005).

Some hospitals are interested in providing tobacco-use treatment services and education to the community. Others may engage in tobacco-control activities, such as clean indoor air campaigns. Still others may be interested in doing all of the above.

Hospitalized patients may be particularly motivated to try to quit smoking for two reasons. First, the illness resulting in hospitalization may have been caused or exacerbated by tobacco use, highlighting the patient's personal vulnerability to the health risks of smoking. Second, every hospital in the United States must now be smoke-free to gain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). As a result, every hospitalized smoker is temporarily housed in a smoke-free environment. For both these reasons, clinicians should use hospitalization as an opportunity to promote tobacco-use treatment among their patients who smoke (Fiore et al., 2000; Cochrane Collaboration, 2005).

### ***Challenges Hospitals Face***

Like clinics, hospitals are faced with complex and competing pressures that can influence their tobacco-use treatment activities.

#### JCAHO's tobacco-related measures:

- Acute myocardial infarction.
- Congestive heart failure.
- Pneumonia (formerly community-acquired pneumonia).

The measure assesses the percentage of smokers with these conditions who are given tobacco-use treatment advice and treatment during their hospital stay.

#### **Length of stay**

The average length of stay (i.e., number of days that patients remain in the hospital) is growing shorter, and the inpatient population is increasingly acutely ill (Hall and DeFrances, 2003). These acutely ill patients require complex medical care that affords little time or attention for chronic issues, including tobacco-use treatment. The new JCAHO requirements are beginning to change this picture (see below).

#### **Staffing**

Many hospitals experience shortages of skilled nursing staff. Professional nurses have less time to spend with individual patients who are increasingly acutely ill.

#### **Accreditation**

Hospitals are accredited by JCAHO, which evaluates the quality and safety of care for more than 16,000 health-care organizations. To maintain and earn accreditation, organizations must have an extensive on-site review at least once every 3 years. Tobacco-related measures are included in three of JCAHO's core measures (see left sidebar) (JCAHO, 2003). Hospital staff may be more interested in tobacco-use treatment activities for selected patients who are covered by the standards.

Hospitals are also assessed by Quality Improvement Organizations (QIOs) that are under contract with the federal government to assess and improve the hospital-based care provided to Medicare patients. Quality measures are used to identify areas with the greatest potential for improvement. Like

JCAHO, QIOs use three measures that pertain to tobacco. These measures assess the percentage of smokers (patients who have smoked in the year prior to hospital admission) with acute myocardial infarction, congestive heart failure, and pneumonia who are provided tobacco-use treatment advice and offered counseling and medication, if appropriate (Medicare Quality Improvement Clearinghouse, 2005).

### **Quality of care**

Hospitals are concerned with quality of care and patient safety—both of which can be affected by the patient’s tobacco use. To improve both elements, evidence-based guidelines exist for the treatment of tobacco use among hospitalized smokers (Fiore et al., 2000).

## **Health Plans**

Health plans provide and manage administrative services for the health-care system. For the purposes of this document, a **health plan** is the organization that offers a variety of health insurance products and may take responsibility for coordinating and improving the delivery of care. The **insurance product** is the insurance policy or benefit coverage offered to a group or individual by the health plan.

Health plans vary substantially in their approaches to managing health care, the types of insurance products offered, and the populations served. Today it is common for health plans to offer both **indemnity** and **managed care** plans, to serve both **fully insured** and **self-insured** customers, and to serve both government and commercial purchasers.

To work effectively with health plans of all types, it is not necessary for public health professionals to understand the numerous variations. Instead, they can focus on the major points outlined below.

### **Assignment of Risk**

The concept of financial risk is central to understanding insurance. The entity that bears the risk for a population is financially responsible for paying the cost of health-care claims incurred by that population.

A fully funded or **fully insured** product is one under which the health plan bears the financial responsibility (American’s Health Insurance Plans, 2003). Most small employers are fully insured. Health plans typically offer a defined set of benefits, sometimes with different options and potential “a la carte” additions, for these subscribers.

Health plans have greater control over tobacco-use treatment medication and counseling benefits for their fully insured members. State and federal legislation mandating standards and benefits for fully insured plans and members often do not apply to self-insured plans.

A self-funded or **self-insured** product is one under which an employer or other group sponsor, rather than the health plan, is financially responsible for paying expenses, including claims (America's Health Insurance Plans, 2003). Large employers (over 500 employees) are frequently self-insured, and they select a benefits package for their employees. Self-insured companies usually contract with a health plan or independent company (known as third-party administrators) to process claims and handle other administrative needs.

If a health department wants to increase the percentage of people with insurance coverage for effective tobacco-use treatment medications and counseling, they must work with health plans, large self-insured employers, and broader government agencies (e.g., county, city) to structure benefits appropriate for supporting cessation (see Appendix G).

### ***Reimbursement System***

Under a **fee-for-service** payment system, a health plan (**indemnity**) reimburses the member or pays the health-care clinician directly for each covered medical expense after the expense has been incurred (America's Health Insurance Plans, 2003). By contrast, under **capitation** (**managed care**), the clinician is paid a fixed amount for each patient served, regardless of the actual number or nature of services provided.

### ***Types of Health Plans***

Health plans can be categorized by whether they offer **indemnity** or **managed care** insurance products to their customers. It is common for health plans to offer multiple insurance products, and the differences between the various products are becoming less clear over time, as more hybrid options become available.

#### **Indemnity**

Sometimes called "traditional" health insurance policies, indemnity products provide coverage for health-care services on a fee-for-service basis. These policies typically include a **deductible**, which is an amount that a member must pay out of pocket each year. Most also charge a **co-payment** for covered services and have maximum overall benefit limitation or limitations on specific services.

Unlike managed care plans, members of an indemnity plan can generally receive care from any licensed health-care clinician at any location and time they choose. But these broader choices are typically accompanied by increased out-of-pocket expenses and more administrative procedures for the members.

## Managed care

Managed care plans and products typically involve a network of clinicians from whom a subscriber can receive care, some type of limitation on benefits to subscribers who choose to use clinicians outside of that network, and some type of authorization or approval system (Essentials of Managed Care). There are three major types of managed care plans: **Preferred Provider Organizations (PPOs)**; **Point of Service (POS) plans**; and **Health Maintenance Organizations (HMOs)**.

**PPOs** are companies that arrange for lower fees with a network of health-care clinicians, giving policyholders a financial incentive to seek care within that network. Members pay higher rates for services obtained from a clinician who is not part of their network.

**POS** refers to a type of coverage that allows plan members to choose a clinician within the plan's network or one outside the network at the time that the care is needed. Choosing an out-of-network clinician usually involves higher costs.

**HMOs** are the oldest form of managed care (AHRQ, 2002; Health Insurance Association of America, 2002). They offer members a range of health benefits, including preventive care, for a set monthly fee. The health plan pays for services for members in advance, rather than as they are provided (AHRQ, 2002). There are many kinds of HMOs, distinguished in large part by their different relationships with clinicians.

Public health professionals have tended to assume that managed care organizations, especially HMOs, are more likely to be receptive to efforts to decrease tobacco use. The theory is that because they use capitation, HMOs have a clearer incentive to control costs and provide preventive care. This has proven to be partially true, with surveys of insurers finding that HMOs are more likely than other insurance plans to cover tobacco-use treatment



counseling and medication and to systematically identify tobacco users (Rigotti et al., 2002). However, some traditional indemnity plans have proven to be very interested in and effective at addressing tobacco-use treatment, while some HMOs have virtually ignored it (Manley et al., 2003). Indemnity plans may actually be able to document savings from decreases in utilization that result from tobacco-use treatment more easily than HMOs.

### ***Challenges Health Plans Face***

Health plans face several challenges that may negatively or positively affect their capacity and interest in working on tobacco-use treatment. Public health professionals will be more effective in working with health plans on tobacco control if they understand these pressures.

#### **Rising health-care costs**

Nationally, private health insurance premiums increased 13.9% in 2003 and 11.2% in 2002 (Kaiser Family Foundation, 2004). Health plans are increasingly being challenged by purchasers to control rising costs resulting from expensive new drugs and medical technologies. Tobacco-use treatment is cost-effective; although it results in higher short-term expenses, it will yield long-term benefits in lower overall costs (Winer, 1994). (See Appendix H for a detailed discussion of reimbursement issues.)

#### **Competition and purchaser demand**

In many markets, health plans are concerned for their economic survival. In response to rising health-care costs and purchaser demand, low-cost insurance options are being offered by new companies that are entering the market as well as by existing companies. These options may cover only major medical expenses, not routine clinic visits. They are attractive to employers who are faced with annual premium increases that are often in the double digits, but these low-cost plans may also result in fewer reimbursed opportunities for tobacco treatment. New products such as “medical savings accounts” and “consumer-directed health policies” are also emerging. Their effect on tobacco-use treatment is still unknown.

#### **Quality of care and accountability**

Many health plans see achievement of accredited status from the NCQA as a necessity for attracting employer/purchaser business in a competitive environment. In 2002, the focus of the HEDIS tobacco measures expanded from providing documentation of smoking status and giving advice to quit to providing medications and support and assistance with quitting. JCAHO has implemented an additional measure for hospitals that assesses the

provision of tobacco-dependence treatment for heart disease and pneumonia. Establishing goals and monitoring service provision within health plans and hospitals is important for creating change over time.

## Purchasers of Insurance

Purchasers are important and often-overlooked players in the health-care system. Purchasers include companies, government agencies, or other consortia that purchase health-care benefits for a group of individuals (U.S. Department of Health and Human Services, 2005).

As the major purchasers of health insurance plans for the U.S. workforce, employers determine whether their employees and the employees' dependents have access to tobacco-use treatment benefits. More than 60% of Americans receive their health coverage through their employer (Partnership for Prevention, 2002). Of employers who provide coverage, currently only 24% provide any coverage for tobacco-use treatment and only 5% provide coverage for both medication and counseling (Partnership for Prevention, 2002).

### *Government Purchasers*

Local, state, and federal governments finance health insurance coverage for groups such as seniors (Medicare), the poor and disabled (Medicaid), veterans (Veterans Administration or VA), government employees, and others. Government purchasers pay for plans that cover 25% of all insured people (Mills and Bhandari, 2003). Public health professionals can make substantial gains in reducing out-of-pocket costs for tobacco-cessation treatments by focusing on changing the purchasing behavior of state governments and working with larger employers or business-health coalitions. State and county officials should ensure that tobacco-dependence treatment is covered by the insurance they provide. The provision of comprehensive coverage is a first step in reducing tobacco dependence among government employees at the state and county levels. If prevalence is high in this group, initiating coverage, along with creating tobacco-free campuses and ties to the state quitline, will help reduce tobacco-use rates (Cochrane Collaboration, 2005).

In 2000, approximately 32 million people in the United States received health insurance coverage through a state Medicaid program (Kaiser Family Foundation, 2000). Of these, about 11.5 million—or 36%—were smokers (CDC, 2004a), making smoking prevalence in this population much

Medicare currently covers tobacco-dependence counseling and prescription medications. Over-the-counter medications are **not** covered at this time.

### Counseling:

- Medicare will cover two cessation attempts per year.
- Each attempt may include a maximum of four intermediate or intensive sessions.
- Total annual benefits cover up to eight counseling sessions in a 12-month period.

## Medicare reimbursement for eligible providers:

- Physicians/dentists.
- Physician assistants.
- Nurse practitioners.
- Clinical nurse specialists.
- Nurse midwives.
- Other Medicare-recognized practitioners.

Larger companies, particularly those with dedicated employee health staff and lower employee turnover rates, may be more interested in and capable of offering tobacco-use treatment interventions.

higher than that in the general population. In 2002, a total of 36 Medicaid programs (71%) reported offering coverage for at least one form of tobacco-dependence treatment for all Medicaid recipients. Of these, 12 states offered some form of tobacco-use treatment counseling services, and 36 covered pharmacotherapy treatments (CDC, 2004a). One of the national health objectives for 2010 is for all 50 states and the District of Columbia to provide Medicaid coverage for nicotine-dependence treatments.

In 2003, only three states' Medicaid benefits packages included comprehensive coverage for tobacco-use treatment medications and counseling (Halpin, Bellows, and McMenamin, 2006). Public health professionals should become aware of the current level of coverage and programming provided through state-administered programs like Medicaid and work to move toward the provision of comprehensive coverage where it does not exist.

Extending tobacco-treatment insurance coverage to all federally covered lives would ensure that a large proportion of the U.S. population (approximately 100 million people and their families) has effective and comprehensive insurance coverage for the treatment of tobacco dependence. Covered lives would include Medicaid and Medicare beneficiaries, Department of Defense beneficiaries, persons covered by the Department of Veterans Affairs, federal employees enrolled in the Federal Employee Health Benefits Program, and individuals receiving health care at federally funded clinics (Fiore et al., 2004).

To encourage implementation of more comprehensive Medicaid coverage, Medicaid purchasing specifications were developed by CDC's Office on Smoking and Health in conjunction with George Washington University. These provide contract language based on the PHS guideline and the Community Guide to assist states in purchasing coverage for tobacco-dependence treatment (George Washington University, 2002; Hopkins et al., 2001).

### *Commercial Purchasers*

Both large and small employer groups purchase health-care benefits. As discussed earlier, many large employers are **self-insured** and design their own benefits and manage their own financial risk, while smaller employer groups are typically **fully insured**. Some groups engage brokers who act as agents licensed by the state to sell and service contracts for multiple health plans.

## *Purchasing Groups*

These groups usually offer affordable group health coverage to businesses with fewer than 100 employees. They are also known as health insurance purchasing co-ops, employer-purchasing coalitions, and purchasing coalitions. Most are locally or regionally based and funded through voluntary agencies, grants, and membership dues (America's Health Insurance Plans, 2003). Public health professionals can be more efficient by educating the leaders of purchasing groups on tobacco-use treatment issues than by working one on one with small employers.

## *Union Trust Funds*

Union trust funds (sometimes referred to as Taft-Hartley funds after the 1947 Labor Management Relations Act, which governs relations between employers and labor unions) may be used to provide health insurance to union members (American Federation of State, County, and Municipal Employees, 2000; Barbeau et al., 2001). Union trust funds typically insure members for their entire working career, even when a member changes employers. Therefore, the union may have a longer-term perspective in considering their return on investment for tobacco-use treatment.

## *Challenges Purchasers Face*

### **Cost**

As described in Section 3, health-care costs are rapidly increasing. Cost is a leading barrier to providing comprehensive health insurance coverage (Partnership for Prevention, 2002); however, concerns about cost due to tobacco-related disease may also help convince employers to provide tobacco-use treatment coverage. Employers and insurers sometimes neglect to assess the extent of the cost of tobacco-related diseases. It may be valuable to assist them in determining these costs in relation to the cost of expanded benefits (Pacific Center on Health and Tobacco, 2002).

Brokers can be a key audience for public health professionals seeking to influence purchasing decisions and influence the products offered by **health plans and businesses** (Pacific Center on Health and Tobacco, 2003a).



### **Quality**

A focus group study of employers revealed multiple factors influencing purchasers' health plan selection. These include cost, quality and breadth of benefits, reputation, and level of customer service (Partnership for Prevention, 2002).

### **Productivity**

Employers/purchasers are concerned about their workforce's health and productivity. Employers with less employee turnover may have greater interest in the longer-term payoff that investing in reducing tobacco use provides. See Issues Brief in Appendix H.

### **Insurance mandates**

Not all insured individuals are affected by state health mandates because Medicare and self-insured employer health plans may not be subject to state regulation. Even so, in 1997 health mandates influenced coverage for more than 60 million insured people. From the employer and health plan perspective, there are strong arguments both in favor of and in opposition to health mandates. Some mandates may improve worker productivity and protect small businesses, but at the same time mandates can increase costs to health plans, consumers, and employers (Partnership for Prevention, 2002).

# Effective Tobacco-Control Interventions and the Health-Care System's Role

**O**ver the years the harmful effects of smoking have been well documented. Although great progress has been made, a challenging struggle remains. We all need to strengthen our efforts to prevent young people from ever starting to smoke and to encourage smokers of all ages to quit (U.S. Department of Health and Human Services, 2004).

*Richard Carmona, M.D., M.P.H., F.A.C.S., U.S. Surgeon General  
The Health Consequences of Smoking: A Report of the  
Surgeon General, Executive Summary*

The scientific literature shows broad agreement that tobacco-use treatment interventions are effective as well as cost-effective (Fiore et al., 2000; Warner et al., 1996; Coffield et al., 2001; Maciosek et al. 2006). Tobacco-use treatment interventions that have been proven to be effective can be categorized in a number of different ways. In this section, we describe four categories of effective interventions:

- Individual treatment, including behavioral counseling and pharmacotherapy.
- Health-systems changes that support clinician intervention.
- Reducing patient out-of-pocket costs for tobacco-use treatment.
- Community policy changes and mass media campaigns.

We also present specific tobacco-use treatment objectives for each of these categories, ways to achieve those objectives (strategies), and examples of tactics for implementation (service delivery, coordinated initiatives, administration) and specific roles that professionals from each component of public and private health-care systems (health plan administrators, purchasers, etc.) can play in achieving the tobacco-use treatment objectives.

## Individual Treatment

The U.S. Public Health Service (PHS) clinical practice guideline, *Treating Tobacco Use and Dependence*, found counseling and medication to be safe and effective in increasing a person's chances of quitting smoking (Fiore et al., 2000). Studies show that tobacco-use treatment counseling and pharmacotherapy treatment each double quit rates (Cochrane Collaboration, 2005; Fiore et al., 2000).

**Objective:**  
Increase the delivery of effective tobacco-use treatment counseling and FDA-approved medications.

## Case Study #1

### QuitWorks: Linking Hospitals in Massachusetts to the Quitline

#### ***Objective:***

Illustrate how public health officials can collaborate with health plan managers to promote institutional adoption of the PHS guidelines and use of the state's Quitline.

---

In 2002, the Massachusetts Department of Public Health, in collaboration with all major health plans, launched QuitWorks, a cessation service for all Massachusetts residents operated by the Try to STOP Tobacco Resources Center (Quitline) in Boston. QuitWorks is a program for use by any provider with any patient regardless of health insurance status.

At the heart of QuitWorks is a simple fax enrollment form. Upon receipt (by fax) of a completed form, the quitline calls the patient and offers free confidential tobacco-treatment counseling by telephone and describes the full range of the state's evidence-based treatment programs. Referring providers receive a fax-back status report on each patient enrolled and, at 6 months, an outcome report on the patient's quit attempts and quit status.

The initiative was initially introduced to more than 4,000 physician practices statewide. In 2003, hospitals in Massachusetts began expressing a need for the program, in part to meet Joint Commission on Accreditation of Health Organizations (JCAHO) core measures. In response, QuitWorks for Hospitals was launched, creating a continuum of effective treatment interventions from admission to post-discharge or post-outpatient visit. More than 22 of 62 hospitals in Massachusetts have adopted the QuitWorks program or are in the process of doing so.

More than 20 hospitals have implemented the PHS guidelines and many have purchased training for their staff. Hundreds of clinicians have received training in QuitWorks or brief interventions. Some hospitals have added in-house tobacco-treatment specialists and have sent them to the University of Massachusetts Medical School (UMMS) certification training or participated in obtaining online training in basic cessation-treatment skills. Several hospitals have initiated a system-wide program to screen for tobacco-use status, including in the emergency room.

It takes a dedicated team of hospital executives and clinic managers from 3 to 6 months to integrate QuitWorks into patient care. A *QuitWorks Guide for Hospitals and Health Centers* directs the hospital team to consider the systems-level changes needed and to create and sustain tobacco-free campuses and provide counseling and nicotine replacement therapy (NRT) for patients and staff members.

**Case Study #1, continued**

QuitWorks for Hospitals has had important partners: Massachusetts General Hospital, Tobacco Research and Treatment Center, and Tufts New England Medical Center helped design QuitWorks for Hospitals, while Massachusetts's health plans and the Massachusetts Peer Review Organization contributed training and financial support. Opening a new and important arena for QuitWorks, BlueCross/BlueShield of Massachusetts recently awarded a grant to the UMMS to adapt QuitWorks for community health centers serving cultural and linguistic minorities.

**Lessons Learned:**

- Effective relationships can be developed between quitlines and hospitals.
- Hospitals and health-care systems may be willing to pay for staff training in using the system and receiving data feedback from the quitline.
- Quitlines cannot implement a system of this magnitude alone. Public health department involvement is needed in convening all partners.
- Endorsement by all major health plans, and any funding they provide, has helped QuitWorks achieve legitimacy, credibility, effectiveness, and a sense of permanence.
- Follow-up and reporting of client outcomes also adds to program credibility.

## **Recommendations related to pregnancy:**

- Although quitting in the first trimester is preferred, quitting at any time during the pregnancy will yield benefits. Clinicians should offer effective interventions at the first prenatal visit and throughout the pregnancy.
- Pregnant smokers should be offered extended or augmented psychosocial interventions that exceed minimal advice to quit.
- Many pregnant women are reluctant to admit they smoke. Careful and supportive questioning may be needed.
- Pharmacotherapy should be considered when a pregnant woman is otherwise unable to quit. In such cases, the clinician and the pregnant smoker must contrast the risks and benefits of the medication against the risk of continued tobacco use.

(Fiore et al., 2000)

Counseling can be provided in a number of different venues, including face to face (individual or in a group) or by telephone. The effectiveness of counseling services increases as their intensity (i.e., the number and length of sessions) increases. Counseling can be provided effectively by many different kinds of health-care clinicians. Even brief counseling for tobacco cessation (i.e., 1–3 minutes) can be beneficial (Fiore et al., 2000).

The U.S. Food and Drug Administration (FDA) has approved six medications to help smokers quit (see medications chart in Appendix G). Five are nicotine replacement therapies that relieve withdrawal symptoms. These include nicotine gum, patches, inhalers, nasal sprays, and lozenges (CDC, 2004a). The sixth medication, which is not a nicotine replacement product, is the oral medication bupropion. Bupropion is an antidepressant that is thought to reduce the urge to smoke by affecting the same chemical messengers in the brain that are affected by nicotine (Fiore et al., 2000). Except in the presence of identified contraindications, all patients attempting to quit should be encouraged to use FDA-approved pharmacotherapies. Long-term tobacco-use treatment pharmacotherapy should be considered as a strategy to reduce the likelihood of relapse (Fiore et al., 2000). Most people use these medications for a period of 4–6 weeks.

### ***Specific Populations***

Although smoking prevalence is higher among men than women, the PHS guideline indicates that the same tobacco-use treatments are effective for both sexes, with the exception of pregnant women (Fiore et al., 2000). The guideline outlines specific recommendations for pregnant women because of the serious risk of smoking to these women and their unborn children (see sidebar).

There are well-documented differences between racial and ethnic groups in the United States in terms of smoking prevalence, smoking patterns, and quitting behaviors (CDC, 2005b). The PHS guideline concludes that treatments identified in the scientific literature as safe and effective should be offered to patients across all racial and ethnic groups and states that it is essential for the treatments to be conveyed in a language that is understood by the smoker. Using culturally appropriate models and examples may also increase the smoker's acceptance of treatment. Clinicians also should remain sensitive to individual differences and health beliefs that may affect treatment acceptance and success (Fiore et al., 2000).

## Clinicians

### *Strategies*

A number of strategies have been shown to increase clinicians' delivery of effective tobacco-use treatment counseling and appropriate medication.

These include

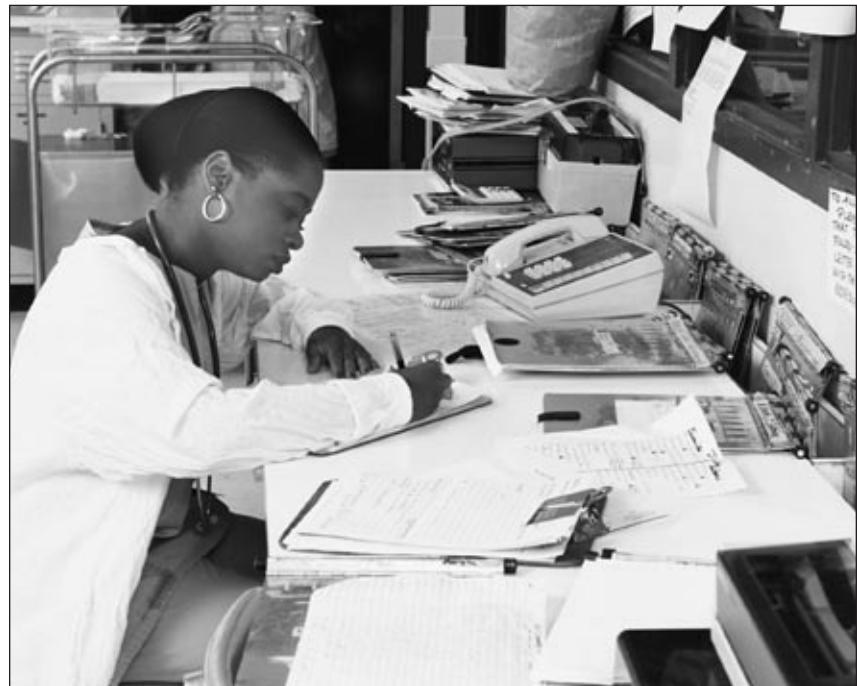
- Using clinician prompts and reminder systems (Hopkins et al., 2001).
- Providing education, resources, and feedback to promote clinician intervention in conjunction with provider reminder systems (Hopkins et al., 2001; Fiore et al., 2000).
- Dedicating staff to provide tobacco-dependence treatment and assessing the delivery of this treatment in staff performance evaluations (Fiore et al., 2000).
- Providing telephone counseling support as an adjunct to other interventions by using health plan or state-based quitlines (Hopkins et al., 2001; Cochrane Collaboration, 2005).
- Coding for tobacco dependence (305.1) in both inpatient and outpatient settings (Fiore et al., 2000).

### *Tactics*

There are many ways in which a variety of people in the health-care system can promote access to effective tobacco-dependence treatment. Examples of effective actions for clinicians, hospital staff members, administrators, insurance purchasers, and public health professionals are presented below.

#### **Service delivery (clinicians)**

- Provide brief counseling to patients who use tobacco or have recently quit and refer patients to quitlines and other available cessation resources (Revell, 2005).
- Offer FDA-approved first-line tobacco-dependence pharmacotherapies to all tobacco users who are trying to quit (Fiore et al., 2000).
- Provide intensive counseling or refer to telephone quitlines (Fiore et al., 2000; Revell, 2005; Cochrane Collaboration, 2005).



- Recommend pharmacotherapy if appropriate for pregnant smokers (Fiore et al., 2000).
- If hospital-based, provide inpatient tobacco-dependence consultation services and medication and ensure that discharged patients are referred to a quitline or other services for ongoing counseling and follow-up (Solberg et al., 2004).

#### **Administration (insurance providers)**

- Provide annual coverage for at least two courses of all first-line FDA-approved pharmacotherapies (including over-the-counter medications) and two courses of counseling (George Washington University, 2002).
- Collaborate with public health professionals in establishing quitlines as an adjunct to treatment services.
- Ensure access to comprehensive cessation coverage benefits and monitor benefit utilization.
- Integrate tobacco-use treatment counseling into all case management services, including those for pregnancy as well as chronic disease.
- Participate in quitline oversight to ensure quality service and promote collaboration between the health plan and the quitline.
- Assess and report on Health Employer Data and Information Set (HEDIS) Consumer Assessment of Health Plans (CAHPS) measures for the provision of medication and the provision of support and assistance in quitting; set targets to improve to 90th percentile rates (National Committee for Quality Assurance [NCQA], 2003b).
- Eliminate or minimize co-pays or deductibles for counseling and medications.
- Advocate for sustained state quitline funding.

#### **Health plans/hospitals/quality assurance**

- Develop procedures to identify smokers at health plan or at hospital admission and refer them to tobacco-use treatment services.
- Expand formularies to include first-line FDA-approved tobacco-dependence pharmacotherapies.
- Encourage clinicians to prescribe first-line medications to reduce a patient's nicotine withdrawal symptoms, even if the patient is not intending to quit following his or her hospital stay.
- Monitor adherence to JCAHO tobacco-treatment standards and consider broadening these to all tobacco users admitted to the hospital.
- Communicate results of tobacco-use treatment interventions to clinicians and health-care staff and primary care providers following discharge.

- At discharge, refer patients who smoke to a quitline or other local services for follow-up.
- Include tobacco-use treatment in community wellness programs.
- Promote hospital and clinic policies that support tobacco-use treatment and provide for in- and outpatient tobacco-dependence services and post-discharge follow-up (Fiore et al., 2000).
- Review HEDIS scores on tobacco measures, set targets, and monitor progress.

### **Quality promotion (public health)**

- Work with quality improvement organizations (QIOs) to support and monitor existing tobacco-control standards (e.g., Medicaid standards).
- Ensure that the state quitline represents the needs of the community and health-care systems (hospitals, clinics, health plans, etc.). Public health professionals could invite a representative of the quitline to talk with health-care systems and could offer feedback from the service to a business or health plan (Tobacco Technical Assistance Consortium, 2003).
- Act as a neutral convening body for collaborative tobacco-centered quality improvement initiatives between state health plans or clinics.
- Consider clinical and health plan quality measures related to tobacco use when selecting networks, health insurance products, and health plans (George Washington University, 2002; NCQA, 2003a; JCAHO, 2003).
- Ensure that all public health programs such as Title V (Maternal and Child Health Block Grant), Title X (The National Family Planning Program), and others address tobacco cessation.

### **Public health**

- Actively promote tobacco-use treatment interventions to health-care employers and health insurers.
- Coordinate with employers to contract with quitlines to provide tobacco-use treatment counseling for employees. (This strategy would apply primarily to larger employers.)
- Fund, promote, or administer a statewide quitline.
- Promote or support tobacco-use treatment services for uninsured and underinsured people in public clinics.
- Proactively seek health system participation in quitline promotion and referral systems as well as implementing quality improvement efforts to ensure that the quitline is meeting health-care system needs.

- Promote implementation of tobacco-free campuses for health-care systems and employers.
- Serve as an advocate for funding (e.g., advocate for monies received from a tobacco tax to be dedicated for tobacco-use treatment) (Tobacco Technical Assistance Consortium, 2003).
- Encourage health-care systems and employers to provide funding to state quitlines or funding for promotional initiatives.
- Promote tobacco-use treatment counseling and medication coverage to self-insured groups.

## Health-Care Systems Strategies

<b>Individual Treatment Service Delivery</b>	<b>Administration</b>	<b>Quality Assurance (Health Plans/ Hospitals)</b>	<b>Quality Promotion (Public Health)</b>	<b>Public Health</b>
Provide brief counseling to patients who smoke or have recently quit and refer patients to quitlines and other available resources for more intense counseling.	Provide annual coverage for at least two courses of all first-line FDA-approved pharmacotherapies (including over-the-counter medications) and two courses of counseling.	Develop procedures to identify smokers at health plan or at hospital admission and refer them to tobacco-use treatment services.	Work with quality improvement organizations (QIOs) to support and monitor existing tobacco control standards.	Actively promote tobacco-use treatment services to health-care employers and health insurers.
Offer FDA-approved first-line tobacco-dependence pharmacotherapies to all tobacco users who are trying to quit.	Collaborate with public health professionals in establishing quitlines as an adjunct to treatment services.	Expand formularies to include first-line FDA-approved tobacco-dependence pharmacotherapies.	Ensure that the state quitline represents the needs of the community and health-care systems (hospitals, clinics, health plans, etc.).	Coordinate with employers to contract with quitlines to provide tobacco-use treatment counseling for employees.
Provide intensive counseling or refer to telephone quitlines.	Ensure access to cessation coverage benefits and monitor benefit utilization.	Encourage clinicians to prescribe first-line medications to reduce a patient's nicotine withdrawal symptoms, even if the patient is not intending to quit following his or her hospital stay.	Act as a neutral convening body for collaborative tobacco-centered quality improvement initiatives between state, health plans, or clinics.	Fund, promote, and/or administer a statewide quitline.
Recommend pharmacotherapy if appropriate for pregnant smokers.	Integrate tobacco-use treatment counseling into all case management services, including those for pregnancy as well as chronic disease.	Monitor adherence to JCAHO tobacco-treatment standards and consider broadening these to all tobacco users admitted to the hospital.	.	.

*Health-Care Systems Strategies, continued*

<b>Individual Treatment Service Delivery</b>	<b>Administration</b>	<b>Quality Assurance (Health Plans/ Hospitals)</b>	<b>Quality Promotion (Public Health)</b>	<b>Public Health</b>
If hospital-based, provide inpatient tobacco-dependence consultation services and medication and ensure that discharged patients are referred to a quitline or other services for ongoing counseling and follow-up.	Participate in quitline oversight to ensure quality service and promote collaboration between the health plan and the quitline.	Communicate results of tobacco-use treatment interventions to clinicians and health-care staff and primary care providers following discharge.	Consider clinical and health plan quality measures related to tobacco use when selecting networks, health insurance products, and health plans.	Promote or support tobacco-use treatment services for uninsured and underinsured people in public clinics.
	Assess and report on Health Employer Data and Information Set (HEDIS) Consumer Assessment of Health Plans (CAHPS) measures for the provision of medication and of support and assistance; set targets to improve to 90th percentile rates.	At discharge, refer patients who smoke to a quitline or other local services for follow-up.	Ensure that all public health programs such as Title V (Maternal and Child Health Block Grant), Title X (The National Family Planning Program), and others address tobacco cessation.	Proactively seek health system participation in quitline promotion and referral systems as well as implementing quality improvement efforts to assure that the quitline is meeting health-care systems needs.
Eliminate or minimize co-pays or deductibles for counseling and medications.	Include tobacco-use treatment in community wellness programs.			Promote implementation of tobacco-free campuses for health-care systems and employers.
Advocate for quitline funding.	Promote hospital and clinic policies that support tobacco-use treatment and provide for in- and outpatient tobacco-dependence services and post-discharge follow-up.			Serve as an advocate for funding.
	Review HEDIS and JCAHO scores on tobacco measures, set targets, and monitor progress.			Encourage health-care systems and employers to provide funding to state quitlines or funding for promotional initiatives.
				Promote coverage of tobacco-use treatment counseling and medication coverage to self-insured groups.

## Case Study #2

### Use of Outreach in Tobacco-Control Training and Assistance

#### ***Objective:***

To increase understanding of tobacco dependence and the use of effective tobacco-dependence treatments through a collaborative outreach program.

---

The Wisconsin Department of Health has closely partnered with the Center for Tobacco Research and Intervention, University of Wisconsin–Madison (UW-CTRI), which focuses on improving the understanding of tobacco dependence and increasing the use of effective treatments to help smokers quit for good. Partnerships with health-care systems, insurers, and employers have increased tobacco-use treatment coverage in the state.

The CTRI outreach program provides academic detailing to office practices. Academic detailing\* supports providers in implementing effective tobacco-dependence treatment by providing training to health-care providers, clinics, and health-care delivery systems. The six Wisconsin outreach specialists conduct on-site trainings with a CME credit option, provide guides and materials, and conduct specialized technical assistance for integrating tobacco-dependence treatment within each clinic's unique care-delivery system. The outreach program has reached more than 10,000 clinicians in at least 500 different organizations through trainings, materials, and consultative services.

The outreach staff members offer health-care providers direct access to the Wisconsin Tobacco Quit Line, a proactive, individualized counseling service that has helped approximately 40,000 callers from its inception in 2001 until June 2005. The Quit Line and UW-CTRI recently began the “Fax to Quit” program, which has increased the number of clients served by the quitline by faxing a referral to the quitline and having the quitline make a proactive call to the client. Health-care providers generate a steady stream of referrals to the Quit Line—approximately 500 each month.

UW-CTRI coordinates with 45 federally funded clinics, health departments, and other organizations that treat low-income patients on training for clinic staff, linkages to the Quit Line, and the provision of free nicotine patches to uninsured or underinsured smokers. In addition, UW-CTRI partners with First Breath, a program of the Wisconsin Women’s Health Foundation, to promote smoking cessation among pregnant women.

---

\* Academic detailing is similar to detailing used by the pharmaceutical industry, but it brings a training/systems-change message to office practices.

### ***Case Study #2, continued***

UW-CTRI also partnered with the Wisconsin Hospital Association to disseminate a recently developed “hospital packet.” This effort provides on-site technical assistance to help hospitals implement key tobacco-dependence treatment recommendations.

Supporting strategies for change is difficult. Quality standards such as HEDIS, JCAHO, coding systems, and organizing elements (e.g., electronic medical records) can be used to support integration of tobacco-dependence treatment within health-care systems. Tracking and evaluation should be used to monitor the implementation and delivery process and provide feedback to clinicians.

### ***Lessons Learned:***

- Outreach staff can be effective in promoting integration of tobacco-control strategies within the practice setting.
- Encouraging providers to fax referrals to the quitline improves care outcomes.
- Partnering with key health-care and business organizations can improve coverage for tobacco-dependence treatment.

**Objective:**  
Ensure that all tobacco users are offered effective tobacco-use treatment at all clinical encounters.

## Systems Changes to Support Clinician Intervention

Clinicians and health-care systems play an important role in encouraging patients who use tobacco products to attempt to quit and in helping ensure the success of these attempts. The PHS guideline indicates that even minimal intervention by a clinician (i.e., as little as 3 minutes of face-to-face counseling) can increase overall abstinence rates, and both the PHS guideline and the Community Guide recommend strategies to encourage health-care clinicians to assume an active role in helping patients quit.

Working with systems to incorporate the range of effective strategies will promote improved treatment. The guidelines advocate five key steps to intervention in the **primary care** setting that are collectively known as the 5A's (Fiore et al., 2000). They involve

- **A**sking if patients smoke.
- **A**dvising them to quit.
- **A**specting readiness to quit.
- **A**ssisting with counseling and pharmacological treatments.
- **A**rranging for follow-up.

An alternative to the 5 A's has been proposed by Dr. Steven Schroeder and the Smoking Cessation Leadership Center at the University of California, San Francisco. One of their central strategies is Ask-Advise-Refer (i.e., to a quitline or other effective program) (Schroeder, 2003).

Not every patient who is identified as a smoker or other tobacco user will be ready to make a quit attempt. Therefore, after asking about tobacco use, advising the smoker to quit, and assessing his or her current readiness to quit, it is important to provide a motivational intervention known as the 5R's for those not currently ready to quit. Its steps emphasize

- **R**elevance—Encourage the patient to consider how quitting or not quitting specifically affects them and their loved ones.
- **R**isks—Suggest and highlight relevant risks of continued tobacco use.
- **R**ewards—Help the patient identify potential benefits of stopping tobacco use.
- **R**oadblocks—Identify barriers or impediments to quitting and ways these can be addressed.
- **R**epetition—Repeat this intervention each time the patient visits the clinic.

## **Strategies**

Strategies to promote clinician intervention could include

- Adopting a clinical system that identifies smoking or other tobacco-use status in conjunction with the collection of vital signs (Fiore et al., 2000).
- Using a centralized system that features clinician reminder elements and a clinician education component to encourage clinicians to address tobacco use and to assist them in helping their patients quit (Hopkins, 2001).
- Implementing office-wide systems to support delivery of the 5A's to patients who are willing to quit, followed by documentation of the treatment services provided, and encouraging follow-up with the 5R's motivational intervention for patients who are currently unwilling to quit smoking (Fiore et al., 2000).
- Including tobacco-dependence treatment in the defined duties of clinicians (Fiore et al., 2000).
- Using electronic medical records to support and document tobacco-dependence treatment (Bentz, Davis, and Bayley, 2002).
- Coding for tobacco dependence using the 305.1 ICD-10 code (Fiore et al., 2000).\*
- Providing quitline linkages to support treatment intervention and follow-up (Pacific Center on Health and Tobacco, 2003b).
- Reimbursing for treatment of tobacco use as a chronic disease (Fiore et al., 2000).
- Implementing a centralized system to identify and treat tobacco users who are hospitalized for any reason (Rigotti et al., 2002).



---

\* Some systems are also using the following CPT codes: 0002F: Tobacco use, smoking assessed; 0003F: Tobacco use, nonsmoking assessed; G0375: Smoking and tobacco use cessation counseling visit, Intermediate, greater than 3 minutes up to 10 minutes; G0367: Smoking and tobacco use cessation counseling visit, Intensive, greater than 10 minutes; 99383–99387: Preventive Medicine Examination; 99393–99397: Established Patient Periodic preventive medicine evaluation; 99401–99412: Preventive Medicine, Individual Counseling; 90804–90809: Office or other outpatient facility—behavior modification; 90816–90822: Inpatient hospital, partial hospital or residential care facility; 01320: Dental code.

## **Tactics**

Examples of effective roles that each component of the health-care system plays in promoting use of the 5A's and the 5R's and achieving a greater level of clinician intervention are described below.

### **Service delivery**

- Promote state-run or other quitline services to clinicians, health plans, and insurers (Fiore et al., 2000).
- Coordinate with quitlines to provide post-discharge follow-up (Pacific Center on Health and Tobacco, 2003b).
- Integrate tobacco-use treatment in programs administered by health departments, including services for children with special health-care needs; Maternal and Child Health Block Grant (Title V) programs; family planning grants (Title X); Medicaid; and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs (Fiore et al., 2000).

### **Quality assurance/quality improvement**

Quality assurance/quality improvement staff or other designated individuals within the health-care system should coordinate the following:

- Provide feedback to individual clinicians and groups on their effectiveness in delivering medications and referrals to counseling or quitline services (Hopkins et al., 2001).
- Become champions and, along with committed team members (physicians, nurses, medical assistants, and others), provide training for clinicians in evidence-based treatment.
- Initiate a system where tobacco users can be referred to state or health plan tobacco-cessation quitlines.
- Ask health plans for NCQA HEDIS data that report rates of clinician advice to quit, provision of medication, and support and assistance with quitting. (Information on HEDIS measures related to tobacco use is provided on page 10 of this document [NCQA, 2003a].)
- Monitor benefit utilization and feed results back to health-care systems and clinicians providing services and use to determine if quality indicators are being met.

## **Administration**

- Implement office-based reminder systems that trigger clinical staff to ask all patients about tobacco use, provide chart documentation of tobacco-use status, and offer and document quitting assistance to users (Fiore et al., 2000).
- Encourage office practices to define roles among clinical staff to ensure that counseling and medications are systematically provided and their provision documented in medical charts or electronic records.
- Implement a system to identify and document the tobacco-use status of all clinic and hospitalized patients.
- Develop inpatient treatment systems, referral networks, and quality assurance mechanisms to support such systems.
- Provide incentives and support to clinician groups that want to set up systems for implementing the PHS guidelines and increase treatment rates (America's Health Insurance Plans, 2003).

## **Finance**

- Provide annual coverage for at least two courses of both counseling and FDA-approved medications with minimal or no co-payments (George Washington University, 2002).
- Coordinate with state Medicaid programs to ensure comprehensive coverage of counseling and medication (George Washington University, 2002).
- Collaborate with the business sector to promote comprehensive coverage and quitline services.

## **Quality care**

- Assess JCAHO scores relating to tobacco-use treatment and set targets for improvement.
- Provide "quality surveillance" by sharing data within and between clinician groups that allow comparisons of their own performance on tobacco-related indicators with others (e.g., provision of medication by assessing pharmacy data, referral to telephone counseling through feedback from the quitline service).
- Assess HEDIS scores for provision of medication and support and assistance with quitting (counseling).
- Identify "best practices" for tobacco-use cessation interventions within health systems and promote successful models and structures.

## Systems Changes to Support Clinician Intervention

<b>Service Delivery</b>	<b>Quality Assurance/Quality Improvement</b>	<b>Administration</b>	<b>Finance</b>	<b>Public Health</b>
Provide feedback to individual clinicians and groups on their effectiveness in delivering medications and referrals to counseling and/or quitline services.	Assess JCAHO/HEDIS scores relating to tobacco-use treatment and set targets for improvement.	Implement office-based reminder systems that trigger clinical staff to ask all patients about tobacco use, provide chart documentation of tobacco-use status, and offer and document quitting assistance to users.	Provide annual coverage for at least two courses of both counseling and FDA-approved medication with minimal or no co-payments.	Coordinate with quitlines to provide post-discharge follow-up.
Provide "quality surveillance" by sharing data within and between clinician groups that allow comparisons of their own performance on tobacco-related indicators with others.	Define roles among clinical staff to ensure that counseling and medications are systematically provided and their provision documented.	Coordinate with state Medicaid programs to ensure comprehensive coverage of counseling and medication.	Promote state-run or other quitline services to clinicians, health plans, and insurers.	Become champions and, along with committed team members (physicians, nurses, medical assistants, etc.), provide training for clinicians in evidence-based treatment.
Implement a system to identify and document the tobacco-use status of all hospitalized patients.	Initiate a system where tobacco users can be referred to state tobacco cessation quitlines.  Assess HEDIS scores for provision of medication and support and assistance with quitting (counseling).	Collaborate with the business sector to promote comprehensive coverage and quitline services.		Integrate tobacco-use treatment in programs administered by health departments, including services for children with special health-care needs; Maternal and Child Health Block Grant (Title V) programs; family planning grants (Title X); Medicaid; and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs.
Develop inpatient treatment systems, referral networks, and quality assurance mechanisms to support such systems.	Identify "best practices" for tobacco-use cessation interventions within health systems and promote successful models and structures.			Ask health plans for NCQA HEDIS data that report rates of clinician advice to quit, provision of medication, and support and assistance with quitting.
		Provide incentives and support to clinician groups that want to set up systems for implementing the PHS guidelines and increase treatment rates.		

## **Reducing Patient Out-of-Pocket Costs for Tobacco-Use Treatment**

As previously noted, smoking cessation treatments are not only clinically effective, but also are extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments (e.g., treatment of elevated cholesterol, mammography screening) (Fiore et al., 2000). Reducing or eliminating patient out-of-pocket costs for tobacco-dependence treatments increases treatment rates (CDC, 2000; Curry et al., 1998; Cochrane Collaboration, 2005).

### **Objective:**

Reduce or eliminate patient out-of-pocket costs for tobacco-use treatment.

### ***Strategies***

Approaches for increasing tobacco-use treatment by reducing patient costs include

- Providing effective tobacco-dependence treatments (both counseling and pharmacotherapy) as paid or covered services for all subscribers or members of public and private health insurance packages (Fiore et al., 2000; George Washington University, 2002; Cochrane Collaboration, 2005).\*
- Encouraging initiation of reimbursement mechanisms to compensate clinicians for delivery of effective tobacco-dependence treatments and including these interventions in the defined duties of clinicians (Fiore et al., 2000).

### ***Tactics***

There are a variety of tactics that health plan administrators, purchasers, and public health professionals can employ to promote implementation of these strategies.

### ***Service delivery***

- Provide medication and counseling (e.g., state-run quitlines or other counseling services) for uninsured or underinsured populations (George Washington University, 2002).
- Promote quitline services and collaborate with Medicaid, health-care systems, and employers to provide low- or no-cost services (George Washington University, 2002).
- Ensure maximal utilization of services (George Washington University, 2002).

---

\* As of March 2005, Medicare began reimbursing physicians for tobacco-dependence treatment counseling. Medicare also began providing coverage for prescription tobacco treatment medications in January 2006.

## **Public health**

State public health and/or large public health agencies need to coordinate the following:

- Work with insurance agents and brokers, health consultants, sales staff, and purchasing coalitions to promote the inclusion of tobacco-use treatment services, including counseling and medication coverage, in benefit contracts.
- Ensure that purchasers understand the financial benefits of tobacco-use treatment interventions.
- Negotiate tobacco-use treatment benefits as part of union contracts.
- Provide and promote tobacco-use treatment benefits for employees through insurance contracts, self-insurance, and work-site programs.
- Consult with federal, state, and local government decision makers to provide and promote tobacco-use treatment benefits for government employees and people who receive health-care benefits through Medicare, Medicaid, the Indian Health Service, Community Health Centers, the Veterans Administration, the Department of Defense, and the Bureau of Prisons.
- Encourage employers to learn how benefits they already have can be used for tobacco-use treatment and to promote their use by employees (Tobacco Technical Assistance Consortium, 2003; Pacific Center on Health and Tobacco, 2002).
- Demonstrate to employers that coverage of tobacco-use treatment is cost effective and cost saving (Coffield et al., 2001; Tobacco Technical Assistance Consortium, 2003; Cochrane Collaboration, 2005; Maciosek et al., 2006).

## **Administration**

- Support coding for tobacco dependence (ICD-10, Code 305.1) within the health-care system to assist in identifying tobacco users and to assess costs of tobacco-related diseases.
- Remove or minimize barriers to accessing tobacco-use treatment benefits by decreasing or eliminating co-pays and removing utilization caps (Hopkins et al., 2001).
- Inform clinicians and office managers of coverage availability.
- Understand current coverage levels. Ask insurers about all products or services (e.g., benefits, riders, discounts) that address tobacco-use treatment (Pacific Center on Health and Tobacco, 2003a).
- Promote coverage of tobacco-use treatment counseling and medication coverage to self-insured groups.
- Provide disease management and treatment for tobacco-related diseases and conditions.

## Reducing Patient Out-of-Pocket Costs for Tobacco-Use Treatment

<b>Service Delivery</b>	<b>Quality Assurance/Quality Improvement</b>	<b>Administration</b>	<b>Finance</b>	<b>Public Health</b>
Provide medication and counseling for insured, uninsured, or underinsured populations.	Monitor benefit utilization and feed results back to health-care systems providing services.	Support coding for tobacco-dependence (ICD-10, Code 305.1) within the health-care system to assist in identifying tobacco users and to assess costs of tobacco-related diseases.	Include tobacco-use treatment counseling and medications as a standard part of all fully insured contracts.	Work with insurance agents and brokers, health consultants, sales staff, Medicaid, and purchasing coalitions to promote the inclusion of tobacco-use treatment services, including counseling and medication coverage, in benefit contracts.
Promote quitline services and collaborate with Medicaid, health-care systems, and employers to provide low- or no-cost services.		Remove or minimize barriers to accessing tobacco-use treatment benefits by decreasing or eliminating co-pays and removing utilization caps.	Reimburse for tobacco use treatment in the same way that clinicians are reimbursed for other chronic diseases.	Ensure that purchasers understand the financial benefits of tobacco-use treatment interventions.
Ensure maximal utilization of services by reducing or eliminating co-pays.		Inform clinicians and office managers of coverage availability.	Include coverage for office visits to treat "tobacco-use disorder" as a standard benefit.	Negotiate tobacco-use treatment benefits as part of union contracts.
		Understand current coverage levels. Ask insurers about all products or services (e.g., benefits, riders, discounts) that address tobacco-use treatment.	Cover at least two courses of counseling and medication per year to support the quitting process.	Provide and promote tobacco-use treatment benefits for employees through insurance contracts, self-insurance, and work-site programs.
		Promote coverage of tobacco-use treatment counseling and medication to self-insured groups.	Offer health benefits that include comprehensive counseling and medications for employees.	Consult with federal, state, and local government decision makers to provide and promote tobacco-use treatment benefits for government employees and people who receive health-care benefits through Medicare, Medicaid, the Indian Health Service, Community Health Centers, the Veterans Administration, the Department of Defense, and the Bureau of Prisons.
		Provide disease management and treatment for tobacco-related diseases and conditions.	Work with self-insured employers (including states) to ensure that their health plans provide coverage for both tobacco-use treatment counseling and pharmacotherapies.	Encourage employers to learn how benefits they already have can be used for tobacco-use treatment and to promote their use by employees.
				Demonstrate to employers that coverage of tobacco-use treatment is cost-effective.

## **Finance**

- Include tobacco-use treatment counseling and medications as a standard part of all fully insured contracts.
- Reimburse for tobacco-use treatment in the same way that clinicians are reimbursed for treatment of other chronic diseases.
- Include coverage for office visits to treat “tobacco-use disorder” as a standard benefit (305.1 IDC-10 code).
- Cover at least two courses of counseling and medication per year to support the quitting process (George Washington University, 2002).
- Offer health benefits that include counseling and medications for employees.
- Work with self-insured employers (including states) to ensure that their health plans provide coverage for both tobacco-use treatment counseling and pharmacotherapies (Tobacco Technical Assistance Consortium, 2003).

### **Objective:**

Create social and economic environments that promote tobacco-use treatment.

## **Community Policy and Mass Media**

Mass media campaigns, when part of multicomponent interventions, also are effective in increasing the number of tobacco users who seek treatment. Such campaigns do not necessarily have to be focused on tobacco-use treatment (CDC, 2000). Increasing the unit price of tobacco, primarily through an increase in excise tax, also helps people seek treatment and decreases smoking prevalence and tobacco consumption (Hopkins et al., 2001). Data show that a 10% increase in the price of tobacco products generally results in a 4% decrease in the amount of tobacco used by the general population (Hopkins et al., 2001). Research findings also show that legislation that bans smoking in the workplace creates an environment favorable to tobacco cessation (Cochrane Collaboration, 2005). Workplace smoking bans decrease daily tobacco consumption while increasing quit attempts and the success of these attempts (Center for Tobacco Cessation, 2004).

Like the general population, pregnant women and racial and ethnic minority groups benefit from a comprehensive approach to tobacco-use treatment that includes increases in the price of tobacco and the establishment of smoke-free workplace policies. Tax increases are especially helpful in promoting cessation among pregnant women, adolescents, and low-income individuals, thereby increasing the need for adequate coverage for and access to cessation services for these groups (CDC, 2000; Hopkins et al., 2001).

## **Strategies**

Effective methods for using policy changes and the media to promote tobacco-use treatment include the following:

- Implementing smoking bans and restrictions to reduce exposure to environmental tobacco smoke (Hopkins et al., 2001).
- Increasing the unit price for tobacco products to reduce the initiation of tobacco use and prevalence, increase cessation attempts, and increase the use of tobacco-use treatment (Hopkins et al., 2001).
- Combining mass media education (campaigns) with other interventions to reduce tobacco-use initiation and prevalence, increase cessation, and increase tobacco-use treatment (Hopkins et al., 2001).
- Marketing quitlines to encourage their use (and unaided quit attempts as well) (Zhu et al., 2000).

## **Stakeholders**

In the policy and media categories, the roles of the various health system players are similar. A willing organization could play one or more of the roles identified below.

- **Coalition member:** Representatives of clinics, hospitals, and health plans can be powerful members of coalitions that promote policy change and the maintenance of funding for tobacco-control programs, including quitlines.
- **Bridge to employers:** Health plans and large clinic or hospital systems are businesses as well as health-care organizations. They can provide a link to the business sector that public health professionals and advocacy organizations may lack. Senior executives of large health-care organizations can reach out to other business leaders and involve them in policy changes.
- **Effective lobbyist:** Health system lobbyists with key legislative relationships may be able to open doors previously closed to traditional tobacco-control advocates.
- **Funder:** Health systems can be dues-paying members of organizations or coalitions that promote policy change or work-site health initiatives and may be able to financially support media campaigns.
- **Champion:** Clinicians are trusted sources of health-care advice and credible tobacco policy messengers at the state and local levels. Rural health-system organizations and leaders often have even greater influence than their metropolitan peers because they may have more direct relationships with legislators, or their organizations may carry substantial clout as employers.

- **Defender:** Effective media campaigns and policy initiatives are vulnerable to attack from opponents of tobacco control. Health systems leaders can support a program under attack—or better yet, proactively educate decision makers about the importance of tobacco-dependence treatment and the key role media campaigns and public policies play in encouraging and supporting quitting.
- **Business health coalition:** A number of larger communities have business health coalitions with valuable relationships in both the health-care and business communities that may be an asset in moving an agenda forward. A business health coalition typically comprises health-care system and business members who collaborate to address key health issues in the community.  
Business health coalitions can
  - Encourage members to initiate or expand coverage for tobacco-dependence treatment.
  - Increase members' awareness of the state quitlines and promote financial support.
  - Support smoke-free policies among businesses and in the community.

For additional information on effective coalitions and campaigns, refer to the following Pacific Center on Health and Tobacco documents: *Health Insurance Benefits for Treatment of Tobacco Dependence: Summary and Invest in Tobacco Cessation for a Healthy, Productive Workforce*, available at [www.ttac.org/leadership/resources.html](http://www.ttac.org/leadership/resources.html). Also, please visit the Centers for Disease Control and Prevention's Media Campaign Resource Center at [www.cdc.gov/tobacco/mcrc](http://www.cdc.gov/tobacco/mcrc) and the Tobacco-Free Coalition of Oregon's site at [www.tobaccofreeoregon.org](http://www.tobaccofreeoregon.org). The *Make It Your Business* campaign (available at [www.tobaccofreeoregon.org](http://www.tobaccofreeoregon.org)) is another valuable resource. (See Case Study #6 on page 56.)

# **Building Relationships Within Health-Care Systems**

---

**T**obacco control seeks to end the death and disease caused by tobacco use and by exposure to secondhand smoke. But, unlike diphtheria, pertussis, or tetanus, there is no vaccine to inoculate people against tobacco's harmful effects. Instead, individuals, agencies, and organizations must work together to take on a complex mix of social, cultural, economic, and political issues which encourage tobacco use (Tobacco Technical Assistance Consortium, 2004).

*Communities of Excellence Plus in Tobacco Control:  
Training and Resource Manual*

Informed by a basic understanding of the structure and concerns of health-care system organizations, public health professionals can more knowledgeably approach potential partners and begin the important process of building relationships. The challenge is to move beyond simple cooperation and coordination to create a spirit of collaboration and partnership to address tobacco as a community issue (Winer and Ray, 1994).

When a comprehensive and complex set of goals will be pursued over a longer period of time, the more intensive approach of collaboration may be the best investment. This can result in systems change to impact tobacco-dependence treatment and thereby reduce rates of illness and death.

## **Reasons to Collaborate**

Organizations collaborate to achieve some result or results that one organization cannot achieve alone (Ray, 2002). Whether your goal is to increase access to effective tobacco-use treatment counseling or to create smoke-free environments that support tobacco-use treatment, it is unlikely that a single organization can achieve that objective alone.

## **Keys to Successful Collaboration**

Several factors support successful collaborations, including mutual trust, shared decision making, open communication, and having a skilled convener (Winer and Ray, 1994). In addition, having committed leaders,

a common purpose, dedicated resources, external accountability, and clear time lines increases the chances for success (Solberg, 2000).

## Getting Started:

### Selecting Appropriate Public Health Staff

The “right” person to initiate contact with a health system organization depends on your objectives. If you are trying to increase clinician referrals to a quitline, you may need to work with someone other than your community policy contact. You should be prepared to talk to a number of people before finding the right person.

Health department staff members who have previous experience with community organizing or coalition development may be a good choice to assist in building a new tobacco-use treatment coalition and anticipating and addressing potential problems.

Tobacco-control collaborations are prone to experiencing the same barriers as other collaborations: disparate visions, flawed communications, lack of role definition, and unclear responsibilities. In addition, tobacco-use treatment collaborations are often challenged by competition over tobacco-control resources and attempts by outside forces to divide health coalitions.

## Beginning a Collaboration

Collaboration between public health systems and the nongovernmental health-care system involves the coming together of distinct cultures. Early on, participants must develop trust, and to do so, they must rely on each other’s honesty, integrity, and fairness. Developing relationships takes time, effort, and persistence. It is also very helpful at the beginning to take the time to develop a common vocabulary so everyone is communicating effectively.

In addition to having potentially different educational backgrounds and work experience, public health professionals and health-care system professionals work for organizations with different missions and cultures.

Experienced collaborators emphasize the primacy of personal relationships. Successful development is more likely to grow out of individual contacts and relationships that turn eventually into a small cooperative project over time. Only then is there sufficient trust to start thinking about shared values and mission.

An interagency collaboration works best if there is sponsorship by senior leaders in participating organizations. If the health department director contacts the health-care system CEO and obtains buy-in, the initiative frequently begins with a solid base.

## Roles Within the Collaboration

In any given state, there may be multiple collaborations that are relevant to tobacco control—a purchasers’ coalition, a Medicaid benefits task force, a clinical guideline-focused collaborative, and others. In each, certain roles must be filled. These include convenor, facilitator, funder, technical assistance provider, and active participant. The right organizations to perform each of those roles depends on the specific situation.

## The Public Health Contribution

To be effective collaborators, public health professionals must identify what they can contribute to the collaboration. Skills and resources that public health professionals can contribute might include

- Knowledge of effective tobacco-control strategies.
- Common ground and the ability to foster cooperation and agreement among competitors for shared efforts.
- Group facilitation and management skills.
- Technical support.
- Leadership in tobacco-control policy advocacy, if appropriate.
- Experience in reaching specific populations (e.g., pregnant smokers, low-income populations, populations with health disparities).
- Data collection, analysis, and reporting.
- Funding to support the collaboration and its work; recognition of the skills and resources that health-care systems and professionals bring and the importance of focusing on tobacco control as a strategy for improving quality of care.
- A clear mission. Public health groups can be more mission-driven and help keep the work going.
- Relationships with existing programs in the voluntary sector (American Heart Association, American Lung Association, American Cancer Society, pregnancy programs, etc.) that may be of assistance in supporting tobacco-control initiatives.

Health-care systems may have a different culture than that of public health. Using the contacts discussed on the previous page, the health-care systems may appreciate public health support in establishing internal committees within the system. Having representation from management, nursing, benefits, respiratory therapy, pharmacy, quality improvement, legal, and other departments will be helpful in planning the initiative and ensuring that key departments integrate tobacco-control strategies into their system components (see Health-Care Systems Primer, pp. 7–20, for additional details.)

## Next Steps: Finding a Health-Care Systems Contact

Differing program needs will require contact with different health-care systems contacts. The following are suggestions for developing contacts to meet specific program needs:

Some clinics, hospitals, and health plans employ medical and nursing staff with specific quality improvement (QI) accountabilities. Look for a “QI medical director” or “Director of QI” when searching for a contact for clinical systems or individual treatment efforts.

In the policy and media arenas, key contacts include health system lobbyists, communications directors, market researchers, and medical directors who might serve as spokespeople. If the health system has a philanthropic arm, such as a foundation or community relations department, you might want to try that area, too.

Try contacting the hospital’s community relations department or marketing departments about offering tobacco-use treatment services at the hospital or work sites or developing relationships that will provide quitline referrals.



# Implementation Strategies

**R**esults from community-based interventions and statewide programs show that a comprehensive approach to tobacco control is needed to curtail the epidemic (U.S. Department of Health and Human Services, 2000).

*Donna E. Shalala, former Secretary of Health and Human Services*

In beginning to work with health-care systems, selecting appropriate staff and developing initial relationships between the leaders of all organizations lays the foundation in which the collaboration can be developed to improve tobacco-use cessation. Changing systems is a long-term process that requires working with health-care systems to determine perceived problems, gaps in care, and willingness to change. Identifying a champion's willingness to commit resources and develop opportunities for systems change is a good starting point. Potential opportunities include the following:

- Is a health-care system looking to create a tobacco-free campus before insurance coverage for tobacco cessation is expanded?
- Are there practices or components of the system that have effectively implemented Public Health Service (PHS) guidelines for treating tobacco dependence?
- Would these providers or health-care practices be willing to provide leadership?
- What are the barriers to effective implementation of provider reminders?
- What current programming is in place that could potentially be used as a model for tobacco-use treatment (e.g., diabetes, hypertension)?

## Lessons Learned

The most progressive health plans have used a number of strategies and components in successful tobacco-control initiatives (Rigotti et al., 2002). Some of their lessons learned include the following:

- Establish evaluation mechanisms up front. This is important for demonstrating the effectiveness of the initiative.
- Work with partners to establish an internal committee, which is critical for developing reasonable time lines, setting feasible goals and objectives, and obtaining buy-in and support for the implementation process. Key players might include
  - Medical director.
  - Benefits manager.

- Health promotion representative.
- Pharmacists.
- Nurses.
- Quality assurance personnel.

## Measuring Progress

The plan may be willing to share its Health Employer Data Information Set (HEDIS) and JCAHO scores on these measures, or the state insurance commissioner's office may have the scores. Because insurers make multiple coverage plans available to purchasers, determine the extent of tobacco-dependence treatment coverage provided within the more popular plans. Public health staff can view the coverage and provide feedback comparing coverage to PHS and Community Guide recommendations. (See Coverage document, Appendix G.) If current coverage for tobacco-dependence treatment is not in line with the PHS guidelines, recommendations as to what steps might be taken to increase coverage for medication and counseling could be provided. Establishing baselines in tobacco cessation facilitates goal setting. One baseline measure could be the current level of medications being provided to treat tobacco dependence. Health systems often closely track the provision of pharmacotherapy.

The HEDIS measures have three components. The "advice to quit" measure is the first indicator. Plans at the highest levels in the country are scoring in the 70% range. Second, the HEDIS scores relate to the provision of support and assistance in quitting, which is a proxy for counseling. The highest rate in 2004 was 45%. The HEDIS "offer of medication" question is a third source of information (NCQA, 2003a), also with the highest rate around 45%.

## Increasing Systems-Change Effectiveness

A plan identifying implementation components, time lines, and evaluation criteria should be developed.\* Data collection and analyses are also integral parts of effective systems change. If health-care systems are interested, public health staff could share practice assessments, which assists in identifying strengths and opportunities at the practice level and provides support for implementing evidence-based practices. (See Practice Assessment document, Appendix F.)

---

\*The National Business Coalition on Health (NBCH) also conducts an annual assessment of health plans—eValue8. This tool requests treatment information from plans that is compared to national data and fed back to the plans in terms of strengths and opportunities. Tobacco-use treatment information is collected in the prevention section of the tool.

Public health departments could also assist health-care systems in identifying and using baseline data to develop implementation targets. If medication prescriptions are at the 20% level, this is in line with current practice. A 10 percentage point increase (to 30%) over the next 1 to 2 years might be a reasonable target. System pharmacies usually have excellent data systems for tracking medication dispensing. These data can then be used to show change over time.

One example of work in this area is from Oregon. The Oregon Department of Health assessed which health plans were most likely to have a high percentage of tobacco users and then worked closely with the plans to enhance coverage and treatment strategies.

Other questions to consider when addressing these issues include: Can a mechanism be instituted with the quitline vendor to provide feedback to the health plan and individual providers on patient enrollment progress, and can a system of fax referrals to the quitline be established? For example, Wisconsin has developed a mechanism for providers to fax referrals to the quitline, which accounts for 35% of all referrals. What additional strategies can be developed to integrate tobacco control into existing systems? If electronic medical records are in use, tobacco-use status should be logged into the system and any treatment provided should be documented. These data should then be collected, analyzed, and fed back to providers on a regular basis as a means to measure progress toward reaching treatment targets set by the system.

Another strategy is to develop coordination between health plans. Health plans within a geographic area are frequently staffed by the same clinicians. If health plans promote the same message across plans, providers may be more likely to implement effective tobacco-control treatment. The state health department could assist in supporting health plan implementation of strategies coordination in tobacco control, including

- Identification of tobacco-use status.
- Advice to quit.
- Offer of medication.
- Referral to a quitline or other counseling services.

### ***State Examples***

In Minnesota, health plans were encouraged to improve medication coverage and alleviate the quitline burden of providing medications to otherwise insured individuals, thus assuring state funding to provide medications for the underinsured and uninsured.

The California Next Generation Alliance developed an office practice guide, the *Health Care Provider's Tool Kit for Delivering Smoking Cessation Services*, that is designed to promote effective office-based tobacco-cessation practices (Next Generation California Tobacco Control Alliance, 2003).

The Pacific Center on Health and Tobacco in Oregon developed a *Linking Health Care Systems and Quitlines* document that contains a number of case studies illustrating successful strategies (Pacific Center on Health and Tobacco, 2003b).

In Michigan, the Michigan Association of Health Plans took a leadership role in coordinating health plan change efforts, establishing minimum suggested standards for coverage of tobacco-use treatment and bringing implementation staff together to share strategies and materials to improve treatment. The states of Oregon, Maine, and Wisconsin and the Columbia University Dental School have provided academic detailing to office practices promoting science-based tobacco-control activities within the office setting (Swartz et al., 2002).

Educating purchasers about the importance of coverage and enlisting their assistance in implementing comprehensive coverage for their employees has also been an effective strategy. For example, the Tobacco-Free Coalition of Oregon (TOFCO) has developed a business health document, *Make It Your Business*, which provides examples of working with businesses to improve coverage of tobacco-use treatment (TOFCO, 2003).

Several tactics for systems change are as follows:

- The Arizona Health Department works with WIC clinics to support faxed referrals to the quitline.
- Prescription pads listing the quitline telephone number can be distributed to promote referrals.
- A video could be shown for providers and their patients to familiarize them with the quitline service.
- Quality-assurance strategies can be developed that will assess the extent of
  - Provision of medication.
  - Referrals to the quitline or other counseling services.
  - Coding for tobacco dependence (305.1).

The next section provides case studies to more fully illustrate effective implementation strategies.

## Case Studies

### Case Study #3

#### Connecting Private Clinics to State-Level Quitlines

***Providence Health System, Oregon***

##### ***Objective:***

To increase compliance with the PHS guidelines on clinician–quitline collaboration, updated tobacco-use tracking systems, and efficient clinician feedback methods.

---

Providence Health System in Portland, Oregon, implemented a project to increase compliance with the Public Health Service (PHS) guidelines for the 5 A's intervention in 20 local primary care clinics. This project featured three unique health-care delivery components designed to increase clinicians' ability to consistently deliver tobacco-cessation and other preventive health services: 1) a direct link from the clinic to a statewide tobacco-cessation quitline; 2) an electronic medical record (EMR) charting system that prompted providers to consistently screen for tobacco users and manage them appropriately; and 3) a provider feedback system that motivated providers to increase compliance with the PHS tobacco-cessation guidelines.

In a 1-year study, 100,000 unique outpatient visits were documented in the 20 Providence clinics (Bentz, 2002). Fifteen percent of patients (15,000) were identified as tobacco users, and 4.3% of tobacco users (643) were referred to the quitline either through direct fax referral from the clinic or via self-referral after receiving a brochure. The effect of provider performance feedback had a significant, positive influence on the documentation of Asking, Advising, Assessing, and Assisting in the EMR. The total Assistance rate (referrals to the quitline or to a Providence tobacco program, provision of written cessation materials by clinic staff, prescriptions for and counseling on medications, etc.) in clinics receiving feedback was almost double that of the clinics that received no feedback (controls).

The costs per quitline connection were very reasonable (between \$21 and \$35 per patient) during the first year of the study. After the start-up costs were paid, the cost per quitline connection dropped significantly (down to less than \$6 per patient) during the second year. This compares favorably to the costs that are typically incurred when using media connections to drive quitline uses (\$100 to \$400 per patient connected).

##### ***Lessons Learned:***

Connecting smoking patients in physicians' offices directly to state-level quitlines is feasible, effective, and well accepted by clinicians and patients. This method may prove to be an economical way for public health advocates to promote quitline usage.

## Case Study #4

### Involving Health Systems Promotes Public Health Programs' Success

**Oklahoma State Medical Association**

#### **Objective:**

To form a partnership that will meet public health needs by promoting relationships with clinicians.

---

The partnership between the Oklahoma State Department of Health (OSDH) and the Oklahoma State Medical Association (OSMA) resulted in a successful bid for a 3-year grant to develop a best-practice prenatal smoking-cessation intervention. OSMA served as the lead agency on the grant application. Traditionally, the health department would have assumed the role of lead agency and sought OSMA endorsement, but OSDH staff understood that clinicians would be more likely to welcome the best-practice intervention if it were introduced and promoted by other clinicians.

To date, the program has reached 26 private-practice sites, including private physician practices, residency programs, and Native American tribal clinics, and is coordinating the provision of technical assistance, grant-writing support, training, and consultation by OSDH staff with expertise in prenatal tobacco-use treatment. OSMA, representing nearly 5,000 providers, contributed its credibility among clinicians, access to a significant number of doctors and various health systems statewide, and the strong infrastructure of the clinician-developed and -led Physician's Campaign for a Healthier Oklahoma. The purpose was to improve tobacco-dependence treatment for prenatal smokers in the state.

To date, the program has reached 17 private practices and is coordinating with two health-care systems. Providers and staff are encouraged to

- Assess prenatal cessation practices using a modified chronic disease assessment tool. (See assessment tool, Appendix F.)
- Identify areas of tobacco-dependence treatment needing improvement.
- Establish strategies to move toward more effective practice over time.

The OSDH found that when it takes advantage of opportunities to involve health system leadership in public health initiatives, the health system responds by leveraging resources, strengthening partnerships, extending the reach of public health initiatives, and further investing in public health outcomes. Although these opportunities may place health systems in new roles or unfamiliar territory, their success can be considerable if the initiatives build on the health system's strengths.

### **Results:**

The following preliminary results have been identified through independent evaluation of the project. Comprehensive data will not be available until late 2006.

- Familiarity with the 5 A's in practice sites showed an overall increase.
- Self-reported advice to quit, assessing willingness to quit, and assisting patients to quit all increased.
- More resources became available within practices to assist women in quitting.
- Use of the statewide cessation HelpLine has increased dramatically.
- Confidence, on the part of providers and their staff, in implementing the 5 A's intervention increased from the baseline data to the post-implementation survey.
- Practices indicated more awareness of important factors related to comprehensive tobacco-cessation program implementation.
- Self-reported ability to implement the program was high.
- All tasks related to the program implementation were reported as "easy."
- Satisfaction with the Practice Enhancement Assistants (PEAs) was rated very high.
- 100% of practice sites said that they would recommend the PEA implementation process and participation in the Smoke Free Beginnings program to other practices.
- One limitation of the project evaluation: when the baseline and post-implementation surveys were completed by the providers, the same person did not complete the survey in all cases.

### **Lessons Learned:**

- Medical society involvement was invaluable in reaching health-care providers.
- A peer-to-peer approach proved effective in reaching clinicians.
- Using a practice assessment tool helped identify areas of strength and opportunity and provided a guide for selecting targets for change.
- Many practices were able to show changes in office practice as a result of the intervention. However, this will be better quantified as time progresses.

Funding for this project was provided by the Smokefree Families Dissemination Program, Robert Wood Johnson Foundation.

## Case Study #5

### Public–Private Quitline Collaboration *Oregon Medicaid*

#### ***Objective:***

To build an effective partnership to support a broad-based quitline.

---

The state of Oregon created a successful public–private partnership for telephone-based quitting assistance as a way to support the tobacco-use treatment efforts of health plans. This partnership is a collaboration of three public agencies operating at the state level:

- The Public-Health Tobacco Prevention and Education Program (TPEP).
- The Tobacco-Free Coalition of Oregon (TOFCO).
- The Office of Medical Assistance Program (OMAP).

TPEP selected a vendor for its statewide telephone-based (single-call) tobacco-use treatment support program that could also provide a proactive multiple-call program to health plans at a reasonable cost. Participation by health plans is voluntary, and advantages include proactive enrollment, free promotion, volume price discounts, and free evaluation.

OMAP modeled the partnership by contracting with the vendor for its fee-for-service members. It also used its managed care contracting mechanisms and quality improvement forum to encourage its health plans to use this program or a comparable one.

Five of OMAP's (Medicaid) 14 health plans elected to participate in the shared program. Through a Health Systems Task Force, TOFCO convened the plans' tobacco-use treatment staffs to create common guidelines, provide outreach to clinicians and clinics, promote the program to members, and monitor results.

The TPEP policy decision to make the telephone support program a shared public–private responsibility ensured that area health plans would continue their existing financial contributions to tobacco-use treatment programs. But voluntary participation has its limits. Although the combined resources and influence of the prevention program, the Medicaid agency (OMAP), and the advocacy group made it easy for health plans to participate, only the state Medicaid plans expanded their tobacco-treatment offerings as a result of this effort. Prior to the initiative, one Medicaid health plan and three commercial plans provided their members with telephone counseling for quitting tobacco use. Afterwards, four additional

### ***Case Study #5, continued***

Medicaid plans added telephone counseling as a benefit. Now, half of all callers to the Oregon quitline are Medicaid clients.\* No additional commercial plans added telephone counseling as a benefit; however, two of the three plans that already offered telephone counseling switched to the common carrier.

Data show that a “help is here” campaign to promote the quitline generated 700 calls within a 3-week period. Quit rates, though lower than those published in clinical trials, are comparable to those reported in published literature for “real world” applications.

### ***Lessons Learned:***

- Coordination with Medicaid is an effective strategy for reaching low-income populations.
- Medicaid enrollees may be harder to reach at follow-up for determination of quit rates.

---

\* El-Bastawissi A, McAfee T, Zbikowski SM, et al. The uninsured and Medicaid Oregon tobacco user experience in a real world, phone based tobacco use treatment programme. *Tobacco Control* 2003;12(1):45–51.

## Case Study #6

### Building Business Champions

**Tobacco-Free Coalition of Oregon,  
Make It Your Business Campaign**

**Objective:**

**Develop business partnerships to support comprehensive coverage for tobacco-dependence treatment.**

---

In Oregon, about 40% of tobacco users get health-care benefits from their employers, but only about one-third of them are covered for tobacco-dependence treatment. A key to increasing benefit coverage is getting access to large health-care purchasers to make a strong business case for adding these benefits.

Through a series of surveys and focus groups, the Tobacco-Free Coalition of Oregon (TOFCO) identified key audiences needing information about the cost-effectiveness of providing reimbursement for tobacco-use treatment. At the top of the list were the large purchasers as well as insurers and consultants who broker contracts between the purchasers and insurers. To help gather information and gain access to these key groups, staff with the Oregon Department of Human Services Tobacco Prevention and Education Program assisted TOFCO in developing a partnership with the Oregon Coalition of Health Care Purchasers (OCHCP). OCHCP, which prefers system-wide rather than single health issue projects, allowed TOFCO to conduct a survey of its members about tobacco-addiction treatment resources and to assist with member follow-up.

The director of the OCHCP subsequently agreed to serve on a high-level advisory committee for the “Make It Your Business” campaign, a statewide campaign sponsored by TOFCO to involve businesses in providing tobacco-use treatment services for employees. The chairman of the advisory committee is the Oregon Health and Science University (OHSU) medical school president, and other members include representatives from health insurers, businesses, and labor unions. The advisory committee developed a strategic outreach plan and successfully generated earned media through editorials and press releases of survey information. In the process, advisory committee members became advocates for expanding coverage for tobacco-dependence treatment in their own organizations. The medical school president reviewed benefit coverage for the more than 10,000 employees of the university’s hospital, clinics, and research departments. He also met with the executives of the largest health plans in the area to advocate for inclusion of tobacco-dependence treatment as a standard benefit in these health plans. OHSU now provides coverage for employees.

**Case Study #6, continued**

Projects that challenge businesses and insurers to examine their benefit packages for tobacco-use treatment coverage and make the business case for adding these benefits can result in significant progress. The Make It Your Business Campaign tools to help approach businesses and insurers are available at [www.tobaccofreeoregon.org](http://www.tobaccofreeoregon.org). Getting access to the decision makers, while difficult, can be facilitated by recruiting high-level advisors and using targeted media channels such as popular business journals. To build the momentum needed for this change to occur, campaigns to increase consumer demand are also needed.

**Lessons Learned:**

- Purchasers, employers, and the media were more receptive to providing and promoting benefits for tobacco-use treatment than assumed.
- Businesses often do not know if their health plans cover tobacco-use treatment. They may assume their plans provide this coverage when they do not.
- Though many businesses may see the benefits to providing coverage for tobacco-use treatment, there may still be resistance to adding coverage because of the added costs and perceived low demand for these services.

## Case Study #7

### Health Systems Contribute Support in the Face of Funding Cuts *Oregon Tobacco Prevention and Education Program*

#### ***Objective:***

To build an effective partnership to support a broad-based quitline.

---

Because of limited funds, the tobacco-use treatment component of Oregon's Tobacco Prevention and Education Program (TPEP) was designed as a public-private partnership. The state quitline is a cornerstone of this partnership. Successful relationships between the state program and the health plans' and health systems' tobacco coordinators, quality improvement coordinators, health promotion staff, and clinician champions have been created as a result of this collaboration.

When funding for TPEP was cut by the legislature because of a severe state budget shortfall, the day-to-day partners were quick to react. Several of the health systems' medical directors testified at legislative hearings to explain the delivery systems' interconnected dependence on the state program for tobacco-use treatment services. But when sustained funding for the tobacco program was pitted against the need to fund low-income health care, allegiances were split. The primary mission of those with the most influence—that is, the top executives and lobbyists for the health plans and health systems—is health care. So in this situation, the executives and lobbyists' case in favor of protecting health care won over the medical directors' concern about the loss of the state quitline.

#### ***Lessons Learned:***

- The political positions of health systems are quite complex, which makes it very important for tobacco-control programs to work at multiple levels within the insurer and clinician organizations.
- To better withstand state budget crises, a separate strategy is needed to build stronger alliances with leaders at the highest levels of the health systems that exert the strongest political clout.

A strong coalition effort was able to gain renewed reimbursement for the quitline following a short period of extremely limited service.

## Case Study #8

### Partnership Extends and Improves Tobacco-Use Treatment in Oklahoma

**Oklahoma Health Care Authority, Oklahoma State Department of Health, Oklahoma Tobacco Settlement Endowment Trust, Oklahoma Medicaid**

#### **Objective:**

Build partnerships with professional organizations to increase provider provision of tobacco-use treatment.

---

A 4-year strategic partnership brought improved access to tobacco-use treatments to the state of Oklahoma. The Oklahoma State Department of Health (OSDH), the Oklahoma Health Care Authority (OHCA), Medicaid, and the Oklahoma Tobacco Settlement Endowment Trust (TSET) created a formula for success that resulted in better information exchange, stronger interagency relationships, a convincing case for improved access to tobacco-use treatment medications based on health and economic data, and leverage of Master Settlement Agreement (MSA) resources that helped create a statewide helpline for tobacco users.

From 1999 to the present, each partner has contributed resources and support. OSDH staff provided technical assistance to OHCA by

- Presenting the Public Health Service's *Clinical Practice Guideline: Treating Tobacco Use and Dependence* to health plan medical directors.
- Providing model Medicaid contract language that OHCA could use as a guide.

In 2003, TSET funded the statewide Oklahoma Tobacco Helpline, which is provided at no cost to all state residents regardless of their insurance status. OHCA, in turn, built its capacity in tobacco-dependence treatment issues and subsequently moved from providing limited coverage to providing comprehensive coverage that includes tobacco-dependence treatment medications.

To achieve the goal of increasing access to medical coverage for tobacco dependence treatment, OHCA reviewed utilization data and model Medicaid contract language, coordinated training events, and participated in a tobacco-use treatment systems strategy session that was facilitated by a resource staff member from CDC's Office on Smoking and Health. Once OHCA's Drug Utilization Review Committee, Medical Advisory Committee, and Board of Directors better understood potential utilization of the benefit, they approved a policy to lift a preauthorization requirement and covered both prescription and over-the-counter tobacco-use treatment medications for Medicaid clients. This policy also allows medications for a second quit attempt if the client receives counseling from the Oklahoma

### ***Case Study #8, continued***

Tobacco Helpline or other approved tobacco-use treatment program. Furthermore, these medications do not count against the six-prescriptions-per-month limit that normally applies to Medicaid clients.

The administrative rules of this policy were passed on November 13, 2003, and the expanded coverage took effect on January 1, 2004. Data show an increase in tobacco-use treatment claims in January of approximately 20% to 30% above the 2003 calendar year averages. In February, when the preauthorization requirement was waived for the first 90 days of therapy, there was an increase of more than 60% over the January claims. Data available for March 2004 indicate that the number of paid claims will either increase slightly over February or at least remain relatively constant.

Approximately 40% of the Medicaid population is made up of smokers. By removing the prior authorization requirement, Medicaid was able to double the percentage of smokers receiving medications, but this continues to be a small fraction of tobacco users in the program.

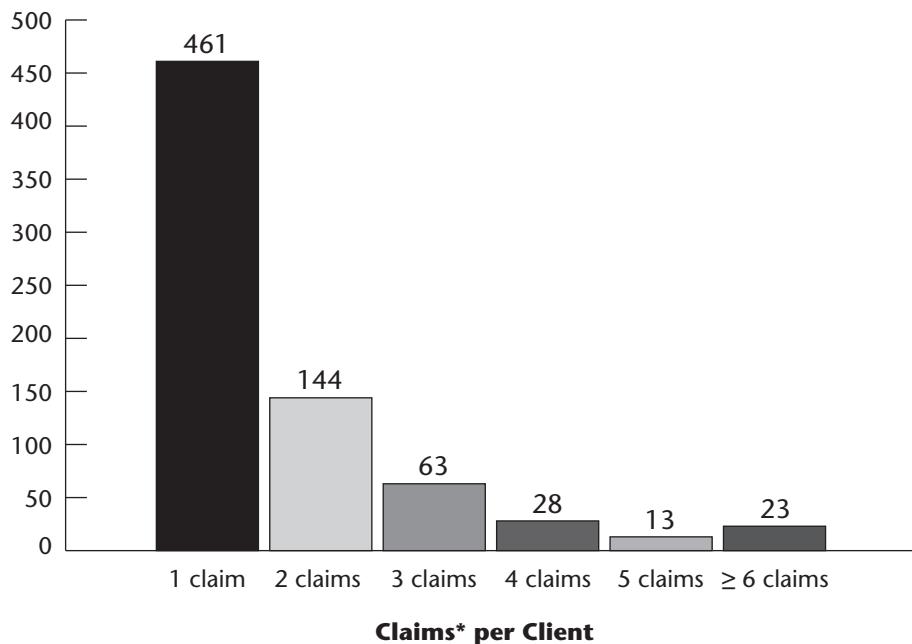
For the period of July 2003 through June 2004, a total of 732 clients received smoking-cessation products through the Medicaid fee-for-service program (due to computer problems, Oklahoma is assuming that the data presented below under-represents demand).

Product (unit)	# of Claims	Total Units	Total Days	Units/ Day	Total Cost	Total Clients	Per Diem
Zyban® (ea)	209	12,686	6,783	1.87	\$24,129.78	165	\$3.56
Spray (ml)	28	1,325	591	2.24	\$4,900.24	15	\$8.29
Inhalers (cart)	271	27,734	4,571	6.07	\$23,073.65	162	\$5.05
Patches (ea)	749	16,774	16,846	1.00	\$64,307.65	540	\$3.82
Gum (ea)	15	2,340	267	8.76	\$924.87	12	\$3.46
Lozenges (ea)	25	2,532	281	9.01	\$1,282.96	9	\$4.56
<b>TOTAL FY 03</b>	<b>1,297</b>	<b>63,391</b>	<b>29,339</b>	<b>2.16</b>	<b>\$118,619.15</b>	<b>732</b>	<b>\$4.04</b>

In summary,

- 165 clients received Zyban®.
- 540 clients received nicotine replacement patches.
- 162 clients received inhalers.
- 732 individuals received medications.
- The standard course of medication was 90 days.

**Case Study #8, continued**



For the period of July 2004 through June 2005, a total of 2,531 clients received smoking cessation products through the Medicaid fee-for-service program.

Product (unit)	# of Claims	Total Units	Total Days	Units/ Day	Total Cost	Total Clients	Per Diem
Zyban® (ea)	461	26,977	14,381	1.88	\$44,893.99	319	\$3.12
Spray (ml)	91	5,860	1,353	4.33	\$18,376.53	34	\$13.58
Inhalers (cart)	737	120,364	15,965	7.54	\$89,288.40	476	\$5.59
Patches (ea)	3,341	78,692	77,810	1.01	\$300,178.23	2,449	\$3.94
Gum (ea)	57	8,359	1,147	7.29	\$3,532.78	47	\$3.08
Lozenges (ea)	100	16,160	1,768	9.14	\$8,050.70	50	\$4.55
<b>TOTAL FY 05</b>	<b>4,787</b>	<b>256,412</b>	<b>112,424</b>	<b>2.28</b>	<b>\$464,320.63</b>	<b>2,531**</b>	<b>\$4.13</b>

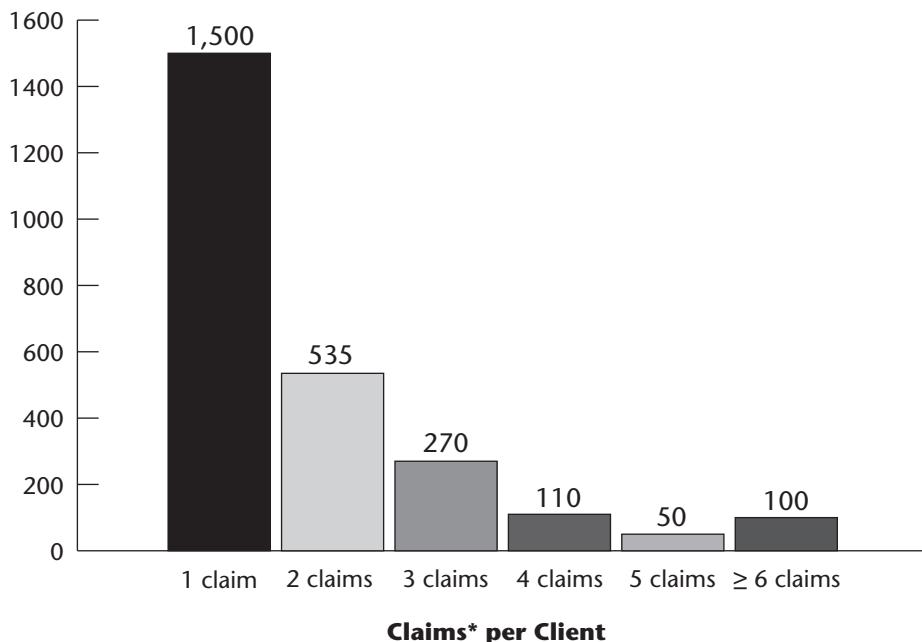
\* A claim should be considered a full course of treatment. Only the first claim is a "free ride." The second and subsequent claims require a preauthorization and a cessation program (helpline or other).

\*\* Total unduplicated clients for FY05.

### **Case Study #8, continued**

In summary,

- 319 clients received Zyban®.
- 2,449 clients received nicotine replacement patches.
- 476 clients received inhalers.
- 2,531 individuals received medications.
- The standard course of medication was 90 days.



### **Lessons Learned:**

- Multiple-organization involvement was key in improving coverage under Medicaid.
- Medicaid was willing to consider policy change when evidence demonstrated that benefit utilization was severely limited by the requirement for prior authorization.
- Having an informed public health champion in the Medicaid office facilitated policy change.

---

\* A claim should be considered a full course of treatment. Only the first claim is a “free ride.” The second and subsequent claims require a preauthorization and a cessation program (helpline or other).

## Case Study #9

### Integrated Statewide Program Provides Spectrum of Services to Maine Citizens *Partnership for a Tobacco-Free Maine*

#### ***Objective:***

Support a comprehensive tobacco-control program with a quitline and provision of medication as core elements.

---

The Partnership for a Tobacco-Free Maine (PTM), a program of the Maine Bureau of Health, was created in 1997 with \$3.5 million in funding from an increase in the state's tobacco excise tax. In 2000, Master Settlement Agreement monies were placed into the Fund for a Healthy Maine, which supports programs to lower health risks, including programs to promote tobacco control, dental health, substance abuse prevention, and school health clinics, among others. Allocation from this fund increased revenues for PTM to \$17.25 million in fiscal year 2001; however, since that time, annual funding has been reduced to about \$13 to \$15 million.

The Tobacco Treatment Initiative, launched in 2001 by PTM, focuses on access to tobacco-use treatments. The initiative comprises

- The Maine Tobacco HelpLine.
- A medication voucher program.
- Tobacco-treatment training to educate health professionals about tobacco use and to train and certify tobacco-control specialists.

The HelpLine offers a total of four counseling sessions to any resident. HelpLine callers who have no insurance or benefits for nicotine replacement therapy (NRT) can receive up to an 8-week supply of nicotine gum or patches. Through collaboration with a pharmacy benefit manager, the HelpLine electronically submits voucher information authorizing callers to obtain NRT products at a Maine pharmacy of their choice. The voucher program is also expanding access to NRT products for patients of primary care clinics in several Maine communities.

Maine works to integrate statewide tobacco-treatment services with the medical community, using an academic detailing model to conduct clinical outreach (Swartz et al., 2002). Across the state, practice-based educational sessions are provided to engage clinicians, nurses, and other clinical and administrative staff in implementing clinical quitlines to improve

### *Case Study #9, continued*

tobacco-dependence treatment. The target audience includes staff of primary care and prenatal clinics, as well as medical specialty, dental, chiropractic, and nonallopathic practices. The sessions aim to increase the following:

- Knowledge about tobacco dependence.
- Awareness of the impact of supportive messages from health-care providers.
- Use of PTM treatment resources and knowledge of Medicaid benefits for tobacco-use treatment.
- Support for integration and monitoring of evidence-based practice.

In practices providing prenatal care, outreach consultants also promote the Every Mother's Wish program. This program, which is tailored to pregnant smokers, provides self-help materials, a quitline video filmed in Maine, and referral by fax to the Maine Tobacco HelpLine. The HelpLine calls women who are referred for services and sends them an Every Mother's Wish T-shirt. After completion of counseling sessions, a silver necklace is mailed to the participating expectant mother.

As a result of conducting extensive clinical outreach, offering medication through the HelpLine, and using pharmacies to provide NRT, Maine has seen significant upward trends in population-based use of its tobacco-treatment services. In the first 2 years, HelpLine use climbed from about 1.5% of adult smokers in Maine to about 3% (from 3,300 to 6,800 per year). In 2003, 31% of callers reported hearing about HelpLine services through a doctor or other health professional. Half of all callers who received counseling were given a voucher for nicotine patches or gum. Just over half of HelpLine callers either had no insurance or were Medicaid beneficiaries. Finally, when use of services across geographic regions was examined, the volume of calls was found to be proportional to the total number of adult smokers residing in each region.

The Maine Tobacco Treatment Initiative plans to continue focusing on increasing treatment capacity across the state. The Center for Tobacco Independence (CTI), the Treatment Initiative contractor, will train tobacco specialists each year, and the American Lung Association of Maine will oversee their certification. CTI, in collaboration with the Maine Coalition on Tobacco and Health, will advocate for insurers (including public payers) to cover services delivered by certified tobacco specialists. And as previously mentioned, the medication voucher program will be expanded to provide access to NRT through public health clinics and other community sites.

### ***Challenges and Opportunities:***

- Only one health insurance company provided medication coverage to Maine residents.
- Coordinating with the business community to increase medication coverage so that state funding could be reserved for medications for the underinsured and uninsured required active HelpLine documentation of callers' insurance status and name of insurance carrier (if any).
- The state health department partnered with the large medical center to develop and implement the program.
- Active collaboration between partners was necessary to develop a common language to overcome cultural differences among partner organizations.

### ***Lessons Learned:***

- Coordinating with a Pharmacy Benefits Manager (PBM) facilitates the distribution of medications in a predominantly rural state.
- Referring pregnant women to the HelpLine via fax provides greater access to this population.
- Active data collection and reporting provides ongoing program support.
- A scientific advisory board provides expertise and support for innovative programming.

## Case Study #10

### State-Level Tobacco-Control Policy Activity: Sometimes a Health Plan Can Help *Group Health Cooperative, The Center for Health Promotion, Inc.*

#### ***Objective:***

**Build an effective partnership to ensure allocation of Master Settlement Agreement (MSA) funding for tobacco control.**

---

The Group Health Cooperative (GHC) in Washington State partnered with seven other community-based organizations, the Governor's Office, the Office of the Attorney General, and the Washington State Department of Health to ensure that state legislators in Washington appropriated tobacco settlement dollars to fund health-care priorities, including tobacco-initiation prevention and tobacco-use treatment. Steps involved in securing this funding included developing a strong coalition of organizations to advocate for public policy aimed at reducing tobacco use. GHC served as a founding member of the coalition. Efforts were also made to establish a sound network of tobacco-control advocates at the grassroots level.

Primary strategies employed in pursuit of public policy support for this funding included

- Direct lobbying of members of the legislature.
- Conducting a highly visible media campaign.
- Emphasizing grassroots organizing and advocacy.

A GHC lobbyist assisted with appeals to the legislature, and more than one-third of GHC clinicians signed tailored letters encouraging their legislators to support the use of tobacco settlement funds for tobacco control and other public health priorities. The health plan also provided funds for the media campaign. In addition, GHC representatives served on advisory councils to the attorney general and the department of health.

As a result of these strategies, Washington became the first state in the nation to commit all funding from the master tobacco settlement to tobacco control and other public health priorities. To solidify this commitment, the partnering organizations then worked to ensure the continuity of tobacco-control funding and increase funding levels by

- Drafting an initiative that would increase the tobacco tax and guarantee more than \$28 million per year in tobacco-control funding.
- Creating a coalition of voluntary organizations, tobacco-control groups, national advocacy organizations, and health groups concerned with the uninsured in close communication with the state department of health.

#### ***Case Study #10, continued***

- Obtaining signatures and conducting an effective campaign in support of the tobacco tax initiative.

GHC remained very active in the coalition and provided significant funding for lobbying in support of the tobacco tax initiative. The GHC Board of Directors formally endorsed this initiative, and its Governmental Affairs Office worked to support it. Other GHC contributions included

- Providing linkages between groups working on obtaining insurance for the uninsured and preventing tobacco use.
- Speaking and writing opinion pieces or editorials in support of the tobacco tax initiative.
- Mobilizing member support for the initiative.

As a result of the coalition members' efforts, including GHC, the tobacco tax initiative was passed in July 2005, receiving more than 60% of votes.

#### ***Lessons Learned:***

- Partnerships between health-care systems, clinicians, and state agencies can be effective in obtaining funding.
- Using health-care system support to lobby for an initiative can be effective.
- Media campaigns add considerable visibility to the initiative.

## Case Study #11

### Achieving Seamless Continuation of Tobacco-Use Treatment Services from Inpatient to Outpatient Settings *Massachusetts General Hospital, Quit Smoking Service*

#### **Objective:**

Electronically identify patient smoking status upon hospital admission to efficiently and effectively meet the needs of inpatient smokers and encourage post-discharge tobacco-use treatment.

---

Many acute-care hospital patients are admitted because they have a smoking-related illness. A hospital admission is an opportunity for a smoker to try to quit. Getting sick often motivates patients to reconsider their life choices and motivates smokers to think about quitting, making the hospital stay a “teachable moment” for tobacco-use treatment. Because a hospital is a smoke-free environment, smokers may undergo nicotine withdrawal symptoms during their stay, including anxiety, irritability, impatience, restlessness, and difficulty concentrating and sleeping. These symptoms often go untreated because they are not recognized as nicotine withdrawal symptoms. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards mandate documentation of inpatient tobacco-use treatment counseling for all smokers admitted with myocardial infarction, congestive heart failure, and pneumonia. To address this, hospitals have expressed increasing interest in implementing system changes to comply with the accreditation standards.

To meet the needs of inpatient smokers and encourage post-discharge tobacco-use treatment, Massachusetts General Hospital’s Quit Smoking Service (MGH QSS) is working with the admissions department to electronically record each patient’s smoking status upon admission to the hospital. The MGH QSS envisions a seamless process in which a coordinator identifies a list of inpatient smokers daily and a trained QSS counselor offers state-of-the-art counseling and drug treatment. All actions are then documented in the patient’s medical record, which helps the hospital improve compliance with JCAHO measures. Subsequently, and when appropriate, a referral is made to “Quitworks,” the Massachusetts state quitline. This proactive telephone-based counseling program provides up to five counseling calls to a patient after discharge. Quitworks also provides feedback to the MGH QSS on the status and outcome of all referrals. The MGH QSS then contacts the patients’ primary care clinicians to provide updated information on the patient’s smoking status.

#### **Lessons Learned:**

- Having specific systems in place is imperative for a seamless tobacco-treatment process from admission to post-discharge.
- Reliable identification of a patient’s smoking status upon hospital admission is key to reaching the largest number of smokers.
- Once a clinical service is developed, referral to the state quitline supports smoking cessation following discharge.

# Conclusion

Effective treatments can more than double a person's chances of successfully quitting smoking (Fiore et al., 2000). Smokers whose benefits cover tobacco-use treatment are more likely to undergo treatment and to quit successfully (Curry et al., 1998; Cochrane Collaboration, 2005). Data from businesses that have included tobacco-use treatment benefits as part of their health insurance also show that providing this coverage is cost-effective over time (Fiore et al., 2000; Wagner et al., 1995; Warner et al., 1996).



In the *Clinical Practice Guideline:*

*Treating Tobacco Use and Dependence*, the U.S. Public Health Service presents recommendations aimed at improving access to effective treatment. Specifically, the guidelines recommend that every patient who uses tobacco should be offered at least brief treatment. Insurers and purchasers should include tobacco-dependence treatments as a benefit so clinicians can be reimbursed for providing these services (Fiore et al., 2000).

A systematic review of published studies on tobacco-use treatment was conducted on behalf of the Task Force on Community Preventive Services (Hopkins et al., 2001). This review, along with the PHS guidelines, reports that approaches used by health-care systems—where clinicians identify patients who use tobacco and discuss with them the importance of quitting, and where the clinicians receive information to assist them in helping their patients understand the risks associated with tobacco use—effectively increase both the number of clinicians who address tobacco use with their patients and the number of tobacco users who attempt to quit. Based on these findings, the Task Force recommends that interventions to increase tobacco-use treatment should include reminder systems for clinicians and

clinician education programs in conjunction with systems-change strategies, sustained media campaigns, availability of quitlines, reduction of patient out-of-pocket costs for treatment, and increases in excise taxes on tobacco (Centers for Disease Control and Prevention, 2000).

To be successful advocates, public health professionals and others who are interested in and have opportunities to promote tobacco-use treatment or reimbursement for these services must understand what types of treatment have proven successful, why reimbursement is such an important issue, and how providing this benefit affects the business sector in both the short and long term. They must also understand how the various components of the health-care system operate, the challenges they face, and their role in tobacco-use treatment. Armed with a comfortable level of knowledge about tobacco-use treatment and the ever-changing health-care arena, they can effectively approach health-care clinicians, health plans, insurers, and purchasers to educate them about effective strategies, assist them in identifying common goals, and plan a strategy for working successfully together to achieve those goals.

Developing effective relationships between public health and health-care systems will require time, effort, and persistence. Providing support and assistance for incremental change, with an effective evaluation system, will be key components in supporting implementation of effective tobacco-control initiatives.

Although the PHS and Community Guide recommendations are not fully implemented, nor are desirable levels of service and coverage for tobacco-use treatment in place, progress is being made, and a foundation has been laid. A strong science base exists for the treatment of tobacco dependence, and additional efforts are required to more effectively translate research into practice. We can now see that the needs and desires of health plans, clinicians, purchasers, and consumers—particularly as they relate to quitting tobacco—often overlap. As demonstrated in the case studies presented in this tool kit, progress often is achieved through collaborative efforts, and these efforts are resulting in significant achievements in tobacco cessation.

Implementation of the strategies contained in this guide, along with establishing strong partnerships with health-care insurers, purchasers, and businesses, will provide opportunities to increase the availability and use of effective treatments for tobacco use. Integration of comprehensive treatment strategies in health-care settings will result in decreases in the prevalence of tobacco use and reduce the public health burden of tobacco-related diseases in the United States.

## References

- Agency for Healthcare Research and Quality. CAHPS® 2.0 Questionnaires. Rockville, MD: U.S. Department of Health and Human Services; December 1998. Available at <https://www.ahq.gov/default.asp>.
- Agency for Healthcare and Research and Quality. *Checkup on Health Insurance Choices*. Rockville, MD; U.S. Department of Health and Human Services and the National Council on Patient Information and Education; 2002. Available at <http://www.ahrq.gov/consumer/insuranc.htm>.
- America's Health Insurance Plans. *Glossary of Managed Care Terms*. 2003. Available at <http://www.ahip.org>.
- American Cancer Society. *Cancer Facts and Figures*, 2003. Atlanta, GA: American Cancer Society; 2003.
- American Federation of State, County, and Municipal Employees, AFL-CIO. *All for One and One for All: Taft-Hartley Health Insurance Plans*. 2000. Available at [http://www.afscme.org/wrkplace/cbr300\\_2.htm](http://www.afscme.org/wrkplace/cbr300_2.htm).
- Barbeau E, Li Y, Sorensen G, et al. Coverage of smoking cessation treatment by union health and welfare funds. *American Journal of Public Health* 2001;91(9):1412–1415.
- Bentz CJ, Davis N, Bayley B. The feasibility of paper-based Tracking Codes and electronic medical record systems to monitor tobacco-use assessment and intervention in an Individual Practice Association (IPA) Model health maintenance organization (HMO). *Nicotine and Tobacco Research* 2002;4(1):S9–S17.
- Center for Tobacco Cessation. *What Works in Tobacco Cessation*. 2004. Available at <http://www.ctcinfo.org>.
- Centers for Disease Control and Prevention. State Medicaid coverage for tobacco-dependence treatments—United States, 1994–2002. *MMWR* 2004a;53(03):54–57.
- Centers for Disease Control and Prevention. State-specific prevalence of current cigarette smoking among adults—United States, 2002. *MMWR* 2004b;52(53):1277–1280.
- Centers for Disease Control and Prevention. Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health-care systems. A report on recommendations of the Task Force on Community Preventive Services. *MMWR* 2000;49(No. RR-12):1–11.

Cochrane Collaboration. Healthcare financing systems for increasing the use of tobacco dependence treatment (review). Issue 1. The Cochrane Library; 2005.

Coffield AB, Maciosek MV, McGinnis JM, et al. Priorities among recommended clinical preventive services. *American Journal of Preventive Medicine* 2001;21(1):1–9.

Conroy MB, Majchrzak NE, Silverman CB, et al. Measuring provider adherence to tobacco treatment guidelines: A comparison of electronic medical record review, patient survey, and provider survey. *Nicotine and Tobacco Research* 2005; 7(1):S35–S43.

Curry SJ, Grothaus MA, McAfee T, et al. Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. *New England Journal of Medicine* 1998;339(10): 673–679.

Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence: Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service; June 2000.

Fiore MC, Croyle RT, Curry SJ, et al. Preventing 3 million premature deaths and helping 5 million smokers quit: a national action plan for tobacco cessation. *American Journal of Public Health* 2004;94(2):205–210.

George Washington University, Center for Health Services Research and Policy, and the Centers for Disease Control and Prevention. *Sample Purchasing Specifications Related to Tobacco Use Prevention and Cessation*. 2002. Available at <http://www.gwhealthpolicy.org/newsps/tobacco>.

Hall MJ, DeFrances CJ. 2001 National Hospital Discharge Survey. Advance Data. Vital and Health Statistics. No 332. Hyattsville, MD: National Center for Health Statistics; 2003. Available at <http://www.cdc.gov/nchs/data/ad/ad332.pdf>.

Halpin HA, Bellows NM, McMenamin SB. Medicaid coverage for tobacco-dependence treatments. *Health Affairs* 2006;25(2):550–556.

Health Insurance Association of America. *Issue Brief: Why Do Health Insurance Premiums Rise?* September 2002. Available at <http://membership.hiaa.org/pdfs/healthinsurancepremiums.pdf>.

Hopkins DP, Briss PA, Ricard CJ, et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *American Journal of Preventive Medicine* 2001;20(2S):16–66.

Joint Commission on Accreditation of Healthcare Organizations. *Specification Manual for National Implementation of Hospital Core Measures*. Version 2.0. Oakbrook Terrace, IL: The Commission; 2003. Available at <http://www.jcaho.org/pms/core+measures/information+on+final+specifications.htm>.

Kaiser Family Foundation. *Medicaid Enrollment: Kaiser Commission on Medicaid and the Uninsured*. Washington, DC: Kaiser Family Foundation; 2000.

Kaiser Family Foundation. *Trends and Indicators in the Changing Health Care Marketplace*. Washington, DC: Kaiser Family Foundation; 2004.

Maciosek MV, Coffield AB, Edwards NM, et. al. Priorities among effective clinical preventive services: results of a systematic review and analysis. *Am J Prev Med* July 2006.

Magnan S, Solberg LI, Giles K, et al. Primary care, process improvement, and turmoil. *Journal of Ambulatory Care Management* 1997;20:32–38.

Manley M, Griffin T, Foldes S, et al. The role of health plans in tobacco control. *Annual Review of Public Health* 2003;24:247–266.

Medicare Quality Improvement Clearinghouse. *Quality Measures*. 2005. Available at <http://www.medqic.org/content/measures/index.jsp>.

Mills RJ, Bhandari S. *Health Insurance Coverage in the United States 2002*. Current Population Reports P60–223. Washington, DC: U.S. Census Bureau; September 2003. Available at <http://www.census.gov/prod/2003pubs/p60-223.pdf>.

National Cancer Institute. *Health Effects of Exposure to Environmental Tobacco Smoke. The Report of the California Environmental Protection Agency*. Smoking and Tobacco Control Monograph 10. Bethesda, MD: U.S. Department of Health and Human Services; NIH Pub. No. 99–4645; 1999.

National Committee for Quality Assurance. *HEDIS 2004. Volume 3: Specifications for Survey Measures*. Washington, DC: the Committee; 2003a. Available at <http://www.ncqa.org/publications/hedispub.htm>.

National Committee for Quality Assurance. *NCQA Overview*. Washington, DC: The Committee; June 2003b. Available at <http://www.ncqa.org/Communications/Publications/overviewncqa.pdf>.

Next Generation California Tobacco Control Alliance. *Health Care Provider's Tool Kit for Delivering Smoking Cessation Services*. Sacramento, CA: The Alliance; 2003. Available at [http://www.cessationcenter.org/pdfs/NGAToolkit\\_FINAL\\_FORWEB.pdf](http://www.cessationcenter.org/pdfs/NGAToolkit_FINAL_FORWEB.pdf).

Pacific Business Group on Health. *Glossary of Terms*. 2004. Available at <http://www.healthscope.org/Interface/glossary.asp>.

Pacific Center on Health and Tobacco. *Health Insurance Benefits for Treatment of Tobacco Dependence: Summary*. Portland, OR: The Center; 2003a. Available at [http://www.paccenter.org/public/reports\\_folder/insurance\\_flier\\_web.pdf](http://www.paccenter.org/public/reports_folder/insurance_flier_web.pdf).

- Pacific Center on Health and Tobacco. *Invest in Tobacco Cessation for a Healthy, Productive Workforce*. Portland, OR: 2002. Available at [http://www.paccenter.org/public/reports\\_folder/cess\\_in\\_wp\\_web.pdf](http://www.paccenter.org/public/reports_folder/cess_in_wp_web.pdf).
- Pacific Center on Health and Tobacco. *Linking a Network: Integrate Quitlines with Health Care Systems*. Portland, OR: The Center; 2003b. Available at [http://www.paccenter.org/public/reports\\_folder/linking\\_broch\\_web.pdf](http://www.paccenter.org/public/reports_folder/linking_broch_web.pdf).
- Partnership for Prevention. *Preventive Services: Helping States Improve Mandates*. Washington, DC: The Partnership; 2002. Available at [http://www.prevent.org/publications/Preventive\\_Services\\_State\\_Mandate\\_Brief\\_FINAL.pdf](http://www.prevent.org/publications/Preventive_Services_State_Mandate_Brief_FINAL.pdf).
- Peto R, et al. Smoking, smoking cessation, and lung cancer in the UK since 1950: combination of national statistics with two case-control studies. *The British Medical Journal* 2000;321:323–329.
- Ray K. *Nimble Collaborations: Fine-Tuning Your Collaboration for Lasting Success*. St. Paul, MN: Wilder Foundation; 2002.
- Revell CC, Schroeder, SA. Simplicity matters: using system-level changes to encourage clinician intervention in helping tobacco users quit. *Nicotine and Tobacco Research* 2005; 7(1):S67–S69.
- Rigotti NA, Quinn VP, Stevens VJ, et al. Tobacco-control policies in 11 leading managed care organizations: progress and challenges. *Effective Clinical Practice* 2002;5(3):130–136.
- Schroeder SA. Thirty seconds to save a life: what busy clinicians can do to help their patients quit smoking. Paper presented at the Meeting of BlueCross BlueShield Association Executives, November 12, 2003, San Francisco, CA.
- Solberg LI. Incentivising, facilitating, and implementing an office tobacco cessation system. *Tobacco Control* 2000;9(Suppl 1):i37–i41.
- Solberg LI, Hollis JA, Stevens VJ, et al. Does methodology affect the ability to monitor tobacco control activities? Implications for HEDIS and other performance measures. *Preventative Medicine* 2003; 37(1):33–40.
- Solberg LI, Quinn VP, Stevens VJ et al. Tobacco control efforts in managed care: what do the doctors think? *American Journal of Managed Care* 2004; 10(3):193–198.
- Swartz SH, Cowan TM, DePue J, et al. Academic profiling of tobacco-related performance measures in primary care. *Nicotine and Tobacco Research* 2002; 4(1): S39–S45.
- Swartz SH, Cowan TM, Klayman JE, et al. Use and effectiveness of tobacco telephone counseling and nicotine therapy in Maine. *American Journal of Preventive Medicine* 2005;29(4):288–294.

Tobacco-Free Coalition of Oregon. *Make It Your Business: Insure a Tobacco Free Workplace*. Milwaukie, OR: The Coalition; 2003.

Tobacco Technical Assistance Consortium. *Communities of Excellence Plus in Tobacco Control: Training and Resource Manual*. Atlanta, GA: The Consortium; 2004.

Tobacco Technical Assistance Consortium. TTAC Exchange Extra! Atlanta GA; November 25, 2003;1(2). Available at <http://www.ttac.org/enews/mailer11-03/mailer11-03full.html>.

Tomar SL, Husten CG, Manley MW. Do dentists and clinicians advise tobacco users to quit? *Journal of the American Dental Association* 1996; 127(2):259–265.

U.S. Department of Health and Human Services, Centers for Medicare and Medicare Services. 2005. Available at <http://www.cms.hhs.gov>.

U.S. Department of Health and Human Services. *Healthy People 2010*, 2nd ed. Understanding and Improving Health and Objectives for Improving Health (2 vols). Washington, DC: U.S. Government Printing Office; 2000.

U.S. Public Health Service. *The Health Consequences of Smoking: A Report of the Surgeon General—Executive Summary*. Atlanta, GA: U.S. Department of Health and Human Services; 2004.

U.S. Public Health Service. *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services; 2004.

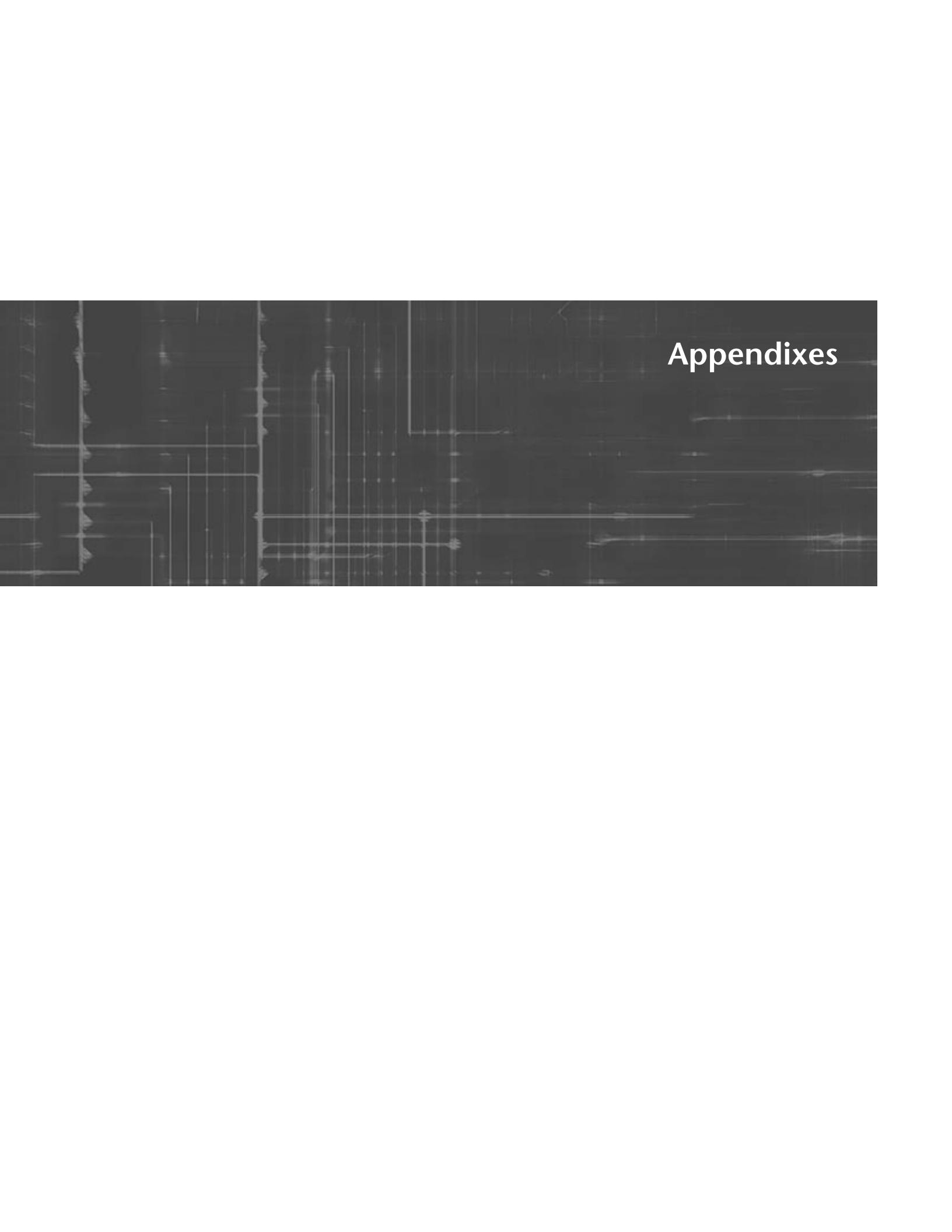
Wagner EH, Curry SJ, Grothaus L, et al. The impact of smoking and quitting on health care use. *Archives of Internal Medicine* 1995;155:1789–1795.

Warner KE, Smith RJ, Smith DG, et al. Health and economic implications of a work-site smoking cessation program: a simulation analysis. *Journal of Occupational and Environmental Medicine*. 1996.

Winer M, Ray K. *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey*. St. Paul, MN: Wilder Foundation; 1994.

Zhu S, Melcer T, Sun J, et al. Smoking cessation with and without assistance: a population based analysis. *American Journal of Preventive Medicine* 2000; 18(4):305–311.





## Appendices

# Appendix A

## Glossary of Terms

**Academic detailing:** Detailing similar to that used by the pharmaceutical industry, but it brings a training systems change message to office practices.

**Broker:** A person who is licensed by the state to sell and service contracts for multiple health plans.

**Capitation:** A method of payment for health services in which the clinician is paid a fixed amount for each patient served regardless of the actual number or nature of services provided.

**Copayment:** A specified amount that the insured pays out of pocket at the time services are provided or prescription medications are purchased.

**Deductible:** An amount the insured pays before insurance plan coverage is in effect.

**Earned media:** Coverage of a story without paying for media placements. Examples include a letter to the editor, op-eds, coverage of press conferences, appearance on talk shows or local news programs, and on-air or print interviews. Such coverage is called “earned media” because you have to develop materials, work with reporters, and expend resources to get it; however, you do not have to pay for the placement of the messages in the stories.

**Fee-for-service:** A method of payment in which the health-care clinician is paid for services rendered instead of receiving a salary or receiving capitated payments (see above). In fee-for-service plans, the insurer may reimburse the plan member or pay the clinician directly after services have been provided.

**Fully insured:** A type of coverage in which the insurance company is paid a monthly premium to assume complete risk for covered charges after the deductible and copayments are satisfied.

**Health insurance products:** The specific types of health-care coverage that are offered by health plans and insurers and may contain differing coverage available for purchase.

**Health plan:** An organization that offers a variety of health insurance products and may take responsibility for coordinating and improving the delivery of care.

**Health Plan Employment Data and Information Set (HEDIS):** A set of standardized performance measures developed by the National Committee on Quality Assurance (NCQA) that is designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health-care plans.

**Indemnity products:** Policies that provide coverage for health-care services on a fee-for-service basis. Often referred to as “traditional insurance,” these plans typically include a deductible and often also require a co-payment.

**Integrated delivery system:** A health-care service organization provides a full range of health-care services, including clinician services, hospital services, and outpatient and ancillary services.

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO):** An independent, not-for-profit organization that sets standards and accredits health-care organizations and programs in the United States.

**Managed care:** A type of health plan or product that typically involves a network of clinicians from whom members can receive care, some limitation on benefits to members who choose to use clinicians outside the network, and some type of authorization or approval system that must be used when securing services.

**National Committee for Quality Assurance:** The NCQA is a not-for-profit managed care accreditation organization that is designed to improve patient care and health plan performance in three ways: (1) through accreditation achieved through a rigorous, on-site review of key clinical and administrative processes that are performed at health plans' requests; (2) through HEDIS, a tool used to measure performance in key areas; and (3) through a comprehensive member satisfaction survey.

**Point of service (POS):** A type of coverage that allows plan members to choose a clinician within the plan's network or one outside the network at the time that the care is needed. Choosing an out-of-network clinician usually involves higher costs.

**Preferred provider organizations (PPOs):** Companies that arrange for lower fees with a network of health-care clinicians, giving policyholders a financial incentive to seek care within that network. Members pay higher rates for services obtained from a clinician who is not part of their network.

**Primary care:** General medical care that focuses on preventive care and the treatment of routine injuries and illnesses.

**Quality improvement organizations (QIOs):** A group of clinicians and other health-care experts who are paid by the federal government to assess the care given to Medicare patients and to plan improvements. QIOs review complaints about the quality of care provided by hospitals (inpatient, outpatient, and emergency room care), skilled nursing facilities, and ambulatory surgical centers. They also assess services provided by home health agencies and private fee-for-service plans. QIOs usually serve on a statewide basis and may be valuable partners in monitoring the implementation of tobacco-control initiatives.

**Self-insured:** A plan in which an employer or other group sponsor, rather than the health plan, is financially responsible for paying expenses, including claims. Most large employers are self-insured, and they select a benefits package for their employees. Self-insured companies usually contract with a health plan or independent company (known as third-party administrators) to process claims and handle other administrative needs.

# **Appendix B**

## **Essential Elements of an Effective Practice-Based Tobacco-Cessation System\***

### **1. Identification of All Tobacco Users**

- Nursing staff or aides ask all patients with unknown status about their tobacco use when patients are placed in the examining room. (Children with daily secondhand smoke exposure are also identified.)
- Charts are labeled to identify current use, recent (past year) use, former use, and nonuse.
- At subsequent visits, patients identified as current or recent users of tobacco are asked about use.

### **2. Clinician Reminders**

- Information is provided about current use.
- Prominent flags call attention to this information, for example, using a colored identification sticker or stamp (current, former, never).
- Electronic medical records can prompt providers to obtain status and provide brief advice.

### **3. Clinician Message**

Clinicians are reminded to

- Assess patient's interest in quitting (i.e., ask if ready to make a quit attempt now).
- Advise patient of the importance of quitting.
- Negotiate a quit date if interested in quitting.
- Offer assistance and follow-up (medication and counseling).
- Refer to state or National Network of Quitlines access numbers (1-800-QUIT NOW).

They also are reminded that it is very difficult for smokers to quit.

### **4. Assistance**

Provide

- Counseling resources, preferably on-site or phone-based.
- Medication (unless contraindicated).
- Educational materials.

### **5. Follow-up**

- Provide follow-up at all office visits, based on #1 and #2 above.
- Telephone patient soon after quit date to assess progress and reinforce action.

---

\* Solberg LI. Incentivising, facilitating, and implementing an office tobacco cessation system. *Tobacco Control* 2000;9(Suppl 1):i37–i41.

# **Appendix C**

## **Essential Elements of an Effective Pediatric Practice-Based Tobacco-Control System**

In addition to addressing tobacco-use treatment with adults in primary care or specialty settings, it is important to recognize the opportunities to intervene in pediatric settings. The pediatric setting provides an opportunity to prevent and eliminate tobacco use by young people **and** adults. Tobacco control in pediatric health care has three primary aims: (1) to eliminate childhood secondhand smoke (SHS) exposure, (2) to eliminate tobacco use by parents and guardians of pediatric patients, and (3) to prevent and eliminate tobacco use by pediatric patients. Steps to accomplish these goals are

### **1. Systematically identify all tobacco users in the household.**

- Ask the parents and guardians of all pediatric patients about the smoking status of household members; this can be done at the front desk, during the recording of vital signs, or during the visit with the clinician.
- Confidentially ask all adolescent and pre-adolescent patients about their tobacco use.

### **2. Systematically document smoking status in the medical record.**

- In the child's medical record, document the smoking status of all smokers, including pediatric patients, their parents, and other household members.

### **3. Inform and prompt child health-care clinicians about the child's SHS exposure or tobacco use.**

- Use stickers or other indicators on the problem list or visit note to cue clinician inquiry and 5 A's counseling on tobacco issues.
- Electronic medical records can systematically prompt clinicians to inquire and follow up on the tobacco issues of pediatric patients and household members.

### **4. Intervene directly and indirectly.**

- Create a smoke-free office that includes posters, brochures, and information on enrolling smokers in evidence-based smoking-cessation counseling, creation of smoke-free environments, and preventing smoking initiation.
  - i. Advise: "I strongly advise that you establish a no-smoking policy in your home and car and that you quit smoking yourself. I can help you."

- ii. Prescribe medications for parent and adolescent tobacco dependence if appropriate.
- iii. Link smokers to quitlines and other tobacco-treatment services.
- iv. Provide more extensive office counseling if possible.

#### **5. Follow up.**

- Address tobacco use with all smoking members of the household at future visits.
- Remind nonsmoking families about smoke-free policies and the dangers of initiating tobacco use.

---

Citation: Winickoff JP, Berkowitz AB, Brooks K, et al. State-of-the-art interventions for office-based parental tobacco control. *Pediatrics* 2005;115(3):750–760.

## Appendix D

# Making the Business Case for Tobacco Control\*†

States may find it helpful to develop a fact sheet containing some or all of the following elements as a means of having key information in one place when beginning to work with health-care systems.

- Provide state-specific and, if possible, organization-specific data on smoking prevalence.
- Provide state-specific data on the cost of tobacco use in terms of direct and indirect health-care costs.
- Use HEDIS data to estimate the percentage of smokers in a health plan.
- Gather organization-specific HEDIS data on rates of advice to quit and assistance with quitting, and provision of medication (may be available from the state insurance office).
- Assess JCAHO data on rates of providing tobacco-dependence treatment for specified diagnostic categories (pneumonia, cardiovascular disease, lung disease).
- Provide a clear description of the health benefits of tobacco cessation. (See consumer materials from the 2004 publication *The Health Consequences of Smoking: A Report of the Surgeon General* at [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco).)
- Describe the effectiveness of available treatments. (See PHS Web site.)
- Describe the cost-effectiveness of available treatments. (See PCHT finance document.)
- Describe short- and long-term costs and cost savings. (See *Make It Your Business Campaign*, [www.TOFCO.org](http://www.TOFCO.org), and *PACT Employer Document*, [www.endsmoking.org](http://www.endsmoking.org).)
- Describe specific case examples of similar organizations that have adopted tobacco-control policies and programs.
- Encourage self-insured businesses and health plans to use the [www.businesscaseROI.org](http://www.businesscaseROI.org) Web site for assessing costs for tobacco use and benefit implementation.
- Use the CDC document *Coverage for Tobacco Use Treatments* to supplement the sheet you have developed. Available at [www.cdc.gov/tobacco/educational\\_materials/cessation/ReimbursementBrochureFull.pdf](http://www.cdc.gov/tobacco/educational_materials/cessation/ReimbursementBrochureFull.pdf)

---

\* The information in this resource sheet was adapted from: Pacific Center on Health and Tobacco. Build a Financial Infrastructure: Health Plan Benefits and Clinician Reimbursement. Portland, OR: The Center; 2003. Available at [http://www.paccenter.org/public/reports\\_folder/reimbursement\\_web.pdf](http://www.paccenter.org/public/reports_folder/reimbursement_web.pdf).

† See State Highlights for state-specific tobacco-control data, [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco).

## Appendix E

### For More Information

Listed below are Web sites where you can find the primary sources of information cited in this tool kit, as well as other policies and practices related to implementing tobacco-use treatment in the health-care setting.

#### Guidelines and Key Documents

- *Treating Tobacco Use and Dependence* is a U.S. Public Health Service (PHS)-sponsored clinical practice guideline that contains evidence-based strategies and recommendations to support effective treatment for tobacco use and nicotine addiction. Available at <http://www.surgeongeneral.gov/tobacco>.
- The *Guide to Community Preventive Services* provides information on the effectiveness of community-based interventions in three areas of tobacco-use prevention and control: (1) initiation of tobacco use, (2) tobacco-use treatment, and (3) reduction of exposure to environmental tobacco smoke. Articles, slide sets, and commentaries can be found at <http://www.thecommunityguide.org/tobacco>.
- *Crossing the Quality Chasm: A New Health System for the 21st Century* is one in a series of reports developed by the Institute of Medicine's Quality Initiative, which has focused on assessing and improving the nation's quality of care. This report, which is the second of two published in the third phase of the initiative, presents key steps to promote evidence-based practice and strengthen clinical information systems. Ordering information and access to online text is available at [http://books.nap.edu/catalog/10027.html?onpi\\_newsdoc030101](http://books.nap.edu/catalog/10027.html?onpi_newsdoc030101).
- Surgeon General's reports related to tobacco are available on the Centers for Disease Control and Prevention Web site at <http://www.cdc.gov/tobacco/sgrpage.htm>. These include the reports cited as sources for this document. The PHS guidelines and related consumer and clinician materials also can be found at <http://www.surgeongeneral.gov/tobacco>.
- *A National Action Plan for Tobacco Cessation* outlines a series of science-based action steps to reduce tobacco consumption and promote tobacco-use treatment, especially among minority and lower-income Americans. This report, sponsored by the American Legacy Foundation, the University of Wisconsin Center for Tobacco Research and Intervention, and the *Journal of American Public Health*, is available at <http://www.ctri.wisc.edu/home/NatActionPlan%2002-04.pdf>.
- Preventing 3 million premature deaths and helping 5 million smokers quit: a national action plan for tobacco cessation, by Michael C. Fiore and colleagues at CDC, was published in the *American Journal of Public Health* in February 2004 (Vol. 94, No. 2, pages 205–210).

## **Data**

- Data on tobacco-use prevalence, morbidity, and mortality are available at the Centers for Disease Control and Prevention Web site at <http://www.cdc.gov/tobacco/data.htm> and <http://www.cdc.gov/nchs>.
- Data on insurance status and type (national and by state) from a survey conducted jointly by the Bureau of Labor Statistics and the Bureau of the Census are available at <http://ferret.bls.census.gov/macro/032002/health/toc.htm>.

## **Pregnancy**

- A Cost-Benefit/Cost-Effectiveness Analysis of Smoking Cessation for Pregnant Women, by J.S. Marks, J.P. Koplan, C.J.R. Hogue, et al. *American Journal of Preventive Medicine* 1990; 6(5):282–289.
- The Partnership for Smoke-Free Families Program (PSF), which focuses on tobacco-use treatment for pregnant women and reducing exposure to tobacco smoke for infants and young children, has created a technical assistance manual that provides other health-care organizations with the information they need to create similar programs in their own health-care settings. Included are lessons learned, recommendations for program implementation, and samples of program materials. The manual is available in PDF format at <http://www.smokefreefamilies.org/documents/PSFManual.pdf>.

## **Quality Assurance**

- The National Committee on Quality Assurance (NCQA) Web site provides information to help consumers, including representatives of large employers, make more informed decisions when choosing a health plan. The site also provides pages for health-care professionals that detail NCQA programs and NCQA publications, including publications on HEDIS. Available at <http://www.ncqa.org/index.asp>.
- *Accelerating Quality Improvement in Health Care: Strategies to Speed the Diffusion of Evidence-Based Innovations* explores the reasons why clinicians and systems are slow to adopt many medical and health-care innovations, best practices, and ways to speed the diffusion of proven treatments and tools that improve the quality of health care. This report, commissioned papers, and related conference proceedings are available at <http://www.nihcm.org>.

## **Finance and Business**

- *Build a Financial Infrastructure: Health Plan Benefits and Clinician Reimbursement* combines evidence-based recommendations and the experiences of the Pacific Center on Health and Tobacco (PCHT), a consortium of five western states (California, Oregon, Washington, Arizona, and Hawaii) concerning tobacco-cessation benefits and clinician reimbursement. The report is designed to guide planning and decision

making by states and other groups that are working to implement tobacco-cessation programs. Also available are two summaries based on this report: (1) *Health Insurance Benefits for Treatment of Tobacco* and (2) *Invest in Tobacco Cessation for a Healthy, Productive Workforce* (see next entry). Visit the PCHT Web site at <http://www.paccenter.org>.

- Implementing Tobacco Interventions in the Real World of Managed Care, by J.F. Hollis, R. Bills, E. Whitlock, et al. *Tobacco Control* 2000; 9(Suppl I): i18-i24.
- *Invest in Tobacco Cessation for a Healthy, Productive Workforce* is a brochure designed to help employers determine the cost of smoking to their businesses and estimate the cost of providing a tobacco-use cessation benefit for their employees. This brochure, developed by the PCHT, is available at [http://www.paccenter.org/public/reports\\_folder/cess\\_in\\_wp\\_web.pdf](http://www.paccenter.org/public/reports_folder/cess_in_wp_web.pdf).
- *Employers' Smoking Cessation Guide: Practical Approaches to a Costly Workplace Problem*, a guide published by the Professional Assisted Tobacco Cessation Therapy (PACT) consortium for large and small employers interested in enacting an affordable, effective smoking-cessation treatment program, is available at <http://www.endsmoking.org>.
- *Reimbursement for Smoking Cessation Therapy: A Health Care Practitioner's Guide*, a guide published by the PACT consortium for clinicians on how to obtain reimbursement for tobacco-use treatment services that also is helpful to employers in the implementation of a tobacco-cessation benefit. Available at <http://www.endsmoking.org>
- A guide to purchasing prevention benefits that was developed for employers by North Carolina Prevention Partners contains information that may be helpful to employers in other states. The guide can be found at <http://www.ncpreventionpartners.org/basic/eguide.htm>.
- Information on the costs of tobacco use to employers and information on smoke-free policies can be found in the publication *Making Your Workplace Smokefree: A Decisionmaker's Guide*. The entire guide or selected chapters are available in PDF format at [http://www.cdc.gov/tobacco/research\\_data/environmental/etsguide.htm](http://www.cdc.gov/tobacco/research_data/environmental/etsguide.htm).
- *Making the Business Case for Smoking Cessation* is a Web site that assists businesses in calculating the costs of smoking and the benefits of cessation in terms meaningful to health-care delivery organizations and purchasers. Available at [www.ahip.org](http://www.ahip.org).
- The Oregon Make It Your Business Campaign encourages businesses to voluntarily help employees become tobacco-free and urges health insurers to include, as a standard benefit, the medications and programs to help people quit smoking or chewing tobacco. The tool kit provides a step-by-step guide for businesses that want to "make it their business" to ensure a tobacco-free workforce. The tool kit also provides checklists, worksheets, and fact sheets. Available at <http://www.tobaccofreeoregon.org/projects/miyb>.

- [www.businesscaseROI.org](http://www.businesscaseROI.org) is a Web-based modeling tool that has been developed for managed care organizations to assess their tobacco-related disease costs and project potential costs for adding tobacco-dependence treatment benefits.
- “Coverage of Smoking Cessation Treatment by Union Health and Welfare Funds” (Barbeau E., Li Y., et al., *American Journal of Public Health* 2001;91(9):1412–1415) presents the results of a survey to determine the level of insurance coverage for smoking-cessation treatment and factors associated with coverage among health and welfare funds affiliated with a large labor union. Information on purchasing a copy of this article is available at <http://www.ajph.org/cgi/reprint/91/9/1412>.

## Quitlines

- *Linking a Network: Integrate Quitlines with Health Care Systems* describes the role that tobacco quitlines play within health-care systems that deliver cessation services. The report combines emerging evidence on the efficacy of quitlines with practical experience from case studies to provide a view of the value of partnerships between quitlines and health-care systems in developing a comprehensive statewide tobacco program. This brochure, developed by PCHT, is available at [http://www.paccenter.org/public/reports\\_folder/linking\\_broch\\_web.pdf](http://www.paccenter.org/public/reports_folder/linking_broch_web.pdf).
- The North American Quitline Consortium is a forum designed to facilitate communication among leaders representing state and provincial health departments, quitline vendors, researchers, and national organizations in the United States and Canada in an effort to better understand quitline operations, promotion, and effectiveness. Information about the Consortium is available at <http://ctcinfo.org>.

## Medicaid

- Links to data from a study conducted by the Center for Health and Public Policy Studies at the University of California, Berkeley, to track changes in coverage of tobacco-dependence treatments by state Medicaid programs and to publications concerning health insurance policy and tobacco control are available in two *MMWR* issues, January 30, 2004, and May 30, 2003. Available at [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco).
- Medicaid Purchasing Specifications provide valuable contract language that can be used by employers and purchasers to structure benefits related to tobacco-use prevention and tobacco-use treatment and are included in the sample purchasing specifications developed by CDC in conjunction with George Washington University Center for Health Services Research and Policy. Designed to assist states in implementing evidence-based tobacco-dependence treatment and improve Medicaid contracts, these specifications are available at <http://www.gwhealthpolicy.org/newsps/tobacco>.

## Databases and Information Services

- The Center for Tobacco Cessation (CTC) serves as a source of science-based information on tobacco-use treatment and works with national partners to expand the use of effective tobacco-dependence treatment and activities. CTC is jointly funded by the American Cancer Society and the Robert Wood Johnson Foundation. For resource tools, policy information, helpful links, and publications such as *A Quick Reference Guide to Effective Tobacco Cessation Treatments and Activities*, visit the CTC Web site at <http://www.ctcinfo.org>.
- Information on tobacco-cessation counseling can be found on the American Cancer Society Web site located at <http://www.cancer.org>. Type “cancer AND counseling” in the search box located in the upper right corner of the home page.
- Information on tobacco cessation and the effects of tobacco use on specific populations can be found on the American Lung Association Web site located at <http://www.lungusa.org>.
- Information on tobacco cessation, including how to access state quitlines and patient self-help materials, can be found at <http://www.smokefree.gov>.
- The *ttac exchange* is an online newsletter produced by the Tobacco Technical Assistance Consortium at the Rollins School of Public Health at Emory University. This technical assistance tool is designed to bring information, strategies, and other tools to the tobacco-control community and to serve as a gateway to resources on current tobacco-control issues. For details, go to <http://www.ttac.org>.
- *Reaching Higher Ground: A Guide for Preventing, Preparing for, and Transforming Conflict for Tobacco Coalitions* provides coalition leaders, members, and facilitators creative ways to address differences within a coalition and work successfully to achieve common goals. The guide is available online at [http://www.ttac.org/products/pdfs/Higher\\_Ground.pdf](http://www.ttac.org/products/pdfs/Higher_Ground.pdf).
- University of Michigan Hospital offers a CD discussing the development of smoke-free campuses for hospitals. To order this CD contact: UMHS Tobacco Consultation Service, 300 N. Ingalls 2D19/0430, Ann Arbor, MI 48109-0430, Phone: 734-936-5988, Fax: 734-647-1516, [quitsmoking@med.umich.edu](mailto:quitsmoking@med.umich.edu), <http://www.naquitline.org>.
- QuitWorks is a free statewide cessation resource program that was developed by the Massachusetts Department of Health in collaboration with all major health plans in Massachusetts. This guide was developed to help hospitals and health centers to integrate the comprehensive QuitWorks program into their practices. The document provides an overview of the QuitWorks program, the scientific evidence supporting it, and the resources necessary to implement this type of program in other states. This document is available at <http://www.quitworks.org>.

## **Partners**

- Centers for Medicare and Medicaid Services. Glossary. Available at <http://www.cms.hhs.gov/glossary>.
- Next Generation California Tobacco Control Alliance. *A Statewide Strategy for Smoking Cessation in California*. Sacramento, CA: The Alliance; 2002. Available at <http://www.tobaccofreealliance.org/Resources.htm>.
- Quality Mapping Solutions Web site. Available at <http://qmsonline.com/jcaho.htm>.

## **Centers for Disease Control and Prevention**

- The Centers for Disease Control and Prevention's Office on Smoking and Health (OSH) has a Web site for Tobacco Information and Prevention Source (TIPS) that contains a wealth of information about tobacco use, economic costs, and policies. The TIPS Web site can be found at <http://www.cdc.gov/tobacco>.
- The Cessation Resource Center Web site contains cessation-focused resources developed and tested by state tobacco-control programs, OSH partner organizations, and other federal agencies. These cessation resources are available to registered state and organizational tobacco-cessation programs. Available at <http://apps.nccd.cdc.gov/crc>.
- *Designing and Implementing an Effective Tobacco Counter-Marketing Campaign*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. First Edition October 2003. Available at [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco).
- *Telephone Quitlines: A Resource for Development, Implementation, and Evaluation* is a guide that discusses the role of quitlines in a comprehensive tobacco-control program and provides detailed information on quitline needs and resources. Available at <http://www.cdc.gov/tobacco/quitlines.htm>.

## Appendix F

### Practice Assessment Document

This document was adapted for the Smoke-Free Families dissemination project and can be further adapted for general adult populations by removing the pregnancy references.

#### Part I: Organization of the Health-Care Delivery System

<b>Components</b>	<b>Little Support</b>	<b>Basic Support</b>	<b>Good Support</b>	<b>Full Support</b>
Support from leadership in our practice for addressing tobacco use in pregnancy...	...does not exist, or there is a little interest.	...is reflected in vision statements and business plans, but no resources are specifically earmarked to execute the work.	...is reflected by senior leadership and specific dedicated resources (dollars and personnel).	...is part of the system's long-term planning strategy, receives necessary resources, and specific people are held accountable.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Organizational goals incorporated into overall activities in our practice for addressing tobacco use in pregnancy...	...do not exist.	...exist but are not actively reviewed.	...are measurable and reviewed.	...are measurable, reviewed routinely, and incorporated into plans for improvement.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Quality improvement strategies for addressing tobacco use in pregnancy in our practice...	...are ad hoc and not organized or supported consistently.	...utilize ad hoc approaches for targeted problems as they emerge.	...utilize a proven improvement strategy such as academic detailing or systems changes for addressing targeted problems.	...include a proven improvement strategy and use it proactively in meeting organizational goals.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
External (state, health plans, etc.) financial incentives for addressing tobacco use in pregnancy...	...are not used to influence clinical performance goals.	...are used to influence utilization and costs of tobacco screening and treatment.	...are used to support patient care goals.	...are used to motivate and empower providers to support patient care goals.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Senior leaders in our practice (e.g., CEO, Medical Director, Director of Operations)...	...do not encourage enrollment of pregnant smokers into smoking cessation programs.	...do not make improvements related to smoking in pregnancy a priority.	...encourage improvement efforts in addressing smoking in pregnancy.	...visibly participate in improvement efforts in addressing smoking in pregnancy.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11

Adapted from the MacColl Institute for Healthcare Innovation, Group Health Cooperative © 2000.

## Part II: Community Linkage

Components	Little Support	Basic Support	Good Support	Full Support
Linking pregnant patients who smoke to resources outside our practice...	...is not done systematically.	...is limited to a list of identified community resources in an accessible format.	...is accomplished through a designated staff person or resource responsible for ensuring providers and patients make maximum use of community resources.	...is accomplished through active coordination between the health system, community service agencies, and patients.
Score	0      1      2	3      4      5	6      7      8	9      10     11

## Part III: Self-Management Support

Components	Little Support	Basic Support	Good Support	Full Support
Assessment and documentation of self-management needs and activities to help pregnant patients who smoke avoid tobacco use...	...are not done.	...are expected.	...are completed in a standardized manner.	...are regularly assessed and recorded in standardized form linked to a treatment plan available to practice and patients.
Score	0      1      2	3      4      5	6      7      8	9      10     11
Self-management support for the pregnant woman who smokes and is interested in stopping...	...is limited to the distribution of information (pamphlets, booklets).	...is available by referral to self-management classes or educators.	...is provided by trained clinical educators who are designated to do self-management support, affiliated with the practice, and see patients on referral.	...is provided by clinical educators affiliated with the practice, trained in patient empowerment and problem-solving methodologies, and see most patients with chronic illness.
Score	0      1      2	3      4      5	6      7      8	9      10     11
Support and addressing concerns of patients and families regarding smoking in pregnancy as they are raised...	...is not consistently done.	...is provided for specific patients and families through referral.	...is encouraged, and peer support, groups, and mentoring programs are available.	...is an integral part of care and includes systematic assessment and routine involvement in peer support, groups, or mentoring programs.
Score	0      1      2	3      4      5	6      7      8	9      10     11
Effective behavior change interventions such as counseling and assistance for quitting smoking...	...are not available.	...are limited to the distribution of pamphlets, booklets, or other written information.	...are available only by referral to specialized centers staffed by trained personnel.	...are readily available and an integral part of routine care.
Score	0      1      2	3      4      5	6      7      8	9      10     11

Adapted from the MacColl Institute for Healthcare Innovation, Group Health Cooperative © 2000.

## Part IV: Decision Support

<b>Components</b>	<b>Little Support</b>	<b>Basic Support</b>	<b>Good Support</b>	<b>Full Support</b>
Evidence-based guidelines for prenatal smoking cessation...	...are not available.	...are available but are not integrated into care delivery.	...are available and supported by provider education.	...are available, supported by provider education, and integrated into care through reminders and other proven behavior change methods.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Involvement of specialists in addressing smoking in pregnancy...	...is primarily through traditional referral.	...is achieved through specialist leadership to enhance the capacity of the overall system to routinely implement guidelines.	...includes specialist leadership and designated specialists who provide clinical care team training.	...includes specialist leadership and specialist involvement in improving the care of pregnant patients.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Education related to effective methods to address smoking in pregnancy for individuals involved in providing care to patients...	...is provided sporadically.	...is provided systematically through traditional methods.	...is provided using optimal methods (e.g., academic detailing).	...includes training all practice teams in regard to smoking cessation methods such as population-based management and self-management support.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Informing patients about guidelines and risks associated with smoking in pregnancy...	...is not done.	...happens on request or through developed protocols.	...is done through specific patient education materials.	...includes specific materials developed for patients that describe their role in achieving guideline adherence.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11

Adapted from the MacColl Institute for Healthcare Innovation, Group Health Cooperative © 2000.

## Part V: Delivery System Design

<b>Components</b>	<b>Little Support</b>	<b>Basic Support</b>	<b>Good Support</b>	<b>Full Support</b>
<b>Our practice functioning as a team...</b>	...is not addressed.	...is addressed by assuring the availability of individuals with appropriate training in key elements of smoking cessation.	...is assured by regular team meetings to address guidelines, roles and accountability, and problems in addressing smoking in pregnancy.	...is assured by teams who meet regularly and have clearly defined roles including patient self-management education, proactive follow-up, and resource coordination and other skills in smoking cessation.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
<b>Practice team leadership...</b>	...is not recognized in the practice or by the system.	...is assumed by the organization to reside in specific organizational roles.	...is assured by the appointment of a team leader, but the individual roles in smoking cessation are not defined.	...is guaranteed by the appointment of a team leader who assures that roles and responsibilities for addressing smoking in pregnancy are clearly defined.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
<b>The system we use for appointments...</b>	...can be used to schedule a variety of appointment types.	...assures scheduled follow-up with prenatal patients.	...is flexible and can accommodate innovations such as customized visit length or group visits.	...includes organization of care that facilitates the patient seeing multiple providers in a single visit.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
<b>Follow-up treatment for pregnant patients who smoke...</b>	...is scheduled by patients or providers in an ad hoc fashion.	...is scheduled by the practice in accordance with guidelines.	...is assured by the practice team by monitoring patient utilization.	...is customized to patient needs, varies in intensity and methodology (phone, in person, email), and assures guideline follow-up.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
<b>Collaborating with other providers the patient has regarding tobacco cessation...</b>	...is not a priority.	...depends on written communication between primary care providers and specialists, case managers, or disease management companies.	...between primary care providers and specialists and other relevant providers is a priority but not implemented systematically.	...is a high priority, and smoking cessation interventions include active coordination between primary care, specialists, and other relevant groups.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11

Adapted from the MacColl Institute for Healthcare Innovation, Group Health Cooperative © 2000.

## Part VI: Clinical Information Systems

<b>Components</b>	<b>Little Support</b>	<b>Basic Support</b>	<b>Good Support</b>	<b>Full Support</b>
A list of patients who have been identified as pregnant patients who smoke...	...is not available.	...includes name, diagnosis, contact information, and date of last contact either on paper or in a computer database.	...allows queries to sort sub-populations by clinical priorities.	...is tied to guidelines that provide prompts and reminders about needed services.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Reminders to providers (stickers, flow sheets, etc.) about delivering information related to smoking cessation...	...are not available.	...include general notification of smoking during pregnancy but does not describe needed services at time of encounter.	...include indications of needed service for populations of patients through periodic reporting.	...include specific information for the team about guideline adherence at the time of individual patient encounters.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Feedback to your team on the status of success related to approaches implemented to address smoking in pregnancy...	...is not available or is non-specific to the team.	...is provided at infrequent intervals and is delivered impersonally.	...occurs at frequent enough intervals to monitor performance and is specific to the team's population.	...is timely, specific to the team, routine, and personally delivered by a respected opinion leader to improve team performance.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11
Patient treatment plans for pregnant women who smoke...	...are not expected.	...are achieved through a standardized approach.	...are established collaboratively and include self-management as well as clinical goals.	...are an established collaborative approach that includes self-management as well as clinical management. Follow-up occurs and guides care at every point of service.
<b>Score</b>	0      1      2	3      4      5	6      7      8	9      10     11

**Process Used:**

Briefly describe the process you used to fill out the form (e.g., reached consensus in a face-to-face meeting; filled out by the team leader in consultation with other team members as needed; each team member filled out a separate form and the responses were averaged).

Adapted from the MacColl Institute for Healthcare Innovation, Group Health Cooperative © 2000.

# Appendix G

## Coverage for Tobacco-Use Cessation Treatments

Why,

What,

and

How

## COVERAGE FOR TOBACCO USE CESSATION TREATMENTS

### Why Is Health Insurance Coverage for Tobacco Use Treatments So Important?

- Smoking is costly to employers both in terms of smoking-related medical expenses and lost productivity.
  - Ten percent of smokers alive today are living with a smoking-related illness.<sup>1</sup>
  - Men who smoke incur \$15,800<sup>2</sup> (in 2002 dollars) more in lifetime medical expenses and are absent from work 4 days more per year than men who do not smoke.<sup>3</sup>
  - Women who smoke incur \$17,500<sup>2</sup> (in 2002 dollars) more in lifetime medical expenses and are absent from work 2 days more each year than nonsmoking women.<sup>3</sup>
  - In 1999, each adult smoker cost employers \$1,760 in lost productivity and \$1,623 in excess medical expenditures.<sup>4</sup>
  - Smoking causes heart disease, stroke, multiple cancers, respiratory diseases, and other costly illnesses. Secondhand smoke causes lung disease and lung cancer.<sup>5,6</sup>
  - Smoking increases costly complications of pregnancy, such as pre-term delivery and low birth-weight infants.<sup>7</sup>
- Smoking is the leading preventable cause of death in the United States.<sup>8,9</sup> Smokers who quit will, on average, live longer and have fewer years living with disability.<sup>10</sup>
- About 23% of American adults and 28% of teens smoke.<sup>11,12</sup> More than 70% want to quit, but few succeed without help.<sup>11</sup> Tobacco use treatment *doubles* quitting success rates.<sup>9</sup>

*Paying for tobacco use cessation treatments is the single most cost-effective health insurance benefit for adults that can be provided to employees.<sup>13,14,15</sup>*

### What Treatments Are Available? How Effective Are They?

Smoking cessation treatments have been found to be safe and effective. These include counseling and medications, or a combination of both.<sup>9</sup>

- Face-to-face counseling and interactive telephone counseling are more effective than services that only provide educational or self-help materials.<sup>9,16</sup>
- The effectiveness of counseling services increases as their intensity (the number and length of sessions) increases.<sup>9</sup>
- Smokers are more likely to use telephone counseling than to participate in individual or group counseling sessions.<sup>16,17</sup>



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION



*Coverage for Tobacco Use Cessation Treatment:  
Why, What, and How*

- The Food and Drug Administration has approved six first-line medications to help smokers quit:
  - Five are nicotine replacement therapies that relieve withdrawal symptoms. They include nicotine gum, patch, nasal spray, inhaler, and lozenge.<sup>9</sup>
  - The sixth medication, bupropion SR (sustained release), is a non-nicotine medication that is thought to reduce the urge to smoke by affecting the same chemical messengers in the brain that are affected by nicotine.<sup>9</sup>

**Prescription and Over-the-Counter Tobacco Cessation Medications\***

Type	Form	Common Brand Name(s)	Availability
Nicotine Replacement Therapy	Gum	Nicorette®	Over-the-counter (OTC)
	Patch	Nicoderm®, Habitrol®, Prostep®, Nicotrol®	OTC and prescription
	Inhaler	Nicotrol®	Prescription
	Nasal Spray	Nicotrol®	Prescription
	Lozenge	Commit®**	OTC
Bupropion SR	Pill	Zyban®, Wellbutrin®	Prescription

\* Approved by the Food and Drug Administration (FDA) and addressed in the 2000 PHS Guidelines.

\*\* Received FDA approval on October 31, 2002, therefore not addressed in the 2000 PHS Guidelines.

*Scientifically proven treatments can double a person's chances of quitting smoking.<sup>9</sup>*

**How Should Benefits Be Designed?**

Benefits for proven tobacco-use cessation treatments have been shown to increase treatment use and the number of successful quitters; therefore, both the Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, and the Community Preventive Services Task Force recommend that all insurers provide tobacco cessation benefits that do the following:

- Pay for counseling and medications, together or separately.<sup>9</sup>
  - Cover at least four counseling sessions of at least 30 minutes each,<sup>9</sup> including proactive telephone counseling and individual counseling. While classes are also effective, few smokers attend them.<sup>19</sup>
  - Cover both prescription and over-the-counter nicotine replacement medication and bupropion (see medication table).<sup>9</sup>
  - Provide counseling and medication coverage for at least two smoking cessation attempts per year.<sup>20, 21</sup>
  - Eliminate or minimize co-pays or deductibles for counseling and medications, as even small copayments reduce the use of proven treatments.<sup>18, 19</sup>

**What Is the Role of Health Insurance Coverage in Tobacco-Use Cessation?**

- Health insurance coverage of medication and counseling increases the use of effective treatments.<sup>18</sup>
- Although 66% of Americans under the age of 65 are insured through an employer,<sup>22</sup> only 24% of employers offer any coverage for tobacco-use treatment.<sup>23</sup>

*Coverage of tobacco-use cessation treatment increases both use of effective treatment and the number of successful quit attempts.<sup>18</sup>*

## How Much Do Cessation Benefits Cost? Are They Cost-Effective?

- Tobacco cessation is more cost-effective than other common and covered disease prevention interventions, such as the treatment of hypertension and high blood cholesterol.<sup>14</sup>
- Cost analyses have shown tobacco cessation benefits to be either cost-saving or cost-neutral.<sup>3, 20</sup> Overall, cost/expenditure to employers equalizes at 3 years; benefits exceed costs by 5 years.<sup>3</sup>
- It costs between 10 and 40 cents per member per month to provide a comprehensive tobacco cessation benefit (costs vary based on utilization and dependent coverage).<sup>19, 24</sup>
- In contrast, the annual cost of tobacco use is about \$3,400 per smoker or about \$7.18 for each pack of cigarettes sold.<sup>4</sup>
- Neonatal health care costs related to smoking are equivalent to \$704 for each maternal smoker.<sup>4</sup> Randomized controlled trials indicate that a smoking cessation program for pregnant women can save as much as \$6 for each \$1 spent.<sup>25</sup>

## What Is the Experience of Companies and Health Plans Providing This Benefit?

Businesses that have included a tobacco cessation benefit report that this coverage has increased the number of smokers willing to undergo treatment and increased the percentage that successfully quit.<sup>24, 26</sup>

- Union Pacific Railroad has experienced a decrease smoking prevalence among its employees from 40% to 25% in the 7-year period that it has offered a cessation benefit as part of a comprehensive cessation program.<sup>26</sup>
- At the Group Health Cooperative in Seattle, enrollees offered full coverage for smoking cessation treatments were four times as likely to try to quit and four times as likely to succeed.<sup>24</sup>

### **How Tobacco Cessation Cuts Cost**

- Over time, tobacco-use cessation benefits generate financial returns for employers in four ways:
  - Reduced health care costs<sup>3, 27</sup>
  - Reduced absenteeism<sup>3, 28, 29</sup>
  - Increased on-the-job productivity<sup>3, 28, 29</sup>
  - Reduced life insurance costs<sup>3, 28</sup>
- Benefits realized more immediately include:
  - Increases in employee productivity<sup>3, 29</sup>
  - Reductions in smoking-attributed neonatal health care costs<sup>25</sup>
- Employers who provide a smoke-free workplace may also realize savings on fire insurance and costs related to items such as ventilation services and property repair and upkeep.<sup>3, 28</sup>

## How Do I Get More Information?

Listed below are Web sites where you can find additional information on tobacco-use cessation or reimbursement for cessation treatment.

### *Smoking Cessation Treatment Effectiveness*

- **Treating Tobacco Use and Dependence** is a Public Health Service-sponsored clinical practice guideline that contains evidence-based strategies and recommendations to support effective treatment for tobacco use and nicotine addiction. The guideline and related consumer and clinician materials also can be found at <http://www.surgeongeneral.gov/tobacco/>.
- **The Guide to Community Preventive Services** provides information on the effectiveness of community-based interventions in three areas of tobacco-use prevention and control: (1) initiation of tobacco use, (2) cessation, and (3) reduction of exposure to environmental tobacco smoke. Articles, slide sets, and commentaries can be found at <http://www.thecommunityguide.org/tobacco/>.
- **Surgeon General's Reports** related to tobacco are available on the Centers for Disease Control and Prevention Web site at <http://www.cdc.gov/tobacco/sgrpage.htm>.
- **Data on tobacco-use prevalence and tobacco-related morbidity and mortality rates** can be found at two Centers for Disease Control and Prevention Web sites: <http://www.cdc.gov/tobacco/data.htm> and <http://www.cdc.gov/nchs/>.

#### *Designing Health Insurance Benefits*

- **Sample purchasing specifications**, which provide valuable contract language that can be used by employers and purchasers to structure benefits related to tobacco-use prevention and cessation, are available to assist states in implementing evidence-based tobacco-dependence treatment and improve Medicaid contracts. These sample specifications, developed by CDC in conjunction with George Washington University Center for Health Services Research and Policy, are available at <http://www.gwhealthpolicy.org/newsps/tobacco>.
- **Build a Financial Infrastructure: Health Plan Benefits and Provider Reimbursement** combines evidence-based recommendations with the experiences of the Pacific Center on Health and Tobacco (PCHT), a consortium of five western states (California, Oregon, Washington, Arizona, and Hawaii) concerning tobacco cessation benefits and provider reimbursement. The report is designed to guide planning and decision-making by states and other groups that are working to implement tobacco cessation programs. Also available are two summaries based on this report: (1) *Health Insurance Benefits for Treatment of Tobacco Dependence* and (2) *Invest in Tobacco Cessation for a Healthy, Productive Workforce*. Visit the PCHT Web site at <http://www.paccenter.org>.
- **Employers' Smoking Cessation Guide: Practical Approaches to a Costly Workplace Problem**, a guide published by the Professional Assisted Cessation Therapy (PACT) consortium for large and small employers interested in enacting an affordable, effective smoking cessation program, is available at <http://www.endsmoking.org>.
- **Reimbursement for Smoking Cessation Therapy: A Health Care Practitioner's Guide**, published by the Professional Assisted Cessation Therapy (PACT) consortium for health care providers on how to obtain reimbursement for cessation services can be helpful to employers in the implementation of a tobacco cessation benefit. It is available at <http://www.endsmoking.org>.
- **Data on insurance status and type** (national and by state) from a survey conducted jointly by the Bureau of Labor Statistics and the Bureau of the Census are located at <http://ferret.bls.census.gov/macro/032002/health/toc.htm>.
- **Coverage of Smoking Cessation Treatment by Union Health and Welfare Funds** [Barbeau E, Li Y, et al. *American Journal of Public Health* 2001; 91(9):1412-1415]. This article presents the results of a survey to determine the level of insurance coverage for smoking cessation treatment and factors associated with coverage among health and welfare funds affiliated with a large labor union. Information on purchasing a copy of this article is located at <http://www.ajph.org/cgi/reprint/91/9/1412>.
- **Data concerning changes in coverage of tobacco-dependence treatments by state Medicaid programs** from a study conducted by the Center for Health and Public Policy Studies at the University of California, Berkeley, and links to publications addressing health insurance policy and tobacco control are available at <http://chpps.berkeley.edu/smoking/index.htm>.
- **A guide to purchasing prevention benefits** that was developed for employers in North Carolina by North Carolina Prevention Partners contains information that may be helpful to employers in other states. The guide can be found at <http://www.ncpreventionpartners.org/basic/eguide.htm>.

#### *Resources Useful for Employers*

- **Making Your Workplace Smokefree: A Decisionmaker's Guide** provides information on the costs of tobacco use to employers. The entire guide or selected chapters are available in PDF format at [http://www.cdc.gov/tobacco/research\\_data/environmental/etsguide.htm](http://www.cdc.gov/tobacco/research_data/environmental/etsguide.htm).
- **Quitline Resource Guide**, published by CDC's Office on Smoking and Health, provides information on contracting for quitline services and key components of quitline services, such as counseling, staffing, quality assurance, promotion, and evaluation. The guide (in press when this document was published) will be available at <http://www.cdc.gov/tobacco>.

- **Linking a Network: Integrate Quitlines with Health Care Systems**, published by the Pacific Center on Health and Tobacco, describes the importance of linking state quitlines with health care systems and presents case studies describing linkages with health care systems. This resource (in press when this document was published) will be available at <http://www.paccenter.org>.
- **A Quick Reference Guide to Effective Tobacco Cessation Treatments and Activities** and other resources are available from the Center for Tobacco Cessation's (CTC) Web site at <http://www.CTCinfo.org>. CTC, which is jointly funded by the American Cancer Society and The Robert Wood Johnson Foundation, serves as a source of science-based information on cessation and works with national partners to expand the use of effective tobacco dependence treatment and activities.
- **Information on tobacco cessation counseling** can be found on the American Cancer Society Web site located at <http://www.cancer.org>. Type "cancer AND counseling" in the search box located in the upper right corner of the home page.
- **Information on tobacco cessation and the effects of tobacco use on specific populations** can be found on the American Lung Association Web site located at <http://www.lungusa.org>.

## Sources

- 1 Centers for Disease Control and Prevention. Cigarette smoking-attributable mortality—United States 2000. *Morbidity and Mortality Weekly Report* 2003;52(35):842–44.
- 2 Hodgson T. Cigarette smoking and lifetime medical expenditures. *The Milbank Quarterly* 1992;70(1):81–125.
- 3 Warner KE, Smith RJ, Smith DG, Fries BE. Health and economic implications of a work-site smoking-cessation program: a simulation analysis. *Journal of Occupational and Environmental Medicine* 1996;38(10):981–92.
- 4 Centers for Disease Control and Prevention. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States, 1995–1999. *Morbidity and Mortality Weekly Report* 2002;51(14): 300–03.
- 5 U.S. Department of Health and Human Services. *Reducing the Health Consequences of Smoking: 25 Years of Progress: A Report of the Surgeon General: 1989 Executive Summary*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1989.
- 6 National Cancer Institute. *Health Effects of Exposure to Environmental Tobacco Smoke. The Report of the California Environmental Protection Agency*. Smoking and Tobacco Control Monograph 10. U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 99-4645, 1999.
- 7 U.S. Department of Health and Human Services. *Women and Smoking: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2001.
- 8 McGinnis JM, Foege WH. Actual causes of death in the United States. *Journal of the American Medical Association* 1993;270:2207–12.
- 9 Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence: Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service; 2000.
- 10 Nusselder WJ, Looman CW, Marang-van de Mheen PJ, et al. Smoking and the compression of morbidity. *Journal of Epidemiology and Community Health* 2000;54(8):566–74.
- 11 Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 2000. *Morbidity and Mortality Weekly Report* 2002;51(29):642.
- 12 Centers for Disease Control and Prevention. Trends in cigarette smoking among high school students—United States, 1991–2001. *Morbidity and Mortality Weekly Report* 2002;51(19):410.
- 13 Warner KE. Cost effectiveness of smoking-cessation therapies. Interpretation of the evidence and implications for coverage. *Pharmacoeconomics* 1997;11(6):538–49.
- 14 Cummings SR, Rubin SM, Oster G. The cost-effectiveness of counseling smokers to quit. *Journal of the American Medical Association* 1989;261(1):75–79.
- 15 Coffield AB, Maciosek MV, McGinnis JM, et al. Priorities among recommended clinical preventive services. *American Journal of Preventive Medicine* 2001;21(1):1–9.
- 16 McAfee T, Sofian N, Wilson J, Hindmarsh M. The role of tobacco intervention in population-based health care. *American Journal of Preventive Medicine* 1998;14:46–52.
- 17 McAfee T. Increasing the population impact of quitlines. Paper presented at the North American Quitline Conference, Phoenix, AZ, 2002.

*Coverage for Tobacco  
Use Cessation Treatment:  
Why, What, and How*

- 18 Hopkins DP, Briss PA, Ricard CJ, et al. Task Force on Community Preventive Services. *American Journal of Preventive Medicine* 2001;20(2 Suppl):16–66.
- 19 Schaufller HH, McMenamin S, Olsen K, Boyce-Smith G, Rideout JA, Kamil J. Variations in treatment benefits influence smoking cessation: results of a randomized controlled trial. *Tobacco Control* 2001;10:175–80.
- 20 Harris JR, Schaufller HH, Milstein A, Powers P, Hopkins DP. Expanding health insurance coverage for smoking cessation treatments: experience of the Pacific Business Group on Health. *American Journal of Health Promotion* 2001;15(5):350–6.
- 21 George Washington University Center for Health Services Research and Policy. Sample Purchasing Specifications Related To Tobacco-Use Prevention And Cessation: a Technical Assistance Document. October 2002. Available at: <http://www.gwhealthpolicy.org/newsps/tobacco/tobacco-prevent.html>. Accessed 06/24/03.
- 22 U.S. Bureau of the Census. *Current Population Survey: Annual Demographic Survey Supplement—Detailed Insurance (P60) Package*. Available at: <http://ferret.bls.census.gov/macro/032002/health/toc.htm>. Accessed 10/18/02.
- 23 Partnership for Prevention. *Insurance Coverage of Clinical Preventive Services in Employer-sponsored Health Plans: Preliminary Results of a Partnership for Prevention/William M. Mercer National Survey*, 2001. Washington, DC. Partnership for Prevention In press.
- 24 Curry SJ, Grothaus MA, McAfee T, Pabiniak C. Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. *New England Journal of Medicine* 1998; 339(10):673–79.
- 25 Marks JS, Koplan JP, Hogue CJR, Dalmat ME. A cost-benefit/cost-effectiveness analysis of smoking cessation for pregnant women. *American Journal of Preventive Medicine* 1990;6(5):282–9.
- 26 Professional Assisted Cessation Therapy (PACT). Employers' Smoking Cessation Guide: Practical Approaches to a Costly Workplace Problem. Available at: <http://www.endsmoking.org/resources/employersguide/pdf/employersguide.pdf>. Accessed 03/26/03.
- 27 Wagner EH, Curry SJ, Grothaus L, Saunders KW, McBride CM. The impact of smoking and quitting on health care use. *Archives of Internal Medicine* 1995;155(16):1789–95.
- 28 Centers for Disease Control and Prevention, American Cancer Society, and Wellness Councils of America. *Making Your Workplace Smokefree—A Decision Maker's Guide*. 1996. Available at: [http://www.cdc.gov/tobacco/research\\_data/environmental/etsguide.htm](http://www.cdc.gov/tobacco/research_data/environmental/etsguide.htm). Accessed 04/05/03.
- 29 Halpern MT, Shikiar R, Rentz AM, Khan ZM. Impact of smoking status on workplace absenteeism and productivity. *Tobacco Control* 2001;10:233–8.

# Appendix H

## Reducing the Burden of Smoking on Employee Health and Productivity

Center for Prevention  
and Health Services

ISSUE Brief

Volume I, Number 5

## Reducing the Burden of Smoking on Employee Health and Productivity



*This issue brief summarizes information presented during the fifth in a series of Business Consultations sponsored by the Centers for Disease Control and Prevention (CDC). The National Business Group on Health and the CDC convened Reducing the Burden of Smoking on Employee Health and Productivity, a consultation with business and health leaders, on May 28, 2003, in Washington, DC. Statistics and figures that are not annotated with a source were presented by the speakers.*

### Why Employers Promote Tobacco Use Cessation

The human and financial costs associated with tobacco use are enormous. In addition to the incalculable physical and emotional distress brought on by tobacco related diseases and deaths, tobacco use exacts a high price from employers via greater costs for health care and life insurance, increased absenteeism and lower rates of presenteeism and productivity.

### Calculating the Cost of Smoking

To calculate the cost of smoking for an individual company, consider the following:

- The overall prevalence of tobacco use is about 25% of the total population, which can be generalized to any workplace population.
- The CDC estimates that companies spend \$3,856 per smoker per year in direct medical costs and lost productivity.

**(Number of employees) × (0.25) × (\$3,856 per year) = Estimated cost per year in excess medical expenditures and lost productivity**

Example:

- (10,000 employees) × (0.25) = 2,500 employees who use tobacco
- (2,500) × (\$3,856) = \$9,640,000 per year in business borne costs associated with smoking

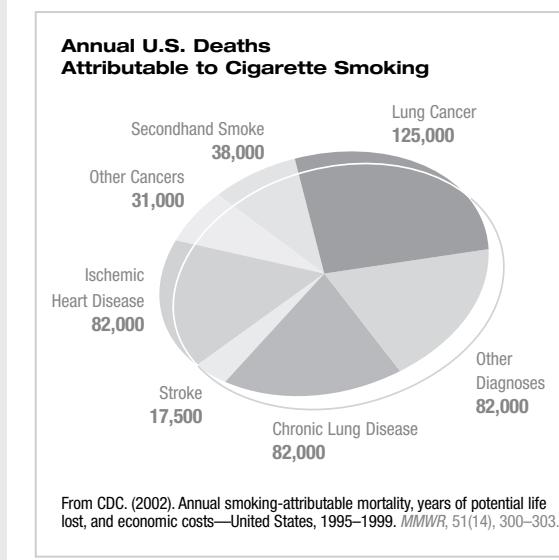
Employers can combat the negative health and economic effects of tobacco use by integrating tobacco cessation treatment into their mix of employee benefits. In fact, paying for an employee's tobacco cessation treatment provides more return on investment than any other adult treatment or prevention benefit.

The National Business Group on Health is committed to providing employers with practical information about the advantages of covering tobacco cessation benefits. This issue brief is one such resource. Here you will find information on the prevalence and health impact of smoking, proof of the economic cost of

tobacco related illnesses, guidelines for designing and implementing the most effective tobacco cessation benefits, and examples from several large employers who have benefited from offering coverage for tobacco use treatment.

**Smoking costs lives, time and money**

- Smoking claims more than 440,000 lives each year, making it the leading preventable cause of death in the United States (see chart below). In fact, smoking kills more people each year than AIDS, drugs and alcohol, homicide, suicide and motor vehicle accidents *combined*.
- Since the 1960s, research has linked more than 50 painful and costly diseases and conditions to smoking, and it is estimated that 10 percent of smokers, or approximately 8.6 million people, are currently living with one or more of these smoking-related illnesses.
- A significant amount of time is lost from business due to smoking breaks and the illnesses and fatalities that are caused by smoking, as smokers are more likely to suffer a disability, are more likely to miss work and are less productive than nonsmokers.
- Female smokers incur \$17,500 more in lifetime medical expenses and miss an average of two more days of work than nonsmoking women.
- Male smokers incur \$15,800 more in lifetime medical expenses and miss an average of four more days of work than nonsmoking men.
- On average, direct medical expenses and lost productivity resulting from premature death for people with smoking-related diseases cost a staggering \$157 billion each year or \$3,856 per smoker per year.



- Additional costs to the economy include those related to permanent or temporary disability, absenteeism, or decreased productivity among living employees who smoke. Other business-related costs of smoking include workers compensation claims and occupational health awards, indoor air pollution, accidents, fires, and cleaning and maintenance.

### **Employer Strategies For Promoting Tobacco Use Cessation**

Smoking is an addiction that often requires repeated attempts and professional intervention to overcome. Because the most successful interventions require medical attention, it is necessary for most employees to have these services covered as part of their health benefit. For businesses, making an investment in tobacco cessation benefits not only improves employee health but also reduces the significant direct and indirect costs associated with tobacco use. In fact, paying for tobacco use treatment is regarded as the single most cost-effective health insurance benefit for adults and it is also considered the benefit with the most positive impact on health.

- Request or select health plans that cover effective treatment of smoking (see “Evaluating Your Health Plan’s Coverage” on p.4).
- Ensure that health care providers (those in on-site medical clinics and those with larger health care plans) adhere to Health Employer Data Information Set (HEDIS®) requirements. HEDIS® measures whether providers screen all patients for smoking, counsel smokers to quit and recommend FDA approved medications.
- Design benefits to cover a variety of treatments (i.e., counseling and prescription as well as over the counter medications) and allow individuals to choose their preferred approach.
- Consider the delivery of telephone counseling, as it is one of the most successful and cost-effective forms of cessation counseling (see “Evaluating Telephone Counseling Programs” on p.5).
- Ensure that smoking cessation counseling emphasizes problem-solving and social support to enhance the likelihood of abstinence.
- Remove fees, co-pays, and other restrictions intended to limit use of benefits. Programs that offer counseling and medications free of charge are more effective than those that require cost sharing.

- Communicate to employees the types of cessation benefits that are covered under their health plans.
- Take a long-term approach to smoking cessation and structure benefits to support multiple quit attempts.
- Offer smoking cessation treatment to employees' spouses and dependents.
- Promote a healthy workplace that discourages smoking and values the well being of all employees. Institute workplace bans on smoking to reduce tobacco use and protect nonsmokers from secondhand smoke.
- Offer incentives to achieve and maintain healthy lifestyles (see "Incentives Add Up for Bank One Employees" on p.6).
- In states that offer telephone counseling "quitlines" or "helplines," consider contracting with the state to provide this service to your employees (many states lack sufficient funding to cover smokers who have insurance). If the state does not have such a service, consider contracting directly with a quitline vendor to provide services to employees.

#### **Evaluating Your Health Plan's Coverage**

Performance data is an invaluable tool to help identify high quality health care. Most managed care plans have data on HEDIS® measures and will provide the data on request. This information is collected through the Consumer Assessments of Health Plans Survey (CAHPS), which added questions to its 2003 survey to determine whether providers recommended medications to help patients quit smoking and/or offered assistance in quitting beyond advice. The results will be published in 2004, but health plans can access the data before it is publicly reported.

The National Business Coalition on Health's eValue8 initiative also assesses health care plans on their efforts to promote smoking cessation. In addition to consulting these resources, purchasers should ask prospective health care plans whether their providers actively try to identify smokers, what smoking initiatives are in place, and what support is provided to former smokers to prevent relapse.

### Evaluating Telephone Counseling Programs

The effectiveness of tobacco cessation counseling services increases as the number and length of sessions increases. Telephone counseling services vary in the number of contacts they provide, the duration of the calls, the type of information they offer and the training required of counselors. When evaluating these services, the following criteria should be considered:

- **Is the counseling consistent with the strategies described in the Public Health Service's *Treating Tobacco Use and Dependence—Clinical Practice Guideline*?** Visit [www.surgeongeneral.gov/tobacco/](http://www.surgeongeneral.gov/tobacco/) for a copy of the Public Health Service's report outlining best practices for the treatment of tobacco dependence or reference the Quitline Resource Guide, which will be available in 2004 at [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco).
- **Does the service allow more than one contact?** Multiple contacts are generally more effective than a single contact, but there are no data to suggest an optimal number of contacts.
- **How long has the service been in business?** A long history in business does not necessarily equate to quality service. However, you can learn a great deal about a company by examining its track record, including quit rates.
- **How are data collected, evaluated, and provided to the purchaser?** Reference the Quitline Resource Guide at [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco) for criteria.
- **What is the service's 6-month quit rate?** 12-month quit rate? How is the quit rate calculated? Is everyone who has agreed to counseling included?
- **Does the service offer an option to link counseling with medications?** Research has shown that when

counseling is paired with medications, smokers experience substantially greater cessation success rates. Consider contracting with a service that has experience integrating counseling with one or more medications.

- **Can the service provide references?** As you would with a new employee or vendor, always insist on references and invest the time in several quality telephone calls to check the service's cessation record and customer service. Make sure to ask about the service's record with call hang ups and any issues related to the service's hours of operation.
- **How are telephone counselors trained and evaluated?** Reference the Quitline Resource Guide at [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco) for criteria.
- **How does the service evaluate its own success?** While there is no system of accreditation for counselors, there are quality assurance measures that the service should be tracking, including call monitoring, quit rates, and numbers of calls managed per hour.
- **Do the counselors seem knowledgeable and helpful?** Make an unannounced call to the service to test your impression of the counselor's expertise and the utility of the service.
- **Do counselors offer clients a "tool kit" to help them abstain from tobacco use?** Smokers can benefit from educational materials including fact sheets and quit tips that complement medications and counseling.
- **How can the company help to promote its services?** Find out if the service can help you to engage employees to use the service via advertising or other forms of promotion. Ongoing promotion is key to program success.

### **Cost benefits of tobacco use cessation programs**

The minor cost of covering tobacco cessation benefits seems insignificant when compared to the major financial burden that tobacco use places on businesses. As health care costs due to tobacco related illnesses increase, they erode employer profits, which in turn creates a cycle of diminished health care coverage, salaries and other benefits for employees.

- Tobacco cessation benefits are more cost-effective than more commonly covered disease prevention interventions, such as treatment for hypertension and high cholesterol.
- Cost analyses prove that tobacco cessation benefits are either cost-saving or cost-neutral.
- Comprehensive tobacco cessation benefits cost between \$1.20 and \$4.80 per employee per year. In contrast, the annual cost of tobacco use is about \$3,400 per smoker.
- Overall, cost/expenditure to employers equalizes at three years and benefits begin to exceed costs by five years.
- Because smoking cessation efforts are relatively inexpensive and yield a large, long-term benefit, they help to stem the rising cost of health care. Measures that keep health care costs in check are valuable because it is estimated that a one percent reduction in health care costs could increase retained profits by five percent.

### **Incentives Add Up for Bank One Employees**

Through its 2002 health risk assessments, Bank One estimated that 11% of its employees are smokers and that the company lost more than \$24 million annually to smoking. To address this issue, Bank One offers a variety of health plans, each with different benefits related to tobacco cessation. Smokers now pay \$14 more per pay period than nonsmokers do for both health and life insurance (\$336 more per year). The additional fees paid by smokers fund wellness programs and offset higher health care costs.

In addition, the company implemented a smoking cessation program that consists of four class sessions. Anyone who completes the program (regardless of whether they quit smoking) is eligible for the nonsmokers' discount. In 2002, Bank One found that about 23% of those who took part in the program said they quit smoking for at least a year.

### Pitney Bowes Meets Federal Health Targets

Pitney Bowes addresses health promotion and tobacco cessation on multiple fronts, including programs offering:

- **incentives** (cash incentives for wellness program participation and discounted life insurance premiums for nonsmokers),
- **discouragement** (no smoking inside the workplace since 1991 at any U.S. worksite), and
- **access** (on-site medical clinics and prescription drug coverage that includes nicotine replacement therapy and bupropion).

The company's more focused efforts have also yielded highly beneficial results:

- The on-site medical clinic in the Connecticut office created a successful smoking cessation program that offers nicotine replacement therapy and bupropion (free of cost through the clinic) as well as referrals for counseling as needed. The program also provides

American Lung Association materials for education and measures lung capacity using a CO monitor to help individuals mark their progress. Although the results have not been studied scientifically, the program reports a 50% quit rate after one year.

- Pitney Bowes contracted with Group Health of Puget Sound to offer smoking cessation to all of its U.S. employees at no cost. The result was "Free and Clear," a one year intervention that combines telephone counseling and educational materials. This program was also highly successful:
  - From 1999 to 2000, nearly 400 individuals participated.
  - Approximately 21% of participants quit for one year and 36% reduced their consumption.
  - Through the Free and Clear program, the company estimated a return on investment of 2.6:1.

### Resources on Tobacco Use, Smoking Cessation, and Smoking-Related Diseases

*Making Your Workplace Smokefree: A Decisionmaker's Guide*  
[www.cdc.gov/tobacco/research\\_data/environmental/etsguide.htm](http://www.cdc.gov/tobacco/research_data/environmental/etsguide.htm)

*Quitline Resource Guide* (in press)  
Will be available in 2004 at  
[www.cdc.gov/tobacco](http://www.cdc.gov/tobacco)

*Coverage for Tobacco Use Cessation Treatments*  
[http://www.cdc.gov/tobacco/educational\\_materials/cessation/index.html](http://www.cdc.gov/tobacco/educational_materials/cessation/index.html)

*Health Insurance Benefits for Treatment of Tobacco Dependence*  
[www.paccenter.org/public/reports\\_folder/insurance\\_flier\\_web.pdf](http://www.paccenter.org/public/reports_folder/insurance_flier_web.pdf)

*Linking a Network: Integrate Quitlines with Health Care Systems*  
[www.paccenter.org](http://www.paccenter.org)

American Cancer Society  
[www.cancer.org](http://www.cancer.org)

American Lung Association  
[www.lungusa.org](http://www.lungusa.org)

National Cancer Institute  
[www.nci.nih.gov](http://www.nci.nih.gov)

National Center for Health Statistics  
[www.cdc.gov/nchs](http://www.cdc.gov/nchs)

**Center for  
Prevention  
and Health  
Services**

# ISSUE Brief

Volume I, Number 5

## Reducing the Burden of Smoking on Employee Health and Productivity



### **About the Center for Prevention and Health Services (CPHS)**

The Center houses the Business Group's projects and resources that relate to the delivery of preventive and other health services through employer-sponsored health plans and worksite programs. Through the Center, employers can find practical toolkits to address preventive health and health promotion issues at the worksite. Employers will find current information and recommendations from federal agencies and professional associations, model programs from other employers, and the latest clinical and health services research results. In addition, the Center provides opportunities for employer participation in teleconferences and in-person solutions workshops. Currently, the Center has initiatives in racial and ethnic disparities in health and health care, terrorism and public health emergency preparedness, maternal and child health, preventive services, health services research and quality, health and work performance, benefit design and wellness programs.

For more information, visit [www.wbgh.org/programs/cphs/](http://www.wbgh.org/programs/cphs/) or contact Ron Finch, Ed.D., Director, at [finch@wbgh.org](mailto:finch@wbgh.org).

### **About the National Business Group on Health**

The National Business Group on Health, formerly the Washington Business Group on Health, is the national voice of large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues. The Business Group represents its 185 members, primarily Fortune 500 companies and large public sector employers, who provide health coverage for more than 40 million U.S. workers, retirees and their families. The Business Group fosters the development of a quality health care delivery system and treatments based on scientific evidence of effectiveness. The Business Group works with other organizations to promote patient safety and expand the use of technology assessment to ensure access to superior new technology and the elimination of ineffective technology.

Helen Darling, President

National Business Group on Health  
50 F Street N.W., Suite 600 • Washington D.C. 20001  
Phone (202) 628-9320 • Fax (202) 628-9244 • [www.wbgh.org](http://www.wbgh.org)

Widmeyer Communications, Inc., Editing and Design

# **Appendix I**

## **Tobacco Quitlines**



# Tobacco Quitlines

## What are tobacco quitlines?

Quitlines are telephone-based tobacco cessation services. Since the late 1980's, quitlines have been established in many countries, states and provinces. Most are accessed through a toll-free telephone number and provide a combination of services including educational materials, referral to local programs, and individualized telephone counseling. Counselors answer callers' questions about the cessation process and help them develop an effective plan for quitting.

Reactive quitlines only respond to incoming calls. Proactive quitlines handle incoming calls and also follow up the initial contact with additional outbound calls, to help initiate a quit attempt or to help prevent relapse. In some cases, as when smokers give consent in their doctors' offices to be called by a counselor, the contact is entirely proactive. Proactive telephone counseling has been shown to have a marked effect on callers' probability of success in quitting and in maintaining long-term abstinence from tobacco use, comparable to the effects of pharmacotherapies.

Where are they available?

Brazil, Iran, New Zealand, South Africa, many European countries, some countries in Asia, and most Australian,

Canadian, and U.S. states and provinces have publicly financed quitlines. Some employers and private health insurers provide quitlines for their employees and members. Many new quitlines have been set up in recent years, as evidence of their efficacy has become more solid and as tobacco control programs worldwide have become more common. Quitlines vary greatly in scale and sophistication.

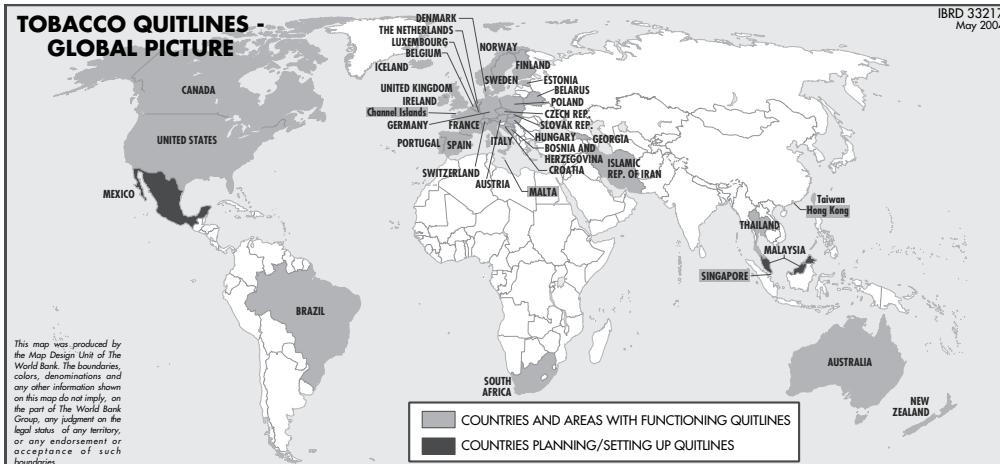
Why have quitlines become popular?

**Easy access.** Traditionally, tobacco users have faced various barriers in accessing cessation services, including:

- Sporadic availability, geographically and over time
  - Transportation difficulties
  - Childcare responsibilities
  - Financial cost of participating.

Quilines reduce these barriers by allowing users to access service from their own homes at a time that is convenient for them, and usually at no cost to themselves. Partly for these reasons, surveys have shown that tobacco users are much more likely to use telephone-based services than face-to-face programs.

**Benefits of centralization.** Because it provides services over the telephone, a quitline can serve a large geographic



May 2004

area from a single, centralized base of operations. So unlike traditional cessation programs in which it is common for participants to have to wait until a group forms, quitlines are able to operate year-round, often with extended hours of business and multilingual capabilities.

The benefits of centralization include:

- Economies of scale, leading to more efficient utilization of counseling resources
- Standardized training
- Better quality control
- Ease of evaluation.

**Ease of promotion.** Most comprehensive tobacco control programs include a media component designed to counteract the effects of tobacco industry advertising. This key part of successful anti-tobacco programs can be very costly, necessitating prudent spending decisions. Media programs are a convenient way to promote cessation services, since advertisements can carry a single telephone number and air across a wide area. This is more efficient than promoting an array of local programs, each with its own method of accessing service. And quitlines can refer callers to local programs as appropriate, thus serving both as a direct cessation service provider and as a hub of coordinated services.

### Strong evidence of quitline efficacy

**Reactive quitlines:** Two studies support use of a reactive quitline in the context of a comprehensive tobacco control program. A California study found that a well-promoted quitline providing a single comprehensive counseling session of about 50 minutes increased quit attempts and reduced relapse, relative to an intervention of self-help materials alone (Zhu et al. 1996). Counties in New York State where a quitline was promoted had significantly higher quit rates than those without such promotion, even though the majority of evaluated quitters did not access the service, indicating that quitline promotion in itself may increase cessation on a population level (Ossip-Klein et al. 1991).

**Proactive quitlines:** The evidence for proactive quitlines is more thorough. Several meta-analytical reviews have established that proactive telephone counseling is an effective intervention for smoking cessation (Lichtenstein et al. 1996, Fiore et al. 2000, Hopkins et al. 2001, Stead et al. 2004). The most recent of these examined 13 studies of proactive interventions and found that callers who received counseling were successful at least 50% more often than those who only received self-help materials (odds ratio of 1.56) (Stead et al. 2004). The *U.S. Public Health Clinical Practice Guideline* and the *Guide to Community Preventive Services* recommend proactive quitlines as a way to help smokers quit (Fiore et al. 2000, Hopkins et al. 2001).

A large randomized, controlled trial ( $n=3,030$ ) that served as the basis for the California Smokers' Helpline, the first publicly supported, statewide quitline, found that telephone counseling increased the percentage of smokers making a quit attempt and decreased the rate of relapse for those

attempts, and found a strong dose-response relationship between the level of intended treatment intensity (i.e., number of follow-up sessions) and the treatment effect (Zhu et al. 1996).

Further research has demonstrated the continued effectiveness of the California quitline after it scaled up to statewide operation (Zhu et al. 2002). Borland et al. (2001) found similar results for a quitline service in Victoria, Australia. These studies increase confidence that the efficacy found in clinical trials can carry over to "real world" settings. With the efficiencies inherent in centralized, telephone-based operations, quitlines appear to be a cost-effective way to deliver cessation assistance (McAlister et al. 2004).

### Quitlines as part of comprehensive tobacco control programs

Most quitlines are supported by state or national health agencies, through tobacco taxes or other public funds. They are often the government's chief or only contribution to providing direct tobacco cessation services, with the rest of its tobacco control funding earmarked for other efforts such as educating people about the harm caused by tobacco use, preventing initiation of tobacco use among young people, and reducing exposure to second hand smoke. If resources were not available to make progress in these areas, it is doubtful that a quitline alone would be a worthwhile investment of public health funds. But in the context of comprehensive tobacco control efforts, a quitline can help to advance larger goals of the program, such as normalizing cessation and eliminating disparities in tobacco use or access to treatment.

### Practical considerations

**The range of services provided:** Quitline callers have a wide range of expectations, so most well established quitlines offer a wide range of services. Adult smokers wanting help to quit are the most common callers, but there are also those who are not yet ready to quit, or who have already quit. There are smokers of cigarettes, cigars, and pipes, and callers who use chewing tobacco or other smokeless tobacco. There are callers of all ages, including minors, and callers who speak different languages. In all of these categories, some want counseling; others just want printed information or referral. Some callers have particular needs such as learning more about smoking while pregnant, or quitting tobacco while managing a psychological condition such as bipolar disorder or schizophrenia. There are non-tobacco-users calling on behalf of friends and family members, and health care professionals or others trying to decide whether to refer their patients, students, or neighbors. Comprehensive quitlines develop protocols, resources, and staff training for each situation.

Evidence-based structured protocols guide the flow of counseling sessions and remind counselors of topics considered to affect quitting success. Counselors using clinically validated protocols help clients to:

- Clarify and enhance their motivation to quit
- Boost their self-efficacy for quitting
- Identify situations that will trigger an urge to use tobacco, and plan effective strategies for getting through them without tobacco
- Identify ways to get the social support they need
- Commit to a quit date, often with counselor follow-up for accountability and extra support.

**Staffing:** Quitlines are staffed to meet demand, which is largely determined by the intensity and timing of promotion. Rather than staying open around the clock, most quitlines focus their resources on peak daytime and evening hours. The staffing plan must take into account both the overall demand for service over time, and the demand at any given moment, especially during the “bursts” of calls that occur when mass media advertisements are aired. For new quitlines, the number of staff required may be calculated by estimating the likely number of callers, which in turn may be done by comparing the promotional plan with similar campaigns elsewhere. Most quitlines require between 30 minutes and two hours of counselor time per caller, depending on the intensity and number of counseling sessions provided. Maintaining a balance between counselors’ productivity and their availability for incoming calls is one of the main challenges of quitline operations, but one which becomes more manageable as the scale grows.

When recruiting counselors, it is helpful to keep in mind that most of the evidence for the efficacy of quitlines is based on the work of paraprofessional counselors using structured protocols, indicating that postgraduate education and licensure are not necessary. Instead of graduate training, most quitlines look for candidates with natural counseling skills such as empathy, reflective listening, and the ability to guide clients through a structured problem-solving process. These skills are crucial to quitline quality and effectiveness.

**Training and supervision:** A quitline’s training program is another key to assuring quality in its services. At a minimum, a good training program addresses:

- The psychology of tobacco use and the process of habit formation, maintenance, and extinction
- General principles of counseling and motivational interviewing
- Effective counseling techniques for behavior modification
- Challenging counseling scenarios, such as crisis calls and callers with psychiatric issues
- Multicultural counseling
- Effective case management practices, including use of protocols
- Health issues related to tobacco use and cessation
- NRT and other quitting aids.

Following up the initial training with a regular program of continuing education helps counselors continuously develop their skills and ensures that their knowledge of the field is up to date.

Besides providing training, quitline supervisors and managers oversee coverage of incoming calls, effective case management, and productivity. They monitor and debrief sessions and make sure the services provided are helpful, appropriate, and factually accurate. They also ensure the program’s compliance with applicable laws and ethical guidelines governing the provision of telephone counseling.

**Evaluation:** Successful and sustainable quitline operation requires rigorous evaluation. Baseline data include, at a minimum, how callers heard about the quitline, demographic variables such as age, ethnicity, and education, type of tobacco used and level of consumption. Process data include percentage of calls answered live and number of callers (especially members of target populations) receiving each type of service. Follow-up data include quit status, length of abstinence, and satisfaction with quitline services. For quitlines serving large numbers of callers, following up a randomly selected sample is adequate.

It may not be feasible or even desirable for every quitline to conduct its own clinical trial to ensure efficacy, but all quitline funding should include an allocation for program evaluation to address key questions:

- What contribution is the quitline making to the overall tobacco control program?
- Is it successful in reaching target populations, especially high-risk and underserved groups?
- Are callers satisfied with services received?
- What percentages of callers make a quit attempt, and maintain abstinence (e.g., for 6 months)?
- Are the results comparable to other published outcomes?

It is important when citing results to identify clearly any characteristics of the population that received service that may have had a bearing on their success, and to address whether and why any participants were excluded from the analysis.

**Promotion:** Increasing public awareness of quitline services can be done in various ways. Mass media advertising—television, radio, newspapers, billboards, and other media—usually plays a central role in promotion. Successful mass media campaigns identify their target audience and do thorough marketing research before launching ads. Cultural and linguistic appropriateness is especially important. Low-cost promotional strategies have been successfully used in some countries, such as requiring manufacturers to print the quitline telephone number on cigarette packages.

Health care providers are natural partners for quitlines and can play a major role in increasing their utilization. Providers who ask all patients whether they use tobacco, advise quitting, and refer patients to quitlines for comprehensive cessation counseling can have a profound impact on patient health. Therefore many quitlines make special efforts to build linkages with health care providers. As with mass media advertising, promoting quitlines through health care systems not only generates calls and

helps callers quit, but also increases cessation among people who do not call the quitline.

- Technology:** A robust and scalable telephone system greatly facilitates operations by allowing quitlines to:
- Queue calls and route them to counselors according to pre-established priorities
  - Monitor calls
  - Track and report on performance (e.g., percentage of calls answered live)
  - Expand capacity as needed.

Information systems are very important to the smooth functioning of proactive quitlines, which over time may serve hundreds of thousands of callers, each receiving service spread out over several calls, in some cases with different counselors. Computer networks and databases must be able to store sufficient information on all contacts with individual callers to ensure a seamless delivery of services. Integration of the communication and information systems, using off-the-shelf Computer Telephony Integration (CTI) software, can greatly enhance efficiency. Other technologies have the potential to expand the range of services offered. Interactive Voice Response (IVR) systems, for example, allow callers to access personalized automated messages based on information they provide. Other emerging options include web-based interfaces, integration with email, and sending text messages or even images and short films to cell phone users.

**Costs:** The costs of establishing and running a quitline can vary widely. Communications and information systems can be a significant start-up cost, although fairly inexpensive options with limited functionality are available. The two largest ongoing expenses are usually for promotion and staffing. The U.S. Centers for Disease Control and Prevention recommend that new quitlines spend as much money on promotion in the first couple of years as on all other direct costs combined. (Quitline promotion, it should be remembered, not only generates calls to the quitline but also promotes cessation in the general population.) Over time, the cost for promotion may stabilize or even decrease as the quitline builds referral relationships with organizations and individuals in the community. Staffing costs, on the other hand, tend to increase steadily over the years.

### Steps in setting up a quitline

- Assess the need for cessation services in the population, considering the prevalence of tobacco use in various communities and their readiness to respond to cessation messaging.
- Determine how direct provision of service fits into the overall plan for decreasing tobacco use in the population.

- Identify a reliable funding source and determine a funding level appropriate to the quitline's intended role in the overall tobacco control program. Tobacco taxes, where available, are a commonly used resource for quitlines.
- Determine a budget and strategies for promotion. Promotional budgets that are roughly equivalent to operational budgets are common.
- Create a competitive process to select a quitline operator. A Request for Proposals (RFP) process, in which the funding agency provides a thorough description of the quitline services to be provided and invites proposals from interested parties, is common.
- Create a similar process for selecting a media contractor. Require both contractors to coordinate their activities with each other.
- Write contracts with the selected providers that include firm deadlines for delivery of service.
- Closely monitor the contracts to ensure adherence to standards and deadlines. Perform ongoing evaluation to ensure the quitline's effectiveness and continued relevance to the overall tobacco control program.

Careful planning, an adequate budget, and rigorous evaluation will help ensure a successful quitline.

### Key Resources for More Information

Anderson CM, Zhu SH. *The California Smokers' Helpline: A Case Study*. Sacramento, CA: California Department of Health Services; May 2000.

Borland R, Segar CJ, Livingston PM, Owen N. The effectiveness of callback counselling for smoking cessation: a randomized trial. *Addiction*. 2001;96:881-889.

Centers for Disease Control and Prevention. *Quitline Resource Guide: Strategies for Effective Development, Implementation, and Evaluation*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

European Network of Quitlines: Guide to Best Practice. Available at [www.enqonline.org](http://www.enqonline.org).

Lichtenstein E, Glasgow RE, Lando HA, Ossip-Klein DJ, Boles SM. Telephone counseling for smoking cessation: rationales and meta-analytic review of evidence. *Health Education Research: Theory and Practice* 1996;1:243-257.

Stead LF, Lancaster T, Perera R. Telephone counselling for smoking cessation [Cochrane Review]. In: *The Cochrane Library* Issue 2, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Zhu SH, Anderson CM, Tedeschi GT, Rosbrook B, Johnson CE, Byrd M, Gutiérrez-Terrell E. Evidence of real-world effectiveness of a telephone quitline for smokers. *New England Journal of Medicine* 2002;347(14):1087-1093.

Zhu SH, Stretch V, Balabanis M, Rosbrook B, Sadler G, Pierce JP. Telephone counseling for smoking cessation: effects of single-session and multiple-session intervention. *Journal of Consulting and Clinical Psychology* 1996;64:202-211.

Expanded versions of the "at a glance" series, with e-linkages to resources and more information, are available on the World Bank Health-Nutrition-Population web site: [www.worldbank.org/hnp](http://www.worldbank.org/hnp)

# Appendix J

## QuitWorks

# QUITWORKS™

Quick Guide To Pharmacotherapy In Tobacco Treatment

### NICOTINE REPLACEMENT OPTIONS

#### PATCHES

Nicotrol® 15 mg	Initial: 1 patch/16 hrs. MAX: Same as above	Treatment Duration: 8 wks.
Nicoderm® CQ 21 mg 14 mg 7 mg	Initial: 1 patch/24 hrs. MAX: Same as above	Treatment Duration: 8 wks.

#### GUM

Nicorette® 2 mg 4 mg	Initial: 1 piece every 1–2 hrs. MAX: 24 pieces/24 hrs.	Treatment Duration: 8–12 wks.
----------------------------	---	-------------------------------

#### NASAL SPRAY

Nicotrol® NS 10 mg/ml	Initial: 1–2 doses/hr. MAX: 5 doses/hr. or 40 doses/day	Treatment Duration: 3–6 mos.
--------------------------	--	------------------------------

#### INHALER

Nicotrol® Inhaler 10 mg/cartridge	Initial: 6–16 cartridges/day MAX: 16 cartridges/day	Treatment Duration: 3–6 mos.
--------------------------------------	--	------------------------------

### NON-NICOTINE MEDICATION

#### BUPROPION HCL SR

Zyban® 150 mg tablets	Initial: 150 mg/day (days 1–3) 300 mg/day (day 4+) MAX: 300 mg/day	Treatment Duration: 7–12 wks.
--------------------------	--	-------------------------------

Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. For insurance benefit information, the patient will need to contact his/her insurer directly. The cost or provision of these medications is not included as any part of the Try-To-STOP TOBACCO Resource Center of Massachusetts or QuitWorks program.

**Make smoking history.**



Patient stamp, label, or info. (name, record number/DOB, date)

## Tobacco Treatment Enrollment

A Collaboration of the Mass. Department of Public Health &amp; Mass. Health Plans

## Tobacco Treatment Checklist

## ADVISE smoker to stop:

 Stop-smoking advice given: "I strongly advise you to quit smoking and I can help you."

## ASSESS readiness to quit:

 Ready to quit    Thinking about quitting    Not ready to quit

## ASSIST smoker to quit:

 Brief counseling  
Reasons to quit   Barriers to quitting   Lessons from past quit attempts   Set a quit date, if ready   Enlist social support Medications if appropriate

Nicotine Replacement (circle): patch   gum   inhaler   nasal spray   Other (circle): Bupropion (Zyban/Wellbutrin SR)

## ARRANGE follow-up:

 Refer to Try-To-STOP TOBACCO Resource Center  
by faxing the lower part of this form to 1-866-560-9113TRY-TO-STOP TOBACCO RESOURCE CENTER OF MASSACHUSETTS  
Massachusetts Resident Enrollment Form

Fax this part of form to 1-866-560-9113

## REFERRING PROVIDER

provider name	UPIN#	phone (area code + number) (   )	fax (area code + number) (   )
provider address		city	state   zip

## PATIENT

first name	last name	date of birth (month/day/year)	
phone (area code + number) (   )	May we leave a message? <input type="checkbox"/> yes <input type="checkbox"/> no	language preference (circle): English   Spanish   other (specify): email address	
patient address	city	state   zip	
insurance	<input type="checkbox"/> BCBSMA <input type="checkbox"/> BMC HealthNet Plan <input type="checkbox"/> Fallon <input type="checkbox"/> Harvard Pilgrim <input type="checkbox"/> MassHealth <input type="checkbox"/> Neighborhood Health Plan (NHP) <input type="checkbox"/> Network Health <input type="checkbox"/> Tufts Health Plan <input type="checkbox"/> Other		

The Resource Center usually calls the patient within three business days of receiving a referral. When should we call?

no preference or circle all that apply:	call Monday	call Tuesday	call Wednesday	call Thursday	call Friday
	morning	morning	morning	morning	morning
	afternoon	afternoon	afternoon	afternoon	afternoon
	evening	evening	evening	evening	evening

## PATIENT CONSENT

I, \_\_\_\_\_, hereby authorize Try-To-STOP TOBACCO Resource Center of Massachusetts, (the "Resource Center"), and its representatives to disclose information about me to:

- 1) the American Cancer Society Quitline to the extent necessary to allow me to participate in its tobacco cessation counseling program; and
- 2) my primary care provider or other provider ("Provider") who referred me to the Resource Center to the extent the Resource Center deems necessary to give my Provider an update of my progress in attempting to stop smoking.

I authorize my Provider to release my name, address, telephone number, and MassHealth or other insurance information to the Resource Center for purposes of my participation in the QuitWorks program. I also authorize the Resource Center and its representatives to contact me upon receiving a referral from my Provider.

signature of the patient or patient's representative \_\_\_\_\_ date \_\_\_\_\_

printed name of patient representative \_\_\_\_\_ relationship to patient \_\_\_\_\_

# Appendix K

## Minimal Data Set Intake Questions

Approved February 2005  
Phoenix, Arizona

MDS Questions - FINAL  
Updated July 19, 2005

### MINIMAL DATA SET INTAKE QUESTIONS

#### **A. REASON FOR CALLING AND AWARENESS OF QUITLINE**

1. How can I help you? (Reason for Calling)  
 Want help / information about quitting  
 Want help / information about staying quit  
 Want to refer someone for help  
 Want general information or materials about quitline service  
 Other \_\_\_\_\_
  
- 2a. Are you:  
 Calling for yourself (SKIP TO Q3)  
 Calling on behalf of or to help someone else (CONTINUE TO Q2b)
  
- 2b. Are you:  
 A health professional  
 A friend or family member  
 A community organization, worksite, insurance  
 Other \_\_\_\_\_
  
3. How did you hear about the Quitline? (Do NOT read. CHECK ALL RESPONSES)  
*(Optional)*

4. Is this your first call to the quitline in the past year?

Yes  
 No   **Optional:** How many times did you call the quitline in the past year? \_\_\_\_\_  
(# of times)

## **B. TOBACCO BEHAVIOURS**

- 5a. **USA:** Do you currently smoke cigarettes every day, some days, or not at all?

(CHECK ONE)

Everyday  
 Some days (if less than 7 days per week or less than 1 cigarette per day)

**Optional if respond "Some Days":** How many days did you smoke in the last 30 days? \_\_\_\_\_

Not at all

↓ When was the last time you smoked a cigarette, even a puff? -- / -- / ----

(if day is unknown, code as 15<sup>th</sup> of month.) dd/mm/yyyy

(IF RESPONSE IS "NOT AT ALL" SKIP TO Q7)

**CANADA:** Do you currently smoke cigarettes daily, occasionally, or not at all?  
(CHECK ONE)

Daily

Occasionally (if less than 7 days per week or less than 1 cigarette per day)

**Optional if respond "Occasionally":** How many days did you smoke in the last 30 days? \_\_\_\_\_

Not at all

↓ When was the last time you smoked a cigarette, even a puff? -- / -- / ----

(if day is unknown, code as 15<sup>th</sup> of month.) dd/mm/yyyy

(IF RESPONSE IS "NOT AT ALL" SKIP TO Q7)

- 5b. How many cigarettes do you smoke per day on the days that you smoke?

Cigarettes per day \_\_\_\_ (If caller says over 100, confirm. 100 cpd = 5 packs per day; If caller says less than one per day, code 5a as Some Days/Occasionally)

6. **Cigarette smokers only:**

How soon after you wake up do you smoke your first cigarette? (DO NOT READ)

within five minutes  
 6 to 30 minutes  
 31 to 60 minutes  
 more than 60 minutes  
 don't know  
 refused

7. Do you currently use other tobacco products such as... (check all that apply)  
 Cigars  
 Pipes  
 Chewing Tobacco or Snuff  
 Other Tobacco Products (e.g. Bidis) **Optional: (specify)** \_\_\_\_\_  
(IF Q5a = EVERYDAY/DAILY OR SOME DAYS/OCCASIONALLY AND Q7 = NO OTHER TOBACCO, SKIP TO Q9)  
(IF Q5a = NOT AT ALL AND Q7 = NO OTHER TOBACCO, SKIP TO Q10)
  
8. How much tobacco do you use per week?  
\_\_\_\_ cigars (number per week)  
\_\_\_\_ pipe bowls (number per week)  
\_\_\_\_ chewing tobacco or snuff (number of pouches / tins per week)  
\_\_\_\_ Other tobacco (amount per week)

**All current tobacco users (smokers and other tobacco users)**

9. Do you intend to quit within the next 30 days? (DO NOT READ)  
 Yes  
 No  
 Don't know  
 Refused to answer

10. **Optional** At what age did you start smoking regularly? \_\_\_\_\_ age in years

**C. CALLER CHARACTERISTICS (Ask of all eligible\* callers)**

(\* eligible is defined by each quitline and should be clearly described)

11. First I need to verify are you male or female?  
 Male  
 Female  
 Refused
  
12. What year were you born? \_\_\_\_\_  
 Refused  
**Optional** What is your date of birth? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Mo./year
  
13. What is your zip code? (Canada = postal code) \_\_\_\_\_
  
14. **Optional:** Do you have any health insurance? USA only  
 Yes  
 No  
 Don't know  
 Refused

15. What is the highest level of education you have completed? (DO NOT READ)

USA

Canada

- |   |   |
|---|---|
| <input type="checkbox"/> Less than grade 9  | <input type="checkbox"/> Less than high school        |
| <input type="checkbox"/> Grade 9 to 11, no degree   | <input type="checkbox"/> High school diploma          |
| <input type="checkbox"/> GED  | <input type="checkbox"/> Technical or trade school    |
| <input type="checkbox"/> High school degree   |   |
| <input type="checkbox"/> some college or university   |   |
| (includes any post-high school education,<br>including technical or trade school, but not<br>a degree.) |   |
| <input type="checkbox"/> college or university degree   | <input type="checkbox"/> College or university degree |
| (includes AA, BA, Masters, Ph.D.)   |   |

16. USA Are you Hispanic or Latino?

- Yes (Hispanic or Latino)  
 No (Not Hispanic or Latino)  
 Refused  
 Not ascertained

**(OPTIONAL)** Reason: \_\_\_\_\_ (include “don’t know” here)

17. USA Which of these groups would you say best describes you? (READ)

- White<sup>1</sup>  
 Black or African American<sup>2</sup>  
 Asian<sup>3</sup>

**Optional if respond Asian:** Which specific ethnicity or race do you identify with  
the most? (Do not read responses; code answer)

- Asian Indian  
 Cambodian  
 Chinese (except Taiwanese)  
 Filipino  
 Hmong  
 Japanese  
 Korean  
 Laotian  
 Pakistani  
 Thai  
 Taiwanese  
 Vietnamese  
 Other Asian (specify): \_\_\_\_\_  
 don't know/not sure  
 Refused

<sup>1</sup> A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

<sup>2</sup> A person having origins in any of the black racial groups of Africa. Terms like Haitian or Negro can also  
be used.

<sup>3</sup> A person having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian  
subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the  
Philippine islands, Thailand, and Vietnam.

Native Hawaiian or other pacific islander<sup>4</sup>

**Optional if respond Native Hawaiian or other pacific islander:** Which specific ethnicity or race do you identify with the most? (Do not read responses; code answer)

Native Hawaiian

Samoan

Tongan

Tahitian

Maori

Guamanian or Chamorro

Other Micronesian (e.g. Marshallese, Palauan, Pohnpeian, Chuukese, Yapese, Saipanese, Kosraean)

Fijian

Other (specify): \_\_\_\_\_

Don't know/not sure

Refused

American Indian or Alaska native<sup>5</sup>

DO NOT READ THE REST:

Other (specify) \_\_\_\_\_

Don't know

Refused

**Canada** To which of the following ethnic or cultural groups did your ancestors belong? (ancestor = great grandparents or further back) (READ; CAN CHECK MORE THAN ONE)

Canadian (English or French Canadian)

Aboriginal (Native Indian, Metis, Inuit)

British (English, Irish, Scottish, Welsh)

European (specify country \_\_\_\_\_)

Asian (specify country \_\_\_\_\_)

Other (specify) \_\_\_\_\_ (DON'T READ)

None of the above (DON'T READ)

Don't know (DON'T READ)

Refused (DON'T READ)

THIS IS THE END OF THE INTAKE QUESTIONS REQUIRED BY THE MINIMAL DATA SET.

<sup>4</sup> A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

<sup>5</sup> A person having origins in any of the original peoples of North, Central, or South America, and who maintain tribal affiliation or community attachment.

### INTAKE ADMINISTRATIVE DATA

Counselor ID (*Optional*)

Caller ID

Date of First Contact with Quitline      \_ / \_ / \_  
    day mo yr

Intervention Provided to Caller (Check All That Apply)

- Basic information
- Literature and/or self-help materials
- Reactive counseling (one counseling session)
- Proactive counseling (more than one counseling session)
- Medications
- Referral
- Other

## **MINIMAL DATA SET *SEVEN MONTH FOLLOW-UP QUESTIONS***

### **7 MONTH FOLLOW-UP ADMINISTRATIVE DATA**

Evaluator ID

Caller ID

Date of First Contact with Quitline                                  /      /      -  
    dd  /mm/yy

Date of Evaluation Interview: seven months after date of first contact with quitline

      /      /      -  
    dd/mm/yy

### **A. CALLER SATISFACTION**

1. Overall, how satisfied were you with the service you received from the Quitline?  
(READ ALL, CHECK ONE ONLY)

- very satisfied
- mostly satisfied
- somewhat satisfied
- not at all satisfied
- don't know
- refused

### **B. TOBACCO BEHAVIOURS**

2a. USA: Do you currently smoke cigarettes every day, some days, or not at all?  
(CHECK ONE)

Everyday

Some days (if less than 7 days per week or less than 1 cigarette per day)

*Optional if respond "Some Days": How many days did you smoke in the last 30 days?* \_\_\_\_\_

Not at all

When was the last time you smoked cigarettes daily? -- / -- / ----  
(if day is unknown, code as 15<sup>th</sup> of month.)                            dd/mm/yy

IF RESPONSE IS "NOT AT ALL" SKIP TO Q4

CANADA: Do you currently smoke cigarettes daily, occasionally, or not at all?

- Daily
- Occasionally (if less than 7 days per week or less than 1 cigarette per day)

**Optional if respond "Occasionally":** How many days did you smoke  
in the last 30 days? \_\_\_\_\_

- Not at all

When was the last time you smoked cigarettes daily? -- / -- / ----  
(if day is unknown, code as 15<sup>th</sup> of month.) dd/mm/yyyy

(IF RESPONSE IS "NOT AT ALL" SKIP TO Q4)

2b. How many cigarettes do you smoke per day on the days that you smoke?

Cigarettes per day \_\_\_\_ (If caller says over 100, confirm. 100 cpd = 5 packs  
per day; If caller says less than one per day, code as Some Days)

3. **Cigarette smokers only:**

How soon after you wake up do you smoke your first cigarette? (DO NOT READ)

- within five minutes
- 6 to 30 minutes
- 31 to 60 minutes
- more than 60 minutes
- don't know
- refused

4. Do you currently use other tobacco products such as... (check all that apply)

- Cigars
- Pipes
- Chewing Tobacco or Snuff
- Other Tobacco Products (e.g. Bidis)

(IF Q2a = EVERYDAY/DAILY OR SOME DAYS/OCCASIONALLY AND Q4 =  
NO OTHER TOBACCO, SKIP TO Q6)

(IF Q2a = NOT AT ALL AND Q4 = NO OTHER TOBACCO, SKIP TO Q8)

5. How much tobacco do you use per week?

- \_\_\_\_ cigars (number per week)
- \_\_\_\_ pipe bowls (number per week)
- \_\_\_\_ chewing tobacco or snuff (number of pouches / tins per week)
- \_\_\_\_ Other tobacco (amount per week) **Optional: (specify)** \_\_\_\_\_

**All current tobacco users (smokers and other tobacco users)**

6. Do you intend to quit within the next 30 days? (DO NOT READ)  
 Yes  
 No  
 Don't know  
 Refused to answer
  
7. Since you first called the Quitline on (*Date of first contact*), seven months ago, did you quit using tobacco for 24 hours or longer? (DO NOT READ, CHECK ONE ONLY) (Note: collect number of *intentional* quit attempts only)  
 Yes  
 No  
 Don't know  
 Refused to answer
  

**Optional:** How many times did you quit using tobacco for 24 hours or longer? \_\_\_\_  
(Note: collect number of *intentional* quit attempts only)

  
8. When was the last time you smoked a cigarette, even a puff? -- / -- / ----  
(if day unknown, code as 15<sup>th</sup> of month) dd/mm/yyyy  
 Don't know  
 Refused to answer
  
9. Have you smoked any cigarettes or used other tobacco, even a puff, in the last 7 days?  
 Yes  
 No  
 Don't know  
 Refused
  
10. Have you smoked any cigarettes or used other tobacco, even a puff, in the last 30 days?  
 Yes  
 No  
 Don't know  
 Refused
  
11. Since your call to the quitline on (*Date of first contact*), seven months ago, have you used anything to help you quit? For example, nicotine replacement (gum or patch), pills (Zyban), group cessation, advice from a health professional, self-help materials?  
 Yes  
 No  
 Don't know  
 Refused

**12. Optional** What kind of treatments or health professionals?  
(Check all that apply – do not read) (Quitlines can expand these categories as necessary)

- Medication       Zyban
- NRT patches
- NRT gum
- NRT lozenges
- other medications as desired
- Advice from       Physician
- Pharmacist
- Nurse
- Group cessation program
- Self-help materials
- Other \_\_\_\_\_

---

THIS IS THE END OF THE 7 MONTH FOLLOW-UP QUESTIONS REQUIRED BY  
THE MINIMAL DATA SET.

# **Appendix L**

## **Medicaid Model Language**

### *A Summary of the Sample Purchasing Specifications Related to Tobacco-Use Prevention and Cessation*

Medicaid populations have been shown to have smoking rates of 36% (almost double that of the population as a whole) (MMWR 11/9/01). Tobacco use is the most preventable cause of death and disability in the United States (McGuinnis). Tobacco use results in \$92 billion in excess health-care costs annually (MMWR 2005).

To address this considerable health-care cost and to promote the provision of tobacco-dependence treatment for this population, the Centers for Disease Control and Prevention's Office on Smoking and Health has coordinated with the Center for Health Services Research and Policy at the George Washington University School of Public Health to develop sample "Purchasing Specifications Related to Tobacco-Use Prevention and Cessation."

These draft specifications are in the form of proposed contract language and are designed to be used by state Medicaid agencies as they develop their Medicaid managed care contracts. Ideally this language would be incorporated in an RFP or contract between the state and HMOs covering Medicaid enrollees.

Several state Medicaid agencies and health departments have reviewed the Specifications and provided input to ensure applicability. The document has also been through a vetting process with selected state Medicaid directors. This process is part of a larger initiative to assist states in standardizing contract language around the most common chronic diseases, such as asthma, hypertension, and cardiovascular disease management.

The Public Health Service (PHS) Clinical Practice Guideline, Treating Tobacco Use and Dependence, summarizes a literature review and, along with the Community Preventive Services Task Force, makes a strong case for implementation of effective tobacco-control treatment and provision of comprehensive coverage (Fiore, Hopkins). The Partnership for Prevention has ranked tobacco-dependence treatment second overall (and first among adults) among proven preventive treatments (based on cost, cost effectiveness, and impact) (Coffield).

Lack of access to tobacco-use treatment and the costs of treatment are major barriers for low-income people trying to quit smoking. At present only 3 states provide comprehensive tobacco treatment coverage under Medicaid, 36 states and the District of Columbia provide a range of partial coverage for counseling and pharmacotherapy, and 15 states provide no coverage

(MMWR 1/30/04). The specifications were developed to improve the level of care available to this vulnerable population and create a higher level of uniformity among services available to the Medicaid population.

The specifications attempt to translate the PHS guideline findings into contract language to support the process. The specifications address

- Systems components to support the treatment process.
- The scope of the benefit.
- Diagnostic and Treatment Services for enrollees who use tobacco or have recently quit, including
  - Pharmacotherapy.
  - Counseling.
- Services for pregnant women.
- Services for adolescents and pre-teens.
- Tobacco use treatment under chronic disease management programs.
- Guidelines.
- Coverage determination standards and procedures.
- Relationship with state (or local) public health agency.

### **Quality measurement, quality improvement, and data reporting**

Quality measures (such as implementation of the HEDIS measure) and regular reporting on sample chart audits, prescription drug monitoring, and interface with telephone counseling services, if available, are suggested to ensure effective implementation.

Medicaid Model Language Summary 8/05

# **Appendix M**

## **Promotion of Tobacco Cessation in the Health-Care System: Suggested Strategies**

The following was created by the Veterans Administration (VA) and the Department of Defense for their Tobacco Use Cessation Clinical Practice Guideline. It was not used for the actual guideline, but is being reprinted with permission from the VA author of the document.

### ***Objective***

- Increase to 100 percent any beneficiary's access to evidence-based tobacco use and dependence treatment services in the DoD/VA system.
- Remove barriers to providers, staff, clinical settings, and administrators from the DoD/VA system, so as to increase provision and utilization of tobacco use and dependence treatment services.

### ***Background***

In the health care system, treatment for tobacco use and dependence often begins with brief advice provided by a health care provider that advises the patient to quit, followed by possible interaction with counseling and pharmacotherapy. Considerable research shows that many evidence-based tobacco use and dependence treatments are effective in addition to health care provider advice and follow-up (Levy & Friend, 2002). With this evidence, the DoD/VA health care system administrators must ensure changes in the DoD/VA systems that develop, support, and sustain a range of evidence-based tobacco use and dependence treatment services. Based on system changes that remove barriers to evidence-based treatment services, the greater the access that DoD/VA beneficiaries have to this range of services, the greater the potential to increase treatment use and quit rates.

Smoking cessation is the “gold-standard” for cost-effectiveness among medical/preventive interventions. Smoking cessation has been called the “gold standard of health care cost effectiveness” (Eddy, 1992). Few interventions, with the exception of vaccinations for children and older adults, offer better value. Compared with other routine preventive interventions, smoking cessation is extremely cost-effective, comparing favorable with other health care interventions such as screening for hypertension and yearly mammography. Coronary bypass graft surgery costs roughly 10 times as much per quality-adjusted year of life saved (Cromwell et al. 1997). A return on the investment made on smoking

cessation can be made relatively quickly. A study by the Group Health Cooperative suggests that 4 years after quitting, smokers who quit have significantly lower health care utilization than smokers who continue (Wagner et al. 1995).

In a systematic assessment of the value of clinical preventive services recommended by the US Preventive Services Task Force, smoking cessation services for adults was one of the highest ranked services (in terms of disease burden and cost-effectiveness) with one of the lowest delivery rates of all preventive services (Coffield et al. 2001). These and other findings would suggest that despite knowledge of the health benefits of tobacco use cessation and availability of cost-effective treatments, many health care providers and health care systems still fail to treat tobacco use adequately.

### *Recommendations*

#### **Main recommendations – “Top 10 system changes”**

Changes at the organization level

1. National and local leadership should fully endorse and support the goal of reducing tobacco use and make it an organizational and institutional priority.
2. Tobacco use cessation treatment (both counseling and pharmacotherapy) should be provided as a covered benefit with no co-payment.
3. Clinical sites should dedicate staff to provide tobacco dependence treatment and assess the delivery of this treatment in staff performance evaluations.
4. The Veterans Health Administration and Department of Defense should each implement standardized data collection to allow tracking and management of tobacco users.
5. The Veterans Health Administration and Department of Defense should establish national Quitlines for smoking cessation, which include provision of smoking cessation medications. Mechanisms should be developed to facilitate provider referral to Quitlines.

Changes at the clinic level

6. Treatment and referral for smoking cessation, (as well as their documentation) should be as convenient as possible, since it increases the likelihood that patients will receive appropriate treatment.
7. Every clinic should implement a tobacco-user identification system (e.g., use nicotine dependence ICD code).

8. The Veterans Health Administration and Department of Defense should each use clinical reminders (electronic, if possible) that are tailored to the specific treatment setting.

Changes at the provider level

9. Every facility should develop and adopt strategies to increase provider's adherence to the guideline (e.g., academic detailing, provider profiling, education outreach).
10. All providers and other health care team members should be trained in providing smoking cessation treatment, as patients who see trained providers are more likely to receive appropriate treatment.

### **Additional recommendations**

Changes at the organization level

11. The Veterans Health Administration and Department of Defense should establish an Internet-based smoking cessation web site, to provide broader access to treatment for smokers and a central resource location for staff.
12. The Veterans Health Administration and Department of Defense should make all installations and campuses smoke-free.
13. Each institution's policies should support and promote the provision of tobacco use cessation services.
14. All facilities should initiate environmental and policy changes that discourage tobacco use among staff personnel, as staff who use tobacco are less likely to assist patients in quitting.

Changes at the clinic level

15. Tobacco users should be offered treatment at all clinical settings, as repeated advice from multiple providers increases the likelihood that they will quit.
16. Barriers to receiving smoking cessation treatment should be eliminated, so that patients can access treatment at any time and place.

Changes at the provider level

17. The Veterans Health Administration and Department of Defense should develop methods to reward clinicians and specialists for delivery of effective tobacco dependence treatments.

## **Discussion**

System changes are one of the most important aspects of tobacco control. Health care providers and staff universally acknowledge the importance of tobacco use cessation, but often fail to advise tobacco users to quit and assist them in quitting. This is in part due to the many competing demands placed on providers (Chernof et al., 1999) and health care institutions. System changes help to reduce barriers, increase knowledge and skills, and modify attitudes with respect to smoking cessation, which in turn increases the provision of effective tobacco cessation services. The changes are broken down into three levels for convenience and clarity (the organization, the clinic, and the provider), although many of the recommendations act at multiple levels.

### **Organization Level Changes**

Changes at the organization level focus on modifying the culture with respect to tobacco use cessation and providing services or resources that are too large or complex for one facility to develop. Making tobacco use cessation a top organizational priority is one of the most important changes, as that makes all other changes much easier to effect. Tobacco use cessation treatment (both counseling and pharmacotherapy) should be a covered benefit, as it dramatically increases the rate of provision of these services (Curry et al., 1998; Fiore et al., 2000). Co-payments for treatment should be eliminated. Curry and colleagues found that elimination of all co-payments led to higher total costs but also to an increased number of non-smokers, through much higher levels of provision of tobacco use cessation treatments. Despite some people's concerns, having smoking cessation treatment available as a covered benefit did not lead to profligate use. When cost-free access of up to four 30-day trials of NRT was provided for over a year, 73 percent used this benefit once, 20 percent used it twice, and only 3 percent and 5 percent used it three and four times, respectively (Harris et al., 2001). On a separate note, telephone Quitlines should be available to all tobacco users, as these are effective and greatly increase access to treatment.

While there is not yet evidence that Internet-based smoking cessation programs are effective, several studies are currently examining this issue. In the absence of data, these programs provide a reasonable and efficient way to support patients who have Internet access. In addition, the Internet provides an efficient way to allow providers to access up-to-date information, including guidelines, handouts, and other materials.

### **Clinic-Level Changes**

Changes at the clinic level focus on making it as easy as possible to provide tobacco use cessation treatment to patients. Providers have many other competing obligations and demands on their time (Chernof et al., 1999), and the more difficult it is to help tobacco users quit, the less likely it is that it will happen. Therefore, clinics should review the entire process for tobacco use cessation, with an eye to making it as simple and easy

as possible. Patients often say that the provider's advice is a particularly important motivating factor in helping them quit (Fiore et al., 2000). Clinics should therefore ensure there is a system for helping remind the provider to advise the patient to quit and then for assisting the provider in assisting the patient to quit. As an example, a typical set-up might include tobacco use status as part of the vital signs, with a reminder (electronic or paper) for the provider if the patient uses tobacco. After the provider advises the patient to quit, another staff member (e.g., nurse, pharmacist) might provide more detailed instructions on medication use and cessation tips, along with one or more follow-up contacts. Specific tasks that a clinic should think about in this regard are: 1) identification of tobacco users in a systematic way, 2) provision of detailed information about cessation, 3) ongoing management of tobacco cessation pharmacotherapy, and 4) follow-up counseling.

### **Provider Level Changes**

At the provider level, changes focus on training and encouraging the provider and making tobacco use cessation treatment the standard of care. Therefore, systems should ensure that all health care providers receive adequate training in counseling tobacco users and providing pharmacotherapy. Training includes both initial training (which focuses on improving everyone's knowledge and skills) and ongoing, follow-up training (which focuses on refining skills and removing barriers). Several ongoing studies are examining the use of provider profiling, whereby the performance of individual providers is audited and providers are given individual feedback. Additional studies are examining the effectiveness of educational outreach (also known as academic detailing). In a typical implementation of this approach, a respected local peer (an opinion leader) might briefly "detail" providers with specific information about tobacco use cessation. Not only does this efficiently give providers helpful information, it also sends the unspoken message that someone they know believes in tobacco use cessation and practices it with their own patients (thereby targeting cultural norms for providers). No studies have examined the use of incentives (either positive or negative) as a way to modify providers' behavior with respect to tobacco use cessation, and studies examining their use in other areas (e.g., increasing immunization rates) have had mixed results (Giuffrida et al., 2000).

[Additional data on strategies for designing the health care system to promote tobacco use cessation can be found in Evidence Report Question #18]





