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

Over 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.
- 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.

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

**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).
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.
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 psycho-social 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

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<tr>
<th>Individual Treatment Service Delivery</th>
<th>Administration</th>
<th>Quality Assurance (Health Plans/Hospitals)</th>
<th>Quality Promotion (Public Health)</th>
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<td><strong>Provide brief counseling</strong> to patients who smoke or have recently quit and refer patients to quitlines and other available resources for more intense counseling.**</td>
<td><strong>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.</strong></td>
<td><strong>Develop procedures to identify smokers at health plan or at hospital admission and refer them to tobacco-use treatment services.</strong></td>
<td><strong>Work with quality improvement organizations (QIOs) to support and monitor existing tobacco control standards.</strong></td>
<td><strong>Actively promote tobacco-use treatment services to health-care employers and health insurers.</strong></td>
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<td><strong>Offer FDA-approved first-line tobacco-dependence pharmacotherapies to all tobacco users who are trying to quit.</strong></td>
<td><strong>Collaborate with public health professionals in establishing quitlines as an adjunct to treatment services.</strong></td>
<td><strong>Expand formularies to include first-line FDA-approved tobacco-dependence pharmacotherapies.</strong></td>
<td><strong>Ensure that the state quitline represents the needs of the community and health-care systems (hospitals, clinics, health plans, etc.).</strong></td>
<td><strong>Coordinate with employers to contract with quitlines to provide tobacco-use treatment counseling for employees.</strong></td>
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<td><strong>Provide intensive counseling or refer to telephone quitlines.</strong></td>
<td><strong>Ensure access to cessation coverage benefits and monitor benefit utilization.</strong></td>
<td><strong>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.</strong></td>
<td><strong>Act as a neutral convening body for collaborative tobacco-centered quality improvement initiatives between state, health plans, or clinics.</strong></td>
<td><strong>Fund, promote, and/or administer a statewide quitline.</strong></td>
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<td>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.</td>
<td>Participate in quitline oversight to ensure quality service and promote collaboration between the health plan and the quitline.</td>
<td>Communicate results of tobacco-use treatment interventions to clinicians and health-care staff and primary care providers following discharge.</td>
<td>Consider clinical and health plan quality measures related to tobacco use when selecting networks, health insurance products, and health plans.</td>
<td>Promote or support tobacco-use treatment services for uninsured and underinsured people in public clinics.</td>
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<td>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.</td>
<td>At discharge, refer patients who smoke to a quitline or other local services for follow-up.</td>
<td>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.</td>
<td>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.</td>
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<td>Eliminate or minimize co-pays or deductibles for counseling and medications.</td>
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<td>Advocate for quitline funding.</td>
<td>Promote hospital and clinic policies that support tobacco-use treatment and provide for in- and outpatient tobacco-dependence services and post-discharge follow-up.</td>
<td>Serve as an advocate for funding.</td>
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<td>Review HEDIS and JCAHO scores on tobacco measures, set targets, and monitor progress.</td>
<td>Encourage health-care systems and employers to provide funding to state quitlines or funding for promotional initiatives.</td>
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<td>Promote coverage of tobacco-use treatment counseling and medication coverage to self-insured groups.</td>
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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.
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

- Asking if patients smoke.
- Advising them to quit.
- Assessing readiness to quit.
- Assisting with counseling and pharmacological treatments.
- Arranging 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

- Relevance—Encourage the patient to consider how quitting or not quitting specifically affects them and their loved ones.
- Risks—Suggest and highlight relevant risks of continued tobacco use.
- Rewards—Help the patient identify potential benefits of stopping tobacco use.
- Roadblocks—Identify barriers or impediments to quitting and ways these can be addressed.
- Repetition—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).

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* 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

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<td>Become champions and, along with committed team members (physicians, nurses, medical assistants, etc.), provide training for clinicians in evidence-based treatment.</td>
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<td>Implement a system to identify and document the tobacco-use status of all hospitalized patients.</td>
<td>Initiate a system where tobacco users can be referred to state tobacco cessation quitlines.</td>
<td>Collaborate with the business sector to promote comprehensive coverage and quitline services.</td>
<td>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.</td>
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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).

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

<table>
<thead>
<tr>
<th>Service Delivery</th>
<th>Quality Assurance/Quality Improvement</th>
<th>Administration</th>
<th>Finance</th>
<th>Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide medication and counseling for insured, uninsured, or underinsured populations.</td>
<td>Monitor benefit utilization and feed results back to health-care systems providing services.</td>
<td>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.</td>
<td>Include tobacco-use treatment counseling and medications as a standard part of all fully insured contracts.</td>
<td>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.</td>
</tr>
<tr>
<td>Promote quitline services and collaborate with Medicaid, health-care systems, and employers to provide low- or no-cost services.</td>
<td>Remove or minimize barriers to accessing tobacco-use treatment benefits by decreasing or eliminating co-pays and removing utilization caps.</td>
<td>Reimburse for tobacco use treatment in the same way that clinicians are reimbursed for other chronic diseases.</td>
<td>Ensure that purchasers understand the financial benefits of tobacco-use treatment interventions.</td>
<td></td>
</tr>
<tr>
<td>Ensure maximal utilization of services by reducing or eliminating co-pays.</td>
<td>Inform clinicians and office managers of coverage availability.</td>
<td>Include coverage for office visits to treat “tobacco-use disorder” as a standard benefit.</td>
<td>Negotiate tobacco-use treatment benefits as part of union contracts.</td>
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</tr>
<tr>
<td>Understand current coverage levels. Ask insurers about all products or services (e.g., benefits, riders, discounts) that address tobacco-use treatment.</td>
<td>Cover at least two courses of counseling and medication per year to support the quitting process.</td>
<td>Provide and promote tobacco-use treatment benefits for employees through insurance contracts, self-insurance, and work-site programs.</td>
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<tr>
<td>Promote coverage of tobacco-use treatment counseling and medication to self-insured groups.</td>
<td>Offer health benefits that include comprehensive counseling and medications for employees.</td>
<td>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.</td>
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<tr>
<td>Provide disease management and treatment for tobacco-related diseases and conditions.</td>
<td>Work with self-insured employers (including states) to ensure that their health plans provide coverage for both tobacco-use treatment counseling and pharmacotherapies.</td>
<td>Encourage employers to learn how benefits they already have can be used for tobacco-use treatment and to promote their use by employees.</td>
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<tr>
<td>Demonstrate to employers that coverage of tobacco-use treatment is cost-effective.</td>
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</tbody>
</table>
Objective: Create social and economic environments that promote tobacco-use treatment.

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).

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. Also, please visit the Centers for Disease Control and Prevention’s Media Campaign Resource Center at www.cdc.gov/tobacco/mcrc and the Tobacco-Free Coalition of Oregon’s site at www.tobaccofreeoregon.org. The *Make It Your Business* campaign (available at www.tobaccofreeoregon.org) is another valuable resource. (See Case Study #6 on page 56.)