

# Helping Addicted Smokers Quit: The Foundation's Tobacco-Cessation Programs

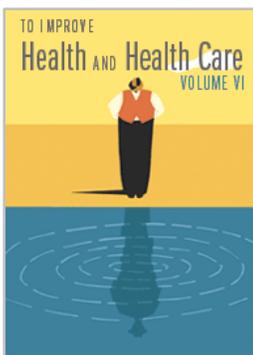
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## *Editor's Introduction*

The Robert Wood Johnson Foundation often supports research or demonstration projects to determine whether a specific type of intervention works—a new organizational strategy, an innovative financing method, an improved treatment. The thought behind this approach is that good ideas are picked up and spread widely. This does not always happen, however. Perhaps the research is convincing, but something more is needed before it gets translated into standard practice. Such is the case with tobacco cessation. The research clearly shows the benefits of certain approaches—those employing counseling and pharmaceuticals. These approaches don't even take much time. Yet they are not widely practiced by physicians or within health care organizations. This chapter examines the Foundation's efforts to translate research into practice to help smokers quit.

The long translation effort began with research to determine which interventions were effective. Once effective treatments were identified and formalized in federal guidelines issued in 1996, the Foundation sought to make them a regular part of medical practice. Its approach included publicizing the guidelines, using them as the basis of standards, attempting to create demand for them, and coaxing insurers to cover the cost of using them.

Much of the Foundation's work has been with managed care organizations. As organized delivery systems that can track patients and benefit from keeping people healthier, managed care organizations should have an incentive to offer a preventive service such as tobacco cessation. However, frequent turnover of enrollees from one plan to another obscures the financial benefits for any given managed care plan and has slowed adoption of tobacco-cessation treatments.

The Foundation's support of efforts to help people quit smoking illustrates the challenge of translating science into medical practice, the difficulty of overcoming addiction (even when people say they want to stop), and the need for a variety of approaches to speed adoption of what seems like a commonsense idea. It also highlights the tension between investment to prevent a problem and investment to treat a problem. To date, the Foundation has invested in both prevention and treatment; it devotes a majority of its antitobacco funding to keeping young people from starting to smoke, while still investing (though less significantly) in helping current smokers quit. Of course, smoking-cessation programs might be considered a form of secondary prevention. The chapter makes the disturbing point that every state Medicaid program covers expensive, intensive medical care to treat people with lung cancer but only twenty-four state Medicaid programs cover treatment to help

smokers quit.

This chapter is written by C. Tracy Orleans, senior scientist at the Robert Wood Johnson Foundation, who has been a key player in developing the Foundation's smoking-cessation strategy; and Joseph Alper, an award-winning freelance writer who has contributed chapters to previous volumes of *The Robert Wood Johnson Foundation Anthology* series.

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**I**n a typical week, 35,000 American teenagers try their first cigarette, and 14,000 become regular smokers, with more than half going on to a lifetime of nicotine addiction. Most of these smokers will try to quit their habit numerous times, some of them successfully, most not. A third of the teenagers who get hooked on cigarettes will die as a result.

Some 40 years ago, Bob Clement<sup>1</sup> became a teenage smoker. Now 54 and living in a suburb of Seattle, Clement, a retired police officer, is a pack-a-day smoker whose only break from his tobacco addiction came during the four times he has tried to quit smoking cold turkey over the past 15 or so years. Clement is a realist. He knows that smoking is damaging his health and will probably kill him eventually if he continues. He also knows how hard it will be to quit for more than the couple of months that he usually lasts before picking up a pack of cigarettes at his local gas station. But this time, he says, he has an added incentive: "Hunting season is coming, and smoking has finally gotten me to the point where I get winded so easily I won't be able to follow my prey. That is completely unacceptable."

This extra motivation has prompted him to take what for him is a radical step: getting help. "I've tried quitting on my own, and I guess I can't do it," says Clement with a grave laugh. "What can you do to help me?"

Kathy Nago, who is talking on the phone with Clement, hears this plea a dozen times a day. She is one of 70 trained smoking-cessation counselors answering the phones at the Tukwila, Washington, facility of Group Health Cooperative of Puget Sound. This is a routing place for smokers who call in on one of the toll-free "quit lines" sponsored by Washington, Oregon, Minnesota, Wisconsin, Maine, Utah and Georgia for the citizens of each state, as well as one for all Group Health Cooperative members. On this beautiful fall morning, Nago has already given advice to a shy 40-something woman from Oregon who was making her first attempt to quit, and has transferred a call from a 39-year-old Minnesota

smoker to a counselor at HealthPartners, a managed care company in the Minneapolis-St. Paul area that runs its own quit line.

Nago's first task with Clement is to engage him in friendly conversation while gathering some general background information—age, address, insurance company and the like—and baseline information about his smoking habits, his overall health and his previous attempts to quit. She is particularly interested in the hows and whys of his previous attempts and in his current motivation to quit, entering all of this information into an online database that will be available to every other counselor if Clement calls back later for further help. She finds out he has never used a nicotine replacement product, such as nicotine gum or a controlled-release patch; when she informs him that nicotine replacement therapy doubles the success rate of quitting, she can hear from the way he says, “Really? How do I get some?” that she has hit the right button.

Given Clement's smoking habits, Nago recommends that he start with an over-the-counter nicotine patch at a strength of 21 milligrams. While she's telling him how to use the patch, she browses the information on her computer screen and finds that Clement's insurance covers over-the-counter nicotine replacement therapy and will also cover the cost of limited-duration group counseling. He's not interested in “that touchy-feely stuff,” he says, but he is interested in receiving any written materials that might help because, as he says, “I'm a good learner when I can read something.”

From her computer terminal, Nago orders a videotape and a collection of materials (tailored to his age and to the fact that he has tried to quit before) to be sent to Clement. Then, in a final, all-important step, Nago gets Clement to commit to a specific date to quit. “How about this Friday?” he says.

“Can you get to the store and have nicotine patches by then?”

“Absolutely,” he responds. “Can you have the reading materials to me by then?”

Nago smiles. “I think you're going to do great this time,” she says, “but make sure you call again if you have any concerns or start running into trouble. It's always free to call, and we're always here to help.”

## A STRUGGLE AGAINST DEATH AND DISEASE

Armed with the nicotine patch, help from the Washington Quit Line, strong motivation, and insights gained from past attempts to quit, Clement stands a far-better-than-average chance of joining the 44 million other Americans who call themselves former smokers.

Tobacco use and addiction are the nation's most important cause of preventable disease and premature death. More than 25 percent of adults and more than 30 percent of high school seniors, nearly fifty million Americans in total, report regular tobacco use. The consequences are staggering. Tobacco use and dependence are responsible for more than 430,000 premature deaths—approximately one in five deaths—every year. Heart disease, stroke, lung disease, cancer, and other chronic illnesses all result from regular smoking. Maternal smoking in pregnancy is the most important preventable cause of low birth weight, mortality in newborns, and sudden infant death syndrome.

The estimated cost to the American health care system is \$80 billion in direct expenditures and \$50 billion in indirect costs.<sup>2</sup> “The single biggest impact we could have on both the overall health of Americans and on reducing the escalating costs of health care would be to convert far more smokers into ex-smokers,” says Dr. Michael Fiore, director of the Center for Tobacco Research and Intervention at the University of Wisconsin Medical School in Madison. “And while it’s critically important that we work hard to prevent more Americans from becoming smokers, the greatest reductions in preventable mortality, morbidity, and health care burden over the next thirty to forty years will come from helping people quit smoking.”

Although the prevalence of smoking has dropped by almost 40 percent since the Surgeon General’s report on tobacco in 1964, more than half of all Americans who have ever smoked still smoke. Perhaps more indicative of how poorly we, as a nation, do in helping smokers quit their habit is the fact that though more than two-thirds of smokers say they want to quit, and half of them make at least one serious attempt to quit in any given year, only 2.5 percent—about 1.2 million a year—are able to quit smoking permanently.<sup>3</sup> “It’s tragic—pathetic, really—that we do so poorly at helping people quit smoking,” says Jack Hollis, associate director of the Kaiser Permanente Center for Health Research. “Particularly since we have smoking-cessation methods at our disposal that work and could have a much bigger impact if we could only get smokers to use them.”

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## THE GAP BETWEEN WHAT WE KNOW AND WHAT WE DO

Nearly two decades of research and development have generated a wealth of pharmacological and behavioral tools that can effectively treat what is essentially a chronic disease, namely, nicotine addiction. Indeed, the U.S. Public Health Service issued clinical practice guidelines in 1996 and 2000 identifying a variety of treatments that could reduce tobacco-related disease and death dramatically. Through use of these treatments, the proportion of adult smokers who achieve long-term success when trying to quit on their own can be increased from 7 percent to as high as 30 percent.<sup>4</sup> Providing these treatments, including brief minimal-contact approaches designed to be integrated into everyday clinical practice, to the 70 percent of adult smokers who see their providers every year would double our national annual rate of quitting.

Such interventions are underused, however, reaching less than a quarter of all smokers. Summarizing this state of affairs, the Public Health Service, in *Treating Tobacco Use and Dependence: A Clinical Practice Guideline*, said, “It is difficult to identify a condition in the United States that presents such a mix of lethality, prevalence, and neglect, and for which effective interventions are so readily available.”<sup>5</sup> As Susan Curry, director of the Health Research and Policy Centers at the University of Illinois at Chicago, puts it, “It’s as if the medical profession decided to ignore diabetes and high blood pressure, which, like cigarette smoking, are chronic diseases that are associated with so-called lifestyle decisions on the part of the individual, and for which the long-term treatment success rates are similar.”

Tobacco researchers talk about the gap between what we know and what we do. What we know is that most smokers want to quit, most see a doctor at least once a year, and most doctors want to help them quit. Moreover, we know that the nation could double its current national annual rate of quitting if doctors routinely offered brief advice, counseling, and effective pharmacotherapy (such as the nicotine patch or Zyban) that the *Guideline* recommends. Unfortunately, only 50–60 percent of smokers report getting any advice on quitting from their physicians, and fewer than 25 percent report any further counseling or drug-based therapy. Low-income and minority smokers are the least likely to get this help.

Granted, the gap between what we know and what we do has grown smaller. The number of quitters who currently make use of effective treatments is somewhere between 20 and 30 percent, which is twice as high as it was a decade ago.<sup>6</sup> There are plenty of reasons to explain why this gap has not shrunk further:

- Doctors and other primary care practitioners are not trained to deliver tobacco-cessation therapies. For example, fewer than 20 percent of medical schools offer even three hours of clinical instruction in treating tobacco addiction.<sup>7</sup>
- Physicians underestimate the difficulty smokers face in overcoming tobacco addiction and feel discouraged by what they perceive as their own lack of success in helping them. Even those who qualify (by helping their patients quit) for what Fiore calls “the good doctor club” note that if they succeed in getting one in five of their smoking patients to stop—a major public health achievement—results are typically delayed and invisible.
- The health care system does not support tobacco-cessation efforts. Surveys funded by the Robert Wood Johnson Foundation show that physicians who work to put the clinical practice *Guideline* into action do so without reminder and follow-up systems, without access to self-help materials, telephone quit lines, or community programs required to deliver effective counseling outside the eighteen-minute clinical visit.
- Insurance coverage and reimbursement policies often do not cover tobacco-dependence treatment that is known to be effective. Medicare, for example, still provides no coverage, and in 2000 only 33 states provided Medicaid coverage for any of the proven treatments recommended by the *Guideline*.
- The business case for tobacco-dependence treatment has not been made. Most purchasers of health care (such as large corporations), most policy-makers, and most benefit consultants are not aware of the actual costs of illness related to smoking or of the economic benefits of quitting.<sup>8</sup> Businesses are unenthusiastic about anything but an immediate return on investment. “Health plans are fighting for their financial lives right now, and many of them claim that since member turnover is so high, they won’t realize the savings three or four years down the road for money they’re spending today,” says Barbara Lardy, director of medical affairs for the American Association of Health Plans, managed care’s national trade organization.
- The community treating tobacco dependence does not think along policy lines. During a time when prevention policies were driving down the number of young people who took up smoking, few advocates focused on the power of these policies to induce smokers to quit. Similarly, until recently, policy-makers and policy researchers largely ignored policy and regulatory strategies for tobacco cessation.
- Even though most smokers want to quit and try to do so, this desire has not translated into demand for treatment. In a focus group funded by the Robert Wood Johnson Foundation, officials from health plans offering the most generous smoking-cessation treatments and benefits voiced a common frustration over smokers’ generally low use of these services.<sup>9</sup> Not that there has been much done to build demand. Aside from recent direct-to-consumer advertising for nicotine gum and patches and Zyban, there have been few efforts to educate smokers about effective treatment. Aids and programs to reduce tobacco dependence are far less available to smokers than are cigarettes.

## CLOSING THE GAP: FOUNDATION GOALS AND STRATEGIES

In 1991, the Robert Wood Johnson Foundation adopted its current goal of reducing the harm caused by tobacco, alcohol, and illicit drugs. For tobacco, keeping children and teens from becoming smokers was the top priority. But the Foundation staff also saw a need to help addicted smokers quit. In both

prevention and cessation, the staff sought to build on and complement the efforts of other tobacco-control funders, to finance initiatives that others could not, and to fill critical gaps.

The Foundation found two ways to further cessation efforts: first, by identifying and promoting effective tobacco-cessation treatments; and second, by translating research on successful treatment into practice. It focused its grants and programs on three underserved and important populations—pregnant smokers, managed care enrollees, and adolescents—and, as shown in Figure 6.1, adopted a three-pronged approach to reach these populations:

1. Improving the scientific basis for and the knowledge of effective tobacco-dependence treatment.
2. Building the capacity of health care systems to deliver effective intervention.
3. Building a market and demand (among health care providers, purchasers, policy-makers and consumers) for them.

#### IMPROVING THE SCIENTIFIC BASIS FOR AND KNOWLEDGE OF EFFECTIVE TREATMENT

The Foundation's efforts have focused on developing and disseminating federal guidelines to aid physicians and other health care professionals in delivering tobacco-cessation treatment. The guidelines examine the relevant research and make recommendations about the kinds of tobacco-cessation intervention that have been shown to be effective.

In 1996, the federal Agency for Health Care Policy and Research, or AHCPR (since renamed the Agency for Healthcare Research and Quality), created an expert panel to review the scientific literature on smoking cessation and to identify treatments that worked. This review culminated with publication of the federal government's first clinical practice *Guideline*. It recommended an intervention of three to five minutes that physicians, nurses, dentists, and smoking-cessation specialists could deliver during a routine primary care visit. It also defined effective behavioral counseling methods and pharmacotherapies.

Once the first guideline was issued, the Robert Wood Johnson Foundation collaborated with the AHCPR and other funders in organizing a national conference in Washington, D.C., to let key provider organizations, policy-makers, and tobacco-control advocates know about the *Guideline* and how it could be used to expand the benefits offered by Medicare, Medicaid, managed care plans, and private insurance companies.

The Foundation also awarded a series of grants to organizations and professional societies having a strong

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track record in educating health care providers and setting national practice standards. Grantees included the American Medical Association, the American Nurses Foundation, the American College of Obstetricians and Gynecologists, the American Women’s Medical Association, and the American Academy of Pediatrics.

These organizations publicized the *Guideline* through their professional journals and meetings and developed aids for special populations, such as pregnant smokers, teenage smokers, and smokers in low-income and minority populations. “We knew that professional society endorsement was critical to providers’ adopting previous clinical practice guidelines, but we also learned from the professional societies that the *Guideline* alone wasn’t enough,” said Harriet Bennett, the tobacco liaison for the Agency for Healthcare Research and Quality, who oversaw the agency’s efforts to disseminate the *Guideline*. “They needed more tailored information and more practical tools, like pocket reminders and patient handouts.” One such tool that the Foundation helped to fund and disseminate was a short parallel guideline from the AHCPR on the health care system changes (such as adding a tobacco user identification system and including tobacco-dependence treatment as a covered benefit) that were required to fully integrate *Guideline*-based care into routine clinical practice.

Given rapid growth in the scientific evidence, the U.S. Public Health Service reconvened the original expert panel, which reviewed three thousand more articles published between 1995 and 1999 and issued an updated *Guideline* in 2000. The new *Guideline* recommended a brief primary care intervention, now known as the 5-As, which had been demonstrated to be effective in getting smokers to quit:

1. *Ask* every patient about tobacco use and smoking.
2. *Advise* all smokers to quit.
3. *Assess* smokers’ willingness to quit.
4. *Assist* those who are motivated with brief counseling, self-help materials, and pharmacotherapy (nicotine replacement products and Zyban) and those who are not with brief motivational counseling.
5. *Arrange* follow-up for continued support and more intensive treatment if needed.

The 5-A model requires as little as two minutes of a physician’s time. This may not seem like much, but research has demonstrated that if a physician with no special training in behavioral counseling spends only two minutes advising patients to quit smoking, twice as many quit as would do so without even this

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briefest of interventions.<sup>10</sup> By itself, this would produce an additional 1.2 million former smokers annually—slightly more than the number of individuals who become smokers each year.

The *Guideline* endorsed a team approach, making it clear that the entire burden of smoking cessation is not meant to fall on the shoulders of primary care physicians. “I’m a practicing primary care physician, and I can tell you that it’s hard to think about adding another two-minute task into the already crowded ten to fifteen minutes that I get for a routine office visit,” says Charles J. Bentz, medical co-director of the smoking cessation and prevention effort for Providence Health System’s Portland Oregon region. “That’s why it’s so important that we make this a systems approach involving every member of the team.”

Michael Fiore, who served as panel chairman for the original and updated *Guideline*, agrees that the 5-A model calls for a team approach: “It starts from the time a patient walks through the door and encounters the receptionist and continues all the way to when a patient picks up a prescription for nicotine replacement therapy or Zyban from the pharmacist and talks with a telephone quit-line counselor for additional counseling and support.” This team extends to counselors outside the primary care context. Confirming a strong relationship between the intensity of tobacco-dependence counseling and its effectiveness, the *Guideline* recommends more intensive person-to-person counseling, particularly from experienced tobacco-dependence treatment specialists for smokers needing more help.

In addition to providing funds to update the *Guideline*, the Foundation contributed again to efforts to communicate and implement it. In 2000, it joined the Agency for Healthcare Research and Quality, the American Cancer Society, the Centers for Disease Control and Prevention, and the National Cancer Institute to support development of a plan for putting the *Guideline* into practice. In collaboration with the American Cancer Society, the Foundation also co-funded a new national Cessation Treatment Center, based in Washington, D.C., to guide, monitor, and stimulate efforts to implement the plan.

The Foundation has paid particular attention to developing and disseminating recommendations for pregnant smokers, investing approximately \$25 million over the past ten years in Smoke-Free Families. The program, whose goal is to eliminate smoking during and beyond pregnancy, funds both a National Program Office to support research on treatment innovations and a National Dissemination Office to promote widespread adoption of existing best practices. To assist the panel charged with updating the *Guideline*, in 1998 Robert Goldenberg and Lorraine Klerman, director and codirector respectively of the Smoke-Free Families National Program Office, organized a conference of experts in the field to define the

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key elements of effective treatment in the prenatal setting. As a result of the consensus reached at the conference, the 2000 *Guideline* included the first evidence-based recommendation for pregnant smokers, an adaptation of the 5-As that adds five to ten minutes of counseling from a trained prenatal-care provider and distribution of pregnancy-tailored self-help materials.

According to Ralph W. Hale, executive vice president of the American College of Obstetricians and Gynecologists (ACOG), whose members provide most obstetric care in the United States, “These new guidelines provide confirmation that obstetricians and gynecologists need to make tobacco treatment a routine part of prenatal care.” ACOG has formally endorsed and disseminated these new guidelines to its members.

Building on this endorsement, Cathy Melvin, who directs the Smoke-Free Families National Dissemination Office, worked with the Smoke-Free Families National Program Office, ACOG’s leadership, Robert Wood Johnson Foundation staff members, other funders, and government agencies to form the National Partnership to Help Pregnant Smokers Quit—a group of forty funding, professional, and service organizations that have joined forces to reduce the number of pregnant women who smoke, from an estimated 12–20 percent in 2000 to 2 percent or less by 2010. The Partnership has developed a plan to change practice patterns and health care systems and policies, and to reach pregnant smokers directly through media campaigns.<sup>11</sup> The Partnership was launched in the spring of 2002, and the Foundation is supporting it with a \$5 million grant.

#### BUILDING CAPACITY: MANAGED CARE AND SYSTEMS-BASED APPROACHES

Both the original 1996 tobacco treatment *Guideline* and the 2000 update pointed out that “the success of any tobacco dependence treatment strategy or effort cannot be divorced from the health care system in which it is embedded.” The updated *Guideline* recommends creating a culture in which failure to treat tobacco use constitutes an inappropriate standard of health care; it suggests that:

- Every clinic should have a tobacco-user identification system.
- All health care systems should provide education, resources, and feedback to promote provider interventions.
- Clinical sites should dedicate staff members to provide tobacco-dependence treatment and assess the delivery of this treatment in staff performance evaluations.
- Insurers and managed care organizations should reimburse clinicians and specialists for delivering effective tobacco-dependence treatments.

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These recommendations emphasized that provider training and knowledge of best practices were necessary (but not complete) ingredients for success.

The Foundation's initial capacity-building efforts centered on its six-year Addressing Tobacco in Managed Care program, launched in 1997 to capitalize on the unique potential and growing reach of managed health care plans. This \$7 million national program funds both a National Technical Assistance Office and a program of applied research. The purpose of the National Technical Assistance Office, directed and co-funded by the American Association of Health Plans, is to help institutionalize best-practice tobacco treatments through hands-on technical assistance, an online clearinghouse for practical tools and resource guides, an awards program to recognize tobacco-control leadership, and regular surveys to monitor progress. The research program, codirected by Michael Fiore and Susan Curry, field-tests a variety of promising systems changes under real-world conditions and in varied types of managed care plan.

Both arms of the program have contributed to capacity building. The annual meetings, the awards program, and research grants helped to keep tobacco cessation on managed care's radar screen and quality improvement priority list during turbulent times. Surveys conducted by the American Association of Health Plans in 1997 and 2000 showed increases in the proportion of plans requiring smoking cessation status in patient charts (from 61 to 83 percent); using computerized databases to identify smokers (12 to 27 percent); offering provider tobacco-cessation training (16 to 22 percent); and providing part-time or full-time staff for tobacco control (7 to 23 percent).<sup>12</sup>

The first round of research grants generated new knowledge about the impact of changing the structure of tobacco benefits, provider training and incentives, and other systems.<sup>13</sup> For instance, the Group Health Cooperative (Bob Clement's health plan, with more than six hundred thousand enrollees) launched an initiative to record patient tobacco use status and provider advice to quit as part of an automated billing system. Performance feedback and senior-level incentives were added to foster compliance.

Documentation of tobacco use status rose from 7.5 percent of primary care visits to 82 percent; the number of smokers who, like Clement, were advised to quit, rose in a similarly dramatic manner.

Much has been learned as well from the plans singled out for Tobacco Control Achievement Awards. For instance, building on *Guideline* recommendations, HealthPartners, one of three large managed care organizations in the Minneapolis–St. Paul area, evaluated a series of financial incentives and bonus

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payments on the basis of simple measures and goals. “We made tobacco use a vital sign, and the use of this sign by physicians was a primary goal for financial rewards,” says Leif Solberg, HealthPartners’s research director and longtime tobacco-cessation investigator.

To receive the bonus, a clinical group must document that its members asked at least 80 percent of its patients about their smoking status and that they provided smoking-cessation advice and assessment (the first and second A’s of the 2000 *Guideline*) in 80 percent of the identified smokers. Between 1996 and 1997, the average rate of asking rose from 49 percent to 56 percent, while the rate of quit-smoking advice increased even more substantially. “Although none of the groups earned the bonus the first year, several came very close and most came to us wanting to learn how to put more effective smoking-cessation systems in place,” Solberg says. “It was clear that providing the measurement tools and the financial incentives was playing out as we had hoped it would.” Two years later, four medical groups received bonuses.

More important, HealthPartners’ efforts were having a positive effect on smokers. Nearly 17 percent of the organization’s smokers reported having quit during the first sixteen months of the system’s installation, compared with only 3.7 percent in the sixteen months before this system started. A follow-up analysis showed that four and a half years after the system was installed, 25 percent of the smokers surveyed had not had a cigarette since their last contact with their primary care clinic, and a third of those who quit had not been smoking for at least a year.<sup>14</sup>

To cut down smoking by pregnant women, Aetna U.S. Healthcare, a 2001 National Tobacco Control Achievement Award recipient, encouraged all of its obstetrical care providers to promote smoking cessation at each patient visit as part of a coordinated, systems-based maternity management program. The program offered pregnant smokers an individualized cessation regimen and provided self-help materials, a video, and a series of follow-up mailings. Forty-five percent of the women who took part quit smoking completely, and 36 percent cut their daily smoking by half or more.

To help ensure that every American prenatal-care provider has similar tools, training, and technical assistance, the Smoke-Free Families National Dissemination Office maintains a Web-based clearinghouse of materials, pregnancy-tailored self-help quitting aids, and links to other organizations offering training. The office is conducting limited studies of systems changes and policy changes and has joined with other

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members of the National Partnership to Help Pregnant Smokers Quit to provide onsite technical assistance to practitioners and administrators in a variety of health care systems across the country.

### BOOSTING MARKET DEMAND AMONG HEALTH CARE PURCHASERS, POLICY-MAKERS AND CONSUMERS

Unless there is a demand, or market pull, for tobacco-cessation interventions, neither strengthening the science base nor increasing the capacity of the health care system to deliver effective interventions is going to create the widespread use of smoking-cessation therapy that is needed to reduce the smoking rate substantially. Unless health care purchasers—from companies and governments to individuals—and policy-makers reward providers and health plans for making tobacco intervention a priority, physicians and health plans have little incentive to invest in closing the gap that now exists between what we know and what we do. Without clear economic incentives or consumer demand, purchasers and policy-makers have found little cause to reimburse or mandate best-practice care for nicotine addiction.

The efforts of the Robert Wood Johnson Foundation to stimulate market demand began with work to make tobacco intervention one of the core measures used by the National Committee on Quality Assurance (NCQA) to grade overall health plan quality for its annual Health Plan Employer Data and Information Set, or HEDIS, report cards. NCQA, a not-for-profit organization often referred to as the watchdog of the managed care industry, developed the HEDIS report card to help health care buyers select the highest-quality health plans.

In 1995, through a Robert Wood Johnson Foundation grant to the Center for the Advancement of Health, more than four hundred tobacco-control researchers and public health and managed care leaders across the country were surveyed about the best empirically based tobacco measures for use in the HEDIS report card. The consensus favored measuring whether health plans routinely asked about and recorded tobacco use. But since this would require costly chart audits, NCQA chose another of the options recommended: asking HMO-enrolled smokers participating in the annual HEDIS survey if they had been advised by any provider to quit in the past year. Tobacco-cessation experts were ecstatic. “This was the first time there was anything having to do with a behavioral risk factor being put into HEDIS, so it was a huge change,” says Corinne Husten, epidemiology branch chief in the CDC’s Office on Smoking and Health. “The *Guideline* and HEDIS are playing off each other—health plans want to look good on the HEDIS measures, and they can turn to the *Guideline* for help.”

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Although the HEDIS report card was not as successful as had been hoped in propelling a shift from cost-based to quality-based health care purchasing overall, HEDIS measures were believed to help advance quality improvement efforts in several areas, including tobacco intervention. The tobacco-reporting measure was adopted by HEDIS in 1996, and first reports appeared in 1997. In 1997, in the 375 or so HMOs that report their HEDIS scores, the percentage of smokers who received advice to quit was 61 percent—about 10 percent higher than in the population as a whole. By 2002, the percentage had risen to 65 percent. The Robert Wood Johnson Foundation funded a small study in 1999 exploring how to strengthen the HEDIS tobacco measure by asking patients not just whether they had received advice (the first A in the 5-A approach) but also whether they had received any assistance (the fourth A) in the form of counseling or medication. NCQA formally adopted this new measure—that is, asking smokers whether their health plans offered them tobacco-cessation counseling or medication—in the spring of 2002.

One way to get smokers to quit is to reduce their out-of-pocket costs for insurance copayments, treatment, and pharmaceuticals. The HEDIS tobacco measure, combined with the advocacy of committed managed care leaders, has been credited with reducing copayments for best-practice treatments among smokers enrolled in managed care. There was no reliable national baseline before 1996, but a survey conducted by the American Association of Health Plans in 1997 found that 75 percent of managed care plans were offering full coverage for at least one component of *Guideline*-based counseling or pharmacotherapy—a rate much higher than that reported for indemnity insurers. By 2000, this had risen to 94 percent.<sup>15</sup>

To highlight the need for similar expansion in Medicaid coverage, the Robert Wood Johnson Foundation has funded annual surveys of Medicaid tobacco-dependence treatment coverage since 1998. Although in 1998 all fifty state Medicaid programs covered the costs of treating lung cancer, and forty-six states had sued the tobacco industry to recover these and other tobacco-related Medicaid costs, only twenty-four states then provided any reimbursement for proven tobacco-cessation treatments. Systematically publicizing annual state survey data helped to raise the visibility of these discrepancies and drew attention to the need for expansion of coverage. In 2000, the number of states providing some coverage had risen to thirty-three, although only thirteen provided coverage for the nonmedication counseling services appropriate for most pregnant smokers.<sup>16</sup>

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Another way the Foundation sought to stimulate market pull was by clarifying the business case for smoking-cessation programs among public and private health care purchasers, including employers.

Nowhere is the business case stronger than for pregnant smokers: every dollar spent on the 5-A intervention for a pregnant smoker saves about three dollars in reduced neonatal intensive care costs. Cathy Melvin, director of the Smoke-Free Families' Dissemination Office, and Kathleen Adams, an Emory University health economist, were convinced that giving states and health plans a clear picture of their actual costs could make a difference, so they set about making the most of this potential payoff. "No one had ever truly done an estimate of what it costs each year, in direct health care dollars, for pregnant women to smoke," Melvin said. "We wanted to raise awareness of those costs, and to be able to use these estimates to demonstrate the cost-effectiveness of treatment." With funds from the Robert Wood Johnson Foundation, the two researchers developed software (now available through the CDC) that a state, region, or health plan can use to estimate the actual costs of smoking during pregnancy and the potential short-term savings that it could realize.

To help document the business case for employers, the Foundation funded Kenneth Warner, a University of Michigan health economist, to develop a detailed cost-benefit analysis for employers.<sup>17</sup> This study found that a smoking-cessation program returns a third of its costs in the first year through lower health care expenditures and reduced absenteeism and breaks even after about three years—a period shorter than the three-and-a-half-year tenure of the average employee in the United States. Yet a 1997 survey funded by the Foundation and conducted by the Partnership for Prevention, a Washington, D.C.-based organization that works to increase the resources for disease prevention and promotion, found that not even a third of employers offered insurance coverage for smoking cessation.<sup>18</sup> These studies point to the need for new efforts aimed at employers, who select and shape the health benefits for more than 152 million employees and their families. In a follow-up survey co-funded by the Robert Wood Johnson Foundation and the CDC, the Partnership for Prevention is investigating how best to motivate employers to expand their smoking restrictions and treatment benefits.

But of all the activities needed to increase market pull, perhaps the most important and most neglected is translating the smoker's desires to quit into a demand for proven treatment services. Pregnant smokers are a prime example. Despite the evidence of the effectiveness of a counseling-centered 5-A approach, and the strong interest of prenatal-care providers in offering this help, significant barriers to the demand for treatment exist among the smokers themselves, according to focus groups conducted by the public

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relations firm Porter Novelli. “Pregnant smokers told us that they knew the risks of smoking to themselves and their babies, but they didn’t believe any real help was available to them, especially not from their doctors or nurses.” said Ed Maibach, director of social marketing at Porter Novelli. “Most felt that their prenatal-care providers would give them more ‘attitude’ than empathy or real help to quit. As a result, several didn’t even confess to being smokers.”

Increasing demand of pregnant smokers will require promotions and campaigns that create an expectation of real and nonjudgmental help, along with parallel efforts to steer providers away from guilt- and fear-arousing tactics toward empathy and effective counseling. A marketing initiative, soon to be launched by Smoke-Free Families and Porter Novelli for the National Partnership to Help Pregnant Smokers Quit, will aim at doing just that.

Pregnant smokers aren’t the only ones who do not ask about effective treatment. Many people, it appears, do not realize that smoking-cessation treatment may be covered by insurance. A study conducted jointly by Blue Cross Blue Shield of Minnesota and Minnesota-based HealthPartners under the Addressing Tobacco in Managed Care program found that only a minority of eligible smokers who were offered expanded coverage for Zyban and nicotine replacement actually made use of the benefit. Another Addressing Tobacco in Managed Care study found that providers did not consistently encourage the smokers they saw to take advantage of health plan benefits. Similarly, surveys of patients and providers in two states with very broad Medicaid coverage (nicotine gum, patch, Zyban, and counseling), conducted as part of the year 2001 Medicaid coverage survey, found that the vast majority of patients and providers were unaware of the benefits available.<sup>19</sup> “These findings are disturbing,” says Helen Schaffler, who directed the survey. “These states have adopted the most effective policies, but this is all for naught if providers and patients don’t even know about them.”

### Lessons Learned and Challenges Ahead

Perhaps the most important lesson from the Foundation’s work to close the gap between best practice and usual care in tobacco cessation has been that major change is unlikely to come about quickly or from efforts on any single front. Instead, closing the gap takes a combination of improving the scientific basis for and knowledge of effective tobacco-cessation treatments, building the capacity of health care systems to deliver proven best practices, and building a market and a demand for them. There has been encouraging progress on each front, but major change requires sustained, coordinated efforts across the board. As with most social issues, the investments of a single funder pale in comparison to the

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investment of government and to the need. Most foundations work by leverage. This includes not only strategic partnering but also finding the right points, such as the HEDIS tobacco measure, that can lead to an across-the-board domino effect. Several other, more specific, lessons have emerged as well:

- Scientific evidence alone cannot motivate practice or policy. In the tobacco treatment area, just having a *Guideline* has not been enough. Behind each of the changes linked to the *Guideline* (such as the HEDIS measure or expanded Medicaid and managed care treatment coverage) has been a focused and deliberate effort to translate the science of the *Guideline* into a rationale for practice improvement or policy change.
- The difficulty that many providers have in translating research done in an idealized clinical setting into their own real-world practice has made it clear that we need to work more creatively not only to get research into practice and also to get practice into research, so that interventions are designed *from the beginning* to fit the constraints and capitalize on the unique resources of the actual practice setting.
- Capacity building in a broken health care system is hard, and major systems change—even systems overhaul—is essential if treating tobacco addiction is to become a part of routine health care. This is the same conclusion reached by the 2001 Institute of Medicine report *Crossing the Quality Chasm*, which decried a health care financing and reimbursement system that is “toxic to prevention.”<sup>20</sup>
- The experience of trying to increase the use of tobacco-dependence treatments by the majority of smokers who try to quit has underscored the need to find new ways to build consumer demand and to make a stronger (or clearer) business case for best practices. Judging from recent consumer-driven expansion in coverage for and use of complementary medicine remedies, focusing more on the consumer seems essential. If we are serious about creating more people like Bob Clement, smokers must be actively involved in efforts to improve access to, and use of, proven treatments. Boosting consumer demand requires doing a better job of promoting the treatments that already exist as well as making them more effective and appealing.
- Finally, the past two decades of research have given us not just the federal clinical practice *Guideline* for helping addicted smokers quit, but also a new set of community guidelines for broader strategies to promote cessation, including raising tobacco prices, strengthening smoking restrictions, launching media campaigns, and reducing smokers’ out-of-pocket costs for proven cessation treatments.<sup>21</sup> The Foundation’s continuing goal and challenge will be to expand the implementation of both sets of guidelines and to find creative ways to capitalize on the synergy between proven clinical, public health, and policy approaches to prevention and cessation. Only through such a comprehensive approach can we achieve the goals of preventing tobacco-caused death and disease, and improving health and health care for all Americans.

## Notes

<sup>1</sup> “Bob Clement” is a pseudonym.

<sup>2</sup> *Substance Abuse: The Nation’s Number One Problem. Key Indicators for Policy.* The Robert Wood Johnson Foundation, 1995.

<sup>3</sup> Centers for Disease Control and Prevention. “Cigarette Smoking Among Adults—United States, 1995.” *Morbidity and Mortality Weekly Report*, 1997, 46, 1217–1220.

<sup>4</sup> Fiore MC and others (Tobacco Use and Dependence Clinical Practice Guideline Panel, Staff, and Consortium Representatives). “A Clinical Practice Guideline for Treating Tobacco Use and Dependence: A U.S. Public Health Service Report.” *Journal of the American Medical Association*, 2000, 283, 3244–3254.

<sup>5</sup> U.S. Public Health Service. “Treating Tobacco Use and Dependence: A Clinical Practice Guideline.” (AHRQ publication no. 00–0032) U.S. Department of Health and Human Services, 2000. ([www.ahrq.gov](http://www.ahrq.gov))

<sup>6</sup> National Cancer Institute. “Population-Based Smoking Cessation.” (NIH publication no. 00–4892) U.S. Department of Health and Human Services, 2000.

<sup>7</sup> Ferry LH, Grission LM and Rinfola PS. “Tobacco-Dependence Curricula in U.S. Undergraduate Medical Education.” *Journal of the American Medical Association*, 1999, 282, 825–832.

<sup>8</sup> Warner K, Smith R, Smith D and Fries B. “Health and Economic Implications of a Worksite Smoking-Cessation Program: A Simulation Analysis.” *Journal of Occupational and Environmental Medicine*, 1996, 38, 981–992; Harris, J. and others, “Expanding Health Insurance Coverage for Smoking Cessation Treatments,” *American Journal of Health Promotion*, 2001, 15, 350–356.

<sup>9</sup> *Substance Abuse ...* (1995).

<sup>10</sup> Kottke T and others. “Attributes of Successful Smoking Cessation Interventions in Medical Practice: A Meta-Analysis of 39 Controlled Trials.” *Journal of the American Medical Association*, 1988, 259, 2883–2889.

<sup>11</sup> “National Partnership to Help Pregnant Smokers Quit: Action Plan.” (Unpublished) The Robert Wood Johnson Foundation, 2002.

<sup>12</sup> McPhillips-Tangum C. “Results from the First Annual Survey on Addressing Tobacco in Managed Care.” *Tobacco Control*, supplement to vol. 7, S11–13, 1998; McPhillips-Tangum C. “Addressing Tobacco in Managed Care Survey of Health Plans.” Paper presented at the fourth annual Addressing Tobacco in Managed Care conference, Nashville, Tenn., February, 2001.

<sup>13</sup> Curry S and others. “Addressing Tobacco in Managed Care,” *Nicotine and Tobacco Research*, 2002, 4 Supp: S1–S45.

<sup>14</sup> Ibid.

<sup>15</sup> McPhillips-Tangum C (1998 and 2001).

<sup>16</sup> Centers for Disease Control. “State Medicaid Coverage for Tobacco- Dependence Treatments—United States, 1998 and 2000.” *Morbidity and Mortality Weekly Report*, 2001, 50, 979–982.

<sup>17</sup> Warner, Smith, Smith and Fries (1996).

<sup>18</sup> Partnership for Prevention. “Why Invest in Disease Prevention?” Washington, D.C.: 1999.

<sup>19</sup> Mordavsky J and others. “Coverage of Tobacco Dependence Treatments for Pregnant Women Under Medicaid and for Children and Parents Under EPSDT.” *American Journal of Public Health*, in press.

<sup>20</sup> Institute of Medicine. *Crossing the Chasm: A New Health System for the 21<sup>st</sup> Century*. Washington, D.C.: National Academy Press, 2001.

<sup>21</sup> Centers for Disease Control. “The Guide to Community Preventive Services: Tobacco Use and Prevention. Reviews, Recommendations, and Expert Commentary.” *American Journal of Preventive Medicine*, supplement to vol. 20, 2002.

## FIGURES

### 6.1 Getting Evidence-Based Tobacco Treatments into Practice