
Community-Level Tobacco Interventions

Perspective of Managed Care

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The work of the Task Force on Community Preventive Services (TFCPS) is an impressive contribution to the growing body of rigorous, evidence-based recommendations to reduce the prevalence of tobacco use and exposure to environmental tobacco smoke. As is pointed out often and in many contexts, rates of tobacco use are unacceptably high in this country, and it remains the largest contributor to premature morbidity and mortality from tobacco-related diseases. It is not surprising that rigorous evidence reviews result in comparable recommendations. The TFCPS's health care system-level recommendations are similar to those in the recently published U.S. Public Health Service (PHS) clinical practice guideline on treating tobacco use and dependence¹ and they address the critical elements of effective tobacco control strategies at the individual, practice, and organizational levels.² At the individual level, the TFCPS recommends multicomponent programs (e.g., counseling and pharmacotherapy) that include telephone support. At the practice level, the TFCPS recommends the use of provider reminders such as chart stickers and vital sign stamps, as well as provider education on how to motivate and reinforce smokers for efforts to quit tobacco use. At the organizational level, the TFCPS recommends reducing patient costs for effective treatments. Strategies at each of these levels are necessary to achieve the full promise of health care system efforts to reduce tobacco use prevalence.

Managed care organizations (MCOs) are poised to be leaders in implementing these evidence-based guidelines and recommendations. A cornerstone of managed care has been its clinical preventive care focus. Although there are many different permutations of "managed care," at a minimum, MCOs have service delivery systems with an identifiable group of accountable primary care providers to whom they can provide performance incentives and/or reimbursement for addressing tobacco use. MCOs also have centralized resources for quality improvement that include staff and

systems to review and customize evidence-based guidelines and to conduct provider education. Finally, MCOs' centralized data systems can be adapted for population-based tracking registries and to provide feedback on practice patterns. Moreover, MCOs are motivated to implement tobacco guidelines when accreditation organizations such as the National Committee on Quality Assurance include tobacco-related measures such as smoking-cessation advice as benchmarks for quality of care.

Unfortunately, implementation of tobacco-related, evidence-based guidelines has been less than optimal. A recent national survey of MCOs found that less than 10% of the respondents had fully implemented the recommendations included in the 1996 Agency for Health Care Policy and Research (AHCPR; since 1999, the Agency for Healthcare Research and Quality [AHRQ]) clinical practice guideline, and an additional 39% reported partial implementation.³ There are several important barriers to full implementation.

First, a formidable barrier at the organizational level is the concern about costs. The capacity to implement the recommended practice-based systems and individual-level benefits and services costs money. Decision-makers need information on intervention and system costs as well as on the timeline for and amount of cost savings that may accrue as a result of their investments. Costs associated with providing physician advice, behavioral counseling, and pharmacotherapy have been documented.⁴ Compared to other medical treatments, smoking-cessation interventions are a tremendous bargain when assessed through cost-effectiveness analysis. Less studied are patterns of health care utilization and costs among continuing smokers compared to those who quit. Available data indicate higher utilization and costs among quitters in the index year they quit, which likely reflects negative health events as motivators for cessation. This trend reverses within 4 to 5 years, as continuing smokers' costs and utilization increase and quitters' utilization and costs go down and stabilize over time.⁵ Because of health plan attrition among MCO patients, many MCOs do not believe that the patients who take advantage of their tobacco services will stay with them long enough for the MCO to realize any cost savings. There appears to be little data on patient turnover in managed care. However, given a finite

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number of local managed care plans, even with high rates of turnover, it is likely that patients move in and out of the same plans. Thus, many former smokers may leave and subsequently return to the managed care plan, in time for the MCO to benefit from their reduced health care costs.

Second, data on rates of utilization of smoking-cessation services are lacking. It is ironic that many MCOs avoid coverage of smoking-cessation services both because they believe that the demand would be high and costly, and because patients and providers do not demand such services.

A third important barrier is the perception that the effectiveness of most smoking-cessation services is limited. This belief persists even though numerous evidence reviews consistently identified behavioral and pharmacologic treatments as highly effective (i.e., that there are multiple relevant and well-designed randomized clinical trials that yield a consistent pattern of results). It appears that the standards of evidence and success that are applied to smoking-cessation services are often more stringent than those applied to investments in other medical treatments.

Lack of investment by health care organizations in practice-based systems and in patient benefits contributes to the major barriers at the front lines of clinical practice. Low confidence because of limited training and/or treatment resources for their patients, time constraints, no reimbursement or performance incentives for addressing tobacco use, and the absence of supportive infrastructure (e.g., tracking systems) diminish the chances that physicians will screen for and intervene with tobacco users.

Despite these barriers, we are optimistic that health care systems can expand their efforts and resources for interventions to reduce tobacco use. The release of evidence-based recommendations like those of the TFCPS does spur the efforts of MCOs, which can, in turn, lead to additional outside resources for their efforts. The Robert Wood Johnson Foundation's national program initiative, Addressing Tobacco in Managed Care (ATMC), is a prime example of this synergy. This program was launched in response to a high volume of interest among MCOs in evaluating system-level innovations to facilitate implementation of the AHRQ's smoking-cessation guideline. This two-part program includes a national technical assistance office and a grants program.

The technical assistance office, under the direction of the American Association of Health Plans, provides technical assistance to health plans that wish to develop tobacco-cessation programming, conducts a benchmarking awards program to highlight exemplary initiatives by health plans in tobacco cessation, conducts a

biennial survey of health plans to determine practices related to the AHRQ smoking-cessation guideline, and promotes best practices through training workshops and national and regional conferences. Representatives from numerous MCOs have attended the annual ATMC conferences, and the response to the benchmarking awards program has been very enthusiastic.

The grant program's national program office is based at the University of Wisconsin in partnership with the Center for Health Studies at Group Health Cooperative. ATMC grants support the evaluation of organizational policies and practices that lead health care providers, practices, and plans to adopt and adhere to the recommendations of the AHRQ's *Smoking Cessation Clinical Practice* guideline⁶ (also available at www.ahrq.gov) and the recently released PHS guideline, *Treating Tobacco Use and Dependence*.¹ Currently, the program funds eleven 12-month planning grants and four 2–3-year evaluation grants. The projects funded under this initiative are examining the impact of a variety of organizational strategies (including clinical, financial, and administrative practices) on such outcomes as smoker identification, tobacco-use reduction among patients, rates of clinician intervention, and costs of intervention efforts. A second round of planning and evaluation grants will begin in fall 2001. This program of research spans the full spectrum of MCO models so that results may benefit a wide range of providers and health plans.

Other important initiatives include systems-level research funded as part of the National Cancer Institute's Cancer Research Network and translational research sponsored by the AHRQ. As the results of these evaluation efforts are published in the public domain, they will enhance the ability of future task force efforts such as the TFCPS to recommend a broad range of feasible and proven strategies for health care systems to effectively reduce tobacco use among their patients.

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