Realignment of the Nation's Tobacco Agenda: The Need to Treat Tobacco Dependence

Ad Hoc Working Group on Treatment of Tobacco Dependence

Background. Tobacco use remains the leading cause of preventable death in the United States. Although comprehensive tobacco control has a number of essential components, support for cessation services can yield the largest short-term public health benefit. While effective treatments for tobacco dependence do exist, they are not currently available to many of the tobacco users who want and need them. Finding cost-effective, science-based strategies for reducing tobacco dependence in the United States should be a national priority.

Methods. Late in 1997 a group of experts in the science of tobacco control was convened by the Center for the Advancement of Health to develop recommendations regarding the use of federal funds for treating tobacco dependence. These recommendations were prepared based on the priority of the actions and the estimated cost and effort required to implement them. Following the Master Settlement Agreement in 1998, the recommendations were adapted to address the needs of state policy makers.

Results. Effective treatments for tobacco dependence do exist; however, our nation currently lacks the capacity to deliver these services to the many millions who require them. There is a compelling need for funding from a variety of sources to create this capacity.

Conclusions. The priority must be to develop the systems, competencies, and resources needed to deliver, and to monitor the delivery of, evidence-based treatments to tobacco users. Treatment must be delivered in an integrated manner, consistent with the needs of tobacco users. Additionally, financial barriers to treatment must be reduced, and consistent, high-quality treatment services must be ensured for all tobacco users who seek them.

Key Words: tobacco dependence; tobacco use cessation; research priorities; resource allocation; public policy.
METHODS

Late in 1997, a group of experts in tobacco control was convened by the Center for the Advancement of Health through a grant from SmithKline Beecham Consumer Healthcare. Members of this group represented leading researchers and administrators with expertise in addiction, tobacco-related diseases, health behavior and outcomes, health care economics, and health care policy. Many members had served on advisory panels and committees to public and private organizations concerned with tobacco control.

The group engaged in a process of systematically reviewing the available information on the individual and public health costs and outcomes of tobacco use and cessation. Evidence was collected on the range of services available to treat tobacco dependence and assist in tobacco use cessation. Current data were also collected on tobacco use and addiction, the public health costs of continued usage, the estimated cost of providing cessation services, and the availability of such services to tobacco users. The group compiled these data and examined them to assess gaps between tobacco users' desires for cessation services and access to them and the most effective ways to address those gaps.

RESULTS AND RECOMMENDATIONS

State and federal legislation and/or executive action are needed to appropriate and allocate funds from a variety of sources (particularly tobacco settlement funds and tobacco tax revenues) to build and maintain the capacity of health care systems to deliver, as a part of routine care, effective tobacco-use treatment interventions to all who use tobacco products. Funds allocated for tobacco-use cessation should be divided among the following: basic treatment services, delivered within traditional health care settings; intensive treatment services, delivered by health professionals trained specifically in addiction treatment; quality assurance for the services that are delivered; and research and policy to develop more effective cessation services and increase the range of incentives for abstinence from tobacco use.

A. Basic Tobacco Dependence Treatment Interventions

It is recommended that approximately 60% of funds designated for tobacco use cessation be allocated to support basic treatment interventions that:

- promote evidence-based interventions as the standard of care for all clinicians;

4 The Center for the Advancement of Health has recently published a review of the evidence for smoking cessation. Copies of these evidence tables and study abstracts may be obtained from the Center.
• implement tobacco-user identification and monitoring systems in every office and clinic and ensure that clinicians and patients have needed treatment resources (e.g., staff trained to integrate tobacco use interventions into clinical services, reminder systems, and efficacious, evidence-based patient aids and pharmacotherapies);
• provide for treatment that can be accessed outside of the standard health care system, including telephone helplines and FDA-approved nonprescription medications.

Funding should be provided to establish and maintain this basic level of treatment for all tobacco users in all health care settings, including nontraditional settings such as school and workplace-based clinics and community health centers and public systems such as the Indian Health Service, military and Veterans' Affairs, Medicare, and Medicaid. The basic recommendation, then, is that all health care clinicians (including physicians, nurses, dentists, hygienists, pharmacists, respiratory therapists, health counselors, etc.) take the following steps with all patients:

- Ask—systematically identify tobacco use at every visit;
- Advise—strongly urge all tobacco users to quit;
- Assist—with brief (3–5 minutes) behavioral counseling, the provision of treatment materials, and the recommendation/prescription of appropriate pharmacotherapy;
- Arrange—follow-up support/referral to more intensive treatments if needed;
- Anticipate—assess and intervene to reduce the risk for tobacco use in children.

Rationale. Seventy percent of smokers see a clinician each year [17]. If clinicians provided brief interventions to all smokers, the national annual quit rate could be more than doubled [18]. The addition of brief behavioral counseling and pharmacotherapy could more than triple the annual quit rate [19,20]. Because basic interventions can have such a powerful effect at the population level, they are already promoted as the standard of care by health organizations including the National Committee for Quality Assurance, the American Medical Association, the American Academy of Family Physicians, the National Cancer Institute, and the American Cancer Society. In addition, basic services are both inexpensive and cost-effective: the Centers for Disease Control and Prevention estimates the cost of identification and brief counseling to be $3 per smoker [21].

Investing in developing the capacity for delivering a basic level of treatment intervention, in addition to paying individual clinicians for each encounter, is important for three reasons. First, the current health care system lacks, at many levels, the capacity to treat smokers effectively. Second, funds from tobacco settlements or taxes are not likely to be available in perpetuity, so systemic changes are needed to ensure that service delivery continues when the funds are depleted. Finally, insurers and health plans will be more likely to provide incentives to providers if they can be assured that good quality, effective interventions will be delivered by trained clinicians.

Funding should support the systems, competencies, and resources needed to incorporate this standard of care into basic medical care. For instance, funds allocated to publicly and privately funded health care systems, clinics, provider organizations, and health plans should ensure that:

• clinicians understand recommendations for, and are trained to deliver, basic treatment services;
• clinicians and patients have access to a range of treatment resources, from the Public Health Service guideline for smoking cessation, to resources provided by state and local health departments and organizations;
• every office and clinic maintains tobacco-user identification and monitoring systems to evaluate the degree to which health care systems are meeting the basic standard of care.

B. Intensive Tobacco Dependence Treatment Interventions

It is recommended that an additional 20–25 percent of treatment funds be used to develop the capacity to deliver intensive treatment services to certain smokers and to ensure access to treatment services for underserved populations. This would include:

• referral protocols for smokers needing more intensive treatment;
• training for providers to deliver more intensive treatments;
• training and/or certification to encourage and enable the provision of targeted interventions to individuals with varying backgrounds and treatment needs;
• reimbursement for delivery of intensive treatment to low-income, uninsured, and publicly insured populations.

Building the capacity to provide intensive treatment will require training practitioners to address ways in which to meet individual patient needs. Model programs should be funded as well and should include programs tailored to serve specific cultural groups and patients with various physical and psychological health risks and conditions.

Rationale. While basic, low-cost interventions in medical and consumer settings are likely to reach the majority of tobacco users, yielding by far the largest
number of quitters, many tobacco users will require
more intensive treatment services. Those in need of
intensive treatment are often tobacco users with in-
creased health risks, (e.g., pregnancy, alcohol and other
dependency problems, psychiatric comorbidities, life-
or limb-threatening tobacco-related diseases), making
intensive intervention particularly cost-effective [22].
In these cases, treatment should be readily accessible
through providers with demonstrated proficiency in
treating tobacco dependence.

Providing intensive treatment requires knowledge of
the patient’s tobacco dependence and previous quit at-
tempts, the patient's physical and psychological health
status, pharmacologic treatment options, counseling
and other behavioral support techniques, and criteria
for determining the type and scope of treatment re-
quired. In general, intensive treatments involve a com-
bination of components, including multiple treatment
encounters, application of both behavioral and pharma-
cological interventions, individual or group counseling
and follow-up, and treatment of coexisting physical or
psychological conditions.

Funds also should be made available to reduce finan-
cial barriers to accessing treatment by reimbursing the
delivery of intensive treatments through Medicare and
Medicaid, the Indian Health Service, and HRSA-
supported clinics and health departments, as well as for
people who lack health insurance coverage. In addition,
studies should be funded to determine whether health
plans and third-party payers would be encouraged to
establish or expand and maintain coverage for treat-
ment services if incentive programs—such as state or
federal regulations, inclusion in health plan accredita-
tion or reporting indices, or appropriation of tobacco
settlement monies—were established.

C. Enhancing Quality of Treatment Services

It is recommended that another 10–15% of treatment
funds be allocated to assure the quality of both basic
and intensive treatment services by establishing pro-
cedures for:

- ensuring that treatment is guided by the best avail-
  able effectiveness and cost-effectiveness data;
- developing curricula for training and/or certifying
  health professionals in the skills and knowledge needed
to deliver basic and intensive treatment services;
- monitoring program impact.

The proportions of allocations recommended here
apply to the current need for capacity-building; these
proportions should be altered over time to respond to
changing circumstances.

Rationale. Systems should be put into place to en-
sure that both basic and intensive treatments are of
the highest quality and represent state-of-the-art mo-
dalities. The current best evidence regarding efficacious
treatment methods is summarized in the 2000 Public
Health Service clinical practice guideline. However, it
is not clear that these interventions are being widely
implemented. At the same time, treatments with little
or no evidence to support their efficacy (e.g., lobeline
sulfate and its varieties) are being marketed [23]. Mech-
анisms must be developed to ensure that funds are not
diverted to unproven or ineffective treatments. Also, a
mechanism should be established to update and pro-
mulgate new treatment guidelines as more effective
 treatments become available.

Quality assurance also entails ensuring access to pro-
viders who are knowledgeable and proficient in deliv-
ering state-of-the-art treatments. Health professions
educational curricula generally do not include formal
programs or clinical training in the treatment of tobacco
dependence, nor are there standardized criteria for con-
tinuing medical education or training. Treatment of
tobacco dependence should be a standard component
of the training of physicians and nurses, dentists and
hygienists, pharmacists, health counselors, and allied
health professionals.

There is currently no way for consumers, third-party
payers, and health systems to determine whether indi-
vidual practitioners possess the requisite knowledge
and skills to provide high-quality treatment services.
Given the need to provide quality care, it is essential
that proficiency standards be established at the na-
tional level. The Secretary of Health and Human Ser-
tices should be directed to develop such standards and
to provide states with models for adaptation and adop-
tion of such standards; this should include standards
for training and certification or licensing of health pro-
fessionals and others engaged in the delivery of treat-
ment services.

Activities are also needed to promote the use of qual-
ity control measures for both voluntary and mandatory
treatment programs. These should be integrated with
existing quality control measures (e.g., HEDIS indica-
tors) for other clinical interventions. Monitoring will
allow feedback to providers, health systems administra-
tors, purchasers, regulatory agencies, and accrediting
organizations to assess the quality of treatment ser-
vices being provided. Therefore, funding for programs
should be contingent upon the incorporation of reason-
able monitoring methods into service delivery.

D. Related Needs

Finally, it is recommended that 5–10% of funds allo-
cated to the treatment of tobacco dependence be used
to support other research and policy efforts. Substantial
portions of all funds allocated for biomedical and behav-
ioral research should be dedicated to developing in-
creasingly effective tobacco treatment interventions,
particularly for underserved and high-risk populations. In addition, broader tobacco prevention and control activities, such as media campaigns and policy changes, should incorporate tobacco dependence treatment strategies.

Rationale. Research into the processes of tobacco dependence and its treatment has greatly advanced our ability to help smokers quit [24], and research on nicotine and tobacco can significantly benefit public health [25]. However, the level of funding currently devoted to tobacco-use research is insufficient relative to the public health costs of continued tobacco use [26]. Many national and international organizations concerned with public health—including the National Cancer Institute, the World Health Organization, Health Canada, and others—have set priorities for tobacco use research, based on extensive literature reviews and consultative processes, which include improving options for and delivery of treatment services. For example, research has been sparse on the treatment needs of specific populations of tobacco users, and existing treatment methods may be ineffective or unacceptable for some tobacco users. Funds should therefore be leveraged from a variety of sources to support continued research in the following areas:

- assessing and treating tobacco-dependent youth [27], with attention to the different forms of tobacco used, (e.g., smokeless tobacco, cigarettes, cigars, and bidis5) [28];
- enhancing treatment effectiveness among other high-risk or poorly studied populations, including racial and ethnic minorities [29], the elderly, and women [30,31] (particularly during pregnancy [32]);
- increasing the understanding of tobacco dependence and treatment among users of smokeless tobacco, cigars, and pipes [33];
- evaluating new and innovative approaches including more intensive behavioral therapies, new pharmacotherapies, and combination therapies [34];
- expanding the acceptability, reach, and utilization of, as well as adherence to, treatment programs [35];
- increasing the understanding around the reasons why treatment programs and quit attempts may fail [36,37];
- improving the integration of relevant treatment services into general health care settings;
- providing incentives to practitioners to deliver effective treatments.

It is critical that new funds for treatment research expand the research funding pool and not be diverted from or used to replace existing funds.

In order to increase tobacco users' interest in quitting and to better support their current desires and efforts to do so, clinical interventions need to be coordinated with broader tobacco-use prevention and control activities. Activities which would be likely to increase interest in quitting among tobacco users include, as examples:

- media messages, which should not only advocate against initiation of the use of tobacco products, but also promote available behavioral and pharmacological treatments for tobacco dependence; local media messages should provide information on how to access support services such as treatment clinics and hotlines;
- policy changes, which should include clean indoor air laws and an increase in the price of cigarettes;
- worksite smoking bans, which could be accompanied by incentives such as reduced health care premiums for nonsmokers.

Finally, smokers' access to proven interventions, particularly for those smokers who do not regularly use the health care system, could be improved by increasing funding for public health interventions such as telephone hotlines, counseling services, and referral services to existing providers.

CONCLUSION

We can make a dramatic impact on the overall rate of tobacco use and tobacco-related diseases in this country by delivering low-cost, low-intensity interventions to large numbers of smokers using existing health care channels. Attention to tobacco use should be as routine as attention to blood pressure during all medical encounters.

Many smokers will require more intensive treatment from trained providers—particularly those smokers with more severe addictions, with psychiatric comorbidities, or facing illnesses or other factors complicating their care. It is especially critical that effective interventions be available to smokers with conditions such as cardiac disease, vascular disease, or diabetes, where immediate reduction in smoking is necessary in the management of the condition.

Unfortunately, our nation currently lacks the capacity to deliver effective basic and intensive treatments to all those who need them. State and federal policy makers thus have an important obligation to allocate funds to improve the delivery of tobacco dependence treatment services, and in allocating these funds, the highest priority must be assigned to developing the systems, competencies, and resources needed to deliver and monitor integrated, evidence-based treatments to tobacco users.

5 Bidis are small, brown cigarettes made in countries in southeast Asia in which tobacco is rolled in tendu or temburi leaves instead of paper; they often come in appealing flavors, such as chocolate and mango, and they are popular among youth. Typically, bidis deliver more carbon monoxide, tar, and nicotine than other cigarettes.
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