Challenges and opportunities for tobacco control: the Robert Wood Johnson Foundation agenda

C Tracy Orleans

On behalf of my colleagues at the Robert Wood Johnson foundation, let me say that we are very pleased to help support this conference—the first in a series of conferences to recognise and stimulate innovation in the prevention and treatment of tobacco addiction in managed care. It is gratifying to see so many people here who share the vision of an expanded role for managed care in tobacco control.

I should like to examine, from the perspective of the Robert Wood Johnson Foundation tobacco portfolio, where managed care interventions fit in the larger national tobacco control agenda, and why we at the foundation see them as integral to improving health and health care for all Americans. I shall also briefly describe some of the foundation programmes that have laid the groundwork for our new initiative, Addressing Tobacco in Managed Care.

Our most recent annual report focuses specifically on the opportunities and challenges that a market-driven healthcare system present for funding in each of our three major goal areas—assuring access to basic health care; improving care for chronic disease; and reducing the harm caused by substance use. The report notes that the explosive growth in managed care, with its interest in keeping people healthy to contain cost and its ability to institutionalise change, brings new opportunities, especially for grant-making in the field of substance abuse.

Although it is our newest goal, reducing the harm caused by substance abuse has reached parity, accounting last year for fully a third of the foundation’s grants. The sum of our active and committed funds in tobacco control totals a little over $120 million. Tobacco control has been a priority for the foundation because tobacco use and addiction remain the United States’ number one cause of preventable death and disease. Tobacco not only causes more than 420,000 premature deaths each year, but also places an enormous burden on the healthcare system, accounting for $50 billion annually in healthcare costs alone.

There are compelling challenges facing the nation today. Three thousand more children become regular smokers every day. Thirty-six per cent of high school students currently smoke, and a third of them will eventually die from tobacco-caused disease. Adult smoking prevalence has stabilised at 25%, with no real decline since 1990, and no major downturn in sight. Despite much progress, tobacco use remains normative in our society.

Accordingly, the foundation’s tobacco funding has had three goals: to prevent young people from starting to smoke, to help addicted users quit, and to transform the social environment that has made tobacco use socially acceptable. Obviously, achieving these broad goals requires a multi-pronged approach—one that combines “upstream” efforts to promote environmental change through education and policy change, with more “downstream” efforts to identify and disseminate effective prevention and treatment programmes.

Thus, we have sought to fund broadly, supporting a range of initiatives that focus on prevention, on policy research and analysis, and on treatment for addicted smokers. Wherever we can, we have sought to build on or complement the investments of other funders, as well as to link the public and private sectors in needed and powerful partnerships.

At the state level, our largest initiative is the SmokeLess States Program, directed by Tom Houstoun and Kathy Harty at the American Medical Association. Given devolution and the absence of significant federal legislation, the states have been the locus of the nation’s greatest progress in tobacco control.

Similar to the American Stop Smoking Intervention Study (ASSIST), SmokeLess States funds multi-member, statewide coalitions to educate the public about the dangers of tobacco and about the public policy options for curbing use. SmokeLess States coalitions have also worked to improve access to local prevention and treatment programmes, although the emphasis here has been on young people.

Since 1993, SmokeLess States has reached 31 states and the District of Columbia. Education campaigns highlighting the link between price and tobacco use in children have helped propel excise tax increases in 10 of these states, including Alaska and Hawaii, which currently have, at $1.00 per pack, the highest state excise taxes in the nation. Although the focus has been on prevention, Oregon and New Jersey have worked to help assure Medicaid coverage for cessation treatment.

At the national level, our largest investment has been in the Center for Tobacco-Free Kids. The centre was organised in 1996 with the
Challenges and opportunities for tobacco control

The purpose of countering the political clout and youth marketing savvy of the tobacco industry, or to be—as Bill Novelli, the centre’s president, once put it—the counterpoint to the ‘Tobacco Institute.

The centre has striven over the past two years to drive down rates of tobacco use by forming tobacco prevention’s “big tent”. They have recruited more than 130 national organisations as coalition partners dedicated to reducing use among children. They have been effective in marshalling public opinion through targeted communications that keep hammering home the message that the issue is “children” and the solution is a national policy that protects kids by keeping their environment tobacco free. Last year, the centre was a key player in bringing the tobacco industry to the negotiating table. Their aim is to keep pressure on the industry and policy makers during the current legislative debate, as well as to continue to support critical state efforts.

The foundation’s sports initiatives have also had a national as well as a prevention focus. The strategy here has been to use sports and sports heroes as vehicles for reaching children and the adults who are important in their lives—including parents and coaches—with anti-tobacco messages to counteract the industry’s historical reliance on sports as a channel for marketing tobacco to the young.

Our largest grant in this area was for the National Spit Tobacco Education Program (NSTEP), led jointly by Oral Health America’s tireless and impassioned crusader, Joe Garagiola, and the leadership of Major League Baseball. NSTEP’s public education campaign combines anti-spit tobacco public service announcements (PSAs), aired during televised Major League broadcasts, with stadium events focused on young people around the country. One PSA features Lenny Dykstra—once the poster boy for spit tobacco—telling his young fans to admire his hustle and his game, but not his tobacco use. Making this spot proved a real turning point for Lenny. He has not used spit tobacco since. NSTEP’s newest focus is on helping other players quit—to eliminate the free advertising addicted players provide each time the camera catches them chewing, dipping and spitting. Of course, there is still a long way to go not only in reclaiming sports from the tobacco industry’s stronghold, but also countering the powerful pro-tobacco messages sent by Hollywood and the youth music industry.

To guide our investments in action programmes like these, the foundation has made important investments in policy research to identify, evaluate, and analyse public and private policies with potential to reduce tobacco use. This has been the focus of our Tobacco and Substance Abuse Policy Research Grant programmes directed by David Altman at Wake Forest University [Winston-Salem, North Carolina].

Most of our grants under these programmes have focused on prevention policy. One example is Nancy Rigotti’s recent controlled study of the effects of better enforcement of access laws on children’s purchase and use of tobacco products, the first in a series of studies to reveal that better enforcement alone may not be the solution. Another example is Frank Chaloupka’s study showing that tobacco price increases have stronger effects on the young than adults—research that is now widely cited in proposals to raise the federal tobacco excise tax.

However, many studies have focused on cessation. Sue Curry compared different co-pays for smoking cessation treatment in a health maintenance organisation (HMO) and found that they significantly altered smokers’ use of treatment services and population quit rates.

Mike Cummings and his colleagues reanalysed Community Intervention Trial for Smoking Cessation (COMMIT) data to estimate the impact of price, clean indoor air restrictions, and Medicaid coverage for the nicotine patch on adult use and cessation.

Other studies have examined the impact of hospital and workplace smoking bans.

The last group of grants I want to discuss are those which aim to improve the effectiveness and dissemination of treatment programmes for addicted smokers. The findings and products of these efforts are especially important given the current potential for new tax and settlement revenues earmarked specifically for treatment.

The challenges in this area centre around the need for innovation and interdisciplinary research to develop the next generation of more powerful treatments, the need to build a stronger treatment infrastructure and to identify and overcome the policy and systems barriers to wider use of the treatments that we do have that work.

Our flagship programme in this area is the Smoke-Free Families Program, which focuses on treatment for pregnant women and new mothers. The harm maternal smoking causes to the fetus and newborn and the special motivation pregnant women have to quit make pregnancy a critical period for smoking cessation. Yet the challenge is also great. Pregnancy is a time of change and stress, and requires many simultaneous lifestyle changes. Quit rates for behavioural cessation treatments in pregnancy seldom exceed 25%; pharmacological treatment is generally contraindicated; and postpartum relapse is the norm. Yet the potential health and economic return on investment are enormous given the power of cessation to reduce low birthweight deliveries and other pregnancy risks.

The purpose of the Smoke-Free Families Program, directed by Robert Goldenberg and Penny Whiteside at the University of Alabama at Birmingham was to examine pilot tests of novel treatments with the potential to break through the 25% quit rate barrier. To date, the programme has funded 11 trials lasting two years, to test innovative motivational and behavioural treatments for pregnant and postpartum smokers. Many of these trials have investigated promising new technologies involving interactive computer-based interventions and feedback of biochemical risk.
indicators. One project, for example, gives new mothers nicotine dosimeters—small devices that measure environmental tobacco smoke—that are read weekly to monitor infant smoke exposure. Others have explored new and unusual applications of existing treatments, such as motivational interviewing, peer counselling, and even cash vouchers for smoking abstinence. Results of the first set of trials will be available soon, and we are planning a second set of trials and a multi-site demonstration for the second phase of this programme.

In addition, staff from the SmokeFree Families Program are working with the Centers for Disease Control and Prevention (CDC) to develop software that will calculate the health costs associated with women who smoke during their pregnancies—a critical step in shedding light on the economic incentives for tobacco intervention.

Not all treatment programmes are research-oriented, however. Patients in treatment for alcohol and drug addiction are often smokers. Their treatment programmes seldom address nicotine addiction or even ensure tobacco-free environments. Headed by John Slade, at the University of New Jersey School of Medicine and Dentistry, a statewide initiative has developed and promulgated models for treating nicotine addiction among smokers receiving treatment for alcohol and drug dependencies. The programme has just published a state-of-the-art manual for integrating tobacco policies and nicotine dependence treatment into the chemical dependency paradigm. This initiative has been so successful that the state health department has taken over the funding for it.

The publication of the Agency for Health Care Policy and Research (AHCPR) smoking cessation guideline in April 1996 represented a huge opportunity, providing the field with evidence-based standards that emphasised simple primary care interventions designed to fit into everyday practice.

One way the foundation sought to capitalise on the guideline was to work with the Center for the Advancement of Health, the CDC, the National Cancer Institute (NCI), The HMO Group, the American Medical Association (AMA) and many other groups to advocate that the National Committee for Quality Assurance (NCQA) incorporate an AHCPR-based tobacco intervention measure into its Health Plan Employer Data and Information Set (HEDIS) 3.0 health plan report card. We were gratified that so many forces combined to guide the NCQA to take this step.

Another way we sought to capitalise on the guideline was to partner with the AHCPR in funding a series of “dissemination” grants to a broad spectrum of health professional groups and organisations. Among the 11 grants funded were ones to the AMA, the CDC, NCI, The HMO Group, the Center for the Advancement of Health and the National Medical Association (NMA). Most of these grants supported training programmes and the development and dissemination of specialty-oriented guidelines and brochures for specific populations, such as pregnant smokers and young people.

The AHCPR guideline includes recommendations for systems change needed to institutionalise tobacco intervention, such as introducing tobacco-user identification systems in every clinic and hospital, and providing education, feedback, and reimbursement to support providers’ efforts. One of our dissemination grants, to Allina Health System, a large individual practice association (IPA) model HMO in Minnesota, supported an evaluation of multiple system changes—including making tobacco use a vital sign and reimbursing providers for their intervention. Results will help to answer important questions about how best to implement the guideline in IPA model clinics.

Another foundation project grant to The HMO Group, a national alliance of 25 staff, group and mixed model HMOs, also focused on tobacco use prevention and control in HMOs. The HMO Group set out to institutionalise tobacco prevention and cessation advice in primary care through improved tracking of patient tobacco use, stronger linkage with community resources, and the development of a public advocacy campaign aimed at educating young people, in concert with the Campaign for Tobacco-Free Kids. This included support for the creation of a network of tobacco coordinators who were convened in bimonthly telephone conferences for shared planning and problem solving. Fourteen of The HMO Group’s 25 member plans took part. This initiative resulted in the creation of a lasting tobacco coordinator network and internet resource centre, and produced visible improvements in prevention and cessation advice. The HMO Group’s HEDIS rates on the provider advice measure averaged 71%—ten points higher than the national average.

In many ways, The HMO Group initiative served as a model for the final programme I want to discuss—Addressing Tobacco in Managed Care. This initiative is based on the premise that managed care, with its ability to reach defined populations of patients and providers and the use of more advanced information systems, brings with it unique opportunities not only to implement systems changes needed to institutionalise tobacco intervention, but also to evaluate them. This programme was timed to take advantage of several forces—the push of the new AHCPR guideline, the pull of the new HEDIS 3.0 tobacco measures, and the decision by the American Association of Health Plans (AAHP) to make tobacco its number one prevention priority. From the beginning, the foundation worked closely with several partners in designing this new initiative—the AAHP, AHCPR, CDC, and NCI.

This two-part programme includes funding for grants to evaluate the impact of systems to alter provider behaviour and patient outcomes and for an AAHP-directed smoking cessation technical assistance centre. The focus is not on evaluating clinical treatment services, but on...
the effectiveness of varied organisational strategies that lead providers, practices, and plans to adhere to the guideline.

I would like to close by coming back to the theme of partnership—a theme that is central to this conference. This is an extraordinary time in America's tobacco control history—a time of unprecedented challenge and opportunity. Tobacco control has never had greater prominence as a public health issue. The FDA rule and proposed tobacco legislation are rooted in a decade of research to establish nicotine as an addictive substance, and to establish public and private tobacco policy as a critical fulcrum for national, state, and local tobacco control efforts. However, the challenges remain formidable. It will take all of us working together to change the landscape and culture of medical care in the direction of addressing tobacco routinely. We at the foundation look forward to working with you all on this challenge.

Results from the first annual survey on Addressing Tobacco in Managed Care

Carol McPhillips-Tangum

Managed care organisations (MCOs) enjoy a history of promoting health through preventive services and health maintenance activities. In this unique capacity as healthcare providers, these organisations can effect healthy lifestyle changes in their member populations.

The single most important cause of premature death and preventable illness, in the United States today, is cigarette smoking.1 Most individuals who smoke express a desire to quit.2 Through the implementation of smoking cessation programmes, MCOs can play a major part in helping motivated individuals to join the ranks of quitters.

As part of the Robert Wood Johnson Foundation initiative, Addressing Tobacco in Managed Care, an annual survey of all managed healthcare plans is being conducted each year from 1997 to 2000. These surveys have the following objectives.

1 To assess the knowledge, attitudes and practices related to the Agency for Health Care Policy and Research (AHCPR) smoking cessation guideline3
2 To monitor the status of efforts to incorporate tobacco prevention and cessation interventions into routine care
3 To monitor the status of efforts to influence tobacco policies at the state, local or national level
4 To identify barriers faced by managed healthcare plans in their efforts to address tobacco control
5 To identify strategies used by managed healthcare plans to overcome barriers.

The results of the first annual survey are outlined here.

Methods

The survey was a mailed questionnaire with telephone follow up. The 32-item questionnaire was sent to all the health plans in the American Association of Health Plans’ (AAHP’s) database of member and non-member plans (n = 637). Of the 637 MCOs in the original sample, 95 plans (15%) were excluded, due to duplication in the sample, mergers or being inoperative, leaving 542 valid MCOs in the sample. A total of 323 plans replied, a response rate of 60%. The final results of the survey are based on these responses.

Results

As stated earlier, the first objective was to determine the knowledge of, and practices related to, the AHCPR smoking cessation guideline. Over 71% of MCOs responding to the survey were aware of the guideline. Fifty-one per cent (164) of the MCOs had reviewed the guideline, and among those, 9% had fully implemented the recommendations, whereas 39% had partially implemented the recommendations (figure 1). There was substantial variation in the extent to which MCOs implemented specific practices and policies recommended in the guideline. Although most MCOs (61.3%) record smoking status in medical charts, few (11.5%) record smoking status in computerised databases.

8 AHCPR smoking cessation guideline: its goals and impact. Tobacco Control 1997;6 (suppl):S1–S106.
The survey was also designed to monitor the status of eVorts to incorporate tobacco prevention and cessation interventions into routine care. Some MCOs offer provider counselling (31.3%), patient incentives (21.7%), and provider training (16.4%) as the means to reach this goal (figure 2).

Over 67% of the responding MCOs had participated in tobacco prevention activities during the past year. These activities included: establishing policies for a smoke-free workplace (45.8%); participation in community-based activities (20.1%); use of media messages (15.2%); sponsorship of school-based programmes (14.6%); and involvement in legislative activities (13%).

Targeted cessation intervention strategies, aimed at specific population groups, were present in some of the organisations. Pregnant women were targeted as an intervention group by 45% of the organisations responding to the survey; patients with chronic illness by 22.6%; patients who had had a myocardial infarction by 21.7%; adolescent members by 17.6%; paediatric members by 15.8%; postpartum patients by 13.6%; and hospitalised patients by 11.5% of MCOs.

In terms of monitoring tobacco use among members, 25.1% of MCOs measured smoking prevalence, and 14.9% could identify individual smokers among their member populations. Sixty-two per cent had a budget for tobacco control activities. Of those MCOs with allocated funds, 12.4% had a part-time or fulltime tobacco programme coordinator.

Because providers are so important in effectively addressing tobacco use among members, the survey queried MCOs about barriers they perceived at the provider level. These barriers included: time constraints (57.3%); conflicting priorities (tobacco use was viewed as a relatively low priority agenda item) (42.7%); frustration with the low success (quit) rates (35.6%); and lack of reimbursement for cessation counselling (35.3%). MCOs implemented the following strategies to address some of the provider barriers: provider education (44.6%); use of prompts and reminders for providers (20.1%); increased reimbursement (3.7%); and use of incentives (2.5%).

Finally, there is a great deal of interest in monitoring the extent to which MCOs provide benefit coverage for smoking cessation treatments. Coverage for smoking cessation interventions was available in 244 (75%) of the MCOs that responded to the survey. Although full coverage was often provided for self-help materials (54.1%) and less frequently provided for smoking cessation classes (35.7%) and telephone counselling (32.8%), pharmaceutical treatments for tobacco addiction were rarely covered in full by MCOs (figure 3).

In addition to those MCOs that offer full coverage for various smoking cessation interventions, some offer partial coverage (figure 4). For example, whereas 35.7% of MCOs provide full coverage for smoking cessation classes, 20.5% provide partial coverage. Therefore, approximately 56% of MCOs provide some coverage for cessation classes.

**Conclusions**

The current state of smoking cessation interventions in managed care organisations leaves many opportunities for improvement. Among MCOs responding to the survey, 49% were unaware of the AHCPR smoking cessation guideline, and even among those that reviewed the guideline, only half have partially or fully implemented them. In addition, very few (14.9%) of the responding MCOs can identify individual smokers, which is a primary component of the guideline. Although a substantial proportion (44.9%) of MCOs cited
strategies in place to address cessation during pregnancy, only 13.6% have programmes for postpartum patients. These are just a few of the areas with potential for improvement.

Managed care organisations are in a position to make powerful changes in the arena of tobacco control. There are many opportunities for increased success, such as the enhancement of systems to measure smoking prevalence, and the identification of individuals who smoke. Another important area is the barriers related to incentives and reimbursement. There is also a need for MCOs to increase their participation in community-based tobacco control activities. This is an exciting and challenging time for MCOs, particularly regarding tobacco control programmes. Managed care organisations should be in the forefront of the war against tobacco.

The author thanks Linda Schuessler for project management, Lisa Mahoney for assistance with data collection, Jennifer Peale for data analysis and Jeffrey Koplan for his invaluable input.


Challenges and opportunities for tobacco control: the Robert Wood Johnson Foundation agenda
C Tracy Orleans

Tob Control 1998 7: S8-S11
doi: 10.1136/tc.7.suppl_1.S8

Updated information and services can be found at:
http://tobaccocontrol.bmj.com/content/7/suppl_1/S8

These include:

References
This article cites 6 articles, 0 of which you can access for free at:
http://tobaccocontrol.bmj.com/content/7/suppl_1/S8#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/