
PANEL SESSION I—A CLINICAL AND SYSTEMS PERSPECTIVE ON TOBACCO CONTROL: THE AHCPR GUIDELINE

Overview of the Agency for Health Care Policy and Research guideline

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I am honoured to be a part of this panel. Our goal is to provide you with a perspective that is both realistic and positive. That perspective is based around the unique opportunity that managed care organisations (MCOs) have before them. Managed care organisations have an opportunity to help their enrollees quit smoking—an opportunity not only to save lives, but also to decrease the extraordinary morbidity that results from tobacco addiction. Finally, MCOs have an opportunity to do all of this in a cost-effective manner.

The speakers on the panel will first outline the findings of the Agency for Health Care Policy and Research (AHCPR) clinical practice guideline on smoking cessation,¹ and then offer insights about the challenges of disseminating such a set of recommendations. They will describe two real world experiences. We will hear that of a managed care organisation with a wealth of experience and a track record showing how effective systematic tobacco intervention programmes can be implemented. We will also hear about the experience of a managed care organisation that is initiating a new programme to address tobacco addiction among enrollees.

I believe it would be unrealistic to propose that every managed care organisation agree to the immediate, universal provision of smoking cessation services for every enrollee. There are some clear barriers to implementing such a programme. To help address them, I should like to highlight some of those barriers.

First, there are some important “bottom line” issues. A balance must be struck between the short term costs of providing smoking cessation services and the long-term economic benefits to MCOs that are expected to result from the decreased use of healthcare resources by smokers who quit successfully. Unfortunately, it is not always clear just how extensive those cost benefits will be or when they can be anticipated.

Second, I think there is a web of barriers which is tied to persistent myths about tobacco use. One such myth is that brief clinical interventions really do not make a difference. But the AHCPR smoking cessation guideline provides compelling evidence that even brief clinical interventions can be effective, particularly if we take a denominator approach—a system-wide approach in which

everybody who walks through the door gets at least a little something in the way of smoking cessation. The guideline provides compelling evidence that such an approach makes a difference in terms of quit rates across the MCOs.

We face other myths regarding whether tobacco use is something that warrants medical attention. Many policy makers, and even clinicians, still endorse the idea that tobacco use is a lifestyle choice out of the realm of traditional covered services. Many of us have confronted this “bad habit” argument when bringing smoking cessation issues to MCO executives. In fact, there is a compelling body of evidence about the addictive nature of tobacco. In my view, these data fully warrant viewing tobacco addiction as a chronic disease. Just as with hypertension, hyperlipidaemia or diabetes, tobacco addiction is a chronic disease requiring that insurers in managed care communities cover its appropriate treatment.

The final myth that I should like to address is the view that, even if managed care organisations provided coverage, clinicians would not deliver tobacco interventions to their patients. In fact, there are strong data suggesting that if incentives are provided and tobacco intervention is made a priority within an organisation, clinicians will do the right thing. They will give effective treatments—we just need to create an environment that promotes them.

In place of these myths, I should like to propose a new agenda, and to use Dr Nudelman’s words to seize this impressive moment of convergence. I should like to challenge all of us to adopt *a new standard of care*. A standard of care that dictates that every enrollee in a managed care contract, in an insurance plan, in a health system, deserves smoking cessation treatment. A standard of care in which both counselling and pharmacotherapy are part of the covered basic benefits package. This is an agenda worth striving towards.

I should like to describe very briefly a little bit about the AHCPR guideline. It was developed over two years by a distinguished panel of smoking cessation experts. That panel set two goals. The first was to identify which treatments worked and which were not supported by quality data. The second goal was to come up with a means of institutionalising those treatments identified as effective. We

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wanted to move beyond the traditional methods of disseminating this sort of information through in-services or grand rounds—endlessly talking exclusively to the physician or clinician. The panel recognised that, until and unless the healthcare delivery systems adopt tobacco intervention as an essential part of good care, it will not be provided.

The guideline panel was innovative: they identified the following three audiences for their recommendations.

The primary care clinician: the individual at the front line of healthcare delivery who will provide brief, but effective cessation interventions to every patient as they walk through the door, irrespective of what brought them to that clinical setting.

The smoking cessation specialist: the cohort of individuals who provide intensive, formal treatments for those smokers who seek such treatment.

Healthcare administrators, insurers, purchasers, and the managed care community: unlike any other AHCPR guideline, we targeted these groups because they play an essential role in providing effective smoking cessation services.

The panel met over two years and completed an evidence-based review of the existing smoking cessation literature. In essence, we provided a synthesis and summary of the available evidence on smoking cessation treatments to rebut the frequent refrain, “Nothing makes a difference.” A central goal of the panel was to complete a detailed review of the evidence to identify effective and ineffective treatments. We reviewed virtually everything that has been published since the mid-1970s on smoking cessation. This review involved more than 50 meta-analyses, and the guideline underwent a nationwide peer review before it was published in April 1996.

The process produced a series of publications. The first was the full guideline—a 120-page document. At the same time, a series of additional documents were published. These were produced for patients, specialists, primary care clinicians, and insurers and managed care communities, respectively.

More publications have appeared recently. In December 1997, the panel published an article in the *Journal of the American Medical Association*, addressing the cost-effectiveness of this guideline.² This analysis concluded that there is not a single preventive intervention available to adults in America that is as cost-effective as smoking cessation. Overall, we found that the interventions recommended by this guideline cost about \$2500 per year of life saved. To put that in perspective, mammography screening costs about \$50 000 per year of life saved.

All of these documents are available free of charge from the AHCPR. They have a web site at <<http://www.ahcpr.gov/guide>>, then click on “Clinical Practice Guideline Online”.

Although the panel identified three primary audiences for the guideline, today we are going to talk specifically about the findings and recommendations aimed at healthcare admin-

Table 1 Agency for Health Care Policy and Research guideline recommendations for healthcare administrators, purchasers and insurers

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- Implement a tobacco user identification system in every clinic.
 - Provide education, resources, and feedback to promote provider intervention.
 - Dedicate staff to provide smoking cessation treatment identified as effective in the guideline, and assess the delivery of this treatment in staff performance evaluations.
 - Promote hospital policies that support and provide smoking cessation services.
 - Include smoking cessation treatment identified as effective in the guideline as paid services for all subscribers of health insurance packages.
 - Reimburse fee-for-service clinicians for delivery of effective smoking cessation treatments, and include these interventions among the defined duties of salaried clinicians.
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istrators, purchasers and insurers, including managed care organisations (table 1).

First, implementing a tobacco user identification system in every clinic has a measurable impact. This conclusion grew out of a quite discouraging finding noted during patient exit interviews. Over the past decade, many of these exit surveys have shown that only about half of smokers report that anyone asked them if they smoked. A much lower proportion reported that they were offered smoking cessation advice or treatment. However, the research shows that universal assessment and documentation of patients' tobacco use changes clinician behaviour. Specifically, tobacco assessment has been shown roughly to double the rate at which clinicians intervene with their patients who smoke. Therefore, by making a simple system change—having a medical assistant, receptionist or nurse add the question, “Are you a current, or former or never tobacco user?” to the vital signs—you can double the rate at which clinicians will go on to help their patients quit. This simple change is an extraordinarily cost-effective intervention.

Second, the panel found that providing educational resources makes a difference to whether providers will offer smoking cessation treatments.

Third, the panel recognised that the hospital is a unique environment in which patients can be helped to quit smoking. Every hospital in America is now smoke-free. There are a series of very specific steps which can be taken to promote smoking cessation in the hospital setting—for instance, assessing smoking status as part of the intake procedure, and making sure there is a smoking cessation consult service available for in-patients. Another important step is to provide patients who smoke with medicines that promote cessation—both nicotine replacement and non-nicotine medicines have been shown to lessen withdrawal symptomatology. Providing pharmacotherapy can ease the hospital stay for smokers and lay the foundation for a successful quit attempt.

It is critically important that smoking cessation services are provided. The panel reached the conclusion that every insurance plan in

America should be providing smoking cessation counselling and pharmacotherapy as covered services to their patients who smoke. In addition, incentives for clinicians can increase rates of smoking cessation. The data supporting this change is listed in the guideline as well.

Lastly, it is important that each clinic assign dedicated staff to manage smoking cessation services and stock clinics with the appropriate self-help materials. Most clinics take for granted the need for a diabetic nurse or a diabetic health educator. Given the morbidity and the mortality associated with tobacco use, I would propose that every clinic in America should also have someone who manages the identification of smokers and provides smoking cessation services to tobacco users.

These are remarkable times in terms of how our society views tobacco addiction. This is truly an impressive moment of convergence. I believe that we will be successful in this public health/clinical battle in which we are engaged. I also believe it will not be too many more years—probably a decade or two—before we will be able to look back and say that tobacco addiction is a part of our past. And, when the historians write about the steps that led us to this point, key passages of that account will describe what each of us, as individuals and organisations, are doing right now to help the 50 million Americans addicted to tobacco. I commend all of you for being here and for sharing your ideas on how we can assist the great majority of American smokers who want to quit using tobacco.

I should now like to introduce my colleague, Christine Williams, who is the director of the Center For Health Information Dissemination at the Agency for Health Care Policy and Research in Rockville, Maryland. Christine Williams, in this capacity, is responsible for translating and disseminating the work of this agency to healthcare providers, purchasers, policy makers and consumers. For the 12 years

before 1994, she served as health policy staff to former Senate majority leader George Mitchell, where she was responsible for the development of legislative initiatives in health policy and for advising Senator Mitchell on health issues. It has been my pleasure to work with her as we have disseminated the AHCPR guideline.

Our second panelist will be Dr Joachim Roski. Dr Roski serves as the programme director in the Quality and Performance Effectiveness Division of Allina Healthcare Systems in Minnetonka, Minnesota. He is responsible for the development and implementation of a comprehensive performance use clinical quality outcome measurement in improvement systems. He will be speaking on implementing the AHCPR guideline in a primary care setting.

Dr Roski will be followed by Dr Susan Curry, a health psychologist and associate director of the Center for Health Studies at Group Health Cooperative of Puget Sound, Seattle, Washington. She is also a professor of health services in the Department of Psychology at the University of Washington in Seattle. Dr Curry is a recognised international expert for her knowledge of health behaviours research including the development, testing and evaluation of methods to change health behaviours such as smoking, drinking, diet and compliance with breast cancer mammography. Dr Curry serves as co-director of the National Program Office for the Robert Wood Johnson Foundation initiative, Addressing Tobacco in Managed Care.

- 1 Fiore MC, Bailey WC, Cohen SJ, *et al.* *Smoking cessation. Clinical Practice Guideline No 18.* Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, April 1996. (AHCPR Publication No 96-0692.)
- 2 Cromwell J, Bartosch WJ, Fiore MC, *et al.* Cost-effectiveness of the clinical practice recommendations in the AHCPR guidelines for smoking cessation. *JAMA* 1997;278:1759–66.