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Introduction

Addressing tobacco in managed care: documenting the challenges and potential for systems-level change

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An extensive research literature demonstrates the effectiveness of health-care-based interventions for smoking cessation (Task Force on Community Preventive Services, 2001). Unfortunately, there is a considerable gap between what we know from our research and the translation of that knowledge into clinical practice. In particular, there is a knowledge gap regarding effective 'interventions' to increase integration of proven cessation treatments into healthcare delivery. The papers included in this special supplement are examples of efforts to begin to fill this gap. Here we provide some historical and conceptual context for this work.

In 1996, the Agency for Healthcare Research and Quality (AHRQ; then the Agency for Healthcare Policy and Research) released a clinical practice guideline for smoking cessation (Fiore *et al.*, 1996).[1] The guideline process comprised comprehensive review of the extant literature, a series of rigorous meta-analyses of tobacco-cessation interventions, expert synthesis of these findings, and translation of the evidence into specific guidelines. In addition to practice recommendations for front-line clinicians, the guideline outlined strategies to institutionalize effective treatments into healthcare delivery systems. These strategies include: implementing a tobacco user identification system at the clinic level; introducing innovative packages of provider education, resources, and feedback to promote provider intervention; dedicating staff to provide smoking-cessation treatment; promoting hospital policies that support and provide smoking-cessation services; including smoking-cessation treatment and FDA-approved pharmacotherapies as paid services or covered benefits; and providing incentives for clinicians to deliver effective smoking-cessation treatments and including these interventions among the defined duties of clinicians. Similar healthcare system-level recommendations were published in February 2001 by the Centers for Disease Control and Prevention Task Force on Community Preventive Services.

Release of the first smoking-cessation guideline was an important catalyst for the addition of a measure related to smoking cessation (percentage of adult current smokers who received advice to quit smoking from a health plan provider during the previous year) to the 1997 Health Plan Employer Data and Information Set (HEDIS 3.0). HEDIS measures, which are reported by managed care organizations, serve as a type of 'report card' that can influence the selection of health plans by major employers. As a result, the addition of a tobacco-related measure served to stimulate efforts on the part of managed care organizations to increase their tobacco intervention. In 1998, inspired by the release of AHRQ's smoking-cessation guideline and significant interest among managed care organizations in evaluating system-level innovations to facilitate implementation of the guideline, the Robert Wood Johnson Foundation launched Addressing Tobacco in Managed Care (ATMC) as a national program initiative (Orleans, 1998). The program aims to integrate effective tobacco intervention into the basic healthcare provided by managed care organizations. The ATMC program builds on the key conclusions of the AHRQ guideline that brief provider-delivered interventions can increase

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smoking cessation, that the healthcare setting is a vital channel for increasing the reach of proven behavioral and pharmacological treatments for smoking cessation, and that capacities need to be built at the 'system' level for sustained implementation of the guideline's recommendations.

ATMC is a two-part program that includes a technical assistance office and a grants program. The National 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 surveys of health plans to determine practices related to the evidence-based guideline, and promotes best practices through training workshops and national and regional conferences. Additional information about the technical assistance office can be found at www.aahp.org/atmc/mainindex.cfm.

The ATMC National Program Office is based at the University of Wisconsin, and the program is conducted in partnership with the University of Illinois at Chicago. Detailed information about the ATMC grants program can be found at www.medicine.wisc.edu/npo. In short, the purpose of the grants program is not to evaluate the efficacy of cessation programs *per se*. Rather, the focus is on evaluating the effectiveness of replicable organizational strategies (including systems-related clinical, financial, and administrative practices) that lead providers, practices, and plans to adhere to the activities recommended by the AHRQ guideline. The ATMC program includes both planning and evaluation grants. Managed care organizations participating in the grants program underwrite the costs of treatments and system innovations; evaluation grant funding of up to $500,000 over 3 years supports personnel and infrastructure for rigorous outcome evaluations.

The development of high-quality, rigorous evaluations of system innovations for smoking cessation requires considerable time and effort; extensive cooperation between researchers, administrators and clinicians; and identification of effective combinations of system changes. To facilitate these processes, the ATMC program also includes planning grants. These grants can be a mechanism for 'getting practice into research' by involving front-line practitioners and organizational decision-makers in pilot projects of system changes. These grants provide very modest resources (funding of up to $50,000 over 1–2 years). Funds can be used to pilot test innovations; to collect process, clinical, and/or administrative data to better understand the practice setting; and to solidify collaboration between academically based researchers and managed care organizations.

The papers in this special supplement feature reports from five planning grants funded by the ATMC program. The scope of work accomplished with these planning grants is impressive, given their modest resources and focus on feasibility rather than efficacy or effectiveness. Also notable are new interdisciplinary research partnerships resulting from participation in the ATMC program. The individual manuscripts provide the specifics of each project, which will not be reiterated in this introduction. The innovations explored in these pilot studies include practice-level assessment and feedback (McAfee *et al.*; Swartz *et al.*); the use of billing system codes to document tobacco use status and advice to quit (Bentz *et al.*; McAfee *et al.*); enhanced coverage for smoking cessation and provider reimbursement for cessation counseling (Doescher *et al.*; Latts *et al.*); and leadership incentives (McAfee *et al.*). Most of the projects evaluated the feasibility of these system changes by their impact on documentation of smoking status. Two projects also looked at referral to and/or receipt of treatment (Doescher *et al.*; Latts *et al.*). The target populations included all smokers as well as special populations of indigent patients and pregnant smokers.

The results reported in these papers provide insights into the challenges and potentials for system-level changes. For example, the pilot work by Bentz and colleagues demonstrates that automated billing systems have the potential to facilitate population-level tracking of smoking status and cessation intervention, but providers' perceptions of administrative databases as unrelated to patient care challenge that potential. McAfee and colleagues had remarkable success in using an automated billing system to create a 'tobacco registry,' probably because of the use of both performance feedback and incentives to senior-level leaders to foster compliance. Doescher and colleagues were very successful in designing and implementing a substantial cessation benefit that included coverage for nicotine-replacement products and reimbursement for pharmacist counseling for indigent patients. Unfortunately, the combination of modest rates of patient referral and high rates of patient turnover in the insurance plan resulted in limited reach into the target population. Latts and colleagues also experienced low rates of claims for provider reimbursement for smoking-cessation counseling among pregnant smokers. In this pilot project, reimbursement was offered by only one of the several managed care insurers that providers contract with. Because providers are often unaware of their patient's health coverage, the financial incentive may have been insufficient to increase counseling rates. The pilot study by Swartz and colleagues demonstrates the feasibility of implementing common audits and feedback across different managed care plans, a strategy that might be useful in combination with financial incentives for patient counseling.

In summary, the pilot studies reported in these papers provide an important perspective on the efforts needed to enhance the capacity of managed care systems to integrate effective tobacco intervention into basic healthcare delivery. There are no magic systems for MCOs any more than there are 'magic bullets' for smoking-

cessation treatment. Moreover, findings reinforce the need for multicomponent system-level and policy interventions aimed at patients, providers, and the systems themselves. The commitment of researchers and managed care organizations to careful development and, ultimately, rigorous evaluation of promising system changes will help build a much-needed evidence base for translating research into practice.

Note

1. The Public Health Service published an updated guideline in 2000 (Fiore *et al*., 2000).

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