Tobacco Cessation Leadership Network

Involving More Health Care Professionals in Tobacco Cessation: What Works

The 2000 Public Health Service Clinical Practice Guideline[1] summarizes effective, evidence-based treatment for tobacco dependence. The role of the health professional is essential to the implementation of the Guideline. The health professional is responsible for initiating treatment in clinical settings and assisting tobacco users to find help to stop.

Although the participation of health professionals is increasing, more involvement is needed to reach tobacco users. While in general, health professionals are aware of the importance of quitting smoking and recognize that smokers need help, they face significant barriers to providing treatment. Addressing these barriers is helping more health professionals become involved.

What does the PHS Guideline say about the role of health professionals?

- Health professionals should identify and document tobacco use status for every patient at every clinic visit, urge every tobacco user to quit, and assist tobacco users who are ready to quit.
- All clinicians should provide treatment.
- Treatments are more effective when delivered by multiple types of clinicians and delivery of treatment by multiple clinicians is encouraged.

What are the barriers for health professionals to provide treatment?

- The Smoking Cessation Leadership Center[2] has recently queried health professionals about barriers to delivering even brief treatment for smokers. The primary barriers were lack of knowledge and lack of time. Clinicians did not know how to effectively address tobacco use in their tightly scheduled and time starved professions.
- The PHS Guideline cites several barriers for clinicians:
  - Lack of knowledge about how to identify smokers, what treatments are effective, how to deliver treatments, and the relative effectiveness of different treatments.
  - Inadequate clinic or institutional support for routine assessment and treatment.
  - Time constraints.
- Antidotal reports from clinicians[3] serving priority populations also cite lack of knowledge and lack of time as primary barriers for clinicians.
  - Clinicians serving priority populations, especially those working with low socio-economic populations, also have more limited access to resources for referral and treatment.

What is working to address these barriers and involve health professionals?

- The Smoking Cessation Leadership Center, whose mission is to involve more health professionals in tobacco dependence treatment, promotes referrals to quitlines as the primary solution for addressing barriers and involving more health professionals. Why?
  - They work—calling a quitline can double the chance of successfully quitting.[4]
  - They are simple, easy to use, and save time.
  - They are the missing part of a complete management plan for cessation.

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- Linking clinic and health plan systems with quitlines helps get more clinicians involved.
    - Providence Health Plan Oregon has developed an outpatient and inpatient system for treatment and referral to the Oregon Tobacco Quitline, A project using electronic medical records and electronic fax referral to the Quitline was successfully pilot tested through Providence.[5]
    - Western Wisconsin Medical Associates rely on Wisconsin's Fax to Quit system to involved their 50 physicians at 5 sites.[6]
    - Working with professional associations to develop initiatives has also helped get more health professionals involved.
    - Many health professionals identify themselves with their profession. Appeals to their professionalism helps more become involved.
    - Health professional groups that have previously been less involved may be more receptive (e.g. nurses, dental hygienists, pharmacists, emergency physicians, physician assistants).
    - Willingness to get involved improves with the availability of quitlines.
- Integrating smoking cessation with other health services (e.g. stroke programs, pregnancy and maternity outreach, cardiac programs) helps involve more clinicians.

What are some of the unique circumstances for health professionals serving priority populations?[3]

- Disadvantaged populations are more likely to smoke and have a harder time succeeding in their attempts to quit.
- Barriers are especially the cost of effective treatment along with lack of access to services.
- There is insufficient outreach to minority physicians about the PHS Guideline and resources to help smokers quit.
- Making systems changes in settings that serve priority populations help clinicians and help reach tobacco users. Examples are:
    - Offering cessation classes in community settings that are integrated with wellness programs. More likely to reach smokers with a broader appeal than with stand alone smoking cessation programs. By creating a bigger "funnel" more people are reached and then become more interested in treatment. This leads to better treatment.
    - Establishing a written intake procedure to determine tobacco use and ensure referral to treatment.
    - Providing "one-stop shopping" in the community for tobacco treatment along with other health screening.
    - Adopting smoke-free policies for facility grounds and entrances.
- Approaches that are community based, participatory and community empowering work best for priority populations.[7]

QUESTIONS:

What about sustainability? How can we make sure that the initial enthusiasm translates into sustained services?

The more institutionalized the program, the more likely it is to be sustained. That is an important reason for emphasizing systems changes and for incorporating, for example, tobacco use assessment and referral automatically in the electronic medical record. Also, building partnerships with professional associations who can develop and sustain their own initiatives, has the potential for incorporating tobacco use assessment and referral into the standard of practice for a variety of health professions.

QUESTIONS Contd.

Do cessation programs for priority populations offered in community settings work better than stand alone cessation programs?

It depends on the particular setting and the expectations of clients. Community based programs are often known for a range of health services they provide including cessation. Clients come to these programs because they are interested in finding out about other topics such as nutrition. When they come, they can also be screened for tobacco use and receive information and assistance. Since this is where many people in these communities come for health services, it makes sense to locate cessation services there as well. They may be more likely to seek out and trust these resources than stand alone programs or quitlines they know little about.

What about incentives to motivate provider involvement?

A recent review of incentives and health care financing found the following:[8]

- Smokers who had full coverage for tobacco cessation were more likely to participate in treatment.
- When smokers have coverage for medications, their physicians are not more likely to deliver services than when there is no coverage unless the smokers ask for help.
- Current provider incentive systems do not reward quality or performance; need better incentive systems.
- Incentives for meeting performance targets can increase rates of documenting smoking status.
- System changes to support cessation within physician groups are more likely if there is 1) income or public recognition for quality; 2) financial incentives; 3) requirements to report HEDIS measure; 4) awareness of the PHS Guideline.

This suggests that effective incentives for influencing provider behavior still need to be discovered. A new area of research is in pay for performance incentives. The effectiveness of pay for performance incentives is not yet known.

References

[1]Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence: Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service; June 2000. *JAMA* June 28, 2000. 283; 24:3245-3253. Full document available at http://www.surgeongeneral.gov/tobacco

[2]Revell, CC, Schroeder, SA. Simplicity matters: Using system-level changes to encourage clinician intervention in helping tobacco users quit. *Nicotine & Tobacco Research* April 2005; Vol. 7, Supl. 1: S67-69. Smoking Cessation Leadership Center website: http://smokingcessationleadership.ucsf.edu/

[3]Halpin, HA. *The Effectiveness and Costs of Different Benefit Decisions for Treating Tobacco Dependence.* Results from a Randomized Trail. Presented at the 2005 Annual SRNT Meeting, Prague, Czech Republic.

[4]Zhu S-H, Anderson CM, Tedeschi GJ, Rosbrook B, Johnson CE, Byrd M & Gutierrez-Terrell E> (2002) Evidence of real-world effectiveness of a telephone quitline for smokers. New England Journal of Medicine, 347:1087-1093.

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[6]Paul McGinnis, Medical Staff, Western Wisconsin Medical Associates.

[7]Fisher, E, Musick, J, et . al. Improving clinic– and neighborhood-based smoking cessation services within federally qualified health centers. *Nicotine & Tobacco Research* April 2005; Vol. 7, Supl. 1: S45-56.

[8]Halpin HA, *Incentives and Health Care Financing for Smoking Cessation: What Have We Learned?* Presented at the May 2005 ATMC meeting, Chigaco, IL

Related Resources

Find more information about health professionals, health systems, training for health professionals, and priority populations at http://www.tcln.org/cessation topics and resources.

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