eVALUE8 EMPLOYER REPORT:

HEALTH PLAN TOBACCO CESSATION PERFORMANCE

eVALUE8 2008

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ABOUT NBCH

*The **National Business Coalition on Health (NBCH)** has a membership of nearly **60** member coalitions across the United States representing over **7,000** employers and approximately **25 million** employees and their dependents. These business coalitions are composed of mostly mid- and large-sized employers in both the private and public sectors in a particular city, county, or region. NBCH member coalitions are committed to Community Health Reform, including an improvement in the value of health care provided through employer-sponsored health plans and to the entire community. Employers who wish to utilize the RFI results for information on health plans in their area can work directly with NBCH member coalitions. Visit www.nbch.org for information.*

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REPORT OVERVIEW

Employers increasingly recognize the impacts—both direct and indirect—of tobacco use on the health and productivity of the workforce. In spite of the well-known fact that smoking is bad for health, many people still smoke. The good news is that many of them are ready to quit with the proper encouragement and treatment. Effective treatment is available to help people stop smoking. Effective treatment strategies for tobacco users (chew tobacco and smokers) have been defined by the U.S. Public Health Service and are available to physicians and other practitioners in a "clinical practice guideline." That guideline includes ten essential recommendations for care that are supported by the best available research and evaluation of results.

People who stop smoking greatly reduce their risk of dying prematurely. Benefits are greater for people who stop at earlier ages, but cessation is beneficial at all ages. Smoking cessation lowers the risk for lung and other types of cancer as well as for coronary heart disease, stroke and peripheral vascular disease.[1] Both employers and their contracted health plans have responsibilities for helping employees with tobacco cessation.

The effectiveness of treatment shows that it is possible to reduce the health and economic burden of smoking by helping smokers to quit. It illustrates the importance of employers asking their health plans to help doctors more consistently identify and treat members who smoke, and partnering with health plans to ensure that smoking cessation benefits are available to employees. Health plans have clinical expertise and the means to promote and create incentives for both patients (members) and physicians that result in better quality care. For health plans, key responsibilities include:

- Identification: creating methods to identify smokers, including working with physicians and offering direct screening through health risk assessments. This key step of identification dramatically increases opportunities to provide smoking cessation treatment.
- Counseling: offering programs and services that enable patients to access recommended behavioral therapy through qualified providers and for the effective duration.
- Medication: offering key treatments and diverse options "as part of medical or pharmacy benefits," and ideally, reducing barriers to medications and treatments through payment incentives and other strategies.
- Tracking: measuring the number of smokers identified by the plan compared to the expected rate for the population covered by the plan. Effective tracking approaches also enable the plan to measure the success of identification, referral, and treatment programs.
- Outcomes: measuring the effectiveness of identification and treatment programs is an essential capability of health plans. Without measurement, plans cannot report to employers on the effectiveness of smoking cessation interventions.

Employers have a critical role in promoting tobacco cessation. Importantly, employers determine benefits available to employees as well as workplace policies and programs. Employers should offer, and plans should administer, the benefits that are most likely to achieve smoking cessation results. The Centers for Disease Control and Prevention recommends a comprehensive smoking cessation benefit with the following elements:

- Cover at least four counseling sessions of at least 30 minutes each, including telephone and individual counseling sessions
- Cover all FDA-approved nicotine replacement products and tobacco cessation medications
- Provide counseling and medication coverage for at least two smoking cessation attempts per year
- Eliminate or minimize co-pays or deductibles for counseling and medications[2]

With its eValue8™ Request for Information (eValue8 RFI), the National Business Coalition on Health (NBCH) conducts an annual assessment of health plans on behalf of employers. eValue8 questions are aligned to ask plans about the benefit design for smoking cessation recommended by CDC. This report is a snapshot of eValue8 data on health plan strategies to address tobacco cessation. It is based on data and information from 103 health plans with data verified by NBCH member scoring staff.

The following describe the purchaser expectations for health plan performance with respect to tobacco cessation and key results from eValue8. It is important to note that eValue8 results show the plan capability to provide a program or service. Most plans deliver what employers request – so plans and employers must partner up to maximize effectiveness of health plans programs.

Plan member identification and communication:

- *Purchasers expect health plans to work with them to identify tobacco users and reach out to those tobacco users.* Plans have a number of strategies - including self referral, using claims data, and disease management programs - to identify smokers. Identification is a necessary step to ensuring that smokers receive treatment. Plans appear to have challenges identifying smokers; the CDC has found that about 21% of the population smokes, yet plans report that the range of smoking rates in their covered population is between .1% and 19%, with an average of 4%. Many plans appear to focus on smoking cessation for individuals who are already diagnosed with chronic disease. They do this by identifying members who are enrolled in disease management programs or whose physicians have sought out special designation as “recognized” for offering high quality care for patients with chronic diseases.

  Most health plans offer a health risk appraisal (HRAs) that asks members to identify their tobacco use, and 37% of plans cite the HRAs as the most effective way to identify and therefore potentially engage members. However the average HRA completion rate among plan members is only 4%. 58% of plans have capability to offer financial incentives to members to encourage them to take the HRA, and 56% can offer non-financial incentives. 61% of plans have capability to offer incentives for members to participate in wellness and

Employer Case Studies

As part of the Tobacco Cessation Project, the National Business Coalition on Health (NBCH) developed a series of case studies examining employer practices to reduce tobacco use. The case studies present real life examples of employer-based tobacco cessation programs and describe how employers implemented these programs, the challenges they faced and the outcomes of their experiences. The companies were recommended by NBCH coalition members and reflect a variety of geographies, industries, and types of workforce, and to demonstrate how different companies handle smoking cessation issues.

For complete case study on each of the companies below, visit NBCH's web site at:
http://www.nbch.org/resources/smoking_cessation.cfm

Quintiles Transnational Corporation *- Adhering to the CEO Cancer Gold Standard*
Quintiles Transnational Corporation is a global leader in pharmaceutical services, providing professional expertise, market intelligence and partnering solutions to the pharmaceutical, biotechnology and health care industries. With 44 percent of its work force home-based, Quintiles successfully implemented a corporate-wide, integrated smoking cessation benefit based on the CEO Cancer Gold Standard.
http://www.nbch.org/resources/smoking_cessation.cfm

Caterpillar *- Implementing International Programs*
As the largest maker of construction and mining equipment, diesel and natural gas engines, and industrial gas turbines in the world, Caterpillar overcame the challenges of its multiple, multinational office locations to provide smoking cessation benefits to its employees.
http://www.nbch.org/resources/smoking_cessation.cfm

Cerner *Data Driven Benefit Design*
Founded in 1979, Cerner is a leading supplier of healthcare information technology. Cerner's integrated health management approach provides wellness-based incentives, personal health assessment and biometric screening, a health advisor, primary care, pharmacy, chronic condition management, and education, nutrition, and fitness options to promote a healthy lifestyle. Using a tool to bring together Cerner's data—including cost and demographics related to health, benefit design, claims, lost work time, and employee satisfaction, Cerner adopted a value based benefit design for tobacco cessation.
http://www.nbch.org/resources/smoking_cessation.cfm

health coaching, and for chronically ill patients, 62% can offer incentives for participation in a disease management program. Plans also offer general communications with members about smoking: 94% of plans provide general information about tobacco use through their web site and/or newsletters. 79% have a "quit kit" or tool kit available for members by mail. Despite these varied approaches, the identification of tobacco users is an area for improvement, as plans are not consistently or aggressively using all of the data sources available to identify and reach out to tobacco users.

Provider performance measurement and engagement

- *Purchasers expect plans to provide actionable information to physicians to help them identify and treat patients who use tobacco.* One way that plans can increase the number of tobacco users identified and treated is to offer assistance and reports on performance to physicians. They can provide general information to physicians, specific information on which patients appear to need treatment, and they can create physician incentives. Currently 15% of plans provide member specific reports or reminders to screen to physicians, and 33% provide member specific reports or reminders to treat. 11% of plans provide practitioner incentives to screen for tobacco use, and 12% provide incentives to refer the member to a program or to treat the member. 17% of plans provide support to the practice for work flow change to support physician screening.

Health plans are increasingly using NCQA Physician Recognition Program as an external validation of physician quality. "Recognition" by NCQA is specifically for physicians who treat patients with chronic conditions such as heart disease or diabetes. To receive recognition, physicians follow practices known to result in the

Employer Case Studies

***City of Savannah** - Demonstrating Long-term Commitment*
The city of Savannah comprises a workforce providing services for a diverse local economy including manufacturing, distribution, tourism, military, health care, port operations and retail sectors. With a rich history of promoting wellness benefits to employees, Savannah demonstrates its long-term commitment to a smoking cessation program that continues to evolve.
http://www.nbch.org/resources/smoking_cessation.cfm

***International Truck and Engine Corporation** - Realizing Cost Savings*
International Truck and Engine is an Illinois-based subsidiary of Navistar International Corporation dedicated to integrated truck and engine product development. Using evidence-based data highlighting higher medical costs of smoker versus nonsmoker employees, the implementation of International's smoking cessation benefit demonstrates cost savings and a return on investment.
http://www.nbch.org/resources/smoking_cessation.cfm

***Paychex** - Measuring Outcomes*
Recognized as a top national provider of business solutions, Paychex has approximately 12,000 employees and more than 100 locations across the country. Paychex tackled the dual challenges of enforcing a company-wide smoke-free policy in multiple locations and leased spaces, and effectively measuring outcomes from its smoke-free policies and smoking cessation benefits.
http://www.nbch.org/resources/smoking_cessation.cfm

***United Parcel Service** - Coordinating Internal and External Efforts*
United Parcel Service (UPS) is the world's largest package delivery company and a leading global provider of specialized transportation and logistics services. The company is a prime example of how coordinating internal and external efforts led to a successful smoking cessation benefits program.
http://www.nbch.org/resources/smoking_cessation.cfm

best outcomes for people with chronic disease. This includes a requirement that the physician must assess smoking status and offer smoking cessation treatment to at least 80% of patients with the disease. Plans that recognize or reward physicians for achieving recognition therefore are also rewarding physicians who routinely offer smoking cessation treatment. 28% of plans offer some type of payment incentive to Recognized physicians and 52% offer some type of public acknowledgement of high performing physicians.

Tobacco cessation program features – counseling and medication support

- *Purchasers expect plans to provide effective evidence based programs to support tobacco users with cessation of tobacco use.* The comprehensive tobacco cessation benefit recommended by the Centers for Disease Control and Prevention includes both counseling support and access to FDA approved nicotine replacement products and tobacco cessation medications. 85% of plans provide telephonic counseling support and 77% of plans provide a minimum of at least 4 sessions. 81% of plans provide access to over-the-counter nicotine replacement medications and 68% provide incentives for patient use of these medications. 74% to 80% (see details in report by medication type) provide access to tobacco cessation prescription medications but only 25% to 33% provide incentives to members for these medications through lower copayments or deductibles. These results show that health plans need to partner with employers to consistently offer health plan benefit design that has been shown to be most effective for tobacco cessation.

Health plan results and outcomes

- *Purchasers expect health plans to evaluate their programs and outcomes.* Health plans reporting patient survey data to eValue8 indicate that 76% of plan members who smoke report that their

physician advised them to quit. Less than half of these members report that their physician discussed smoking cessation medications or quit strategies. Plans still have much to do to measure physician performance and the effectiveness of their smoking cessation programs. Only 7% of plans measure physician smoking cessation performance. Member outcomes are measured as quit rates, yet only 49% of plans track quit rates at 6 months and 20% track quit rates at 12 months. 73% of plans report tracking member participation in tobacco cessation programs.

This national snapshot report offers a glimpse of health plan activities to improve tobacco cessation treatment. Overall, 83% of plans scored lower than the 75% threshold for tobacco cessation in the summary scores (see Table III). Through ongoing improvements, health plans are applying data, information and expertise to support physicians and health plan members in tobacco cessation. Employers are encouraged to work with local coalitions for plan specific eValue8 information that can be used to assess activities of health plan vendors and maximize the value of health benefits.

SECTION 1. INTRODUCTION

According to the Centers for Disease Control and Prevention (CDC), approximately 24% of adults ages 18–44 years are smokers, along with 22% of adults ages 45-64. Men are more likely than women to be current smokers[3]. Although the rate of smoking is slowly going down, the CDC reports that smoking causes at least 30 percent of all cancer deaths, including more than 80 percent of lung cancer deaths, and 80 percent of deaths from chronic obstructive pulmonary disease. Smoking is responsible for early cardiovascular disease and death. As a result, about half of all long-term smokers, particularly those who began smoking as teens, die prematurely, many in middle age, and tobacco use is a factor in deaths due to most chronic diseases.[4]

Tobacco use is a chronic and relapsing condition or dependency that requires behavioral change to successfully quit.[*] Its impact on employers includes both the direct and indirect costs associated with tobacco use.[5] Risk factors for such conditions as cancer, coronary heart disease, and COPD decrease significantly in the immediate years after a smoker quits and there are both short and long term medical savings for quitters.[6] Increasingly, employers are providing more robust smoking cessation benefits to help smokers quit while simultaneously realizing cost savings.

Impact of Smoking on Health

Each year, cigarette smoking causes an estimated 438,000 deaths, or about one of every five deaths. This estimate includes approximately 38,000 deaths from secondhand smoke exposure.[7] Nonsmokers who are exposed to secondhand smoke at home or work increase their heart disease risk by 25-30 percent and their lung cancer risk by 20-30 percent.[8] More deaths are caused each year by tobacco use than by all deaths from human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined[9]. Much can be done to mitigate this public health concern, as tobacco use is the leading *preventable* cause of death in the United States. On average, smokers who quit will live longer and have fewer years living with disability.[10]

Economic Burden of Smoking

Smoking places a tremendous economic burden on employers. In 1999, lost productivity due to smoking and smoking-related illnesses cost employers $2,312 per smoking employee. Excess medical expenses due to smoking and smoking-related illnesses cost employers $2,132 per smoking employee (both figures are adjusted to year 2008 dollars).[11] Nationally, the CDC estimates that in 2001–2004, average annual smoking-attributable health care expenditures were approximately $96 billion, compared to $75 billion in 1998. Accounting for direct health

[*] Tobacco use includes smoking and chew tobacco, both of which are health hazards. This report mainly focuses on smoking.

care expenditures and productivity losses ($97 billion), the total economic burden of smoking is approximately $193 billion per year.

Employer impacts from tobacco use are in both direct costs associated with health care for both employees and dependents, as well as lost productivity. Tobacco use has cost implications for employers. Employers pay the cost of employees continuing to smoke through[12]:

- Higher health care costs
- Increased absenteeism
- Increased life insurance costs
- Decreased on-the-job productivity

Additional employer costs may be associated with building maintenance and insurance as well as worker safety.

Effectiveness of Tobacco Use Treatment Programs

Smoking cessation treatment is effective. Treatments are based on a national evidence based guideline developed by the U.S. public health service and adopted by most scientific and professional organizations, *Treating Tobacco Use and Dependence: 2008 Update*. The guideline includes 10 essential findings for treating tobacco use that incorporate practices deemed effective using strongest research evidence. The *Treating Tobacco Use Guideline* includes both interventions that should be carried out by physicians and other providers and environmental changes that can be adopted by employers and others to promote tobacco cessation.

U.S. Public Health Service (PHS) Guideline for Treating Tobacco Use and Dependence

Ensure that all smokers are offered effective tobacco-use treatment at all clinical encounters.

Increase access to and participation in effective tobacco-use counseling.

Increase access to and appropriate use of effective tobacco-treatment medications.

Reduce patient out-of-pocket costs for tobacco-use treatment.

Create a social and economic environment that promotes quitting

From the U.S. Surgeon General, Treating Tobacco Use

The sidebar in this page illustrates some of the *Treating Tobacco Use and Dependence* findings, including several directed at physicians and several that would need to be carried out through an employer benefits strategy. Appendix 1 includes a list of all 10 findings.

Recommendations in clinical guidelines are intended to reflect what we know about effective tobacco cessation interventions, and what we know about practical application. For example, the United States Preventive Services Task Force (USPSTF) found good evidence that brief smoking cessation interventions—screening, brief (less than 3 minutes) counseling, and pharmacology delivered in primary care settings are effective in increasing the proportion of smokers who successfully quit smoking and remain abstinent after one year.[13]

Research also shows additional, more intensive counseling and behavioral cessation therapies, along with medications, increase the success rates for treatments[14]. Research has also shown that treatments with more person-to-person contact and greater intensity (e.g., more time with counselors) are more effective. Individual, group, or telephone counseling are all effective, as are strategies that employ counseling plus medication therapy.[15] In fact, multiple studies have shown that counseling and pharmacotherapy are effective when used by themselves for cessation treatment, and that they are *more* effective in a combination of counseling and pharmacotherapy.[16],[17],[18] Since patients prefer shorter, more convenient cessation programs, the CDC recommends offering a variety of approaches with varying levels of intensity – to accommodate patient preference.

Cost-Effectiveness of Tobacco Use Treatment Programs

The Partnership for Prevention ranked the health impact and cost effectiveness of 25 recommended preventive health services. Smoking cessation advice and cessation medication tied for highest ranking with daily aspirin use (age/sex related) and childhood immunizations.[19] Smokers who successfully stop smoking reduce their potential medical costs associated with coronary heart disease by an average of $67 during the first year and approximately $1,225 during the next 7 years (in year 2008 dollars).[20]

The design of a tobacco cessation program influences its cost effectiveness. For example, one study found that employees were more likely to enroll in a smoking cessation plan if the employer covered all costs. In the study, full coverage quadrupled the yearly quit rates of smokers, compared with those with reduced coverage.[21] An additional study found covering the full cost of smoking cessation intervention increased the number of quit attempts, the number of successful quitters, and the use of smoking cessation treatment attempts. Therefore, the CDC has concluded that reducing or eliminating out-of-pocket costs for patients who wish to quit smoking increases the use of effective cessation therapies and increases the number of people who attempt to quit.[22]

The Importance of Benefit Design in Promoting Tobacco Cessation

Employers are beginning to recognize the value of providing tobacco cessation benefits to employees relative to overall employee health and health care costs. However, many are not aware of what constitutes a comprehensive smoking cessation benefit. Based on extensive examination of treatments and costs,[23] the CDC recommends the following actions for a comprehensive smoking cessation benefit:

- Cover at least four counseling sessions of at least 30 minutes each, including telephone and individual counseling sessions
- Cover all FDA-approved nicotine replacement products and tobacco cessation medications
- Provide counseling and medication coverage for at least two smoking cessation attempts per year
- Eliminate or minimize co-pays or deductibles for counseling and medications[24]

There is still a long way to go to ensure that smokers have access to the comprehensive smoking benefit: A 2007 nationwide survey by the National Business Group on Health found that a majority of employers ranked smoking as one of the greatest priority health issues facing their companies, second only to obesity. However, although 96% said it would be beneficial to do so, only two percent of employers in the NBGH survey offered the comprehensive benefit recommended by the CDC.[25]

One of the ways employers are helping their employees and family members to address tobacco use is through the health plan coverage that the employer provides. This report focuses on the results of health plan performance with programs and initiatives to address tobacco use.

SECTION 2. eVALUE8 AND TOBACCO CESSATION

eValue8 is the leading evidence-based Request for Information (RFI) Tool and is a key initiative of National Business Coalition on Health (NBCH). Over 100 million Americans, or one in every three Americans, are members of health plans that respond to the eValue8 RFI. It is widely used by business health coalitions, their purchaser members, and national employers to assess and manage the quality of health care vendors. eValue8 raises the bar for health care performance and moves the market to deliver greater value for the purchaser's health care dollar. Employers increasingly use eValue8 as a vendor management tool to assess how health plans respond to and potentially mitigate the downstream cost and productivity impact of health problems—including tobacco use. NBCH and its member coalitions encourage employers to use eValue8 information to improve health plan management, oversight and delivery of health care services. For more information, visit: www.nbch.org/eValue8

The eValue8 RFI survey tool is updated each year to examine health plan activities that address national and employer priorities. In 2008, eValue8 asked for information in seven modules shown in Table1. This report examines health plan responses for tobacco cessation program activities contained in a subset of questions from seven modules.

Table 1. Health Plan Activities Modules in eValue8

• Plan Profile. Plans report on how they organize services and on their accreditation status by an external organization. This section also examines plan use of "value based" benefits to reduce consumer expenses for highly effective services. Plans report on health information technology systems to manage and report information that improves quality.

• Consumer Engagement and Support. Plans report on their programs to support members in choosing the best doctors, hospitals, and treatment alternatives as well as programs supporting self-management. Self-management support includes tools such as personal health records (PHR) where eValue8 challenges plans to leverage their information to help improve health status by pre-populating the PHR with medical services used and enabling the PHR to send outbound messages based on known gaps in care customized to the member's circumstances.

• Provider Measurement. Plans report what measures they use to track, benchmark, and provide performance feedback to physicians and hospitals. Health plans also report their activities designed to promote and reward doctors and hospitals for superior performance, including clinical outcomes.

• Pharmaceutical Management. Plans report on how they manage costs through the use of generic equivalent medications, special programs for managing high cost biologicals, and what steps they have taken to improve safe and appropriate use of medications.

• Prevention and Health Promotion. Plans report on programming and performance in cancer screening, immunizations, tobacco use, weight management, worksite health promotion, risk factor education care during maternity and well-child care.

• Chronic Disease Management. Plans report on accreditation status, performance results and support offered to physicians and members that help their members with cardiovascular disease and/or diabetes manage their conditions.

• Behavioral Health Screening and Management. Plans report on use of clinical guidelines and screening tools for plan members who are depressed and/or use alcohol. The plans report performance results in behavioral health and the support offered to patients and physicians.

Employer Expectations for Health Plan Performance: Tobacco Cessation

The eValue8™ RFI tool sets expectations for health plan performance in screening and cessation support—counseling and medication—for tobacco use. Employers that purchase health benefits expect plans to identify and target members who can benefit from treatment, offer a variety of interventions and track the success of program efforts. Health plan purchasers also expect plans to have a robust primary prevention program that educates members about the risk factors for tobacco use and its relationship to other chronic diseases.

The data presented in this report are from 103 plans responding to the 2008 eValue8RFI and that had their responses verified through a local business coalition representing employer-purchasers. The number of responses to each individual question varies. Note that the responses indicate plan capability to provide the services, not that the service is available to all members.

eValue8 Questions Related to Tobacco Cessation

Health plan standardized expectations that form eValue8 questions for tobacco cessation are based on evidence from peer-reviewed studies and recommendations of national organizations such as the CDC. Each of the seven modules listed in Table 1 includes questions related to tobacco cessation programming. Specific questions related to the identification of tobacco users, program features, and tracking for tobacco cessation program participation is summarized in Table II. Each of the elements shown in Table II factors into an overall eValue8 score for participating health plans. The summary tobacco cessation score reflects the performance of plans in multiple domains, including benefit design, delivery processes, and performance improvement activities.

eValue8 includes a strong emphasis on health plan relationships with and support of physicians in their network. eValue8 encourages plans to offer incentives or financial rewards to physicians who consistently perform well in screening and then treating patients who need smoking cessation services. eValue8 includes questions that focus on the health plan engagement with physicians about the identification of members who use tobacco and

provider advice for smokers to quit. eValue8 questions relating to physicians include whether physicians receive feedback on their performance with respect to patient cessation and whether any of this data is used for consumer reporting or payment rewards.

Table II: Overview of eValue8 Questions Related to Tobacco Cessation

Question Target Area	Question Component Detail
Methods of Identification	▪ Primary Care Physician Referral ▪ Enrollment Question ▪ Health Risk Assessment ▪ Self referral ▪ Electronic Medical Record ▪ Claims Data
Access to Counseling	▪ Interactive on line • Facilitated • Non facilitated ▪ Telephonic counseling ▪ Group sessions ▪ Individual in person sessions
Counseling Duration	▪ Each course of treatment includes at least 4 sessions ▪ Each session at least 30 minutes long ▪ Each course of treatment routinely includes up to 300 minutes of counseling ▪ At least 2 courses of treatment to accommodate relapse
Medication (FDA approved over the counter nicotine replacement products or prescription cessation medications)	▪ Over the counter aids or prescription FDA approved nicotine replacement with copayment or deductible ▪ Over the counter aids or prescription discounted nicotine replacement free or available copay ▪ Buproprion (generic Zyban®) with copay or deductible incentives ▪ Zyban® with copay or deductible, incentives or discounts ▪ Chantix® with copay or deductible, incentives or discounts
Tracking Member Participation	▪ Tracking participation in cessation activities ▪ Tracking participation in cessation activities at employer level
Measuring Outcomes	▪ Health plan performance on CAHPS “Advising tobacco users to quit” survey measure ▪ Health plan quit rates

Method of Health Plan Scoring for Tobacco Cessation

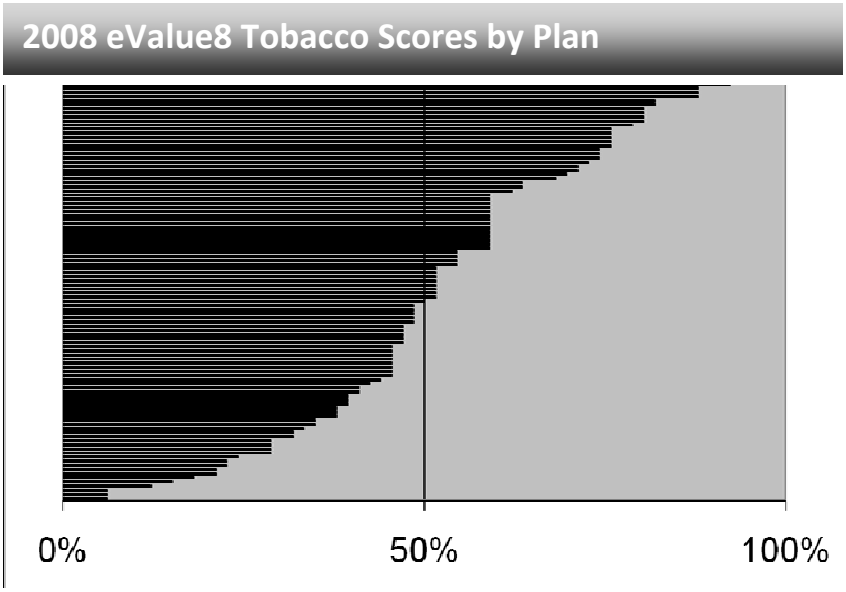
Health plans responses to eValue8 are "scored" based on the activity reported by the plan compared to expectations established through the RFI. The "tobacco score" refers to the percentage of total available points awarded to a plan in the tobacco section A health plan "score" for tobacco cessation activities is the percent of total tobacco score the plan received out of points available in the tobacco section of the eValue8 RFI. Points are allocated according to the relative importance of plan capabilities and results in the following areas: Identifying members in need of service and tracking their involvement and their results; following CDC recommendations regarding treatment sessions, pharmaceuticals and physician involvement; and results of tobacco-related CAHPS questions. A score of 100% would reflect a plan that has implemented all of the evidence based practices and programs recommended in evidence-based guidelines and by the CDC. The top rated plan nationally becomes a benchmark for what can be achieved.

The next sections of this report show some of the health plan performance indicators in specific modules or aspects of performance assessed through eValue8.

SECTION 3: HEALTH PLAN eVALUE8 RESULTS BY MAJOR CATEGORY

The tobacco cessation rollup scores of each plan responding to eValue8 are shown Table III. As the table clearly shows, no health plan achieves 100% and only about half of the plans achieve 50% or better. Just 17% of plans scored 75% or above. These benchmarks, along with specific performance scores of each plan, are used by employers and local business coalitions to identify health plan opportunities for improvement in their tobacco cessation programs.

Table III. Total Score for Tobacco Cessation by Individual Health Plan



The performance of plans related to specific areas of expectation are discussed in this section. Results for tobacco cessation performance of health plans are grouped as:

- Plan member identification and communication
- Provider performance measurement and engagement
- Tobacco cessation program features – counseling and medication support
- Health plan results and outcomes

Plan Member Identification and Communication

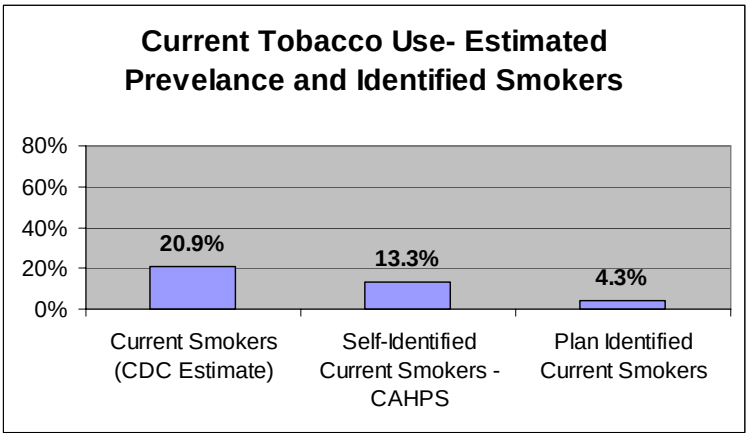
Identification

eValue8 encourages health plans to have multiple mechanisms to identify members who use tobacco. To help plans estimate the number of smokers in their covered population, eValue8 recommends that plans use public data to determine the prevalence of tobacco use in the general population. Approximately 21% of the US population smokes, but that percentage varies greatly by state, age, gender and race /ethnicity[26]. Plans can approximate the number of

smokers they expect, given the population served, and can then ramp up member identification strategies to ensure that members in need of services are identified and provided with access to treatment.

Table IV illustrates the gap in identifying smokers. Column 1 shows the US estimated CDC rate. The second column show that if plans survey members using a standard CAHPS survey (discussed more later in this report), they come up with an average rate of 13% of plan members being smokers. By other methods, plans identify a range of .1% to 19% of members as smokers, with an average of about 4%. This shows that plans need to implement multiple methods to identify smokers to close the gap between the expected number and the actual identified number they report in eValue8.

Table IV: Current Tobacco Use – Estimated by Plans Compared to CDC Defined Prevalence



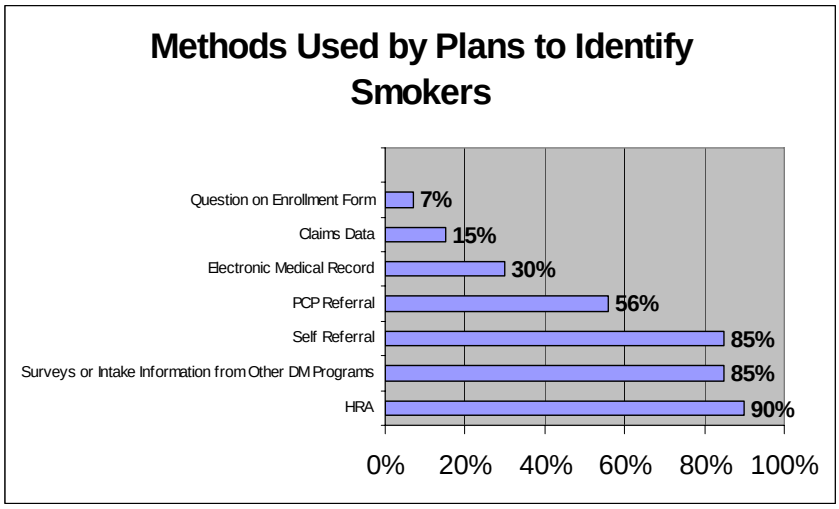
Source: eValue8 2008 and CDC. Note: state by state smoking rates vary

eValue8 focuses on member identification as a core capability and an essential step in the tobacco cessation process. The plan cannot begin to improve the quality of care and interact with patients until it knows who they are. Strategies that could be used by plans to identify tobacco users include asking at the time of enrollment, using a health risk assessment (HRA), analyzing claims data for indications that the patient is a smoker (for example, on a diagnosis code used to bill for services), or asking network physicians to screen at risk members. *Member identification is key* to enrolling patients in disease management programs and reaching out to them with smoking cessation program information.

The approaches used by plans to identify smokers are shown in Table V. 90% of plans currently identify smokers through self identification in health risk assessments, 85% use screening of members in disease management programs, 85% rely on self referral, and only a small minority, 7% ask members on enrollment. Most often health plans identify tobacco user members through referrals from providers and through patient self referral. This shows the importance of educating practitioners and encouraging them to screen patients for smoking, as well as the need to proactively encourage members to use tools such as health risk assessments.

Most plans offer HRAs as a generalized tool to identify member risk factors. HRAs typically assess patient risks related to smoking, nutrition, exercise, other behaviors, and familial risk. eValue8 data show that 94 percent of health plans offer HRAs both online and in print. However, on average, only two percent of plan members completed an HRA in the last year. As such, while HRAs are important strategy to identify patients who are tobacco users and as a tool to engage patients early in prevention and health promotion activities, plans must also use education, information and incentives to encourage members to use the HRA and act on the results.

Table V: Methods Used by Plans to Identify Smokers



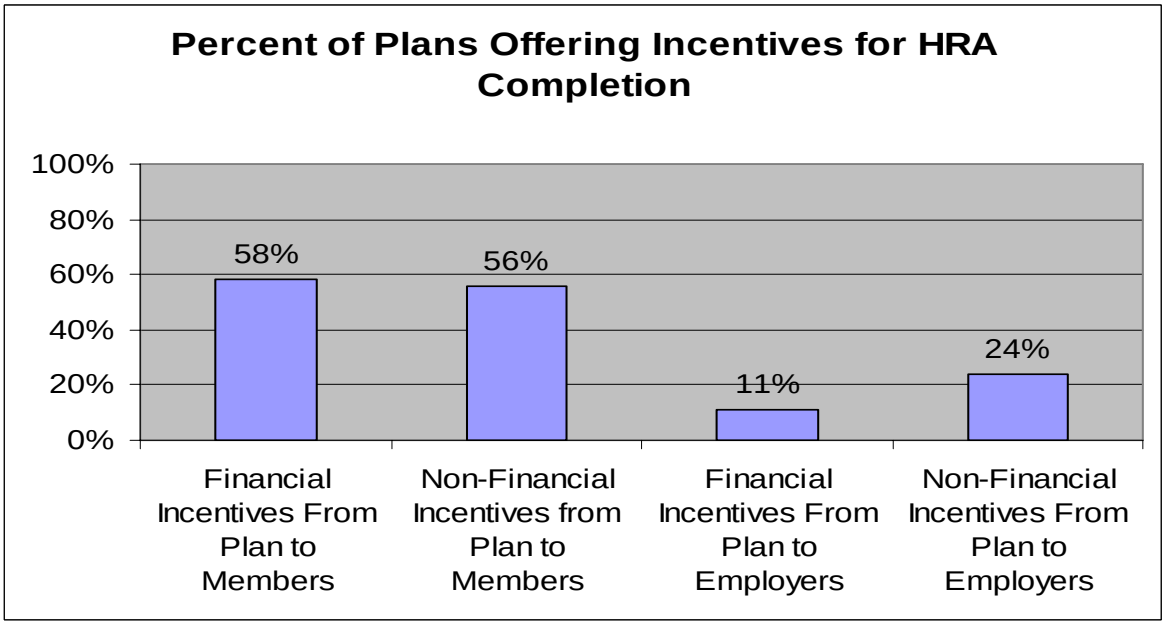
Source: 2008 eValue8 Plans were able to select multiple options. Numbers do not equal 100%

Table VI shows what methods the plans believe are most effective for patient identification. Patient self referral (47%) and HRAs (37%) are viewed as most effective for identifying patients in need of tobacco cessation services. Self referral may indicate that the member is at least at the stage of seriously thinking about tobacco cessation. Health plan activities to educate patient and physician involvement in tobacco cessation complement self-referral programs. Physicians can increase the chance of patients self referring for treatment when the physician routinely offers screening and counseling services at the point of care.

Table VI Percentage of Plans Method Identified as Most Effective

Method Identified	***Percentage Plans Identifying as Most Effective***
Patient self referral	47%
Health Risk Appraisal	37%
PCP referral	11%
Claims data	2%
Electronic Medical Record	1%
Survey/Disease Management	1%

Table VII: Incentives for HRA Completion

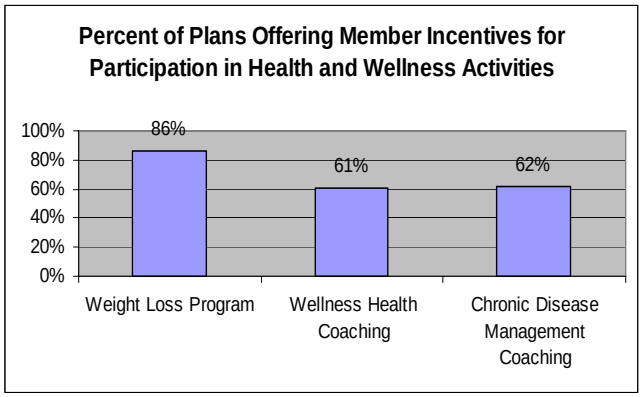


Source: 2008 eValue8 Note: plans and employers may both offer these options. Responses indicate plans and employers have capability, not that the incentive is available to all members.

To engage members and identify risks, many plans offer incentives for the members to take a health risk assessment. Table VII shows the percent of plans capable of offering financial and non-financial incentives used by plans. For example, 58% of plans have capability to offer financial incentives to members, and 56% can offer non-financial incentives. Employers are also an important part of incentive strategies, with 11% capable of offering financial incentives to encourage use of HRAs, and 24% offering non-financial incentives. Non financial incentives include gift cards, coupons, membership discounts and fitness items.

Once members have been identified as tobacco users from any source, another key process step is engaging them in an intervention. As Table VIII shows, 61% of plans have capability to offer incentives for members to participate in wellness and health coaching, and for chronically ill patients, 62% can offer incentives for participation in a disease management program. Virtually all disease management programs include a tobacco use assessment, as smoking is a major contributor to development and complications of heart disease, diabetes, asthma and other chronic conditions.

Table VIII: Incentives for Member Engagement in Health Improvement



Source: 2008 eValue8

Member Communications

Many plans use extensive communications with members to alert them to services and encourage them to take the health risk assessment. Results from the 2008 eValue8 RFI showed that health plans used a variety of interventions to communicate with members and tobacco users for cessation support options. These tobacco-specific communications are in addition to the general education provided by health plans in member newsletters or in scheduled visits with practitioners.

Table IX highlights findings on plan communications with respect to tobacco cessation. Ninety-seven percent of plans include smoking information on their web sites or in newsletters, and 91% include information about second hand smoke (risks to members who are around smokers). Only 14% communicate directly with pediatricians about smoking issues, meaning that there is potential opportunity to work with physicians to prevent children from starting smoking, and helping pediatricians talk with parents about the risks to their children from second hand smoke.

Of particular interest, 79% of plans will mail a "quit kit" to members who request one. A quit kit generally includes a letter to the member advising them of ways to stop smoking, a guide to stopping smoking, worksheets to monitor progress and other tools. It not considered an "intervention" according to eValue8 unless the member also accesses counseling or other benefits. eValue8 encourages plans to use multiple methods to reach the broadest number of health plan members with communications about tobacco cessation.

Table IX: Communication Methods Used by Health Plans for Tobacco Cessation

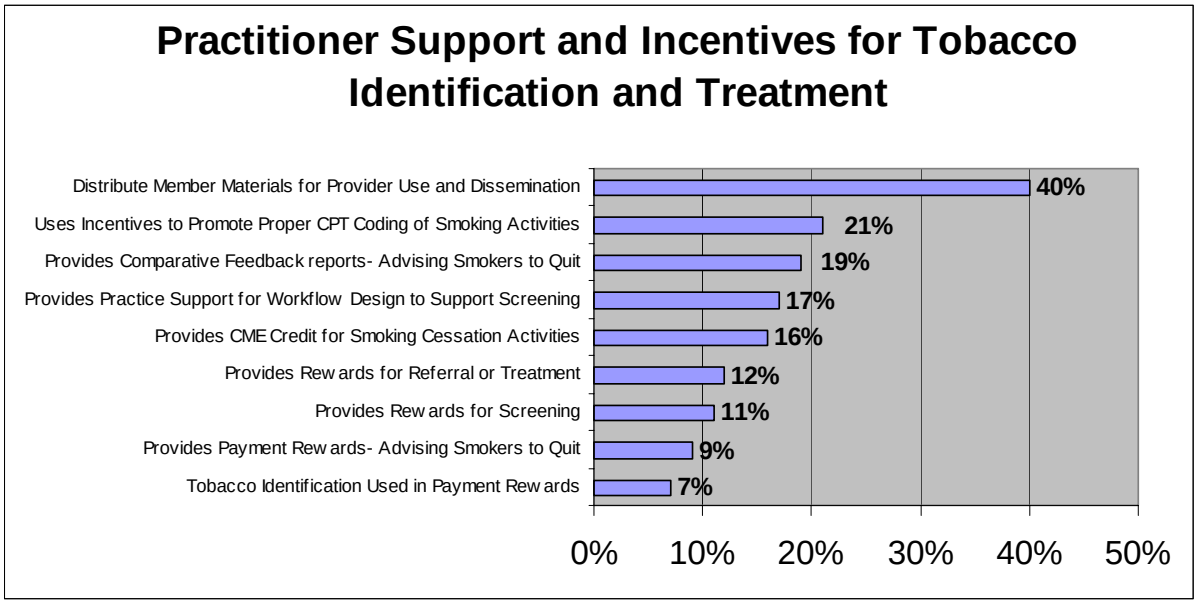
Communication Method	*% of Plans Reporting Using*
• General smoking risk information on web sites and through newsletters	97%
• Inclusion of information on risks of second hand smoke exposure for children and adolescents on plan websites and in newsletters	91%
• Provide a "quit kit" or tool kit that is mailed to a member	79%
• Distribute member information through pediatricians	14%
• Include information about the exposure to second hand smoke in communications provided by pediatricians.	13%

Provider Performance Measurement and Engagement

For most people, their doctor is a very influential individual for initiating the process of smoking cessation[27], yet studies over the years have shown that physicians do not routinely assess and treat tobacco use[28]. The CDC recommends determination of smoking status at every visit as the place to start. As of 2008, the only nationally approved measures related to cessation were three physician measures: advising smokers to stop, counseling them about strategies to stop and to counseling them about pharmaceuticals. To achieve smoking cessation results, plans need to encourage network physicians to use their leverage with their patients who are tobacco users to promote cessation. Plans can improve physician performance by educating physicians, offering incentives for them to screen and treat, and providing feedback to the physicians on their performance. Plans commonly share information about smoking with physicians: 71% provide general information to practitioners about resources and programs available for tobacco cessation and 75% offer general information about clinical practice guidelines.

Health plans often have information that is not available to physicians because they have access to information from health risk assessments and from patient visits to multiple physicians. Plans also tend to have sophisticated analytic capability that enables them to generate reports. eValue8 encourages plans to provide information back to physicians and hospitals to improve their performance in treating tobacco users.

Table X: Percentage of Health Plans Reporting Types of Support for Practitioners



Source: 2008 eValue8

One way that plans can increase the number of tobacco users identified and treated is to work with physicians. Studies have shown that performance feedback with information on achievable "benchmarks" is an effective way for health plans to help physicians understand and improve the care they deliver.[29] Plans can provide general information to physicians, specific

information on which patients appear to need treatment, and they can create physician incentives. Physician performance measurement and feedback is not yet ubiquitous. Currently 15% of plans provide member specific reports or reminders to screen to physicians, and 33% provide member specific reports or reminders to treat. 19% of plans offer comparative reports to alert physicians to how well they are doing compared to other physician peers.

Plans are not yet routinely creating incentives for physicians or linking them up with plan resources to screen and treat patients for tobacco use. Table X shows that only 11% offer rewards (usually financial) for screening, and 12% offer incentives for referring. Twenty one percent promote the use of smoking related billing codes as an indication that physicians are providing smoking cessation services. While 19% of plans offer comparative feedback reports to physicians on how well they are doing in advising members to quit smoking compared to other physicians, only 9% offer financial rewards based on this measurement. As discussed below, 12% reward physicians for "Recognition" which is another way for them to demonstrate that they are advising patients to quit smoking

Plans are also expected to communicate information about physician and hospital performance to members to help the patients make choices and access services and information to improve their health status. One trend among plans is to target incentives and public recognition for physicians that demonstrate high quality care in relation to specific diseases. For example, many plans use the NCQA Physician Recognition Program to identify high performing physicians who care for patients with diabetes or heart disease.

To be "recognized," doctors voluntarily choose to audit their medical records to determine if they are consistently delivering care according to guidelines – and for patients with chronic diseases, that care includes smoking identification and cessation treatment. High-performing doctors consistently offer the hemoglobin testing, lipid testing, medication management, smoking cessation and preventive services identified as essential in guidelines. Over half of plans have a way to highly NCQA Recognized physicians publicly. For example, many plans make a notation about Physician Recognition in the plan provider directory. To date, only a fraction of all physicians eligible for recognition by NCQA have been assessed or designated, suggesting an opportunity for additional physician self assessment. A growing number of plans, as illustrated in Table XI, offer some assistance to physicians to help them achieve this performance recognition.

A majority of plans have the capacity to offer financial incentives to the physicians who perform well on process and outcome measurements. For example, specifically for patients with diabetes, sixty percent of plans have the capability to use bonuses or higher fee schedules to reward high performing physicians and 44 percent have the capability to offer rewards or bonuses specifically for high performance[†].

[†] Recognition programs are disease specific, and these reported rates apply to diabetes recognition. It is perhaps most important to help patients with chronic disease to stop smoking, since risks increase dramatically for smokers and people with multiple conditions. The plans that use these features may establish eligibility requirements that

Table XI: Plan Activities to Actively Promote NCQA Physician Recognition

Plan Activities to Actively Promote NCQA Physician Recognition for Care	
Public Recognition	52%
Payment Incentives (P4P)	28%
Member Steerage (Criterion for Tiered/Narrow Network)	18%
Data Collection/Technical Assistance	13%
Application Fee Assistance	11%
Recognition not Actively Promoted	33%

The breadth of approaches to engage and educate physicians as shown in these results indicates a variation in the mechanisms currently being used—from education to incentives—to both identify and treat members for tobacco cessation.

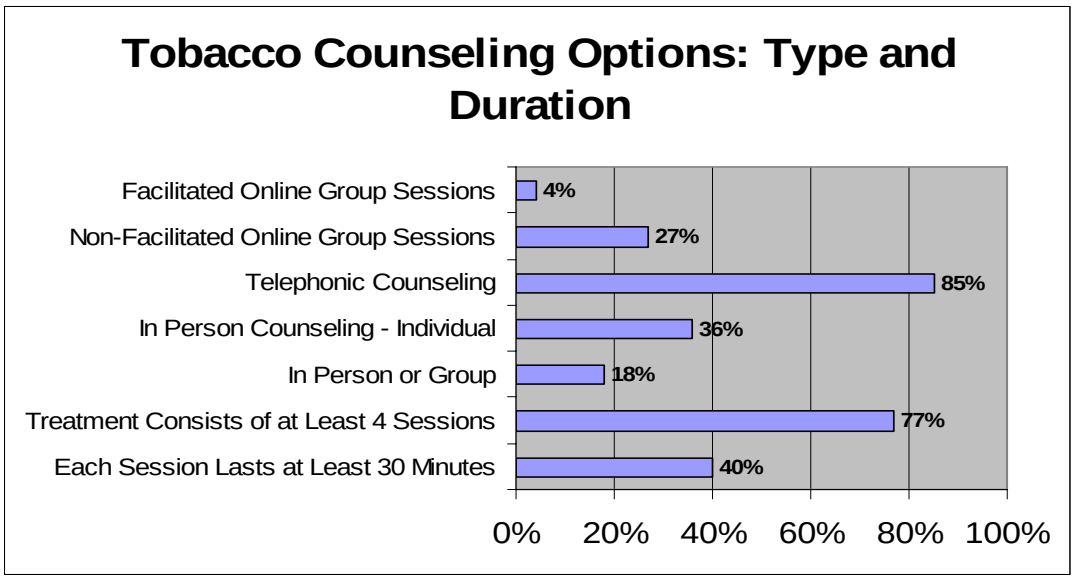
Tobacco Cessation Program Features

Counseling

U.S. Public Health Service guideline on *Treating Tobacco Use and Dependence: 2008 Update* includes 10 essential recommendations for treating tobacco use. For behavioral intervention, the report recommends that clinicians consistently identify tobacco users and offer brief interventions. It also recommends offering individual, group, and telephone counseling as part of tobacco cessation therapy.[30] This benefit design is recommended by the CDC as well, which notes that members are more likely to use a telephone counseling program than more intensive programs so the benefit should include both high intensity and lower intensity options. Effectiveness of the counseling treatment increases with the intensity – therefore CDC recommends including multiple types of counseling programs to ensure access to members ready for any type of intervention. Recommended components of counseling include practical counseling (problem solving and skills training) and social support delivered as part of the treatment program.

limit the number of physicians who can achieve these bonuses. For example, small practices may not have enough patient visits to report on performance measures, so may be ineligible.

Table XII: Tobacco Cessation Counseling Option Provided by Percentage of Plans



Source: 2008 eValue8

Health plans responding to eValue8 are asked to report both on health plan access options as well as the length (intensity) of the counseling intervention. eValue8 asks about 4 characteristics of counseling benefits: 1) each course of treatment includes 4 sessions; 2) each session lasts 30 minutes; 3) at least two courses of treatment available if the first one fails; and 4) 12 sessions available per year. Counseling options may be available at the individual clinician's office including interactive electronic support, facilitated group sessions, or non facilitated chat sessions.

As shown in Table XII, most plans offer at least one type of smoking cessation counseling. Eighty-eight percent of plans offer telephonic counseling, and 37 percent offer in person or group programs. In other elements of the CDC recommended counseling benefits, 45% of plans report that each course of treatment includes up to 300 minutes of counseling and 49% of plans provide a minimum of 12 phone or in person visits per year.

Unfortunately, only 20% of plans offer all four of the counseling elements recommended by the CDC. Specific content elements of tobacco cessation counseling sessions are not tracked by health plans. Many plans also offer mailed "quit kits" as noted above, but without counseling this is not considered a separate "invention" in eValue8

Medication Support

The U.S. Public Health Service recommends that smoking cessation medications be considered an essential treatment strategy[31]. Medication therapy is an important option for smoking cessation treatment. According to the guideline, pharmacotherapy and behavioral interventions can increase quit rates 15-30 percent compared to 7 percent without assistance.[32] With such increased rates of effectiveness with the combination of behavioral

and pharmacology treatments, the evidence suggests the need for health plans and employers to include both behavioral and pharmacologic benefits for smoking cessation.

Clinicians generally refer to FDA-approved smoking cessation pharmacotherapies in terms of first line and second line treatments. First line medications have an established empirical record of efficacy in smoking cessation and should be considered first as part of tobacco-dependence treatment (except in cases of contraindications). Each of these medications has been documented to increase significantly the rate of long-term smoking abstinence.[33] The seven medication treatments include over-the-counter and prescription nicotine replacement therapy (gum, inhaler, nasal spray, patch and lozenge) and two prescription medications bupropion SR (Zyban®) and varenicline (Chantix®).

Once employers and plans have made medication therapy available through benefit design, many continue to work to make treatments more accessible. Reducing out-of-pocket costs for tobacco use treatment medications and nicotine replacement products has proven to further reduce quit rates.[34] Table XIII shows overall coverage of smoking cessation pharmacotherapy, along with financial strategies to increase access to essential treatments. Overall, approximately 80% of plans report covering any FDA approved medication for smoking cessation medications. Fewer plans offer incentives with lower copayments or deductibles, especially for name brand FDA approved prescription medications for smoking cessation.

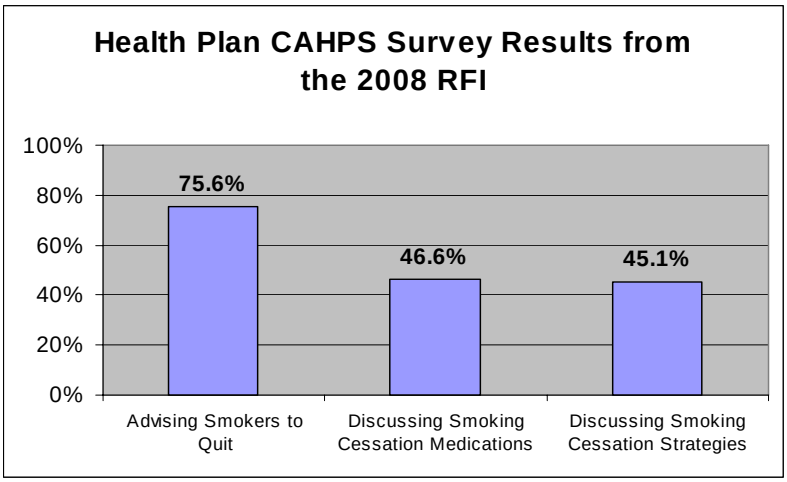
Table XIII: Summary of Pharmacy Options Results from eValue8 2008

eValue8 question for Pharmacy Options	Percent of Plans With Capability
Over the counter (NRT patch, lozenge, gum) discounted, free, or available at usual copay	81%
Over the counter (NRT patch, lozenge, gum) available at usual copay or deductible with incentives	68%
Buproprion (generic Zyban®) usual copay or deductible	80%
Bupropion copay or deductible incentives or discounts	33%
Zyban® usual copay or deductible	74%
Zyban® copay or deductible incentives or discounts	25%
Chantix® usual copay or deductible	77%
Chantix® usual copay or deductible incentives	27%

Health Plan Results and Outcomes

Most plans reporting to the eValue8 RFI are accredited by a national accountability organization called the National Committee for Quality Assurance (NCQA). As part of NCQA accreditation, plans track their overall performance in improving smoking cessation. Health plans use a standard patient survey CAHPS (The Consumer Assessment of Healthcare Providers and Systems) to evaluate whether physicians routinely ask patients about their smoking status and advise tobacco users to quit. CAHPS data is included in "HEDIS" data reporting set that plans report to NCQA for accreditation and NBCH for eValue8.

Table XIV: Health Plan Tobacco Treatment Survey Results

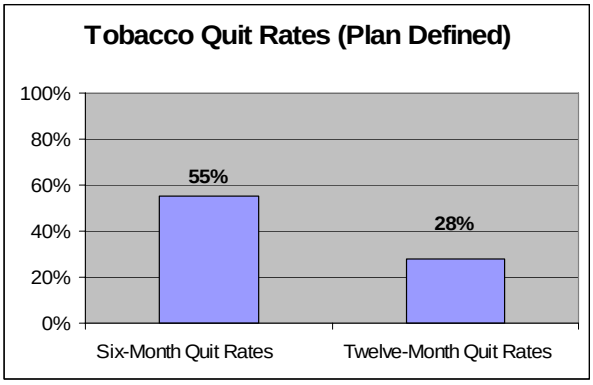


Source: 2008 eValue8

HEDIS does not examine *how* plans achieve their reported performance rates or whether any particular doctor counsels members appropriately, only the overall rate. HEDIS and CAHPS data is useful for an employer to assess the overall health plan performance and activities. HEDIS data is intended to be actionable by encouraging plans to take broad based action such as physician education, member interventions or other actions to improve their results. Many plans use HEDIS data to guide their own measurement and quality improvement activities targeting physicians. Only 7% of plans use CAHPS survey information to track physician performance in advising smokers to quit.

As Table XIV shows, about 76% of smokers surveyed indicated that their physician advised them to stop smoking. While this may seem like adequate performance, it means that 24% of smokers do not recall that their doctor spoke with them about quitting smoking. Further, over half of the respondents do not recall their doctors speaking with them about smoking cessation strategies or medications.

Table XV: Plan Reported Tobacco Quit Rates



Source: 2008 eValue8

eValue8 also asks health plans whether they track member "quit rates" to show the effectiveness of tobacco cessation interventions. The CDC defines a 'cessation attempt" as, "Among current cigarette smokers, making at least one cessation attempt during the preceding year was defined as a "yes" response to the question, "During the past 12 months, have you

stopped smoking for more than one day because you were trying to quit smoking?" Using this definition, CDC reports that approximately 44% of people quit or attempt to each year[35]. As noted above, cigarette smoking is a relapsing condition, so smokers often need multiple quit attempts before succeeding. eValue8 does not require plans to use the CDC definition, but it does ask plans how they track quit rates and participation of members in tobacco cessation activities. Table XV shows the average quit rates reported by health plans.

While 73% track participation of members in tobacco cessation activities, only 49% track quit rates up to 6 months after treatment and 20% of plans track quit rates at 1 year, meaning the plan cannot identify whether tobacco cessation activities have been effective over time. eValue8 responses indicate a low rate for both tracking of participation and even lower for actual quit rates for tobacco users.

Table XVI: Percentage of Plans Tracking Participation in Tobacco Cessation Programs, Quit Rates, and Physician Advice to Quit

eValue8 Query Topic	*% Health Plans*
Track member participation in tobacco cessation activities	73%
Monitor rate of individual physicians who advise smokers to quit	7%
DO NOT track HEDIS “Advising Smokers to Quit” (CAHPS)	27%
DO NOT track discussing smoking cessation strategies (CAHPS)	27%

Employer Tobacco Cessation Action Check List*

- ✓ *Implement an evidence-based benefit design that supports screening, counseling, and over-the- counter and prescription medications that aid tobacco cessation*
- ✓ *Implement smoke-free workplace and campus policies*
- ✓ *Educate and communicate with employees about the benefits of tobacco cessation*
- ✓ *Identify tobacco users through an employer sponsored health risk assessment available either through the employer or the health plan, and create incentives for employees to use the HRA*
- ✓ *Provide information about programs and services to help with tobacco cessation, such as quit lines, CDC resources, other public health sources, or other readily available sources*
- ✓ *Foster a supportive work environment for tobacco cessation*
- ✓ *Provide support for community-based tobacco cessation initiatives including activities addressing children to prevent smoking*
- ✓ *Integrate smoking cessation programs with other available programs and services*
- ✓ *Offer multiple resources to reach specialized populations (e.g., resources to employees who smoke and to those who are pregnant or planning to be pregnant)*
- ✓ *Request details from health plans about the benefits and services offered and how these are accessed by plan participants. Variations in both coverage and approaches to support practitioners vary and are interconnected. These need to be better understood to improve outcomes.*
- ✓ *Track and monitor health plan activities and delivery of services at critical junctions in the tobacco cessation process: identification, delivery of benefits, patient and physician engagement, and cessation results.*

Source: NBCH

Section 4. Discussion and Observations

Employers recognize the need to provide support for employees and their family members who use tobacco products, and that lowering the rate of tobacco users will help to address employee health and productivity. eValue8 helps these employers to understand the performance strengths and opportunities with health plans for tobacco cessation.

Role of Plans: Organizing Care and Closing Quality Gaps

To be effective, health plans must carry out complex and interrelated tasks related to tobacco use cessation, from the identification of tobacco users to getting the member to access the most appropriate available services. Results from eValue8 show that identification of tobacco users is the essential and "rate limiting" step for health plans and physicians. Observations from eValue8 results indicate:

- Self referral as the major source for identification of tobacco users needs a better compliment of mechanisms for identification—HRA, practitioner, referral from disease management program, electronic medical record, etc.
- Identification of tobacco users needs to improve so that rates of users identified by plans approximates the number of expected users according to national and local tobacco use prevalence data.
- Additional work with the practitioner community is needed especially to offer and evaluate the impact of incentives and education.
- Health plans need to determine collective ways to address practitioner engagement. Although not addressed in eValue8, this may be particularly challenging when a clinician provides services for more than one health plan.
- Health plans need to be encouraged to adopt the evidence based plan design as the standard approach for tobacco cessation.
- Health plans employ an array of communication tools and approaches to counseling to help address the preferences of the employee or patient. Continuation of flexible approaches might be enhanced with further evidence for consumer engagement in tobacco cessation.

- Exemplary practices are demonstrated by a small but growing group of health plans, indicating that other plans could achieve better results.

eValue8 data show room for improvement in all areas, although a few health plans leading with best practices and serve as the benchmarks for best performance.

Role of Employers: Workplace and Health Benefits

Tobacco cessation in particular is most effective as a partnership between plans and employers to ensure that both the delivery structure and the health care benefit are aligned. Effective tobacco cessation programs include counseling and medications consistent with the U.S. Public Health Service guideline. In addition, the CDC recommends non-standard benefits as the lower deductible or co-payment option for FDA approved medications or the use of tool kits for members. Employers need to fully understand the details of their benefit design to make certain that the benefit design is aligned with U.S. Public Health Service recommendations. This is an important issue since while counseling and medication are each effective in treating tobacco dependence, and combinations and overlapping approaches are common.

A large part of the employer's role involves helping to educate employees and their families not only about the health impact of tobacco use but also about the programs and services that are available to aid tobacco cessation. Employers need to enhance health plan efforts with their own internal communications and awareness campaigns—including making clear to employees what support is available and how to access services. For example, employers can make certain that other programs and services reference the tobacco cessation support services at important moments for education such as an employee or family member who uses tobacco and who is planning to have a baby or will be a new grandparent. Employers can also offer direct access to a health risk assessment for employees. The employer can coordinate information flow with the health plan to improve rates of identification of tobacco users as well as education about support for tobacco users to quit.

Some essential next steps for employers to promote accountability and performance improvement related to tobacco use cessation include:

What the Research Shows

- *Health insurance that pays the full cost of smoking-cessation treatments can increase quit rates compared to benefit plans that only partially cover cessation treatment or that offer no cessation benefits*
- *Programs to stop smoking delivered during hospitalization that include a 1-month follow-up are most effective*
- *Proactive telephone counseling can be effective compared to an intervention without personal contact. Successful interventions generally involve multiple contacts timed around a quit attempt*
- *All of the commercially available forms of nicotine replacement therapy (gum, transdermal patch, nasal spray, inhaler, and sublingual tablets/ lozenges) are effective as part of a strategy to promote smoking cessation =*
- *Standard self-help materials may increase quit rates compared to no intervention, but the effect is likely to be small*

Cochrane Collaboration, 2005 findings, reported in: A Practical Guide to Working with Health Care Systems on Tobacco Use Treatment, P. 4 http://cdc.gov/tobacco

- Employers need to understand the evidence based plan design elements for tobacco cessation and make these part of their benefit program.
- Employers can promote the benefits of the tobacco cessation program as part of the communication process and reinforce the importance of the issue with workplace policies.
- Employers need to continue to use evaluation tools such as eValue8 to measure the performance of health plans and to promote quality improvement for tobacco cessation.

This report shows that health plans have an important role in administering smoking cessation benefits and encouraging – through education, tools, and incentives - the provider community to implement best practice guidelines for smoking cessation. It also illustrates the importance of active employer engagement in tobacco cessation. Employers have an essential role through their own workplace programs and policies, and in the design of health benefits. Employer activities augment those of the health delivery system. With the evidence of both the cost impact of tobacco use and the successful design for support programs for cessation, employers should work in collaboration with health plans to promote this benefit and the related policies and communications.

Additional Resource Materials

- Office of the Surgeon General. Public Health Services Guideline. *Treating Tobacco Use and Dependence, 2008.* Available at*: http://www.surgeongeneral.gov/tobacco/*
- Centers for Disease Control and Prevention. Office on Smoking and Health. Multiple fact sheets, data and information. Available at: http://www.cdc.gov/tobacco/
- National Business Group on Health. *Purchaser's Guide to Preventive Services: Moving Science into Coverage.* Available at http://www.businessgrouphealth.org/benefitstopics/topics/purchasers/fullguide.pdf
- Partnership for Prevention. *Healthcare Provider Reminder Systems, Provider Education and Patient Education: An Action Guide.* Available at www.prevent.org/actionguides
- Partnership for Prevention. *Investing in Health: Proven Health Promotion Practices for Workplaces.* Available at http://www.prevent.org/content/view/133/
- National Business Coalition on Health. Tobacco cessation employer case studies, background information on tobacco use and cessation, and other resources at http://www.nbch.org/resources/smoking_cessation.cfm
- Centers for Disease Control and Prevention. *A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006. Available at: http://www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/practical_guide.pdf

Key Findings from *Treating Tobacco Use and Dependence: 2008 Update*[‡]

The guideline identified a number of key findings that clinicians should use:

1. Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.
2. It is essential that clinicians and healthcare delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a healthcare setting.
3. Tobacco dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the recommended counseling treatments and medications in the Guideline.
4. Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in the Guideline.
5. Individual, group and telephone counseling are effective and their effectiveness increases with treatment intensity. Two components of counseling are especially effective and clinicians should use these when counseling patients making a quit attempt:
    - Practical counseling (problem-solving/skills training).
    - Social support delivered as part of treatment.
6. There are numerous effective medications for tobacco dependence and clinicians should encourage their use by all patients attempting to quit smoking, except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers and adolescents).
    - Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:
        - Bupropion SR
        - Nicotine gum
        - Nicotine inhaler
        - Nicotine lozenge
        - Nicotine nasal spray
        - Nicotine patch
        - Varenicline
    - Clinicians should also consider the use of certain combinations of medications identified as effective in the Guideline.
7. Counseling and medication are effective when used by themselves for treating tobacco dependence. However, the combination of counseling and medication is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.
8. Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, clinicians and healthcare delivery systems should both ensure patient access to quitlines and promote quitline use.
9. If a tobacco user is currently unwilling to make a quit attempt, clinicians should use the motivational treatments shown in the Guideline to be effective in increasing future quit attempts.

[‡] Copied verbatim from: Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. April 2009. Available at: http://www.ahrq.gov/clinic/tobacco/tobaqrg.htm#Findings

10. Tobacco dependence treatments are both clinically effective and highly cost-effective relative to interventions for other clinical disorders. Providing coverage for these treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans include the counseling and medication identified as effective in the Guideline as covered benefits.

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