TOBACCO CESSATION WORKS: AN OVERVIEW OF BEST PRACTICES AND STATE EXPERIENCES

Despite reductions in smoking prevalence since the first Surgeon General's report on smoking in 1964, approximately 45 million Americans and more than 1.2 billion people worldwide continue to use tobacco. Tobacco use takes a huge toll around the world by causing an enormous amount of health problems and related death and suffering. Tobacco cessation consists of a variety of approaches aimed at reducing the toll of tobacco by helping tobacco users to quit. Helping people to quit smoking is important because of the substantial health benefits to those who are able to quit successfully, such as increased longevity and decreased morbidity and mortality from heart disease, cancer, stroke, and chronic obstructive pulmonary disease. In addition to saving people from suffering from the wide-range of smoking-caused illnesses, cessation results in enormous declines in state health care costs and other smoking-caused expenditures.

Does Cessation Work? The Science Says YES!!

CDC's Best Practices for Comprehensive Tobacco Control Programs.[1] The Center for Disease Control and Prevention's (CDC) *Best Practices for Comprehensive Tobacco Control Programs* is a manual that details the nine essential components for comprehensive tobacco control programs. CDC's recommendations are based on evidence-based analyses of State tobacco control programs. The evidence highlighted below provides the basis for CDC's recommendations.

- "Programs that successfully assist young and adult smokers in quitting can produce a quicker and probably larger short-term public health benefit than any other component of a comprehensive tobacco control program."
- "[T]he cost savings from reduced tobacco use resulting from the implementation of moderately-priced, effective smoking cessation interventions would more than pay for these interventions within 3–4 years."
- "Smoking cessation is more cost-effective than other commonly provided clinical preventive services, including mammography, colon cancer screening, PAP tests, treatment of mild to moderate hypertension, and treatment of high cholesterol."
- "State action on tobacco-use treatment should include the following elements:
  - Establishing population-based counseling and treatment programs, such as cessation helplines.
  - Making the system changes recommended by the AHCPR-sponsored cessation guideline.
  - Covering treatment for tobacco use under both public and private insurance.
  - Eliminating cost barriers to treatment for under-served populations, particularly the uninsured."

Interagency Committee on Smoking and Health.[2] The Interagency Committee on Smoking and Health was established in 1985 to coordinate the Department of Health and Human Services efforts on smoking and health with similar efforts being undertaken by other federal, state, local level, and private agencies. In February 2003 the Committee released a plan, *A*

National Action Plan for Tobacco Cessation, to provide comprehensive cessation assistance to all smokers who want to quit. The plan was based, in part, on evidence that included:

- "Recent comprehensive analyses of hundreds of research reports have revealed that numerous, effective tobacco dependence treatments now exist. Not only do such treatments more than double a smoker's likelihood of achieving long-term abstinence, but research shows that such treatments are highly cost-effective. In terms of life-years saved per dollar spent, effective counseling and medications for smoking cessation have been found to be among the most cost-effective healthcare practices. In fact, tobacco dependence treatment is more cost effective than the treatment of hypertension, diabetes and hyperlipidemia."

- "Recent comprehensive analyses have identified a number of evidence-based policy interventions that will dramatically reduce tobacco use by promoting smoking cessation. These include proactive tobacco quitlines, paid mass media campaigns, increasing the unit price of tobacco products, systems-level changes within healthcare delivery systems to enhance the identification of and intervention with tobacco users; and reducing patient out of-pocket costs for effective treatments."

2000 PHS Clinical Practice Guidelines.[3] In June 2000 the U.S. Public Health Service released its clinical treatment guidelines for tobacco cessation, *Treating Tobacco Use and Dependence*. The guidelines were the result of a an intensive review of all the available scientific literature on tobacco cessation and provided recommendations on the best ways to increase access to, utilization of, and the effectiveness of cessation services and interventions by health care professionals. Below are some of the key findings in the guidelines:

- "It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.

- Brief tobacco dependence treatment is effective and every patient who uses tobacco should be offered at least brief treatment.

- There is a strong dose-response relation between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).

- Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients attempting tobacco cessation:
  - Provision of practical counseling (problemsolving/skills training);
  - Provision of social support as part of treatment (intra-treatment social support); and
  - Help in securing social support outside of treatment (extra-treatment social support).

- Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking, including bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, nicotine patch, and the nicotine lozenge.

- Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

- Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:
  - All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments identified as effective in this guideline; and
  - Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions."

Does Cessation Work? States' Experiences Say YES!

It is important to consider that most states view "cessation" as one component of a broader, comprehensive tobacco control and prevention program. Cessation, in this context, includes both individual services targeting individual tobacco users and population and systems level approaches that include such things as increasing the excise tax on cigarettes, smoke free workplace ordinances, and provider reminder systems within health care delivery systems. Together, these approaches represent a proven and effective strategy to get tobacco users to quit and maintain abstinence. Below is a sampling of evidence from several states about how their approaches, at both the individual and population level to cessation have been effective at increasing both quit attempts and quit rates.

California: The California Tobacco Control Program was established in 1989 after the passage of Proposition 99. California's program uses a variety of methods to address tobacco cessation, including a mass media campaign to encourage smokers to quit, a telephone Quitline and counseling services, and subsidized nicotine replacement therapy. Additionally, the Tobacco Control Program encourages the implementation of smoking restrictions in worksites and public places, funds several cessation programs at the local level, and encourages physicians and other healthcare professionals to advise their patients to quit smoking and to provide referrals to cessation services. The evidence indicates that these efforts have had a significant impact on tobacco use prevalence.

- During the 1990s, per capita cigarette consumption fell by a factor of 57% in California compared to only 27% in the rest of the United States. By the end of 1999, Californians consumed only 4.1 packs of cigarettes per person per month, compared to 9.1 in the rest of the United States.

- During the 1990s, adult smoking prevalence in California declined by 24%, compared to 17% in the rest of the United States.

- More Californian's are trying to quit (a 25% increase since 1990).

- More Californians work and live in places where they cannot smoke indoors. As a result, smokers have reduced their daily cigarette consumption and many have made quit attempts compared to smokers not constrained by smoking restrictions.

- Quit attempts of a one day or longer increased by 25% from 1990 to 1999.

- Use of smoking cessation assistance (including nicotine replacement therapy) has increased by nearly 22% between 1992-1999.

- Physician advice to quit to their patients who smoke increased by more than 20% between 1990 and 1999, and the percentage of smokers who stated they quit because of physician advice to quit increased by 32% between 1996 and 1999, from 25.3% to 33.4%.[4]

Massachusetts: The Massachusetts Tobacco Control Program was established in 1993. The program's cessation efforts include outreach and referral for smokers to tobacco treatment services that consist of assessments, individual and group counseling, subsidized nicotine replacement therapy, and follow-up; a toll-free telephone Quitline; a web-based tobacco treatment service that provides information about services available on the Internet, by phone, or in-person; and a statewide media campaign designed to motivate smokers to quit. Program results demonstrate that Massachusetts' program has been effective.

- Among Massachusetts smokers who try to quit, the success rate has increased by 39%, from 18%n 1993 to 25% in 2000.
- The adult smoking rate in Massachusetts fell from 22.6% to 17.9% between 1993 and 2000, a reduction of approximately 228,000 adult smokers.
- Between 1990 and 1999, smoking among pregnant women in Massachusetts declined by more than 50 percent (from 25% to 11%). Massachusetts had the greatest percentage decrease of any state over the time period (the District of Columbia had a greater percent decline).[5]

Maine: The Partnership for a Tobacco Free Maine's (PTM) Tobacco Treatment Initiative is part of Maine's comprehensive tobacco prevention and control program, funded by the Tobacco Settlement. The Initiative provides vital tobacco-related services currently lacking in clinical settings. Based on scientifically proven methods, the Treatment Initiative provides the public with direct access to counseling and medications that aid cessation, and educates Maine's school and healthcare professionals in treating tobacco use. The following are some highlights from a recent independent evaluation of the Treatment Initiative (based on data from 2002):

- The Maine Tobacco HelpLine increased the number of successful quit attempts by 300%.
- The Maine Tobacco HelpLine was used by residents from every county across Maine.
- 53% of callers reported hearing about the HelpLine through the media.
- Services reached groups with high smoking rates - young adults and the uninsured.
- PTM training increased treatment skills in healthcare workers from every county.
- Of approximately 4,000 tobacco users assisted by the HelpLine in 2002, over 1,500 quit temporarily and 730 quit long-term.
- Outcomes with telephonic counseling by the Maine Tobacco HelpLine are similar to that seen in clinics providing face-to-face smoking cessation interventions, with 21.5% of smokers not smoking six months after HelpLine counseling.[6]

Oregon: Oregon's tobacco cessation efforts are part of a larger comprehensive tobacco control program that focuses on the following themes: second-hand smoke is harmful, youth initiation should be prevented, and cessation assistance should be provided. Oregon's approach to cessation is based on the PHS Clinical Practice Guidelines and combines behavioral assistance with pharmacotherapy. The state's quitline is the way that most smokers enter into cessation services. Oregon is the only state that provides comprehensive Medicaid coverage of all Food and Drug Administration approved pharmaceuticals (including over-the-counter) and individual, group, and telephone counseling. Evaluation results indicate that Oregon's program has been successful at helping smokers quit. Six months following the initial call to the Oregon quitline, 48% of callers have either quit (13%) or have made a serious attempt to quit (35%). Oregon has been successful due to:

- Health care providers and health plans were active participants in the creation of the state's guidelines and continue to be invested in the program;
- Cessation services are covered by Medicaid;

- There has been an emphasis on strong training and education for providers and health care systems coupled with an effective quitline; and,
- Oregon has placed a heavy emphasis on evaluation that has allowed it to monitor progress and implement program changes and improvements.[7]

Arizona: Arizona's cessation program was implemented in 1996 and consists of proactive telephone counseling, mailed self-help publications, information and referral to local services, pre-recorded voice-mail quit tips, an interactive website with decision-making tools, automated FAX on demand quit tips, and cessation technical assistance. An evaluation of these services indicates that Arizona's program has been successful at helping smokers to quit.

- From 1996 to 1999, adult smoking prevalence declined by 21 percent, from 23.1% to 18.3%.[8]
- 10 percent of smokers who entered the treatment program were successful quitters (continuously abstinent) at 12 months follow-up.[9]

National Center for Tobacco Free Kids, October 21, 2003 / Matt Barry

Related Campaign for Tobacco-Free Kids Factsheets (www.tobaccofreekids.org)

Tobacco Cessation: An Overview

Benefits from Tobacco Use Cessation

Resources for Quitting Smoking

How Safe Are Novel Nicotine Products?

Key Tobacco-Cessation Findings and Recommendations from the U.S. Public Health Service and U.S. Preventive Services Task Force

State Cessation-Related Statistics & Potential Savings from Reducing Smoking by One Percentage Point

Medicare and Medicaid Costs & Savings From Covering Tobacco Cessation

What Kind of Tobacco Cessation Might Medicare, Medicaid, and Private Health Insurors Cover?

[Each of these Campaign for Tobacco-Free Kids factsheets on cessation are on the TFK website at: http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=25.]

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[1] U.S. Centers for Disease Control and Prevention (CDC), *Best Practices for Comprehensive Tobacco Control Programs—August 1999*, August 1999. http://www.cdc.gov/tobacco/research_data/stat_nat_data/bpchap7.pdf .
[2] Subcommittee on Cessation, Interagency Committee on Smoking & Health, *Preventing 3 Million Premature Deaths, Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation*, February 3, 2003.
[3] Fiore MC, Bailey WC, Cohen SJ, et al., *Treating Tobacco Use and Dependence.* Clinical Practice Guideline, U.S. Department of Health and Human Services. Public Health Service, June 2000, http://hstat.nlm.nih.gov/hq/Hquest/fws/T/db/local.ahcpr.clin.tob/screen/Browse/s/54866/action/GetText/linek/5.
[4] Gilpin EA, et al., *The California Tobacco Control Program: A Decade of Progress, Results from the California Tobacco Surveys, 1990-1998*. La Jolla, CA: University of California, San Diego; 2001. http://www.dhs.cahwnet.gov/tobacco/documents/CTS99FinalReport.pdf.
[5] Abt Associates Inc, "Independent Evaluation of the Massachusetts Tobacco Control Program, Seventh Annual Report - January 1994 to June 2000. Abt Associates Inc, "Seventh Annual Report - January 1994 to June 2000."
[6] Prepared for the Partnership For A Tobacco-Free Maine by The Center for Outcomes Research and Evaluation at Maine Medical Center, on behalf of the Center for Tobacco Independence, a MaineHealth® program, January 2003.
[7] Subcommittee on Cessation, Interagency Committee on Smoking & Health, *Preventing 3 Million Premature Deaths, Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation*, February 3, 2003.
[8] CDC, "Tobacco Use Among Adults - Arizona, 1996 - 1999," *MMWR* 50(20):402-40, May 25, 2001.
[9] Tobacco Cessation Evaluation Team, University of Arizona College of Public Health, *Arizona Adult Tobacco Cessation Program: Mid-Year Report, July 2000 – January 2002.*