RWJF *Retrospective Series*

More Than a Decade of Helping Smokers Quit

RWJF's Investment in Tobacco Cessation

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A companion report to *The Tobacco Campaigns of the Robert Wood Johnson Foundation and Collaborators, 1991–2010*

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The Robert Wood Johnson Foundation's Investment in Tobacco Cessation

Preface

Twenty years ago the Robert Wood Johnson Foundation decided to put our name and substantial financial and human resources behind a bold initiative to reduce tobacco use in this country. For two decades, RWJF has been working with partners in government, education, philanthropy and the private sector to make literally the air that we breathe safe to inhale and to free many Americans from a gripping, destructive addiction to which they were seduced in their youth. As this retrospective indicates, our tobacco-control campaigns often have seemed an uphill battle, but they have made significant inroads against the harmful effects of tobacco.

Because of that significant progress, we have scaled back our investments in tobacco control to allow us to focus on new public health challenges. Yet the moral injunction of medicine is "First, do no harm." As we wound down these investments (though ongoing, we are still providing $3,589,258 to reduce tobacco use), I was adamant that we needed to monitor the state of tobacco control going forward and to assess the legacy and impact of our body of tobacco-control work.

As we address other critical public health challenges, like the need to roll back the epidemic of childhood obesity, it is important to harvest lessons that can be learned from our tobacco-control work, which has been unique in terms of magnitude, duration, scope and methods. We therefore asked the Center for Public Program Evaluation to conduct an independent assessment to help us and the field understand the results of our efforts, what worked, what didn't, and what could be adopted or adapted to fulfill our mission to improve and make a demonstrable difference in health and health care for all Americans.

I wish to emphasize our insistence that the center's work be truly independent. The center's president, George Grob, is a former Deputy Inspector General of the U.S. Department of Health and Human Services, who personally took charge of this assessment. Grob asked Henry Aaron, Bruce and Virginia MacLaury, senior fellow and former director of economic studies at the Brookings Institution, and Michael O'Grady, senior fellow at the National Opinion Research Center and principal, O'Grady Health Policy, to provide an additional layer of independent review. Aaron and O'Grady advised on study methods and findings, and reviewed draft reports. The resulting assessment report describes both the significance and limits of RWJF's contributions and achievements.

I want to thank the many individuals and organizations—often working in collaboration—who conducted the tobacco-control campaigns, and I especially want to thank the many RWJF staff members (and former staff) who have worked with such competence and endurance on reducing Americans' addiction to tobacco. Among them were: Diane Barker, Michael Beachler, Sallie Petrucci George, Karen Gerlach, Marjorie Gutman, Robert Hughes, Nancy Kaufman, Jim Knickman, Michelle Larkin, Joe Marx, Tracy Orleans, Marjorie Paloma and Steven Schroeder, and many others behind the scenes and too numerous to name.

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Introduction

In 1995, 27.4 percent of American adults, 33.5 percent of high school students and 13.6 percent of pregnant women (average of 1995 and 1996 data), smoked cigarettes.

The health effects of smoking were well known by then. Physicians and experts agreed that smoking was bad for an individual's health. The Surgeon General's warning about the dangers of cigarette smoking had adorned every pack of cigarettes for 29 years. Laws restricting sales of cigarettes to minors were on the books in virtually every state. (As of 1992, all states but Montana and New Mexico had laws banning the sale of cigarettes to minors.)

Most smokers wanted to quit and more than half of them tried, but most did so on their own, with fewer than 10 percent using a formal quit-smoking treatment. And 90 percent to 95 percent of them failed.

This was the year that RWJF stepped into the field of tobacco cessation, with the specific goal of increasing the use of clinically proven tobacco-dependence treatments as part of its broader policy-based efforts to prevent and reduce population tobacco use. Over the next 15 years, RWJF invested almost $86 million in major programs (see Appendix), grants and national leadership to increase access to, and use of, effective tobacco-cessation treatments.

RWJF's investment in tobacco-cessation treatment and policy advances, coupled with strategic partnerships with the nation's leading tobacco-control funders and advocates, were critical in catalyzing and supporting the following accomplishments:

- Researchers identified effective new tobacco-cessation interventions (both policies and medical treatments) for youth and pregnant smokers and these interventions have been included in the U.S. Public Health Service (USPHS) Clinical Practice Guideline.
- The 1996 and 2000 practice guidelines were widely disseminated to a variety of health care providers (e.g., physicians, nurses, dentists) and to smokers themselves. This effort placed special emphasis on reaching providers who serve underserved low-income and minority smokers and those with co-occurring psychiatric and substance-use disorders.
  - RWJF also co-funded the 2008 USPHS Guideline update and its dissemination; the guideline has a greater emphasis on reaching its ultimate audience–smokers and their families.
- Provider tools and training modules, including interactive computer-based continuing medical education programs, were developed and disseminated to help translate the guideline recommendations into everyday practice.

- The national managed care "report card" on health care quality (developed by the National Committee for Quality Assurance and known as the HEDIS measures) was expanded to include measures of provider quit-smoking advice and assistance, including counseling and medication. These measures have been included in major national public "pay-for-performance" measurement sets.
- The Joint Commission for Accreditation of Healthcare Organizations added hospital-based tobacco use screening and intervention as requirements for hospital accreditation.
- Researchers identified changes at the practice level and at the broader level of health care system changes to better integrate tobacco-use screening and intervention into routine care. Effective interventions included: office- and health plan-level reminder systems, routine tobacco intervention measurement feedback and pay-for-performance incentives; expanding insurance coverage and promoting it widely among providers and smokers.
- Managed care and government (Medicaid, Medicare and Veteran's Health Administration) coverage for tobacco-dependence treatments increased substantially. Between 1990 and 2009 the number of states whose Medicaid programs cover at least some cessation aids increased from one to 45. Coverage of at least some cessation treatments was available in up to 97.5 percent of managed care plans in 2003 compared to 75 percent in 1997. Furthermore, 88 percent of plans provided full coverage of pharmacotherapy in 2003, up from 25 percent in 1997.
- Tobacco-use cessation is now seen as a standard of care by physicians treating pregnant smokers. The proportion of smokers receiving advice and help to quit from their primary care provider rose steadily from 1995 to 2007, reaching 61.5 percent in 2006-2007.
- All 50 states now have quitlines accessible through a single national portal (1-800-QUIT-NOW). Some 66 percent of these quitlines dispense free counseling and free medication to adult callers, and 34 (68%) provide counseling tailored to youth.
- Critical studies were funded showing that tobacco tax increases; smoke-free air laws; expanded coverage for tobacco-cessation treatment; the switch from prescription to over-the-counter (OTC) nicotine replacement therapies; tobacco counteradvertising; and expanded state tobacco-control funding are effective population-level cessation strategies, boosting smokers' quitting efforts and successes.
- Other critical research was funded examining causes for smokers' underuse of effective treatments and documenting wide sociodemographic disparities in treatment use.
- Policies related to taxation and smoke-free laws changed considerably as a result of RWJF-funded national state and local advocacy efforts:
  - State tobacco taxes increased 173 times between 1994 and 2009, with the average tax more than quadrupled from 29 cents a pack in 1993 to $1.27 a pack in 2009. The Federal excise tax increased from 24 cents per pack in 1993 to $1.06 in 2009.
  - As a result of these higher taxes and tobacco price increases from the tobacco companies as a result of the Master Settlement Agreement, the number of smokers was reduced by more than 3.7 million and almost 38,000 smoking-related deaths were avoided.

  - Between December 31, 1991, and September 30, 2008, the number of states providing strong protection from tobacco smoke pollution in private worksites, restaurants and/or bars increased from 0 to 32. As of 2009, the percentage of Americans covered by state smoking bans increased from less than 0.5 percent in 1990 to 57 percent in workplaces, 65 percent in restaurants and 54 percent in bars. The percentage covered by both local and state laws in at least one of these settings rose to 71 percent as of October 2009.
  - As a result of the smoke-free indoor air policies, the number of smokers was reduced by 1.7 million and 19,000 smoking-related deaths were avoided. The combined outcome was 5.3 million fewer smokers and 60,000 fewer smoking-related deaths.

- In 2005, 2006 and 2007, the Consumer Demand Roundtable, a multidisciplinary panel, was convened to discover new approaches for boosting demand and use of proven cessation treatments, especially among underserved low-income smokers. Promising efforts include aligning the introduction of tobacco tax increases and smoke-free air laws with promoting and providing cessation services, and redesigning treatment and treatment delivery systems to make them more appealing to users. See Report on the 2006 meeting and the Report providing findings from the 2007 meeting.
- From 2007 to 2010, RWJF awarded a series of grants to help form and support the North American Quitline Consortium (NAQC) to deliver high-quality cost-free services through a network of quitlines reaching all 50 states, the District of Columbia and Puerto Rico. In 2009 state quitlines assisted more than 480,000 people, representing 1.2 percent of U.S. smokers.

Finally, and most importantly, 15-plus years into RWJF's tobacco-cessation efforts and partnerships, the number of former smokers exceeded the number of current smokers, and fewer Americans smoke. Adult smoking prevalence fell from 24.7 percent in 1995 to 20.5 percent in 2008; youth smoking prevalence declined from 33.5 percent in 1995 to 20 percent in 2007.

A THREE-PRONGED STRATEGY

RWJF used a three-pronged strategy to help people quit smoking: "science push" (proving, improving and disseminating evidence-based cessation treatments), "capacity building" (increasing the capacity of providers, health care systems and community services to deliver effective treatments), and "market pull" (increasing policy-maker and consumer demand for proven treatment options).

Science push. By the mid-1990s, scientists had been studying tobacco addiction for more than 20 years, and had identified effective ways to treat it, forming the basis for the first-ever USPHS Clinical Practice Guideline. Unfortunately, few doctors routinely asked about smoking or offered their patients proven help to quit. Most smokers wanted to quit, but very few used effective treatments and the vast majority were unsuccessful when they tried. In addition, effective treatments had not yet been identified for two important high-risk populations–pregnant smokers and adolescents.

RWJF sought to bridge the gap between what the scientific evidence was showing and what medical practitioners were doing. That meant getting the evidence into the hands of practitioners–in a way they could implement in their practices. Special emphasis was given to research and research partnerships to discover effective treatments for pregnant smokers and teens.

The key goals in this component of the strategy were:

- Broadly communicating the science and clinical guideline recommendations to practitioners, health plan leaders, insurers, and health care and government policy-makers, with an emphasis on reaching underserved populations.
- Testing, adapting and disseminating novel interventions for two specific populations–pregnant women and youth.

Capacity building. Pushing the scientific evidence for tobacco-cessation treatments out to providers could only be effective if the health care system had the capacity to implement those treatments. The second aspect of RWJF's strategy was to increase the capacity of health care providers and the offices and health care systems in which they worked to be able to integrate evidence-based tobacco-cessation treatments into routine care. Efforts included:

- Identifying methods to increase providers' capacity to address smoking by their patients as an integral part of quality health care and then getting health plans and providers to implement these methods:
  - Implementing systems to remind physicians to advise and assist their patients to quit smoking, and to monitor and incentivize their performance.
  - Developing and disseminating provider training materials and tools, such as computer-based training and continuing medical education programs.

Market pull and consumer demand. The third aspect of RWJF's strategy was to increase market incentives and consumer demand for proven treatment methods. Efforts included:

- Advocacy, action and communications to promote higher tobacco taxes, smoke-free air laws, expand insurance coverage for treatment and other policies proven to boost smoker quit attempts, quit rates and treatment use.
- Research documenting the health and economic impacts and cost-effectiveness of tobacco cessation for employers and other purchasers of health insurance coverage.
- Working to embed tobacco use screening and treatment into the leading national health care quality improvement metrics and pay-for-performance standards.
- Finding ways to redesign treatments and treatment delivery systems to make them more appealing to smokers, especially underserved low-income smokers.

Strategy 1

Science Push

By 1995 scientists had been studying tobacco addiction for more than 20 years, and had identified effective ways to treat it. That research formed the basis for the United States Public Health Service (USPHS) Clinical Practice Guideline, first published in 1996. Unfortunately, few primary care providers routinely asked about smoking or offered their patients proven help to quit at this time. Most smokers wanted to quit, but very few used effective treatments and the vast majority were unsuccessful in their attempts.

In addition, effective treatments had not yet been identified for two important high-risk populations–pregnant smokers and adolescents.

The Robert Wood Johnson Foundation (RWJF) sought to bridge the gap between what the scientific evidence was showing and what medical practitioners were doing. That meant getting the evidence into the hands of practitioners–in a way they could implement in their practices.

The Foundation program staff gave special emphasis to research and research partnerships to discover effective treatments for pregnant smokers and teens. In addition, RWJF supported research to better understand smokers' behaviors.

WHAT IS KNOWN ABOUT ADULT SMOKING CESSATION IN THE GENERAL POPULATION

Michael Fiore, Ph.D., director of the Wisconsin Center for Tobacco Research and Intervention, and co-director of RWJF's *Addressing Tobacco in Health Care* national program–a principal investigator at Wisconsin's project in RWJF's program, *Partners With Tobacco Use Research Centers: Advancing Transdisciplinary Science and Policy*, and one of RWJF's *Innovators Combating Substance Abuse*–highlighted the following key facts about tobacco cessation in a 2002 article in the *Journal of the American Medical Association* co-authored with D.K. Hatsukami, Ph.D., and T.B. Baker, Ph.D.:

- **Quitting improves health,** even after 50 years or more of smoking.
- **Treatment helps.** Smokers who are treated by a clinical professional using an evidence-based intervention are more likely to have long-term success. Smokers who try to quit on their own succeed only about 5 percent of the time. Using a recommended intervention increases successful cessation rates to 15 to 25 percent.

- **Cessation counseling is effective** when it provides social support and training in skills for handling nicotine withdrawal and everyday stress without smoking. Better results are seen with more intensive counseling–either face-to-face or via telephone–but even one to three minutes of brief primary care advice and counseling boost population quit rates.
- **Medications also help.** The seven medications approved by the U.S. Food & Drug Administration (FDA) and recommended for use in the USPHS Guideline are safe and effective. These medications (bupropion, nicotine patch, nicotine gum, nicotine lozenges, nicotine inhaler, nicotine nasal spray and varneicline) work by either mimicking the positive impact that nicotine has on the brain of a smoker or lessening symptoms of nicotine withdrawal that typically occur when a smoker stops using tobacco. Their use is not advised for some groups of smokers, including pregnant women and those with cardiac conditions.

(See Grant Results on *Innovators Combating Substance Abus*e and a Grantee Profile of Fiore.)

(See the sections that follow for efforts focused specifically on pregnant smokers [Strategy 1.2] and youth [Strategy 1.3].)

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- ***Partners With Tobacco Use Research Centers*** (1999–2008) helped translate the research findings of the Transdisciplinary Tobacco Use Research Centers (TTURCs) into policy and practice. TTURCS were established in 1998 by the National Cancer Institute (NCI) and the National Institute on Drug Abuse (NIDA), both part of the National Institutes of Health (NIH), to integrate scientific studies of tobacco use, prevention and treatment across disciplines. See Grant Results for more information about RWJF's role.
- ***treatobacco.net*** (2001–2003) is a Web-based database offering practical support to treat tobacco dependence. The site–aimed primarily at practitioners–gives one-stop access to the latest research on tobacco-cessation treatment. See Grant Results for more information.
- ***Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy*** sponsored 42 studies of interventions to help pregnant women quit smoking and remain smoke-free. The program disseminated the results by creating a coalition of more than 60 organizations and developing almost 70 products. The dissemination office supported five case studies of health systems changes designed to increase the delivery of evidence-based treatments to pregnant smokers and led the development of the National Partnership to Help Pregnant Smokers Quit. See Grant Results for more information.
- **Tobacco-Free Nurses** (2002–2008) built capacity for tobacco cessation in two ways:
  - By helping nurses quit smoking, enabling them to serve as more effective quitting counselors for their patients.
  - By providing training, tools and resources tailored to nurses' varied roles as cessation counselors in inpatient and outpatient settings. See the Guide for Nurses, for example.

  See Grant Results for more information.

KEY RWJF–SPONSORED INITIATIVES: ADVOCACY AND COMMUNICATIONS

- **National Tobacco Cessation Collaborative** (NTCC) (2002–2009), an outgrowth of the joint RWJF–American Cancer Society Center for Tobacco Cessation, is a coalition of tobacco-cessation organizations dedicated to increasing successful cessation among tobacco users in the United States and Canada. NTCC's first major initiative was the Consumer Demand Roundtable. RWJF published two reports: one on the second Roundtable meeting; the other a summary of findings from all the roundtable meetings. There is also a video "Calling All Smokers" on the RWJF website.
- **A National Action Plan for Tobacco Cessation** (2003), co-funded by RWJF, the Agency for Healthcare Quality and Research, and the American Legacy Foundation, was created by an interagency federal committee that made six recommendations to reduce tobacco use, including developing a government-funded network of state telephone quitlines, which was put into effect by Health and Human Services Secretary Tommy Thompson in 2004. Michael Fiore chaired the committee and received a 2003 *Innovators Combating Substance Abuse* award from RWJF to implement key components of the plan. (See his Grantee Profile.) Fiore was the lead author of a seminal article in the February 2004 *American Journal of Public Health*, "Preventing 3 Million Premature Deaths and Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation."
- ***Smoking Cessation Leadership Center*** (2002–2011) works with dozens of health professional organizations and institutions representing physicians, nurses, pharmacists, hospitals, labor unions, the Veterans Health Administration and myriad other groups to increase their motivation and capacity to refer smokers into treatment and their leadership to promote effective cessation treatments and policies. It has a special focus on smokers with co-occurring mental health and substance abuse problems.
- **North American Quitline Consortium** (NACQ) (2007–2010), funded through a series of RWJF grants. NACQ is organized to assure high-quality, cost-free cessation treatments (1-800-QUIT-NOW) to smokers in all 50 states, the District of Columbia and Puerto Rico.

Strategy 1.1

United States Public Health Service Guideline

The U.S. Public Health Service (USPHS) released the first-ever clinical practice guideline for tobacco cessation in 1996. RWJF helped support the dissemination of the guideline to a variety of health care providers (including physicians, nurses, dentists and others).

RWJF also helped to support updates of the guideline in 2000 and 2008.

WHAT IS KNOWN ABOUT GUIDELINES FOR CESSATION TREATMENT

A simple intervention—the "5 A's"—can help smokers quit. The USPHS Guideline released in 1996 recommended health care providers use a brief intervention, known as the "5 A's," to help the smokers among their patients quit smoking. Taking as little as three to five minutes, health care professionals could significantly increase their patients' quit attempts and successes with the following five steps:

1. **ASK** about tobacco use–Identify and document tobacco use status for every patient at every visit.
2. **ADVISE** to quit–In a clear, strong and personalized manner, urge every tobacco user to quit.
3. **ASSESS** willingness to make a cessation attempt–Is the tobacco user willing to make a cessation attempt at this time?
4. **ASSIST** in cessation attempt–For patients willing to make a cessation attempt, use appropriate counseling and pharmacotherapy to help them quit. For others, provide motivational interviewing to boost quitting readiness.
5. **ARRANGE** follow-up–Schedule follow-up contact, preferably within the first week after the cessation date and refer to additional follow-up care as needed.

The guideline included recommendations for the types of health care system and policy changes needed to support widespread adherence to this brief intervention.

KEY RWJF-SPONSORED INITIATIVES: RESEARCH

RWJF sponsored a number of independent research projects that tested the effectiveness of the 5 A's model and the USPHS Guideline. These projects included:

- **The impact of practice guidelines on physician behavior.** A survey of physicians examined the impact of the practice guideline on how well they provided support for smoking-cessation treatment. (See the RWJF abstract of an article in the *American Journal of Preventive Medicine* that reported these results.)
- **A study of the incremental costs of using the 5 A's.** The incremental costs for using the 5 A's among pregnant smokers range between $24 and $34 for each pregnant smoker, according to the RWJF abstract of an article in Public Health Reports.
- **USPHS Guideline and Medicaid recipients.** A study found that only 10 states used the USPHS Guideline to help design treatment programs or benefit packages for Medicaid recipients. (See the report.)
- **The National Commission on Prevention Priorities** found the 5 A's intervention to be the single most effective and cost-effective clinical preventive service for adults in the general population, saving an estimated $500 per smoker and generating a long-term quit rate of 22 percent among smokers given this advice routinely over the course of their care. (See the RWJF abstract of an article in the *American Journal of Preventive Medicine* that reported these results.)

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- **Original guideline** (1996)–When USPHS developed the original guideline, RWJF helped support its dissemination to a variety of health care providers (physicians, nurses, dentists and others), making special efforts to reach those who served underserved low-income populations, racial or ethnic minority groups, and youth and pregnant women. For instance, dissemination grants were awarded to the American Medical Association, the National Medical Association (for Black physicians), the National Association of Black Nurses, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists. (See Grant Results on ID# 29466, ID# 30028, ID# 30465 and ID# 30525, et al.)
- **Guideline updates** (in 2000 and 2008)–RWJF supported the update of the guideline in 2000 (based on a review of more than 6,000 articles) and 2008 (based on a review of more than 9,000 articles). The 2008 version gives greater emphasis to reaching the guideline's ultimate audience–smokers and their families–and pays special attention to smokers with limited income and formal education, and to pregnant women, youth and smokers with co-occurring psychiatric and substance use disorders. RWJF also supported communication efforts to widely publicize the updated guideline. (See Grant Results on ID# 34068, ID# 45383, ID#55358 and a news release on the 2008 guideline.)
- ***treatobacco.net*** (2001–2003)–RWJF supported this web-based database offering practical support to treat tobacco dependence. The site–aimed primarily at practitioners–gives one-stop access to the latest research on tobacco-cessation treatment. (See Grant Results.)

KEY RWJF-SPONSORED INITIATIVES: ADVOCACY & COMMUNICATIONS AROUND WHAT WORKS

- The ***Smoking Cessation Leadership Center*** has provided resources and tools to health care professionals to help them implement evidence-based smoking cessation treatments in their daily practices.

OTHER RESOURCES AND RESEARCH FINDINGS FUNDED BY RWJF

- The Oregon Research Institute implemented and evaluated a five-step guideline similar to the 5 A's with a group of dentists and dental hygienists in Oregon. (See Grant Results.)
- A study to determine the most effective way of measuring whether providers follow smoking-cessation guidelines. (See the RWJF abstract or the full article in *Nicotine & Tobacco Research*.)
- A study published in the *Archives of Internal Medicine* in March 2006 to determine the optimal dosage for nicotine replacement therapies. (See journal article.)

Strategy 1.2

Reducing Smoking Among Pregnant Smokers

WHAT IS KNOWN ABOUT PREGNANT SMOKERS

In 1995 researchers estimated that 20 percent of pregnant women smoked during their pregnancies. Smoking during pregnancy was considered the single greatest cause of serious, preventable pregnancy complications and fetal harms, including low-birthweight babies (babies born to smoking mothers weigh less on average than babies born to nonsmoking mothers), preterm deliveries and perinatal deaths, including those caused by sudden infant death syndrome.

An estimated 20 percent or more of low-weight births could be prevented by eliminating smoking during pregnancy. Thus, for women and their providers, pregnancy represents a unique "teachable moment"–a time when there is heightened motivation to quit, and the opportunity to provide more support for doing so. But until 1996 there were no guidelines for the effective treatment of pregnant smokers. RWJF targeted pregnant smokers, especially low-income pregnant smokers who are Medicaid beneficiaries, both because of the heightened health risks and because studies have shown that women who smoke are most likely to quit when they are pregnant.

KEY RWJF-SPONSORED INITIATIVES: RESEARCH

- RWJF's ***Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy*** (1993–2008) was the Foundation's first and longest-funded cessation-focused national program. It funded 42 small-scale pilot studies to identify effective and innovative strategies to help smokers quit that could be integrated into routine prenatal and postpartum care for all pregnant smokers. The program disseminated the results through a coalition it created of more than 60 organizations and by developing almost 70 products. The dissemination office grew to become part of the National Partnership to Help Pregnant Smokers Quit. (See Grant Results for more information.)

After the first round of studies, the national program office, directed by Robert Goldenberg, M.D., teamed up with the U.S. Centers for Disease Control and Prevention (CDC), several National Institutes of Health agencies, and the American College of Obstetricians and Gynecologists to conduct a systematic review of the existing research on smoking-cessation treatments for pregnant smokers. Then *Smoke-Free Families* funded several studies that tested the U.S. Public Health Service Guideline for cessation counseling among pregnant smokers. (The USPHS Guideline is described in Strategy 1.1 in this report and in an RWJF Anthology chapter.)

The most successful interventions were those that involved person-to-person advice and counseling to quit that exceeded the minimal three to five minutes recommended in the brief 5 A's primary care intervention (i.e., extended individual and group interventions involving at least 12 to 15 minutes of cognitive-behavioral counseling, augmented with quitting materials tailored toward pregnant women). No medications were found to be both safe and effective during pregnancy.

For more information on this review of existing research, as well as on the pilot research studies and demonstration projects supported by *Smoke-Free Families*, see the Anthology chapter, the Capstone Meeting Report and Grant Results. Other studies funded by *Smoke-Free Families* documented that:

- **Incentives help.** Vouchers and other incentives give pregnant smokers an extra push to quit, particularly when coupled with other interventions, such as counseling and follow-up.
- **Quitlines help.** Counseling offered directly to pregnant smokers via telephone quitlines is effective.
- **Biofeedback is a promising supplement to counseling.** While not effective on its own, biofeedback to demonstrate the potential harms of smoking may be useful when combined with counseling.
- **Practice-level changes help.** Health care systems can make changes in the way their providers practice that help pregnant women quit. The most effective system changes are those that combine reminders, provider education and feedback to providers.
- **Covering treatment in pregnancy is cost-effective.** Expanding Medicaid and private coverage for tobacco-cessation counseling for pregnant and parenting women is highly cost-effective, with significant one-year returns on investment that reflect reductions in pregnancy complications and fetal risks.

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- ***Smoke-Free Families'*** systematic synthesis of research related to smoking among pregnant women was shared with the panel of the Agency for Health Care Policy & Research (AHCPR) that created the original clinical practice guideline in 1996. AHCPR (now known as the Agency for Healthcare Research & Quality or AHRQ) disseminates guidelines for evidence-based clinical practice to health care professionals across the country. *Smoke-Free Families*' research synthesis helped to form AHRQ's core recommendations for treating pregnant smokers. It also formed the basis for the treatment protocol recommended and promulgated

by the American College of Obstetricians and Gynecologists (see Grant Results), and the many professional organizations participating in the National Partnership to Help Pregnant Smokers Quit. Similar recommendations were made in the 2008 update of the clinical practice guideline. (See Grant Results.)

- **National Partnership to Help Pregnant Smokers Quit** (December 2000–2008), directed by Cathy Melvin, Ph.D., who also directed the national dissemination office of *Smoke-Free Families*, was a coalition of organizations formed to reduce smoking among pregnant women by increasing access to effective interventions–cessation treatments, health care system changes and public health policies. The partnership synthesized evidence for use by health care professional and voluntary health organizations in advocating for expanded tobacco-cessation treatment coverage and for health care system changes and other public health policies to promote and support treatment use. See Grant Results on *Smoke-Free Families* for more information.

KEY RWJF-SPONSORED INITIATIVES: ADVOCACY & COMMUNICATIONS AROUND WHAT WORKS

- **National Partnership to Help Pregnant Smokers Quit** (2001–2008) described above, has a website that provides fact sheets and tools to guide evidence-based care for pregnant and post-partum smokers. Recommendations for health care decision-makers and policy-makers also are provided. (See the National Action Plan to Reduce Smoking During Pregnancy. Also see the Smoke Free Families website and Grant Results on *Smoke-Free Families* for more information.)

OTHER RESOURCES AND RESEARCH FINDINGS FUNDED BY RWJF

- A study that investigated why Medicaid-insured pregnant smokers change or do not change their smoking behavior. (See Grant Results.)
- A study funded by the RWJF *Substance Abuse Policy Research Program* (see Strategy 1.3) found that tobacco tax and price increases are particularly effective in promoting quitting among pregnant women. (See the RWJF abstract of an article published in the *American Journal of Public Health*.)
- A study to identify critical "markers" of successful smoking cessation or reduction among pregnant women.
- Efforts to disseminate tobacco treatment guidelines to obstetricians and gynecologists. (See Grant Results.)
- An effort to make the U.S. Public Health Service cessation guideline a routine part of prenatal care. (See Grant Results.)
- A multimedia training tool for prenatal care practitioners. (See Grant Results.)

Strategy 1.3

Youth

Each day about 1,200 children and adolescents become daily smokers. In 2006 an estimated 3.3 million U.S. adolescents had used tobacco within the previous month. Adolescents and young adults in the United States are the populations with the highest smoking prevalence.

Although quitting benefits are greatest for those who quit at younger ages, numerous studies conducted in the 1990s found that counseling approaches and medications effective for adult quitters are not as effective for youth. A 2006 national survey funded by RWJF and the CDC's Office on Smoking and Health found that more than 60 percent of adolescent and young adult smokers had tried to quit within the previous year.

Reducing tobacco use among youth has been one of RWJF's major goals since it first entered the tobacco-cessation field in the early 1990s. The cessation effort has focused on identifying how and why youth begin smoking and how they progress from occasional smokers to daily smokers, as well as on developing the best treatment methods for helping youth quit.

WHAT IS KNOWN ABOUT SMOKING AMONG YOUTH AND YOUNG ADULTS

- **Influences on youth quitting.** Peers, family, individual attributes and external environment all influence the likelihood that kids will quit. (This factsheet from the Youth Tobacco Cessation Collaborative details the research on youth tobacco influences.)
- **Young smokers try to quit as often or more often than adult smokers.** The RWJF-funded National Youth Smoking Cessation Survey found that more than 80 percent of young smokers want to quit. About three-quarters have tried to quit at least once and failed. (See this factsheet from the Youth Tobacco Cessation Collaborative for more information on young smokers' quit attempts.)
- **Most young smokers don't use effective treatments when they try to quit.** (See news brief on a summer 2007 article in the *American Journal of Public Health* about a study of young adult smokers' quit attempts.)
- **Treatments that are effective for adult smokers are not as appealing or as effective for teen and young adult smokers.** The 1996 and 2001 USPHS clinical practice guideline panels did not recommend any counseling or pharmacotherapeutic treatment methods for youth.

KEY RWJF-SPONSORED INITIATIVES: RESEARCH

- ***Substance Abuse Policy Research Program*** (SAPRP) (1994–2010) and its predecessor, the *Tobacco Policy Research and Evaluation Program* (TPREP) (1992–1996) have supported policy-relevant, peer-reviewed research that increases understanding of policies for reducing harm caused by substance abuse, including tobacco use. These programs provided seminal findings showing the beneficial effects of tobacco tax and price increases, especially on young smokers, as well as the impact of anti-smoking media campaigns and smoke-free air laws on smoking prevention and cessation. They also documented the synergistic effects of comprehensive and combined public health tobacco-control policies on population-wide smoking and use of treatment. Results for youth smoking initiation and cessation can be found in SAPRP Knowledge Assets and reports ("Increasing the Use of Smoking Cessation Treatments," "Cigarette Taxes and Pricing" and "Research Agenda for Achieving a Smoke-Free Society.") (See Grant Results on TPREP, Grant Results on SAPRP and SAPRP Knowledge Assets.)
- ***Tobacco Etiology Research Network*** (TERN) (1996–2006) was a transdisciplinary research network that focused on the causes and progression of tobacco use and dependence and on processes of tobacco use initiation and cessation in youth and young adults. TERN brought researchers together from a variety of fields to study the origins of tobacco dependence. (See Grant Results.)
- ***Bridging the Gap/Informing Practice and Policy for Healthy Youth Behavior/*ImpacTeen** (1997–2012), co-directed by Frank Chaloupka, Ph.D., and Lloyd Johnston, Ph.D., is an interdisciplinary research program that has examined the links between youth behavior (including smoking) and national, state and local policy, economic and social factors. (See Grantee Profiles of Chaloupka and Johnston.)
- ***Helping Young Smokers Quit: Identifying Best Practicies for Tobacco Cessation*** (2001–2009) was a two-phase program that surveyed the growing number of existing adolescent tobacco-cessation programs to identify major program offerings, both promising and potentially harmful treatment practices, and the resources/resource constraints in the real-world settings in which they are offered. While a growing number of teen cessation programs are available, little has been known about:
  - How many programs exist
  - Where they are located
  - What services they offer
  - What populations they serve
  - How they provide treatment

Moreover, only a handful of such programs have been evaluated. (See article in the *American Journal of Public Health* and a report on the program's survey of youth cessation programs.) In its second phase, the program disseminated effective, developmentally appropriate cessation programs for adolescent smokers. (See Advocacy & Communications, below.)

- **The National Youth Smoking Cessation Survey** (launched in July 2003, findings released in July 2006), co-led by Gary Giovino, Ph.D., and Dianne Barker, M.P.A., and co-funded by RWJF, the CDC and the National Cancer Institute, was a two-year longitudinal telephone survey that asked smokers ages 16 to 24 about their cessation activity. Findings have provided national estimates of quitting activity, clarified factors associated with quitting among adolescents and young adults, and clarified youth preferences for different types of treatment. (See the report on *rwjf.org*.)

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- **Campaign for Tobacco-Free Kids** (started by RWJF in 1996 and ongoing–now known as the National Center for Tobacco-Free Kids) advocates for policies and programs that prevent tobacco use initiation and promote cessation among youth and young adults. (See the campaign's website.)
- **Youth Tobacco Cessation Collaborative** (YTCC) (1998–2008). In 1998 the major U.S. funders of tobacco-control research, programs and policy initiatives joined forces to establish and fund the YTCC to accelerate progress in helping young people quit tobacco use. Participants included the CDC, the Legacy Foundation, the National Cancer Institute, the National Institute on Drug Abuse and RWJF. The ambitious goal of the collaborative was to ensure that every young tobacco user (ages 12 to 24) had access to appropriate and effective cessation interventions by the year 2010. YTCC was formed to eliminate unplanned duplication of effort and to ensure, through their collective efforts, that the full range of key gaps would be addressed. (See Grant Results and an RWJF abstract of an article in the *American Journal of Health Behavior* about YTCC and its National Blueprint for Action.)

KEY RWJF-SPONSORED INITIATIVES: ADVOCACY & COMMUNICATIONS AROUND WHAT WORKS

- After conducing research on effective, developmentally appropriate cessation programs for adolescent smokers, *Helping Young Smokers Quit* (2001–2009) (described above) addressed the critical need to disseminate information about those programs. (See article in the *American Journal of Public Health* and a report on the program's survey of youth cessation programs.) In addition, researchers developed evaluation tools for use by any youth-oriented quit-smoking program.
- A meeting of experts explored how regulations affect youth smoking-cessation research. (See Grant Results.)
- A meeting of tobacco-control donors explored new ways to involve philanthropies in tobacco-control initiatives targeted at youth. (See Grant Results.)

OTHER RESOURCES AND RESEARCH FINDINGS FUNDED BY RWJF

- A study comparing the use of smoking-cessation treatments by young adults and older adults. (See RWJF abstract; journal article in the *American Journal of Public Health* available from the abstract.)
- Research findings that young adults do not take advantage of proven smoking-cessation treatments that can double their chances of quitting. (See RWJF news brief.)
- A pilot study that examined the efficacy of a motivational interviewing intervention for adolescent smokers. (See Grant Results.)
- A study that found that bupropion, an FDA-approved cessation medication, is effective in helping teen smokers quit. (See Grant Results.)
- A study that indicates that evidence-based tobacco-cessation treatments are underused by young adult smokers. (See RWJF Research Highlight.)
- A conference where participants considered methodological issues in studying adolescent use of tobacco-cessation treatment. (See Grant Results.)

Strategy 2

Capacity Building

WHAT IS KNOWN ABOUT BUILDING CAPACITY TO PROVIDE EVIDENCE-BASED CESSATION TREATMENT

The first prong of RWJF's plan to reduce tobacco use, pushing the scientific evidence for tobacco-cessation treatments out to providers, could only be effective if the health care system had the capacity to implement those treatments. RWJF learned that lesson in funding a small project at Allina Medical Clinic, where it became apparent that a key component of a planned intervention, specifically physician incentives, was lacking. (See Grant Results.) The second aspect of RWJF's strategy was therefore to increase the capacity of health care providers–including health care professionals and the facilities in which they work–to integrate evidence-based tobacco-cessation treatments into routine care.

Systems-level strategies work. Researchers funded through Addressing Tobacco in Health Care found that clinical practices and health plans that implement specific strategies to facilitate tobacco-dependence treatment can effectively lower the incidence of smoking among their patients. (See Grant Results on the program.) Among the findings reported by the researchers who received grants under the program were:

- By capitalizing on the unique strengths of managed care organizations, feasible and replicable improvements in tobacco-dependence treatment delivery are achievable.
- Systems innovations can increase the provision of evidence-based treatment to underserved and socioeconomically disadvantaged populations.
- Reaching out to dental practices can foster tobacco user intervention.
- Patient satisfaction is improved by providing tobacco-dependence treatments.
- Electronic medical records are a promising means of documenting and facilitating the identification of smokers and the delivery of smoking-cessation interventions.
- No single strategy or systems change will ensure that all tobacco users receive evidence-based care.

In addition, the USPHS Guideline recommends the following evidence-based systems-level strategies to reduce smoking:

- Implementing systems and registries to identify tobacco users.
- Training clinicians to treat smokers.
- Implementing systems to remind clinicians to ask about smoking status.
- Giving clinicians incentives and reimbursement to include tobacco-dependence treatment in their core responsibilities.
- Increasing smoker awareness of available Medicaid and health plan treatment benefits.
- Dedicating staff to address smoking cessation.
- Targeting hospitalized patients who smoke.
- Providing insurance coverage for evidence-based tobacco-dependence treatments.

The most effective strategies are those that affect system operations. Reminder systems, for example, work, while provider education alone appears ineffective.

A review essay by program co-director Susan Curry, Ph.D., M.A., shows that between 1996 (when RWJF entered this field) and 2006 progress has been made in providing cessation treatment to smokers.

KEY RWJF-SPONSORED INITIATIVES: RESEARCH

- ***Substance Abuse Policy Research Program*** (SAPRP) (1994–2010) and its predecessor, the *Tobacco Policy Research and Evaluation Program* (TPREP) (1992–1996) have supported peer-reviewed research that increases understanding of policies for reducing the harm of tobacco use. These programs provided seminal findings showing the beneficial quitting effects from reducing smoker's out-of-pocket costs for tobacco-dependence treatments and creating smoke-free hospitals and hospital campuses. Results are summarized in SAPRP Knowledge Assets and reports, including "Increasing the Use of Smoking-Cessation Treatments" and "A Research Agenda to Achieve a Smoke-Free Society." (See Grant Results on TPREP, Grant Results on SAPRP and SAPRP Knowledge Assets.)
- ***Addressing Tobacco in Managed Care*** (ATMC) (1995–2005) supported evaluations of replicable efforts by managed care organizations to integrate effective tobacco-cessation interventions into the basic health care provided in everyday clinical practice. ATMC studies evaluated the impact of reminder systems, coverage expansions, treatment promotions, and provider and pay-for-performance incentives. (See Grant Results, Capstone Meeting Report and a Conference Report.)
- ***Addressing Tobacco in Health Care*** (ATHC) (2005–2008), which grew out of *Addressing Tobacco in Managed Care*, was a research network connecting researchers, health care providers and other partners interested in developing and implementing changes to health care systems to improve the delivery of tobacco-dependence treatments. The network facilitated collaboration among tobacco-control researchers, provided technical assistance for grant preparation and research dissemination, and provided resources and tools to foster systems change research. (See Conference Report and other citations.)

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- **Including Cessation Treatment as a Measure of Quality.** RWJF helped expand the national managed care "report card" on health care quality (developed by the National Committee for Quality Assurance [NCQA] and known as the HEDIS measures) to include measures of the provider quit-smoking advice and assistance, including counseling and medications. These measures are included in major national public "pay-for-performance" measurement sets. (See Grant Results on ID# 28757 and ID# 37080.)

KEY RWJF-SPONSORED INITIATIVES: ADVOCACY & COMMUNICATIONS AROUND WHAT WORKS

- **National Partnership to Help Pregnant Women Quit** (December 2000 to December 2008) was a coalition of diverse organizations that joined forces to increase the number of pregnant smokers who quit smoking.
- **Tobacco-Free Nurses** (which RWJF supported from 2002 to 2008) builds capacity for tobacco cessation in two ways:
  - By helping nurses quit smoking, enabling them to serve as more effective quitting counselors for their patients.
  - By providing training, tools and resources tailored to nurses' varied roles as cessation counselors in inpatient and outpatient settings. (See the Guide for Nurses, for example.)

  (See Grant Results for more information.)
- ***Smoking Cessation Leadership Center*** (2002–2011) works with a variety of health professional organizations and institutions to increase their motivation and capability to refer smokers into treatment and their leadership to promote effective cessation treatments and policies. It has a special focus on smokers with co-occurring mental health and substance abuse problems. (See an article in the *Journal of the American Medical Association* by Steven Schroeder, M.D., the director of the *Smoking Cessation Leadership Center*, in which he offers advice to clinicians who want to help smokers quit.)

OTHER RESOURCES AND RESEARCH FINDINGS FUNDED BY RWJF

Research

- Results of a survey of access to tobacco-cessation treatment in managed care. (See journal article.)
- A study of whether instituting smoking status as a "vital sign" within primary care practices would increase the likelihood that clinicians will advise patients to quit smoking. (See Grant Results.)
- A study of systems-level changes implemented by health care providers since the U.S. Public Health Service Guideline was put in place in 1996. (See journal article.)

Action to Put Research Into Practice

- The *Smoking Cessation Leadership Center* teamed up with the U.S. Department of Veterans Affairs to highlight best practices for cessation treatment in medical settings. (See Conference Report.)
- A group of New Jersey managed care organizations worked together to improve tobacco-prevention and cessation activities. (See Grant Results.)
- A working group convened to expand knowledge about reimbursement for smoking-cessation treatment and identify strategies to increase the availability and accessibility of treatment. (See Grant Results.)
- An initiative produced and distributed a multimedia educational tool to help health care practitioners treat tobacco dependence in pregnant women. (See Grant Results.)
- A review article introduced pharmacological treatments for tobacco dependence to health care providers. (See journal article.)

Strategy 3

Increasing Market Pull and Consumer Demand for Proven Treatment Methods

This strategy is based on the hypothesis that if smokers know that proven treatments will improve their chances of quitting, they will demand effective treatments from their health care professionals. Thus, the third aspect of RWJF's strategy was to increase the consumer demand for proven treatment methods.

In this area, RWJF's efforts included:

- Advocacy, action and communications to promote higher tobacco taxes, smoke-free air laws, expand insurance coverage for treatment and other policies proven to boost smoker quit attempts, quit rates and treatment use.
- Research documenting the health and economic impacts and cost-effectiveness of tobacco cessation for employers and other purchasers of health insurance coverage.
- Working to embed tobacco use screening and treatment into the leading national health care quality improvement metrics and pay-for-performance standards.
- Finding ways to redesign treatments and treatment delivery systems to make them more appealing to smokers, especially underserved low-income smokers.

Strategy 3.1

Increasing Policy Supports and Incentives for Smoking Cessation and Treatment Use

WHAT IS KNOWN ABOUT POLICIES TO ENCOURAGE QUITTING AND PROVEN TOBACCO-CESSATION TREATMENTS

RWJF's effort to increase the use of proven tobacco-cessation methods included supporting research, advocacy, action and communications to identify and expand tobacco-control policies that boost population quit rates and treatment use. Such policies make smoking less appealing by increasing the social and financial "costs" of smoking or decreasing access to places to smoke, and thus increase the motivation to quit, use of accessible treatment, and social support for quitting and staying smoke-free.

Tobacco-control policies can improve smokers' chances of successfully quitting. Studies show that policies that make tobacco use less appealing (including increased taxes, restricting tobacco industry marketing, smoke-free policies and anti-tobacco media campaigns) have the greatest chance of reducing tobacco use. (See Ten Policy Changes That Could Curb Tobacco Addiction.)

KEY RWJF-SPONSORED INITIATIVES: RESEARCH

- ***Substance Abuse Policy Research Program*** (SAPRP) (1994–2010) and its predecessor, the *Tobacco Policy Research and Evaluation Program* (TPREP) (1992–1996) have supported policy-relevant, peer-reviewed research that increases understanding of policies for reducing harm caused by substance abuse, including tobacco use. These programs provided seminal findings showing the beneficial effects of tobacco tax and price increases, anti-smoking media campaigns and smoke-free air laws on smoking prevention and cessation. They also documented the synergistic effects of comprehensive and combined public health tobacco-control policies on population and treatment use. (See Grant Results on TPREP, Grant Results on SAPRP and SAPRP Knowledge Assets.)

- ***Bridging the Gap*/ImpacTeen** is an interdisciplinary partnership of nationally recognized substance abuse researchers dedicated to improving the understanding of the role of policy and environmental factors in youth substance abuse, including tobacco use. This program helped document the links between school, community, state and federal tobacco-control policies and the initiation and cessation of tobacco use among youth. (See Grantee Profiles of the two program directors Frank Chaloupka, Ph.D. and Lloyd Johnston, Ph.D.)

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- ***Smokeless States®: National Tobacco Policy Initiative*** (1993–2004) supported the activities of statewide coalitions working to improve the tobacco policy environment, with the goal of reducing tobacco use. Coalitions of community groups developed and implemented comprehensive tobacco-control programs that included education, treatment and policy initiatives to prevent tobacco use and promote adult cessation. During the program's life many states increased their tobacco taxes. (See Grant Results, Anthology chapter and compilation of key products from the initiative.)
- ***Tobacco Policy Change: A Collaborative for Healthier Communities and States*** (2004–2009) provided resources and technical assistance for community, regional and national organizations, and tribal groups advocating for effective tobacco-prevention and cessation-policy initiatives. The initiative had a special emphasis on reaching underserved, high-risk populations where tobacco-use prevalence is highest and tobacco-control resources are least available.
- **Tobacco Technical Assistance Consortium** (2001–2008) provided technical assistance to community-based organizations working for tobacco-policy change. (See Grant Results.)
- **The National Action Plan for Tobacco Cessation** (2003), co-funded by RWJF, the Agency for Healthcare Quality and Research, and the American Legacy Foundation, was an interagency federal committee that made six recommendations to reduce tobacco use, including developing a government-funded network of state telephone quitlines, which was put into effect by Health and Human Services Secretary Tommy Thompson in 2004. Michael Fiore chaired the committee and received a 2003 *Innovators Combating Substance Abuse* award from RWJF to implement key components of the plan. (See his Grantee Profile.) Fiore was the lead author on a seminal article in the February 2004 *American Journal of Public Health*, "Preventing 3 Million Premature Deaths and Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation."
- **The Center for Tobacco Cessation** Policy Roundtable on Statewide Cessation Services developed recommendations for expanding statewide cessation services. (See Grant Results.)

KEY RWJF-SPONSORED INITIATIVES: ADVOCACY & COMMUNICATIONS AROUND WHAT WORKS

- **Campaign for Tobacco-Free Kids** (1996–ongoing) is an advocacy and public education organization dedicated to reducing tobacco use and its devastating consequences. (See Grant Results.) It advocates for expanded coverage for tobacco-use treatment, for other public policies that encourage quitting and treatment use among youth and adults (e.g., tobacco excise tax increases, smoke-free air laws, anti-smoking media campaigns), and for greater investment of Master Settlement Agreement funds and tobacco-excise tax funds into proven comprehensive tobacco-control programs, including cessation programs and services.

OTHER RESOURCES AND RESEARCH FINDINGS FUNDED BY RWJF

- Julia Carol received a 2001 *Innovators Combating Substance Abuse* award from RWJF to expand a Tobacco Industry Tracking Database and make it available on the Internet. The database provides information to help individuals and organizations expose and counter tobacco industry interference with public health efforts. (See her Grantee Profile.)
- James L. Repace, M.Sc., received a 2002 *Innovators Combating Substance Abuse* award from RWJF to test whether nonsmoking sections and ventilation systems in restaurants can protect nonsmoking patrons from inhaling secondhand smoke. (See his Grantee Profile about how he secretly measured secondhand smoke in restaurants and what he found.)
- Jack E. Henningfield, Ph.D., received a 2003 *Innovators Combating Substance Abuse* award from RWJF to establish a systematic approach to bring tobacco-addiction science to the attention of policy-makers. (See his Grantee Profile.)

Strategy 3.2

Improving the Accessibility, Reach and Use of Proven Cessation Services

Quitlines and Other Cessation Service Delivery Innovations

WHAT IS KNOWN ABOUT INCREASING ACCESS TO CESSATION-TREATMENT SERVICES

As part of its efforts to widen the demand for and use of evidence-based tobacco-cessation treatments, RWJF supported several efforts to bring treatments directly to consumers in ways that enhanced their appeal, reach and use, especially among underserved smokers. RWJF funded efforts to expand the availability of quitlines–telephone and Web-based tobacco-cessation counseling–and also encouraged the availability of nicotine-replacement therapy.

- **Quitlines have been found to be an effective way to deliver tobacco-cessation services.** The U.S. Public Health Service Clinical Practice Guideline recommend proactive telephone quitline counseling (including structured outgoing follow-up calls to smokers) as an effective, high-reach cessation treatment with the potential to reduce or eliminate disparities in treatment access. All states offer quitline counseling in multiple languages, most provide counseling tailored to the needs of pregnant and young smokers, and many provide free nicotine-replacement therapy and access to websites for ongoing counseling and support. Many have created fax-to-quit services allowing health care providers to easily refer patients for follow-up quitline counseling and many offer referrals to community-based cessation programs. A study in the *New England Journal of Medicine* concluded: "A telephone counseling protocol for smoking cessation, previously proven efficacious, was effective when translated to a real-world setting." (See journal article.)
- **Online cessation programs are effective.** Research at the University of California, Berkeley, found that computer- or Web-based smoking-cessation programs can effectively aid smokers in their efforts to quit. The study analyzed results from 22 randomized controlled trials. (See news release.)

- **Over-the-counter nicotine-replacement therapy has increased use and quit rates.** In 1996 the U.S. Food & Drug Administration permitted the sale of certain nicotine replacement therapies (NRTs) over the counter to make them more accessible. Research supported by the *Substance Abuse Policy Research Program* found that the switch increased their use and population quit rates. (See journal article and Grant Results.)

KEY RWJF-SPONSORED INITIATIVES: RESEARCH

RWJF sponsored independent research projects on quitlines and NRTs. These projects included:

- A national survey of quitlines showed that as of 2004 every state in the country plus the District of Columbia operated a quitline providing a variety of quitting information, referrals and products. (See the journal article, plus a summary of the results.)
- A controlled trial found that smokers offered free nicotine-replacement therapy were more likely to quit. (See Grant Results.)
- An evaluation of the Massachusetts Quitline looked at differences between smokers calling the quitline, their attempts to quit, their use of other services and other variables. (See Grant Results.)

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- ***Substance Abuse Policy Research Program*** (SAPRP) (1994–2010) and its predecessor, the *Tobacco Policy Research and Evaluation Program* (TPREP) (1992–1996) have supported policy-relevant, peer-reviewed research that increases understanding of policies for reducing the harm of tobacco use. These programs provided seminal findings showing the beneficial quitting effects from reducing smoker's out-of-pocket costs for tobacco-dependence treatments and creating smoke-free hospitals and hospital campuses. Results are summarized in SAPRP Knowledge Assets and reports, including "Increasing the Use of Smoking Cessation Treatments" and "A Research Agenda to Achieve a Smoke-Free Society." (See Grant Results on TPREP, Grant Results on SAPRP and SAPRP Knowledge Assets.)
- **The National Action Plan for Tobacco Cessation** was an interagency federal committee that made six recommendations to reduce tobacco use. Michael Fiore chaired the committee and received a 2003 *Innovators Combating Substance Abuse* award from RWJF to implement key components of the plan. The major recommendation of this plan, implemented in 2004 by Secretary of Health and Human Services Tommy Thompson, was to create a network of government-funded state tobacco quitlines. Fiore was the lead author on a seminal article in the February 2004 *American Journal of Public Health*, "Preventing 3 Million Premature Deaths and Helping 5 Million Smokers Quit: A National Action Plan for Tobacco Cessation." (See his Grantee Profile.)
- **North American Quitline Consortium.** This national membership organization of quitline service providers, funders of quitlines, researchers and strategic partners promotes evidence-based quitline services. RWJF funded activities to evaluate quitline capacity and ways to expand reach and use, especially among underserved populations. (See Grant Results on an evaluation of the Massachusetts quitline.)

KEY RWJF-SPONSORED INITIATIVES: ADVOCACY & COMMUNICATIONS AROUND WHAT WORKS

- **The Consumer Demand Initiative** (2005–2008), co-funded by the American Cancer Society, American Legacy Foundation, CDC, NCI, NIDA and RWJF, and conducted under the auspices of the National Tobacco Cessation Collaborative, developed six core strategies for increasing consumer demand for and use of evidence-based tobacco-cessation products and services. This initiative focused specifically on reaching traditionally underserved, low-income smokers (See the report on the six strategies and a report from their May 2007 conference. See their website for summaries and products of each consumer demand roundtable session and a Content Alert for a podcast and video on smoking-cessation tools.)
  - The March 2010 Special Issue of the *American Journal of Preventive Medicine* focuses on increasing consumer demand for cessation services.
- With two grants from RWJF, the Academy for Educational Development (AED) and IDEO (a design consultancy) teamed up to create a toolkit, Designing for Innovation: A Toolkit for Creating Solutions to Build Consumer Demand for Tobacco-Cessation Products and Services. It can assist tobacco-control organizations in applying consumer-demand design principles to tobacco-cessation products and services. The process of thinking differently about smoking-cessation products and services has five main steps: observe, look for patterns, brainstorm, prototype and get feedback.
- IDEO also produced a booklet, Consumer-Demand Design Principles: 8 Design Principles for Redesigning Tobacco-Cessation Products and Services. The principles are:
  - Allow them to kick the tires
  - Lower the bar
  - Make it look and feel good
  - Facilitate transitions
  - Make progress tangible
  - Foster community
  - Connect the dots
  - Integrate with their lives

For more information, see the abstract of the article in the *American Journal of Preventive Medicine*.

OTHER RESOURCES AND RESEARCH FINDINGS FUNDED BY RWJF

- The North American Conference of Smoking Cessation Quitlines considered strategies to advance quitlines. (See Grant Results.)
- A survey by the North American Quitline Consortium on the organization, financing, promotion and cost of state quitlines. (See journal article.)
- A survey by the North American Quitline Consortium to determine the factors related to the presence or absence of a state quitline. (See journal article.)

Strategy 3.3

Making Treatment More Affordable: Expanding Coverage

RWJF has espoused the belief that tobacco use should be treated like other chronic diseases. As such, health plans should cover treatments for tobacco dependence in the same way they do for other chronic illnesses. (Read more about the case for treating tobacco dependence as a chronic disease in this journal article.)

WHAT IS KNOWN ABOUT INSURANCE COVERAGE FOR TREATMENT SERVICES

To expand the reach and impact of evidence-based cessation treatments, RWJF supported efforts to expand insurance coverage for treatment. This work included research documenting the health and economic effects of smoking, and the cost-effectiveness and population-level cessation effects of expanding coverage via government programs (e.g., Medicare, Medicaid and the Department of Veterans Affairs), health plans and HMOs, employers, unions and other purchasers of health insurance coverage.

- **Covering cessation treatment is cost-effective.** As documented by the RWJF-supported National Commission on Prevention Priorities, brief primary care quit-smoking interventions save money. Similarly, studies funded under the *Substance Abuse Policy Research Program* documented that "the costs of [tobacco-cessation treatment services] are low relative to the potential return on investment in the form of reduced smoking-related health care expenditures." (from SAPRP Knowledge Assets)
- **Full health coverage would save 100,000 lives.** SAPRP-funded research using the "Sim-Smoke" simulation modeling program found that more than 100,000 fewer lives would be lost to smoking-related deaths cumulatively by 2020, if full coverage were available for existing smoking-cessation treatments. (See news release.)
- **Smokers with full coverage have higher quit rates.** Researchers at the Group Health Cooperative of Puget Sound published an article in the *New England Journal of Medicine* stating that one and a half times as many smokers would quit per year if they were fully covered for treatment, compared to a plan that only provides partial coverage. (See Grant Results.)

- **Cost of coverage is a barrier.** Another RWJF-funded study by Helen Schauffler, Diane Barker and C. Tracy Orleans found that barriers to coverage and use of tobacco-dependence treatments include, among other things, the cost of coverage.

Together the studies mentioned above provided the evidence on which the CDC's Community Preventive Task Force based its recommendation for reducing smokers' out-of-pocket treatment costs in order to boost population quit rates.

- **Coverage is growing.** In 1995 no state Medicaid program covered tobacco-dependence treatments. As documented by RWJF-funded surveys, by 2005, 42 states provided Medicaid coverage for tobacco-cessation counseling and/or medication. In 2002 nearly all private insurance plans provided full coverage for at least one type of smoking-cessation intervention. In 2005 Medicare added cessation counseling benefits and the Department of Veterans Affairs expanded its coverage for counseling and medication. According to the American Lung Association, in 2008, 43 states provided full coverage for at least one form of evidence-based cessation treatment. (See research summary, a journal article and news release, Campaign for Tobacco-Free Kids report and Lung Association research report.)

KEY RWJF-SPONSORED INITIATIVES: RESEARCH

- **Medicaid surveys.** Between 1994 and 2008, RWJF supported regular surveys of state policies for covering tobacco-cessation treatments under Medicaid. (See the Center for Health and Public Policy Studies for a full list of the surveys.)
- **Managed care coverage surveys.** Between 1996 and 2004, in partnership with the American Association of Health Plans, RWJF funded regular surveys of managed care plans to assess their coverage of tobacco-cessation medication and counseling. (See results from the 2002 survey, 2003 survey and the 2004 survey.)
- **Need for coverage awareness efforts.** Both the *Substance Abuse Policy Research Program* and *Addressing Tobacco in Managed Care* (ATMC) funded studies of coverage expansions that document, among other things, that expanding benefits is not sufficient by itself to increase use of cessation treatments in the absence of effective communications and promotions to enrollees and beneficiaries. (See a description of the SAPRP study and Grant Results on ATMC.)
- **A related study of Medicaid beneficiaries and providers.** This study, in two states that covered all approved cessation treatments, found that only 36 percent of beneficiaries and 60 percent of their providers were aware of these benefits. The study's findings suggest that state Medicaid programs need to improve their communication with enrollees who smoke to inform them about coverage for tobacco-dependence treatments and their effectiveness. (See journal article.) These findings led to recommendations by the Partnership for Prevention to both expand and promote available tobacco-dependence treatment benefits.

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- **Network of advocates.** The Connecticut Peer Review Organization organized a network of advocates in seven states (Alabama, Florida, Missouri, Ohio, Oklahoma, Nebraska and Wyoming) who reached into their communities to enroll seniors in the Medicare Stop Smoking Program. (See Grant Results.)
- **Group of experts.** In 1996 the Pinney Group convened a working group of experts to examine the available evidence on insurance coverage for tobacco cessation and to identify strategies for expanding coverage. (See Grant Results.)

KEY RWJF-SPONSORED INITIATIVES: ADVOCACY & COMMUNICATIONS AROUND WHAT WORKS

- **Three advocacy initiatives.** *Smokeless States, Tobacco Policy Change* and the *National Center for Tobacco-Free Kids* (CTFK) included expanding benefits expansion as a core state and federal tobacco-control policy target. In December 2006, CTFK issued the first-ever model benefit for comprehensive cessation-treatment coverage.

OTHER RESOURCES AND RESEARCH FINDINGS FUNDED BY RWJF

- A survey of employer coverage for preventive health services, including tobacco-cessation treatment. (See journal article.)
- A research agenda for studies of the financial benefits of offering insurance coverage for smoking-cessation treatment in managed health care plans. (See Grant Results.)
- A study testing whether a mailing describing a health plan's new coverage for smoking-cessation medications increases benefit knowledge, utilization and quitting. (See journal article.)
- A survey of Medicaid coverage for smoking-cessation treatment for pregnant women. (See journal article.)
- A review of cessation coverage provided by states through Medicaid programs, state employee health plans and standards for private insurance. (See publication.)
- A study of the effects of adding or removing full coverage for smoking-cessation treatments in primary care settings on treatment referrals and use. (Krist et al., *American Journal of Preventive Medicine*, February 2010.) (See journal article.)

Strategy 3.4

Making Treatment More Appealing: Building Consumer Demand for Evidence-Based Tobacco Treatment

RWJF and its partners are finding ways to redesign and promote tobacco-cessation treatments and delivery systems so that they are more appealing to smokers, especially to underserved low-income smokers.

WHAT IS KNOWN ABOUT BUILDING DEMAND FOR TREATMENT SERVICES AND PRODUCTS

Creating demand for tobacco-treatment services and products faces obstacles, such as awareness, cost, coverage and people's belief they can quit on their own. A coordinated approach is needed to overcome these barriers as a single approach is unlikely to work.

- **Knowledge of coverage.** A 2006 article in the *American Journal of Preventive Medicine* wrote that "knowledge of Medicaid coverage and the perceived effectiveness of TDTs [tobacco-dependence treatments] are associated with increased use of TDTs in the Medicaid population." (See journal article abstract.)
- **Cost of tobacco-dependence treatments.** In a 1996 article in *Addictive Behavior*, Hines wrote that young adult smokers rated their probability of using a stop-smoking program or a nicotine patch on cost, convenience and increased likelihood of success. "They were extremely sensitive to cost of the methods. … Young smokers would be likely to choose assisted methods when attempting to stop if they appreciated the increased likelihood of success with these methods and if the cost was not high." (See journal article abstract.)
- **Appeal of quitting solo.** At the same time, Hines' study and one by Hammond et. al. in *Addiction* found that smokers thought they were just as likely to quit on their own as with assistance. (See journal article abstract.)

- **Need for a multifaceted, coordinated approach to build demand.** RWJF's *Addressing Tobacco in Managed Care*'s 2005 conference report stated that behaviors around tobacco use are not rational. "Financial incentives will not … be enough to get people to quit or demand and seek effective treatment." The report went on to say that "incentives that derive from lower overall health care costs will not motivate younger tobacco users who do not identify themselves as high-risk and also are healthy and therefore not currently incurring high costs." Instead the report recommends coordinated policy and environmental changes to not only prevent smoking initiation but promote cessation and the use of proven quitting treatments, products and services. These will "motivate and support quitters' efforts." (See Conference Report.)

KEY RWJF-SPONSORED INITIATIVES: RESEARCH

- ***Substance Abuse Policy Research Program*** (SAPRP) (1994–2010) and its predecessor, the *Tobacco Policy Research and Evaluation Program* (TPREP) (1992–1996) have supported policy-relevant, peer-reviewed research that increases understanding of policies for reducing the harm of tobacco use. These programs provided seminal findings showing the benefits from:
  - Reducing smoker's out-of-pocket costs for tobacco-dependence treatments.
  - Promoting and funding state tobacco quitlines.
  - Implementing cessation policies, in concert with comprehensive smoke-free airs laws and tobacco tax increases–which have been found to generate consumer demand for cessation services.

  Results are summarized in SAPRP Knowledge Assets and reports, including "Increasing the Use of Smoking Cessation Treatments" and "A Research Agenda to Achieve a Smoke-Free Society." (See Grant Results on TPREP, Grant Results on SAPRP and SAPRP Knowledge Assets.)

Other research projects include these findings:

- **Smokers are more likely to quit if treatments are easily accessible.** Findings from a study of smokers covered by Medicaid suggest that "state Medicaid programs need to develop better communication with their enrollees who smoke to inform them about coverage for TDTs [tobacco-dependence treatments] and the effectiveness of TDTs." (See publication.)
- **Exposure to ads for smoking-cessation treatment makes people more likely to attempt to quit, more likely to succeed and more likely to purchase smoking-cessation products. It also improves the chances of quitting even without the use of products.** (See National Bureau of Economic Research working paper.)
- **Medicaid coverage of smoking-cessation therapies does not have a statistically significant effect on consumer demand for treatment.** (Grant ID# 53957)
- **Those who are insured are more likely to respond to advertising for smoking-cessation treatment by quitting or attempting to quit than those without insurance.** (Grant ID# 53957)

- **Changing the classification of nicotine gum and the nicotine patch from prescription only to over-the-counter increases their use.** The U.S. Food and Drug Administration reclassified the gum and the patch in 1996. A 2002–2005 RWJF-supported study by the Roswell Park Cancer Institute in Buffalo found the overall use of nicotine-replacement therapy increased despite an increase in the cost. (See Grant Results.)

KEY RWJF-SPONSORED INITIATIVES: ACTION TO PUT RESEARCH INTO PRACTICE

- **Doctors, nurses and their patients who smoke need to be made aware of Medicaid coverage benefits. The Medicaid Covers It Campaign in Wisconsin** (Grant ID# 63261) provided information to providers and a simple saying, "You Can Afford to Quit" to Medicaid beneficiaries. See presentation.
- **Consumer Demand Roundtable has identified innovations to increase consumer demand for tobacco-dependence treatments**, especially among low-income and racial/ethnic minority populations, and to embed these innovations into ongoing national cessation practice, policy, research and treatment product research and development. (See Grant Results, journal article, December 2005 meeting report and May 2007 meeting report.)

  Participants identified the following areas as having the most potential for increasing demand for evidence-based tobacco-cessation products and services:

  - View smokers as consumers and take a fresh look at quitting from their perspectives.
  - Design evidence-based products and services to meet consumers' needs and wants.
  - Market cessation products and services in ways that will reach into smokers' lives, especially smokers who are members of underserved groups.
  - Seize policy changes as opportunities for "breakthrough" increases in the use of treatment and in quit rates.
  - Systematically measure, track and report quitting efforts and treatment use –and their drivers and benefits–to identify successes and opportunities.
- **Seniors can be enticed to enroll in smoking-cessation programs sponsored by Medicare.** Seven states established an outreach network of senior services and tobacco-control advocates to expand recruitment activities for the Medicare Stop Smoking Program, a federally funded demonstration project to test tobacco-cessation interventions as a Medicare benefit. Some 7,354 seniors enrolled. The RAND Corporation piloted three different smoking-cessation interventions and is evaluating their effectiveness. (See Grant Results.)
- **Dentists can convince low-income patients in public clinics to quit smoking.** A program called CRUISE teaches dentists and dental hygienists to routinely assess patients' tobacco use and advises them on ways to help their patients quit. Dentists and hygienists needed training in the intervention. Patients in the intervention group were three to four times more likely to report at three months and six months that they had quit using tobacco than patients receiving usual care. (See Grant Results.)

The March 2010 Special Issue of the *American Journal of Preventive Medicine* focuses on increasing consumer demand for cessation services.

- With two grants from RWJF, AED and IDEO teamed up to create a toolkit, ***Designing for Innovation: A Toolkit for Creating Solutions to Build Consumer Demand for Tobacco Cessation Products and Services***. It can assist tobacco-control organizations in applying consumer-demand design principles to tobacco-cessation products and services. The process of thinking differently about smoking-cessation products and services has five main steps: observe, look for patterns, brainstorm, prototype and get feedback.
- IDEO also produced a booklet, ***Consumer-Demand Design Principles: 8 Design Principles for Redesigning Tobacco-Cessation Products and Services***. The principles are:
  - Allow them to kick the tires
  - Lower the bar
  - Make it look and feel good
  - Facilitate transitions
  - Make progress tangible
  - Foster community
  - Connect the dots
  - Integrate with their lives

For more information, see the article in the *American Journal of Preventive Medicine*.

Appendix

Major RWJF Grants Focused Solely on Tobacco Cessation

Program	Dates	RWJF Funds
Annual Surveys of Medicaid Coverage	**1996–2004**	**$481,420**
Tobacco Etiology Research Network	**1996–2006**	**$8,987,728**
Development and Dissemination of Smoking Cessation Clinical Practice Guidelines	**1996–2007**	**$1,492,753**
Part 1: Agency for Health Care Policy and Research Smoking-Cessation Clinical Practice Guideline	1996–2000	$512,493
Part 2: Developing a Five-State Consortium to Implement the Tobacco-Cessation Guideline	2001–2004	$774,865
Part 3: Blueprint for Disseminating Tobacco-Dependence Guideline	2001–2002	$107,641
Part 4: Co-Funding an Update of the National Clinical Guideline for Treating Tobacco Use and Dependence	2006–2007	$97,754
Addressing Tobacco in Managed Care	**1996–2008**	**$7,206,699**
Part 1: Managed Care Performance Indicators for Prevention and Treatment of Tobacco Use and Addiction	1996	$46,699
Part 2: Addressing Tobacco in Managed Care	1997–2008	$7,160,000
Assessing Insurance Coverage of Preventive Services by Private Employers	**1996–2006**	**$473,605**
Part 1: Assessing Insurance Coverage of Preventive Services by Private Employers	1996–1998	$50,000
Part 2: Examining Insurance Coverage for Clinical Preventive Services in Employer-Sponsored Health Plans	2001–2006	$423,605

Program	Dates	RWJF Funds
Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy	**1993–2008**	**$23,233,205**
National Partnership to Help Pregnant Smokers Quit	2002–2006	$1,972,600
Youth Tobacco Cessation Collaborative	**1998–2009**	**$4,689,908**
Helping Young Smokers Quit: Identifying Best Practices for Tobacco Cessation	**2001–2009**	**$7,497,108**
Partners With Tobacco Use Research Centers	**2000–2007**	**$14,034,989**
Center for Tobacco Cessation	**2002–2006**	**$1,362,914**
Promoting the Use of Evidence-Based Tobacco Cessation Treatments and Services	**2002–2007**	**$1,131,986**
Why Youth Don't Quit: Finding Answers to Design Effective Smoking-Cessation Programs	**2002–2010**	**$3,676,288**
Smoking Cessation Leadership Center	**2003–2011**	**$9,871,538**
Tobacco-Free Nurses	**2003–2008**	**$1,800,000**
Total		**$85,940,141**