III Cessation Interventions

Justification

Interventions that increase quitting can decrease premature mortality and tobacco-related health care costs in the short-term.[1,2] Quitting by age 30 eliminates nearly all excess risk associated with smoking, and smokers who quit smoking before age 50 cut in half their risk of dying in the next 15 years.[2,3] Tobacco use screening and brief intervention by clinicians not only is a top-ranked clinical preventive service in terms of its relative health impact, effectiveness, and cost-effectiveness but also is a cost-saving measure.[4-6] Tobacco use treatment 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.[5,7,8]

Although quitting smoking has immediate as well as long-term benefits, tobacco use is addictive. More than 40% of smokers try to quit each year, but without assistance, most will relapse.[9,10] To increase tobacco use cessation, the independent Task Force on Community Preventive Services' *Guide to Community Preventive Services* strongly recommends:[11]

- Increasing the unit price of tobacco products
- Conducting mass media education campaigns combined with other community interventions
- Providing telephone-based cessation counseling
- Reducing out-of-pocket costs for patients
- Implementing health care provider reminder systems (alone or combined with provider education)

The Public Health Service's (PHS) evidence-based clinical practice guideline on cessation states that brief advice by medical providers to quit smoking is an effective intervention.[10] More intensive interventions (individual, group, or telephone counseling) that provide social support and coaching on problem-solving skills are even more effective. FDA-approved pharmacotherapy (e.g., nicotine patch, gum, nasal spray, inhaler, and lozenge as well as non-nicotine medications such as bupropion hydrochloride and varenicline) is also proven effective in helping people quit smoking. Combining counseling and medication is most effective.

The PHS guideline stresses that health care system changes are needed (e.g., implementing a system of tobacco use screening and documentation, linking tobacco users to quitline services, and providing insurance coverage for proven treatments). Model programs in large managed care plans show that full implementation of the health care system changes, quitline services, comprehensive insurance coverage, and promotion of the services increases the use of proven treatments and decreases smoking prevalence.[12]

In 2004, the Department of Health and Human Services announced the availability of the National Network of Tobacco Cessation Quitlines, providing callers nationwide with fast and easy access to their state's quitline services through a single toll-free portal number (1-800-QUIT NOW). This service was made possible through a partnership between CDC's Office on Smoking and Health, the National Cancer Institute's Cancer Information Service, the North American Quitline Consortium, and state tobacco prevention and control programs. As of 2007, all 50 states, the District of Columbia, and five territories offer some degree of telephone-based tobacco cessation services.

State action on tobacco use treatment should include the following elements:

- Sustaining, expanding, and promoting the services available through population-based counseling and treatment programs, such as cessation quitlines
- Covering treatment for tobacco use under both public and private insurance, including individual, group, and telephone counseling and all FDA-approved medications
- Eliminating cost and other barriers to treatment for underserved populations, particularly the uninsured and populations disproportionately affected by tobacco use
- Making the health care system changes recommended by the PHS guideline

Cessation Interventions III

Tobacco control programs need to foster the motivation to quit through policy changes and media campaigns and promote their quitline services. The Ohio Tobacco Quit Line demonstrates the importance of promotion to generate call volume. The Quit Line received more than 100,000 calls between 2004 and 2007, reaching smokers through media campaigns, partnerships, and the offer of free nicotine replacement therapy.[13]

As a result of targeted promotion, Colorado's quitline has experienced extremely high recognition and utilization rates. During 2006–2007, 71% of Colorado smokers reported knowledge of the state quitline, and more than 9% had called for cessation assistance. This rate translates to more than 3,400 smokers enrolling each month, with a success rate at six months of 38%.[14] During 2005–2006, the Colorado tobacco control program demonstrated success in targeting cessation interventions by utilizing different spokespersons in its televised promotions. The number of African Americans calling the state's quitline nearly doubled during the phase of the campaign featuring an African American sports celebrity, compared with a promotion featuring one of his Caucasian teammates.[15]

The California Smokers' Helpline provides cessation services and culturally appropriate information in multiple languages for different audiences. Language- plus culturally-specific promotions have increased use of treatment services among tobacco users from various racial and ethnic groups.[16]

Budget

Cessation interventions should include both health care system-based interventions and population-based interventions (quitlines) that provide services to the individual smoker. System-based initiatives should ensure that all tobacco users seen in the health care system are screened for tobacco use. All tobacco users should receive advice to quit and should be offered brief or more intensive counseling services (in person or via a quitline) and FDA-approved cessation medication. Cessation quitlines are effective in increasing successful quitting and have the potential to reach large numbers of smokers. Quitlines also serve as a resource for busy health care providers, who can ask patients about their tobacco use status and then link them to quitline cessation services for counseling. Optimally, quitline counseling should be made available to all tobacco users willing to access the service.

Budget recommendations for providing health care screening and brief interventions are based on the 1999 funding formula, adjusted for changes in state population and inflation. The recommended level of investment for telephone-based cessation services has been updated to reflect new evidence regarding attainable rates of quitline usage and limited provision of no-cost or low-cost over-the-counter nicotine replacement therapy (NRT). With sufficient promotion and clinician referral, and with NRT made more easily available, a state quitline could serve 8% of tobacco users aged 18 years and older. Budget estimates assumed approximately 75% of callers (6% of a state's tobacco users) would seek counseling services, and of those, approximately 85% would accept NRT if it is offered. State experience suggests that programs should offer two weeks of free NRT to all callers receiving counseling and at least four weeks for callers who are uninsured or who receive publicly financed insurance.

The funding range for Cessation Interventions allows for variability in the percentage of callers who receive counseling (from 2% to 10%) and the amount of NRT provided. The funding model includes a minimum of two weeks of NRT for all callers enrolled in counseling anticipated to accept NRT, ranging up to an eight-week course for those who are uninsured or receiving publicly financed insurance. However, it is expected that states will work with Medicaid and private insurers to ensure comprehensive insurance coverage of tobacco use treatment by all insurers. States may also be able to lower implementation costs by engaging in cost-sharing partnerships with Medicaid and health insurance providers for the provision of NRT and other services. Negotiating volume discounts can also decrease the cost of providing NRT.

III Cessation Interventions

Core Resources

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