Smoking Cessation Guidelines for Providers

BACKGROUND

The most common cause of chemical dependence in the United States is nicotine. Nicotine addiction means that an individual is dependent on nicotine – nicotine can be found in cigarettes or smokeless tobacco. Nicotine can be as addictive as heroin, cocaine, or alcohol. The Centers for Disease Control and Prevention (CDC) estimate 443,000 deaths occurred in the United States from 2000-2004 due to smoking and tobacco use. Of the total, the causes included:

<table>
<thead>
<tr>
<th>Cause</th>
<th>No. of Deaths</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Lung Cancer</td>
<td>128,900</td>
<td>29%</td>
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<tr>
<td>Ischemic Heart Disease</td>
<td>126,000</td>
<td>28%</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>92,900</td>
<td>21%</td>
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<tr>
<td>Other diagnoses</td>
<td>44,000</td>
<td>10%</td>
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<tr>
<td>Other cancers</td>
<td>35,300</td>
<td>8%</td>
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<tr>
<td>Stroke</td>
<td>15,900</td>
<td>4%</td>
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The CDC reports that in 2010, 43.5 million adults (19.3%) in the United States were current smokers. Over 50% of adult smokers stopped smoking for at least 1 day during the preceding 12 months because they were trying to quit. Due to prevention efforts and initiatives, since 2002 the number of former smokers exceeds the number of current smokers. Tobacco use is the single most preventable cause of disease and death in the United States, and nearly 500,000 Americans still die prematurely from tobacco use each year. Nearly 90% of smokers start by the time they are 18 years old, and there is a disproportionate use of tobacco by the poor, those with limited education, unemployed status, chronic mental illness, and certain ethnic populations. WellCare Health Plans, Inc. enrolls members from Medicaid and Medicare with a high rate of smoking and the chronic conditions associated with cigarette use (e.g. Chronic Obstructive Pulmonary Disease, Hypertension, Asthma, and Coronary Artery Disease). In addition, smoking is a prominent cause of obstetrical complications seen in our Medicaid population of pregnant women. Based on this information and desire to improve health outcomes in our members, WellCare has developed a specific program to address smoking cessation for our beneficiaries and embraces goals outlined in the CDC Best Practices for Comprehensive Tobacco Control Programs:

- Prevent initiation among youth and young adults
- Promote quitting among adults and youth
- Eliminate exposure to second-hand smoke
- Identify and eliminate tobacco-related disparities among population groups

Two-thirds to three-quarters of smokers who try to quit do not use any evidence-based cessation counseling or medications. Smokers improve their odds of successfully quitting when they use evidence-based treatments so those are the methods that we have incorporated into our program. Essential steps in the Smoking Cessation Program include:

- Motivational interviewing to assess readiness to change in the member;
• Member education regarding treatment options for smoking cessation;
• Provider education regarding smoking cessation strategies;
• Connection to state and national programs offering counseling, support for members desiring to quit smoking; and
• And monitoring results through HEDIS measures related to smoking cessation.

### KEY RECOMMENDATIONS

The USPSTF recommends that clinicians ask all adults, including pregnant women, about tobacco use and provide tobacco cessation interventions for those who use tobacco products (Grade A recommendation). The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for tobacco use or interventions to prevent and treat tobacco use and dependence among children or adolescents.\(^4,5\)

In addition, the United States Department of Health and Human Services outline the following recommendations in the 2008 update to the guideline *Treating Tobacco Use and Dependence*.\(^6\)

1. Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.

2. It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.

3. Tobacco dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in the guideline *Treating Tobacco Use and Dependence* (see References for link).

4. Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in this Guideline.

5. Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt: (a) practical counseling (problem solving/skills training) and (b) social support delivered as part of treatment.

6. Effective medications are available; clinicians should encourage use by patients trying to quit smoking (except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness [i.e., pregnant women, smokeless tobacco users, light smokers, adolescents]). The following first-line medications reliably increase long-term smoking abstinence rates (5 nicotine, 2 non-nicotine): Bupropion SR, Nicotine gum, Nicotine inhaler, Nicotine lozenge, Nicotine nasal spray, Nicotine patch and Varenicline.

7. Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.

8. Telephone quit line counseling is effective with diverse populations and has broad reach. Therefore, clinicians and health care delivery systems should ensure patient access to quit lines and promote quit line use.

9. If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivational treatments shown in this Guideline to be effective in increasing future quit attempts.

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

Patient Presents to a Health Care Setting  
(Clinic, Hospital, Work Site, Other)

Does Patient Now Use Tobacco?

- **Yes**
  - Is Patient Now Willing to Quit?
    - **Yes**  
      - Provide Appropriate Tobacco Treatments  
        (Tables 1, 2, 3, 4, 7)
    - **No**  
      - Promote Motivation To Quit  
        (Table 5)

- **No**

Does Patient Once Use Tobacco?

- **Yes**  
  - Prevent Relapse  
    (Table 5)
- **No**  
  - No Intervention Required - Encourage Continued Abstinence

### MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) refers to a counseling approach in part developed by William R. Miller, Ph.D., and Stephen Rollnick, Ph. D. from their experience in treating problem drinkers. The fundamental concepts and approaches work on facilitating and engaging intrinsic motivation within the client in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. This technique has wide application to changing unhealthy behaviors, and is a core skill in WellCare’s Care Model. We emphasize the role of MI again as a primary step in the smoking cessation program. There are various ways of describing MI; however they all concern the steps in engaging a change in unhealthy behaviors.

- **Lay definition:** A collaborative conversation style to strengthening a one’s own motivation/commitment to change.
- **Clinical definition:** A person-centered counseling style for addressing ambivalence about change.
- **Technical definition:** A collaborative, goal-oriented style of communication with particular attention to the language of change, designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.\(^7\)

For additional information on MI, please reference *Motivational Interviewing and Health Behavior Change: HS 1042*.

### LEVELS OF MEMBER READINESS TO CHANGE

Following assessment using MI techniques, the member’s readiness to change is categorized into one of the following:

- **Precontemplation.** People at this stage usually have no intention of changing their behavior, and typically deny having a problem. Although their families, friends, neighbors, doctors, or co-workers can see the problem quite clearly, the typical precontemplator can’t. Precontemplators resist change. They may change if there is enough constant external pressure, but once the pressure is removed, they quickly revert.

- **Contemplation.** “I want to stop feeling so stuck,” are typical comments of contemplators. In the contemplation stage, people acknowledge that they have a problem and begin to think seriously about solving it. However, while people in this stage may have vague plans to make changes, they are often not ready to take action yet. Many

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people remain in the contemplation stage for years.

- **Preparation.** Most people in the preparation stage are planning to make changes within the next month. An important first step is to make their intention public. However, they may still need to convince themselves that this is the best step. People who cut the preparation stage short lower their chances of success. It is important to develop a firm, detailed scheme for action to carry them through.

- **Action.** The action stage is the one in which people most overtly modify their behavior and surroundings. They stop smoking, remove all desserts from the house, pour the last beer down the drain, or confront their fears. In short, they make the move for which they have been preparing. Action is the most obviously busy period, and the one that requires the greatest commitment of time and energy. Changes made during the action stage are more visible to others than those made during other stages. It is important to realize that, while the action stage is the one that usually receives the most amount of recognition, it is not the only stage during which members can make progress toward overcoming their problem.

- **Maintenance.** In the maintenance stage, you consolidate the gains you made in the action stage and work to prevent relapses. This stage is a long, ongoing, and critically important process. We all know someone who lost many pounds on a diet, but regained them all in a few months. Successful maintenance requires active alertness.

- **Termination.** The termination stage is the ultimate goal. Here, the former addiction or problem will no longer present any temptation or threat; member does not need to make any further effort and will exit cycle of change.

Member education plays a key role in the smoking cessation program, but is geared to the level of readiness in the member. In addition, there is ample evidence that smoking cessation rates increase when a health care professional initiates the discussion about quitting rather than waiting for the member to bring up the topic. It should be noted that management of smoking cessation during pregnancy has additional factors to consider.

### Educational Activities Based on the Member’s Readiness to Change

#### Pre-contemplation
- General information about the relationship of smoking to their chronic conditions.
- Health benefits of quitting smoking.
- Encouraging data regarding the success of programs when members are ready to quit smoking.

#### Contemplation
- Repeat three messages above.
- Introduce information regarding smoking cessation strategies.

#### Preparation
- The care manager works directly with the member to create a “quit strategy”.
- Establish a “quit date”.
- Ensure that resources are in place (i.e. where nicotine patches, or prescriptions for smoking-cessation products can be obtained).
- Ensure ongoing supportive counseling is in place (through state programs and “quit-lines”).
- Ensure the member’s PCP is engaged in the treatment place.

#### Action
- Initiate plan.
- Ensure the member has engaged in support and counseling resources.
- Encourage, and where possible identify early successes, health improvements.

#### Maintenance
- Ensure the member has solidified gains and has adequate supports in place to maintain success.

#### Termination
- Member graduates from program and no longer requires active management.
MEMBER EDUCATION

Questions to Consider. For members who wish to stop smoking or using tobacco products, you may wish to ask members the following:

- Why do you want to quit?
- When you tried to quit in the past, what helped and what didn't?
- What will be the most difficult situations for you after you quit? How will you plan to handle them?
- Who can help you through the tough times? Your family? Friends? Health care provider?
- What pleasures do you get from smoking? What ways can you still get pleasure if you quit?
- Here are some questions to ask your health care provider.
- How can you help me be successful at quitting?
- What medication do you think would be best for me and how should I take it?
- What should I do if I need more help?
- What is smoking withdrawal like? How can I get information on withdrawal?

Health Risks. The following benefits can be found in the days, weeks and months of smoking cessation:10

- Heart rate and blood pressure begin to return to normal
- Levels of carbon monoxide in the blood decline
- Lung function and overall circulation improves - less phlegm is produced and coughing and wheezing decreases
- Sense of smell and taste increases

Long term benefits include reduced risk of cancer and diseases (e.g., heart disease, COPD) and premature death.10 In addition, studies show the following risk of premature death:

- Quitting at age 30 reduces a member’s risk by more than 90 percent
- Quitting at age 50 reduce a member’s risk by 50 percent
- Quitting at age 60 or above will still live longer than if they continue to smoke

For members diagnosed with cancer, smoking cessation will improve their body’s ability to respond to surgery, chemotherapy, or other treatments and reduce the risk of pneumonia, respiratory failure, and reduce the chance of cancer recurrence or the development of a second cancer.10

Health Benefits. Smoke caused by cigarettes contain a mixture of over 7,000 chemicals, many are toxic and at least 70 are linked to cancer.2 Smoking can cause health problems for smokers and those around them. Cessation of smoking and the use of tobacco products can lead to better health at any age and reduce risk of premature death. Other health benefits include lowering an individual’s risk of:

- Lung and other types of cancer
- Coronary heart disease, stroke, and peripheral vascular disease (effects on coronary heart disease can be seen within 1 to 2 years of stopping smoking)
- Respiratory symptoms (e.g., coughing, wheezing, shortness of breath)
- Developing chronic obstructive pulmonary disease (COPD), a leading cause of death in the United States
- Infertility among women during childbearing years
- Having a baby with low birth weight (for women who smoke while pregnant)

The following talking points can also be implemented:

1. Get Ready! Encourage members to a date and change their surroundings. Remove all cigarettes and ashtrays in the home, at work and in their car. Encourage them to tell others about their goal.

2. Get Support and Encouragement. The more support someone has, the more successful they will be at quitting.
   - Members can ask family, friends, and co-workers for support, including asking them not to smoke around them or leave cigarettes where they can see them.
   - Solicit advice from their health provider, psychologist, or enlist a smoking cessation counselor.
3. **Learn New Skills and Behaviors.** Ask the member to identify what distracts them from their goal and substitute it with a different behavior (e.g. call someone, go for a walk, or focus on a task). A change in routine can also help – drive a different way to work, have breakfast in a different place, reduce stress (e.g., exercise, read a book).

4. **Get Medication and Use It Correctly.** Encourage adherence and questions. FDA-approved medications and/or individual, group or phone counseling may double their chance of success. Products may include:
   - Nicotine replacement products
   - Over-the-counter (e.g., nicotine patch, gum, lozenge)
   - Prescription (e.g., nicotine inhaler, nasal spray)
   - Prescription non-nicotine medications, such as bupropion SR (Zyban®) and varenicline tartrate (Chantix®)

5. **Be Prepared.** Let members know that relapse can occur within the first 3 months - many people try several times to quit smoking before finally doing so. Tell members they can avoid the following potential triggers:
   - *Drinking alcohol* can lower their chance of success.
   - Being around *other smokers* may make them want to smoke.
   - Follow a healthy diet and exercise regularly; do not let possible *weight gain* keep them from your goal.
   - Be prepared for *mood changes*. A referral to a counselor or smoking cessation counselor may be warranted.

### PROVIDER EDUCATION

Provider education is given once the member has entered the preparation stage as determined by motivational interviewing. This education includes using “the 5 A’s” of (1) ask about tobacco use; (2) advise to quit; (3) assess willingness to make a quit attempt; (4) assist in the quit attempt and; (5) arrange follow-up. The intent of the provider education is to reinforce the evidence in favor of success in smoking cessation even in historically difficult populations such as long-term smokers, members with chronic mental illness and members in poor health status or with malignancy.

In addition, the provider education is geared to ensure a positive reception when the member initiates a smoking cessation strategy, and the provider will order the appropriate treatments to assist the member in their program. Provider education includes materials regarding the evidence-based treatments for smoking cessation in order to assist in selecting those treatments that are most appropriate to the member. Evidence-based treatments for smoking cessation include all of the following:

- Counseling for smoking cessation (including telephonic, group and individual)
- FDA approved medications (including Bupropion, Varenicline and Nicotine Replacement Therapies (NRT) such as patches, gums, lozenges, inhalers and nasal sprays.

Successful outcomes in smoking cessation attempts improve when these treatments are used as part of a comprehensive program that is tailored to the member’s individual needs and consistent with the medical treatment of any co-occurring medical conditions.

### CONNECTION TO STATE AND NATIONAL PROGRAMS

A critical component of the WellCare smoking cessation program is connecting the member to appropriate resources to assist them in a successful endeavor. One such resource is the National Quit Line. The National Network of Tobacco Cessation Quitlines was developed through a partnership among the CDC, the NCI Cancer Information Service, the North American Quitline Consortium, and the states. This system provides callers from across the nation with a single, toll-free access point (1-800-QUIT NOW) that automatically routes them to their state’s telephone based cessation services. When the member is assessed as being ready to engage in creating a “quit plan” or ready for “action” this connection is facilitated. Finally, it should be noted that there is Federal support for continued efforts for smoking cessation in recent legislation. The enactment of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act provides expanded coverage for recommended clinical preventive services, including...
evidence-based smoking cessation treatments. As services become more prevalent and state strategies drive further lowering of their smoking related health expenses, we anticipate increasing demand for our smoking cessation program.

**PHARMACOLOGIC INTERVENTION DURING PREGNANCY**

Pregnant patients should try to quit smoking without using pharmacologic agents. The 5 A’s approach has been shown to be an effective behavioral strategy for smoking cessation. Pharmacologic aids such as nicotine replacement therapy (NRT), bupropion, and varenicline have not been sufficiently tested for efficacy and safety in pregnant patients and should not be used as first-line smoking cessation strategies for these patients. Evidence is inconclusive that smoking cessation medications boost abstinence rates in pregnant smokers. In addition, U.S. clinical trials with sufficient power to determine statistical significance have been pulled or ended due to data or safety monitoring issues.\(^\text{12}\) If pharmacotherapy is considered for pregnant smokers who are unable to quit smoking by other means, it is important the woman demonstrate a resolve to quit smoking and to understand the benefits and risks of the use of the medication to herself and her fetus. Clinicians should carefully review patient information, drug side effect profiles, and current information in medical literature when recommending pharmacologic aids. Since antidepressants marketed for smoking cessation, such as bupropion, carry risks of adverse effects including: increased risk for suicide, insomnia and rhinitis. Pregnant patients who choose to use smoking cessation medications should be closely supervised.

**ADDITIONAL RESOURCES\(^{10,13}\)**

**CDC State Tobacco Activities Tracking & Evaluation (STATE) System** - [http://apps.nccd.cdc.gov/statesystem](http://apps.nccd.cdc.gov/statesystem)
An interactive application that displays current and historical state-level data on tobacco use prevention and control.

**National Cancer Institute** - [http://www.smokefree.gov](http://www.smokefree.gov)
- Smoking Quitline (877) 44U–QUIT : individualized counseling, printed information, and referrals to other sources

**Internet Resources**
- **American Cancer Society**
- **American Heart Association**
  [http://www.heart.org/HEARTORG/GettingHealthy/QuitSmoking/Quit-Smoking_UCM_001085_SubHomePage.jsp](http://www.heart.org/HEARTORG/GettingHealthy/QuitSmoking/Quit-Smoking_UCM_001085_SubHomePage.jsp)
- **National Tobacco Control Program** - [http://www.cdc.gov/tobacco/tobacco_control_programs/ntcp/](http://www.cdc.gov/tobacco/tobacco_control_programs/ntcp/)
- **Smoke Free Teen** - [http://teen.smokefree.gov/](http://teen.smokefree.gov/)
- **Smoke Free Women** - [http://women.smokefree.gov/](http://women.smokefree.gov/)
- **UCanQuit** - [http://www.ucanquit2.org](http://www.ucanquit2.org) (for military personnel and their families)
- **FDA 101: Smoking Cessation Products**
  [http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm198176.htm](http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm198176.htm)
- **Pathways to Freedom: Winning the Fight Against Tobacco**
- **Staying Healthy** - [http://www.ahrq.gov/consumer/healthy.html](http://www.ahrq.gov/consumer/healthy.html)

**Smoking Quit and Information Lines**
- **(800) LUNG-USA** : helpline and education for those wishing to stop smoking
- **(800) QUIT-NOW** : educational materials and coaches that can help you quit smoking or chewing tobacco
- **(877) 44U–QUIT** : individualized counseling, printed information, and referrals to other sources

**HEDIS AND STAR MEASURES**

CMS has not published any measures for this topic. NCQA has published the following standard metrics related to
smoking cessation:

**Medical assistance with smoking cessation.** Current smokers who were seen by a practitioner during the measurement year and received advice to quit, cessation medications were recommended and discussed, and cessation methods were recommended or discussed.

### RELATED CLINICAL PRACTICE GUIDELINES

In addition to this CPG, please reference the following CPGs: *Asthma* (HS: 1001) and *COPD* (HS 1007).

### REFERENCES


### LEGAL DISCLAIMER

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### MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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<tr>
<th>Date</th>
<th>History and Revisions by the Medical Policy Committee</th>
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<tr>
<td>2/5/2015</td>
<td>• Approved by MPC. Inclusion of additional materials from 2014.</td>
</tr>
<tr>
<td>2/7/2013</td>
<td>• Approved by MPC.</td>
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Original Effective Date: 2/7/2013 Revised: 2/5/2015