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Designing tobacco control systems and cessation benefits in managed care: skill building workshop

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The following article describes highlights from the skill building workshop "Designing tobacco control systems and cessation benefits in managed care". This workshop was conducted by Carolyn Link Carlson, Blue Cross Blue Shield of Minnesota, and Peggy Chute, formerly of Healthsource Maine.

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Minnesota (Blue Cross) is Minnesota's oldest and largest health insurer. Blue Cross is a not-for-profit organisation which provides services to more than 1.8 million members throughout Minnesota and its border states, as well as nationally. Blue Cross has a network based system of care providers, and contracts with 100% of hospitals and over 90% of physicians in the state. Blue Cross offers a full portfolio of commercial and government products, and serves broad market segments, including individuals, small groups of 2–49 employees, self funded and fully funded groups of 50 or more employees, and members of state and federally funded programs.

Over five years ago, Blue Cross was the first health plan in the nation to sue the tobacco industry. We successfully settled that suit in May 1998 for unprecedented public health and financial gains. While the litigation is certainly Blue Cross' best known tobacco reduction initiative, it is one of several components within a comprehensive program involving clinical practice, community leadership, and policy making. For example, Blue Cross was instrumental in passing Minnesota's recent youth access restrictions and in 1998 convened community forums across the state (in a year long effort called Minnesota*Decides*), bringing new constituencies into the tobacco conversation. In addition, Blue Cross offers non-smoker premium discounts, and was one of the first large employers in the state to become smoke free many years ago.

Designing tobacco control programs is complex, and at Blue Cross the broad spectrum of services we provide increases that complexity. Groups and individuals can elect to purchase benefits which vary significantly in coverage levels. For instance, some of our members elect only comprehensive major medical coverage. Benefit design that requires an office visit for a nicotine replacement therapy prescription (as we have done at Blue Cross) requires that the claims system be adjusted to allow those with coverage for a single office visit per year to still have reasonable access to the pharmacy benefit. Additional complexity arises from the fact that approximately half of our members are covered through their self insured employer who may or may not choose to offer tobacco

1. Tobacco reduction program planning: six critical success factors (adapted from McAfee *et al*[3])

1: Use of a population perspective and data
- Treat tobacco as a key health indicator— it is the leading cause of death, disability, and cost.
- Focus on your population's needs and be evidence driven.
- Know the scientific research and apply it early and often. Tobacco initiatives often are held to a higher than usual standard, but can live up to it.

2: Obtain broad organisational support
- Seek out buy-in at all levels of the organisation—from the CEO to middle managers to customer service staff.
- Figure out departmental self interest and work with it.
- Set a high level goal/timeline *and* the interim steps and measures for getting there.

3: Integrate centralised support and clinic level activity
- Walk the talk and remove financial and organisational barriers to cessation.
- Rigorously and comprehensively evaluate. Be prepared for internal and public scrutiny.
- Work with all health care providers. Integrate tobacco with other existing CQI requirements and guideline projects (NCQA, HEDIS, etc).
- Communicate directly with members through various existing outlets (member newsletters, direct mailings, company advertisements).
- Team up program staff and clinical staff for ongoing consultation and support, not just when you need something.

4 and 5: Establish local ownership and empower and support health care teams
- Identify and support local leaders.
- Share data and progress reports.

6: Provide organisational support for community and policy based activities
- Apply organisational weight to policy and community initiatives.
- Engage physicians in policy advocacy—legislators and the public trust doctors.

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2. Team roster and integration points for designing tobacco control programs in managed care

Achievement of your health plan's tobacco reduction goals requires a corporate wide effort. Buy-in and active involvement from multiple departments is essential. Specific areas that have a stake in the process and/or expertise to contribute include:

- quality improvement and NCQA
- provider relations
- contracting
- information systems
- marketing
- sales
- actuarial
- communications and public relations
- behavioural health or mental health services
- customer service
- benefit design and set up
- claims management
- clinic administration
- credentialing
- medical directors
- health education and worksite programs
- pharmacy benefits management
- foundation or philanthropic department

Avoid the temptation to assemble a tiny team of like minded individuals. The multiple and at times conflicting needs and perspectives that your team members bring are essential for developing a program that will endure. A program that meets public health goals but ignores marketing needs will not succeed. Likewise, a program focused on marketing objectives alone will lack the scientific rigour necessary for meeting health improvement goals. "Substance and sizzle" can coexist.

cessation benefits and programs. Employers, too, are challenged as they balance the interests of providing for their employees the most comprehensive preventive services with the need to control cost.

In the fall of 1998 each of the three major health plans in Minnesota independently and voluntarily began to offer cessation pharmacy benefits to their fully insured enrollees. Blue Cross' decision to add the benefit was driven by the Agency for Health Care Policy and Research (AHCPR) guideline and recently published research regarding the effectiveness and cost effectiveness of the pharmacotherapies.[1 2] At Blue Cross the benefit covers the nicotine patch, nicotine gum and bupropion SR (Zyban; GlaxoWellcome), at the members' usual pharmacy co-pay. Both over the counter (OTC) and prescription preparations are covered, as long as a physician's prescription is written. There is no cap on utilisation—this is left to the physician and patient, and is a major reason for the requirement that a prescription accompany the request, even for OTC (in addition to the evidence that brief physician advice is effective in supporting quit rates).

Approximately one year earlier than the commercial availability of the cessation pharmacy benefit, the state of Minnesota mandated that all health maintenance organisations (HMOs) provide coverage for the nicotine patch and behavioural counselling for prepaid Medical Assistance and MinnesotaCare enrollees. MinnesotaCare, a health care program subsidised by the state of Minnesota, was established to provide health care coverage to low income individuals who do not have access to health coverage. As of January 1997, all MinnesotaCare enrollees receive their services through managed care health plans. At Blue Cross, since the commercial benefit includes additional pharmaceuticals (nicotine gum and bupropion SR) we have expanded the public programs benefit to include these medications.

Today's challenge is to build on these efforts while significantly increasing both prevention and treatment based approaches to tobacco reduction. Blue Cross has established the Center for Tobacco Reduction and Health Improvement to lead the charge toward reducing member tobacco use rates by 30% over the next 10 years. Current efforts include a scientific evaluation of the effect of the cessation pharmacy benefit, the development of a tobacco cessation counselling program, and collaboration with external partners on the state of Minnesota's settlement planning.

Healthsource Maine

Healthsource Maine is an independent practice association HMO licensed to offer a full spectrum of managed care products throughout the state of Maine. Healthsource Maine was founded in 1986 on the belief that managed care is the best way to mitigate the rapidly rising costs of health care. Recognised as a leader in quality promotion, Healthsource Maine was rated by US News and World Report in October 1998 as one of the nation's highest ranked HMOs. Acquired by Cigna HealthCare in 1997, Healthsource Maine offers a variety of fully insured and self funded products to over 160 000 members and has developed a comprehensive network of over 2500 primary care physicians, specialists, hospitals, laboratories, and ancillary providers.

3. Benefit design: key decision points and considerations

GETTING STARTED: ASK YOURSELF AND YOUR TEAM THE FOLLOWING QUESTIONS:

What is driving the cessation benefit design? Health? Politics? Competition? Cost reduction?
Get departmental self interest on the table and be clear about expectations. Also be clear about what you can expect out of the benefit: a benefit in and of itself cannot be expected to accomplish the health plan's health improvement and cost reduction goals!

What is the scientific basis?
Know the evidence behind the recommendations you will make from the public health and/or medical perspective. What makes sense scientifically may be at odds with what is easy to implement operationally.

Are the right players at the table?
Do not forget operations, membership systems, IS, claims, etc. Medicine and public health should be the foundation, but the nuts and bolts of operations determine whether the benefit will work day-to-day.

Is your senior sponsor ready to remove roadblocks and release necessary resources?
If this is a top corporate priority your sponsor has to be ready to come to bat for the team. Program design often runs on borrowed time and good will. When faced with competing priorities some departments will need an extra push or resources to stay focused.

What is the communications plan?
Communication are essential. Doctors, pharmacists, members, employers, and numerous internal stakeholders need tailored, effective, and timely information.

NUTS AND BOLTS CONSIDERATIONS

What exactly is covered?
Is this solely a pharmacotherapy benefit? Which pharmacotherapies are covered—patch, gum, Zyban, inhaler? Are OTC preparations covered, or just prescriptions? Will you require a physician's prescription for OTC coverage? What about counselling? Is counselling required if the member wants the medication covered? If you require counselling make sure effective options are available.

Who is eligible?
Does the benefit cover fully insured members only? What about self insured groups? Is there already a benefit for public programs (like Medicaid)? How does the public programs benefit compare with the commercial benefit you are designing?

Who pays and how much?
Will there be a co-pay? Is it the same as the regular pharmacy co-pay, or different?

When is it available?
Will it be rolled out all at once or upon renewal? It may be easier for pharmacy benefit management to make it available all at once, but owing to contractual obligations and state filing requirements it may be necessary to make the benefit available on renewal. Whatever is decided must be communicated repeatedly to all stakeholders.

Is there a cap on utilisation?
Most smokers make multiple quit attempts before ultimately succeeding. Will a utilisation cap interfere with that process? If you have a cap can you actually enforce it? If not, assess your rationale for putting a cap in place.

Committed to its mission of "creating healthier communities", Healthsource Maine's products and programs consist of a multidisciplinary approach linking medical management, quality assurance, and health education. Supported by national resources and vast financial strength, the integration of Healthsource Maine and Cigna HealthCare offers unprecedented opportunity for product expansion and enhancement while maintaining the strategic value of a locally managed HMO.

The state of Maine ranks among the top 10 states for smoking related deaths in the United States. According to the Centers for Disease Control and Prevention, the state of Maine has the highest incidence of 18 to 30 year olds who smoke. Healthsource Maine's membership is broad based, expanding from northern Maine to the southern tip, including many remote areas. Many members reside more than an hour's drive from a health care facility, making facility based health education impractical. In response to the problem of geographically remote smoking cessation programs, Healthsource Maine saw a unique opportunity to create a healthier community by developing Maine's first telephonic smoking cessation program in 1994. Healthsource Maine's telephonic program consists of 21 calls to each member attempting to quit smoking over a two year period. Daily reports from the pharmacy database identify members who fill a prescription for Zyban or nicotine replacement therapy. These individuals are called and informed of the program benefits and voluntary enrollment process. Health educators establish a rapport with the member, determine their stage of readiness to quit, and assist in the development of coping strategies to help a member successfully stop smoking. In February 1999, the six month quit rate for Healthsource Maine's telephonic smoking cessation program was 39%. The quit rate drops slightly over the two year period to 28.3%.

Looking toward the upcoming millennium, Healthsource Maine, in conjunction with Cigna HealthCare, will continue to enhance the smoking cessation program. In time we hope our program will be adopted as a best practice model for other Cigna health plans.

4. Sample questions for assessing "vendors" of tobacco cessation counselling services

EVALUATION
- Is the program science based?
- Are the evaluation methods sound?
- Are "success" and "completion" appropriately defined and measured?
- What are the 6 and 12 month quit rates?
- What are the population level participation rates?
- How does the system identify and track smokers?

EXPERIENCE
- How many and what type of members/patients has the vendor served?
- Has the program been successfully offered in your type of health plan (that is, in a network based system or in a staff model plan)
- How long has the vendor been in this business?
- Can you interview past and current clients?

REFERRAL, RECRUITMENT, OUTREACH
- How are members referred into the system?
- How are the non-English speaking members served? Members requiring assistive devices like TDD?
- Is there specific outreach to high risk groups such as teens or pregnant women?
- How are providers involved in referrals?
- Are providers given feedback on patient participant and/or outcomes?

COUNSELLING COMPONENT
- Does the program include both inbound and outbound calls?
- Are supporting materials used?
- What behavioural techniques does the counselling staff use?
- What is the process from initial contact through treatment and follow up?
- Is "readiness to change" or another conceptual approach applied?
- What are the qualifications and training of the staff that interact with the members?
- How are after hours calls handled?
- How is relapse prevention addressed?
- How are requests for cessation pharmacotherapy handled?

MARKETING AND PROMOTION
- What is the marketing plan and what is the cost of marketing materials?
- Are marketing and promotions the responsibility of the vendor or the health plan?

COST AND VOLUME CAPACITY
- What is the cost per member?
- Can the vendor handle the volume of new members your plan would enroll?
- Does the implementation timeline meet health plan needs?

Introduction of planning tools

We have created a number of tools, four of which are highlighted here (boxes 1–4), that provide an overview of some of the major decision making processes we have been through in our organisations. Our intent is to provide you with tips and questions to ask along the way when designing your own comprehensive tobacco prevention and control programs.

SIX CRITICAL SUCCESS FACTORS IN DEVELOPING COMPREHENSIVE TOBACCO PREVENTION AND CONTROL PROGRAM

This is a tool we adapted, with permission, from the article "Awakening the sleeping giant, mainstreaming effort to decrease tobacco use in an HMO"(box 1).[3] The team at Group Health of Puget Sound, which authored the article, has achieved impressive success. The article provides a strategic approach that is both tobacco and managed care specific. In creating this one page adaptation, we highlighted questions and considerations to guide users along the way.

DEVELOPING A TEAM ROSTER

At Blue Cross in Minnesota, we developed a roster of people willing to act as leaders and contributors to help us shape our programs (box 2). On our cessation counselling strategy team, for example, we have representation from the actuarial department, our behavioural health subsidiary, marketing, medicine, public health, and communications. The implementation team includes a few "swing team" members, those who serve on both strategy and implementation teams to provide continuity, plus representatives from claims, membership, benefits set up, and additional staff with operational expertise.

BENEFIT DESIGN: KEY DECISION POINTS AND CONSIDERATIONS

The call for health plan coverage of cessation counselling and pharmacotherapies has come from many quarters, not least of which is the AHCPR guideline. Other advocates include state tobacco control groups, physicians, and health plan members. For many health plans, the development of a cessation benefit is a first phase tobacco reduction effort (box 3). Benefit design and implementation processes and outcomes will be closely scrutinised internally and externally, and the success or failure significantly influences subsequent efforts. Benefit design is more complicated

than most people appreciate, and the unprepared can quickly get overwhelmed. As with all parts of tobacco program design, we recommend you bring together a cross functional team. Make sure you include not only those with health related expertise, but also operational experts.

ASSESSING VENDORS OF TOBACCO CESSATION COUNSELLING SERVICES

While Healthsource Maine developed an in-house counselling program (see the earlier description), Blue Cross and Blue Shield of Minnesota chose a hybrid approach to the buy-or-build question. We developed and issued a request for proposals as the first step in finding a partner with whom to develop tobacco cessation counselling services. The tool provided here is a streamlined version of that request for proposals (box 4).

Conclusion

Effective tobacco prevention and cessation programs currently exist in managed care and can be adapted to work in a variety of settings.

CQI: Continuous Quality Improvement
HEDIS: Health Plan Employer Data and Information Set
NCQA: National Committee for Quality Assurance
TDD: Telecommunication Device for the Deaf

Using the tools provided in this workshop, in addition to those from the Addressing Tobacco in Managed Care project office, the scientific literature and experiences of peers, participating health plan professionals can design their own programs.

1 Cromwell J, Bartosch WJ, Fiore MC, *et al*. Cost-effectiveness of the clinical practice recommendations in the AHCPR guideline for smoking cessation. *JAMA* 1997;**278**:1759–66.
2 Croghan IT, Offord KP, Evans RW, *et al*. Cost-effectiveness of treating nicotine dependence: the Mayo Clinic experience. *Mayo Clin Proc* 1997;**72**:917–24.
3 McAfee T, Wilson J, Dacey S, *et al*. Awakening the sleeping giant: mainstreaming effort to decrease tobacco use in an HMO. *HMO Practice* 1995;**9**:138–43.