

# The Nicotine Challenger

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This issue: Reaching Out

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## A View From The Director

by Jonathan Foulds, PhD

*How can we make tobacco treatment available to more smokers?*

Although the US Public Health Service Clinical Practice Guideline for the Treatment of Tobacco Use and Dependence recommends that physicians ask all patients about their tobacco use, and all smokers be offered an approved medication to help them quit, this is clearly not happening<sup>1</sup>. An analysis of the 2001-2 national Ambulatory Care Survey<sup>2</sup> found that tobacco counseling occurred in 22.5% of visits by tobacco users, and cessation medications were prescribed on only 2.4% of occasions (with the odds being 15 times higher if the patient requested it). These rates are no higher than were found in this survey in 1991. A different study involving direct observation of physician encounters with patients<sup>3</sup> found that of 244 smokers identified, physicians provided assistance with smoking cessation for 38% (range among practices = 0%-100%). Bupropion and nicotine replacement therapies were discussed with smokers in 31% and 17% of encounters, respectively. Numerous other studies have documented poor adherence of physicians to the basic recommendations in the 1996 and 2000 Tobacco Treatment Guidelines<sup>1</sup> regarding the "5 As" (Ask, Advise, Assess, Assist, Arrange), with particularly low rates of "assisting" on use of medications and "arranging" follow-ups.<sup>4-6</sup> This partly relates to lack of familiarity with the Guideline,<sup>7</sup> but time constraints and the perception that smokers are unreceptive to counseling were the two most common barriers cited by both physicians and office managers in one study<sup>8</sup>. Thorndike et al<sup>9</sup> reported that there has been a small increase in physicians' rates of patients' smoking status identification and a small decrease in rates of counseling smokers over the decade 1993-2003. This lack of progress may reflect barriers in the US health care environment, including limited physician time to provide counseling.

A National Commission on Prevention Priorities, led by former US Surgeon General Dr David Satcher, ranked 25 preventive healthcare interventions for their population impact and cost-effectiveness<sup>10</sup>. Three interventions achieved the top ranking on both of these measures (total score=10): daily aspirin for people over 40, childhood immunizations, and brief counseling and pharmacotherapy for tobacco use. Of all the interventions evaluated, the tobacco intervention was estimated to have by far the biggest impact on Quality-Adjusted Life Years saved if widely implemented (1.3 million annually). Under-treatment of tobacco dependence therefore represents a major failure in the US healthcare system. So what are the causes and potential remedies? Here are my thoughts:

*continued on page 3*

## CHANTIX: MIRACLE PILL OR DANGEROUS DRUG?

by Michael B. Steinberg, MD MPH  
Medical Director and Associate Professor

The answer is **neither**...

Chantix (varenicline) is the latest FDA approved medication to be used for treating tobacco dependence. In the clinical trials to date and in early anecdotal reports from tobacco treatment clinicians, Chantix is performing very well as an effective aid to help smokers quit. Here at the Tobacco Dependence Clinic, we are prescribing Chantix quite actively, and have found it to be a very useful, effective, and well-tolerated medication both for smokers who have never used pharmacotherapy and those who have battled tobacco dependence with other medications in the past. Despite these results, smokers (and providers) need to be continually reminded that this is not a "magic-bullet" and that all pharmacological agents perform better when made part of a comprehensive tobacco dependence treatment plan.

Recently, widely broadcasted case reports have aroused concern over the safety of Chantix, but the forces at play here are complex:

- In the few thousands of subjects enrolled in Pfizer's published clinical trials, there did not seem to be concerning reports of erratic behavior, depression, or suicidal ideation
- It should be noted that in these early trials (as customary for many initial trials), subjects were screened out for many psychiatric and medical illnesses
- The current market of Chantix is estimated around 3,000,000 users, much greater numbers than were able to be studied in clinical trials
- It stands to reason that now that the medication is out in the general public, previous rare effects might present themselves more commonly (this is why post-marketing surveillance is so important)
- The reports of erratic behavior in the media are not clearly linked solely to the use of this medication, because there are often several factors in play. For example, stopping smoking



*continued on page 2*

### Causes

1. Although very thorough evidence-based reviews and clinical practice guidelines are available, most clinicians are unaware of them, and few healthcare systems require that they be followed in the same way that guidelines on the treatment of other comparable disorders (e.g., hypertension) are followed. If the healthcare system (whether that be the hospital system or the health plan) does not explicitly value tobacco treatment one should not be surprised that busy clinicians are not going out of their way to find and follow clinical guidelines on this issue.
2. Clinicians have found that it is not simple to get paid for tobacco treatment interventions. Where these are covered by health plans there may be high copays or deductibles, payments are frequently low, and certain effective treatment components are not covered (e.g., over the counter nicotine replacement therapy or group treatment). Therefore, for both clinicians and patients, there is uncertainty about what (if any) treatment components are covered, and this itself is a barrier to treatment provision.
3. Clinicians are unsure about the effectiveness of tobacco treatment. Their experience is that of 50 patients counseled and offered a medication, 40 will still be smoking when they are seen a year later. This can seem unrewarding compared to some other clinical interventions.

### Solutions

1. All the effective components of tobacco treatment should become covered benefits of all health plans. Model benefit designs have already been described and widespread adoption of these would take away that doubt/barrier<sup>11</sup>. This will


require both patients and employers to ask for it, as well as insurance companies to offer and provide it.

2. We need to ensure that a new tier of healthcare provider can be trained and eligible for reimbursement for tobacco treatment. Physicians' and other prescribers' time is valuable and the counseling component is best provided by counselors who have been trained to specialize in that work. In large hospitals or high population densities, this tobacco counseling can be provided face-to-face in specialist clinics, but in areas that are more rural this can best be provided via telephone "quitlines" and interactive websites. This will require that more tobacco treatment counselors be trained and approved for reimbursement by health plans. Standards for Practice for Tobacco Treatment Specialists have been developed by the Association for the Treatment of Tobacco Use and Dependence (ATTUD): <http://www.attud.org/public/survey.php>
3. Steps 1 and 2 above will enable physicians to move to a model where they routinely ask patients about tobacco use, advise them to quit, offer to prescribe a med, and then refer on to a local counselor or quitline (ideally via an electronic or "fax-to-quit" service). The physician intervention needn't require more than one or two 15-minute appointments, and the counselor intervention would consist of 4-8 30-minute sessions.

I'd be interested to hear from clinicians regarding what they think could be done to improve tobacco treatment provision. For the patients, I think the advice must be to ask your clinicians for help; and, for clinicians, to move towards working in a proactive, rather than reactive, mode.

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11. For details, see <http://www.tobaccoprogram.org/cftfinsurance.htm>

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