PATTERNS OF PRACTICE

NANCY A. RIGOTTI, MD
Tobacco Research & Treatment Center
Massachusetts General Hospital
Harvard Medical School
Harvard Pilgrim Health Care
Boston, Mass

VIRGINIA P. QUINN, PhD
Kaiser Permanente Southern California
Pasadena, Calif

VICTOR J. STEVENS, PhD
Kaiser Permanente Center for Health Research
Portland, Ore

LEIF I. SOLBERG, MD
HealthPartners Research Foundation
Minneapolis, Minn

JACK F. HOLLIS, PhD
Kaiser Permanente Center for Health Research
Portland, Ore

ABBY C. ROSENTHAL, MPH
Health Alliance Plan
Detroit, Mich

JANE G. ZAPKA, ScD
University of Massachusetts Medical School
Worcester, Mass

ERIC FRANCE, MD, MSPH
Kaiser Permanente
Denver, Colo

NANCY GORDON, ScD
Kaiser Permanente Northern California
Oakland, Calif

SABINA SMITH, BS, CCRP
MINA MONROE, MPH
Kaiser Permanente Center for Health Research
Portland, Ore

Eff Clin Pract. 2002;5:130–136.

Edited by James D. Sargent, MD

Tobacco-Control Policies in 11 Leading Managed Care Organizations: Progress and Challenges

CONTEXT. Although evidence-based national guidelines for tobacco-dependence treatment have been available since 1996, translating these guidelines into clinical practice is challenging.

PRACTICE PATTERN EXAMINED. Policies regarding tobacco-dependence treatment (e.g., written guidelines and coverage of pharmacotherapy) and implementation strategies of 11 U.S. managed care organizations known to have strong tobacco-control programs.

DATA SOURCES. Detailed telephone interviews with multiple informants at each health plan and review of written treatment guidelines and policies for tobacco dependence.

RESULTS. Although 10 of 11 plans had adopted tobacco-dependence treatment guidelines consistent with the national guideline, fewer had guidelines for special groups, such as adolescents (6 plans), parents (5 plans), pregnant women (5 plans), and hospitalized smokers (3 plans). Most plans offered clinician training and recommended office systems to support provider efforts; however, fewer actively facilitated their implementation. Most plans provided other support for tobacco treatment, including dedicated budgets, designated staff, and an oversight committee. All plans offered some coverage for tobacco-cessation pharmacotherapy and behavioral counseling, although not to the extent recommended by the national guideline.

CONCLUSION. Implementation of national tobacco-treatment guidelines is feasible in closed-panel managed care organizations. However, even these leading health plans could do more to comply with national practice guidelines on tobacco-dependence treatment and make it easier for clinicians to help patients stop smoking (e.g., through increased training and expanded coverage of tobacco-dependence treatment).

Tobacco remains the most important cause of preventable disease and death in the United States.[1] The health care setting offers a good opportunity to discourage smoking.[2, 3] Strong evidence indicates that physician advice and assistance to smokers in the course of office visits is effective.[4, 5] Using this evidence, the U.S. Public Health Service (USPHS) released a clinical guideline for tobacco treatment in 1996 and revised it in 2000.[3, 4, 6] **Table 1** lists estimates of the efficacy of tobacco-dependence interventions. On the basis of this evidence, the guideline recommends that clinicians ask patients about smoking status at every visit, advise all tobacco users to quit, assess a patient's willingness to try to quit, assist the patient's quitting efforts, and arrange follow-up. This approach is cost-effective but underutilized.[7, 8]

System-level interventions are needed to facilitate the efforts of individual clinicians.[9–15] For smoking cessation, the Centers for Disease Control and Prevention's

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TABLE 1

Efficacy Estimates for Tobacco Treatment Interventions: Results of Meta-Analyses

TREATMENT	ESTIMATED ODDS RATIO FOR TOBACCO ABSTINENCE (95% CI)	
	USPHS GUIDELINE*	COCHRANE LIBRARY†
Clinician intervention		
Physician advice to quit	1.3 (1.1–1.6)	1.7 (1.5–2.0)
Physician counseling	2.2 (1.5–3.2)	1.4 (1.2–1.7)‡
Smoking cessation counseling		
In person (face-to-face)		
Individual	1.7 (1.4–2.0)	1.6 (1.3–1.9)
Group	1.3 (1.1–1.6)	2.1 (1.6–2.7)
By telephone (proactive)	1.2 (1.1–1.4)	1.6 (1.3–2.0)
Self-help material	1.2 (1.02–1.3)	1.2 (1.0–1.5)
Pharmacotherapy		
Nicotine replacement therapy	NA	1.7 (1.6–1.9)
Gum§	1.5 (1.3–1.8)	1.7 (1.5–1.8)
Transdermal patch§	1.9 (1.7–2.2)	1.8 (1.6–2.0)
Vapor inhaler§	2.5 (1.7–3.6)	2.1 (1.4–3.0)
Nasal spray§	2.7 (1.8–4.1)	2.3 (1.6–3.2)
Other agents		
Bupropion§	2.1 (1.5–3.0)	2.7 (1.9–3.3)
Nortriptyline¶	3.2 (1.8–5.7)	2.8 (1.6–5.0)
Clonidine¶	2.1 (1.4–3.2)	1.9 (1.3–2.7)

**Data from reference 4.*
†Cochrane Database of Systematic Reviews. 2001. Available at www.cochrane.org/cochrane.
‡Comparison group is physician advice only for Cochrane Library category. Comparison group is no intervention for USPHS (U.S. Public Health Service) guideline category.
§Approved by the U.S. Food and Drug Administration as a smoking cessation aid; recommended by the USPHS guideline as a first-line agent for treating tobacco use and dependence.
¶Not approved by the U.S. Food and Drug Administration as a smoking cessation aid; recommended by the USPHS guideline as a second-line agent for treating tobacco use and dependence.

Community Services Task Force found strong evidence to support provider reminder systems, multicomponent patient telephone counseling, and reduction of out-of-pocket costs to patients for cessation treatment.[16] The USPHS tobacco guideline incorporates this evidence (**Table 2**).[4, 6] The challenge for health care delivery systems is to translate these evidence-based guidelines into consistent clinical practice.[17]

This paper describes the policies and practices that 11 well-established nonprofit managed care organizations (MCOs) use to discourage tobacco use and compares their efforts with the USPHS tobacco guideline.[4] These plans provide medical care to nearly 9 million members and are in an excellent position to implement strategies to reduce tobacco use.[10, 18–20] The plans share a strong research orientation, clear commitment to control of tobacco use, award-winning tobacco-control programs, and above-average scores on the Health Plan Employer Data Information Set tobacco measure.[9, 14, 21–25] Their strategies provide other health plans, purchasing groups, and policymakers with examples of actions that are feasible to implement and lead to good quality of care.

Methods

Selection of Plans

This study was conducted during the winter of 1999–2000 in 11 medium-sized and large MCOs. Nine

TABLE 2

Systems Changes Recommended To Implement U.S. Public Health Service Guidelines: Treatment of Tobacco Use and Dependence*

- **Every clinic should implement a tobacco-user identification system.**
- **All health care systems should provide education, resources, and feedback to promote provider interventions.**
- **Clinical sites should dedicate staff to provide tobacco-dependence treatment and assess the delivery of this treatment in staff performance evaluations.**
- **Insurers and managed care organizations should include tobacco-dependence treatments (both counseling and pharmacotherapy) as paid or covered services for all subscribers or members of health insurance packages.**
- **Insurers and managed care organizations should reimburse clinicians and specialists for delivery of effective tobacco-dependence treatments and include these interventions among the defined duties of clinicians.**
- **Hospitals should promote policies that support and provide tobacco-dependence services.**

**Data from references 4 and 6.*

are members of the National Cancer Institute's HMO Cancer Research Network, which collaborates on research to increase the effectiveness of cancer control.[26] Two nonnetwork MCOs were added because they had been active in tobacco-control efforts.

We selected plans known for their tobacco-control programs or for good performance on tobacco-control measures. Six plans have won awards from the American Association of Health Plans for their tobacco-control activities.[23–25] The tobacco measure in the Health Plan Employer Data and Information Set is the national benchmark for assessing the adequacy of a health plan in tobacco-dependence treatment and its performance.[27, 28] The 1999 Health Plan Employer Data and Information Set smoking advice rates (the proportion of a health plan's smokers who had been advised to quit smoking by a physician in the past year) for the 11 selected plans (66% to 82%) exceeded the national average (64%).[28]

Interview Protocol

The survey instrument assessed program components recommended by the USPHS tobacco guideline (**Table 2**) and the Centers for Disease Control and Prevention Community Preventive Services Task Force.[6, 16] Specifically, we assessed the content of written guidelines for smoking cessation and prevention, other tobacco-related plan policies, implementation of tobacco-control policies, monitoring and encouraging of provider adherence to tobacco guidelines (e.g., financial incentives), support for systems to address cessation of tobacco use, health plan coverage of tobacco-cessation treatments, and population-focused tobacco-control activities.

Multiple informants with knowledge of the organization's tobacco-control policies, typically physician administrators or health educators, were chosen to complete the survey. A single external interviewer conducted all telephone interviews. Interviews required an average of 8 hours per health plan. Each plan's site investigator determined the final answer if informants provided discrepant responses and reviewed the completed survey for accuracy. Some health plans had diverse organizational structures. It proved difficult to collect and characterize the policies for network and independent practice models. As a result, we report policies for only the staff-model and closed-panel group practices that had exclusive contracts with each plan.

Results

Clinical Guidelines

Ten of the 11 health plans had a written clinical practice guideline for cessation of tobacco use that recommended actions for clinicians treating adult tobacco users. Fewer plans had separate written guidelines for the care of adolescents (n = 6), parents (n = 5), pregnant women (n = 5), or hospitalized smokers (n = 3). **Table 3** compares the actions recommended by plan guidelines with the 2000 USPHS tobacco-treatment guideline.[4] All 10 plans directed clinicians to implement the first two steps of the USPHS guideline. The guidelines of most plans directed clinicians to take three other recommended actions. In addition, 9 of the 10 guidelines directed clinicians to document patient smoking status and smoking cessation advice. Eight of the plan guidelines for adults recommended that physicians assess children's exposure to smoke in the home and provide smoking cessation advice to parents who smoke. Seven plans recommended that parents be advised to provide a smoke-free home.

Office Systems

To implement tobacco guidelines, nearly all plans recommended the following strategies to practices: intake forms to record smoking status and counseling, on-site smoking cessation materials, "vital sign" stamps or stickers to identify smoking status, prompts to providers to advise cessation, a key person in each practice responsible for coordinating smoking cessation activities, training of nurses or support staff to assist clinicians in smoking

TABLE 3

Managed Care Organization Recommendations and Support to Clinicians*

CLINICIAN SUPPORT	PERCENTAGE OF MCOs THAT PROVIDE SUPPORT
MCO guideline recommendation to clinicians (*n* =10)	
Ask about smoking status	100%
Advise about smoking cessation	100%
Assess readiness to stop	70%
Assist cessation efforts	80%
Arrange follow-up	70%
Document smoking status	90%
Document advice to quit	90%
Office systems recommended and actively facilitated (*n* = 10)	
Use of standard intake forms	80%
Self-help materials on site	80%
Use of vital sign stamp/sticker	70%
Prompts for providers	60%
Identify key person at site	50%
Train support staff	50%
Code nicotine dependence	40%
Feedback and incentives provided (*n* = 11)	
Monitor clinician's actions	82%
Feedback to clinicians	55%
Financial incentives to clinicians or practices	45%

**MCO = managed care organization.*

counseling, and coding for nicotine dependence or tobacco-use disorder on encounter or billing forms (**Table 3**). Fewer plans actively facilitated organizational change by sending representatives to practice leaders to encourage and facilitate the development and implementation of policies, procedures, and roles that consistently support application of the guidelines. All plans had provided at least some clinician training, but only six plans had trained at least two thirds of their adult primary care providers in the 3 years before the survey (1997 to 1999).

Feedback and Incentives

Nine plans monitored providers' adherence to the plan's tobacco guidelines, either by medical record audit (*n* = 7) or member survey (*n* = 5) (**Table 3**). Six of the nine plans that monitored providers' actions gave performance feedback to clinicians. In five plans, feedback was coupled with financial incentives that tied clinicians' salaries or practices' reimbursements to clinicians' performance on tobacco guidelines. Two of these five plans also gave awards or other recognition to clinicians with good performance. The efforts of plans to monitor adherence to tobacco guidelines focused almost exclusively on two clinician actions: assessing smoking status and providing smoking cessation advice. Only one plan monitored or rewarded clinicians for providing cessation assistance beyond advice (e.g., prescription of medications or referral to cessation programs).

Health Plan Actions for Tobacco-Control Activities

Table 4 shows the systems-level actions reported by health plans. All 11 plans listed tobacco control as a priority activity. Although most took multiple actions to support this goal, only 3 had a systematic way to identify smokers.

Coverage for Tobacco-Dependence Treatment

All 11 health plans covered at least one first-line pharmacotherapy recommended by the USPHS guidelines,[4] but the level of coverage for these medications varied. **Table 5** shows the percentage of plans that provided comprehensive coverage (defined as offering the product to two thirds or more of plan membership at a cost of $10 or less to the member) for each tobacco-related pharmacotherapy. All health plans offered comprehensive coverage for bupropion (Zyban or Wellbutrin SR [GlaxoSmithKline, Research Triangle Park, NC]) when used to treat tobacco dependence, and all but one plan offered comprehensive coverage for at least one form of nicotine replacement. Most plans limited benefits for tobacco-related pharmacotherapy by setting an annual limit or requiring members to participate in a behavioral program to receive the benefit.

All 11 plans provided group classes in smoking cessation. Only 4 provided one-on-one smoking cessation counseling that lasted 30 minutes or more. Costs to members for the group programs averaged $36 (range, $0 to $85). Costs for individual counseling averaged $16 (range, $0 to $50). Eight plans had multisession telephone counseling programs, with an average cost of $23 (range, $0 to $65). Six of 11 plans had smokers' telephone help lines for members at no cost. No plan covered hypnosis or acupuncture, neither of which is effective for smoking cessation.[4]

Population-Focused Activities

In the year before the survey, 10 of 11 plans sponsored worksite tobacco-control programs, 8 plans sponsored

TABLE 4
Health Plan Actions To Support Tobacco Cessation

ACTION	HEALTH PLAN											
	A	B	C	D	E	F	G	H	I	J	K	TOTAL
Tobacco control listed as a priority	X	X	X	X	X	X	X	X	X	X	X	11
Tobacco coordinator	X	X	X	X	X	X		X	X	X	X	10
Tobacco oversight committee	X	X	X	X	X			X	X	X	X	9
Dedicated tobacco counseling staff		X	X	X	X	X		X	X	X	X	9
Dedicated tobacco training staff	X	X	X		X	X		X	X	X	X	9
Distinct budget	X	X	X		X	X		X	X		X	8
Provider "champion" for tobacco control	X	X	X	X	X			X			X	7
Providers trained about policies	X	X	X	X	X			X				6
Specific tobacco use reduction target		X		X				X			X	4
Systematic way to identify smokers		X	X		X							3

school-based prevention activities, and 4 plans sponsored member counteradvertising messages on tobacco. Seven plans provided review or comment on tobacco-related legislation or policies to policymakers.

Discussion

This survey provides an optimistic picture for tobacco control in committed MCOs. Each health plan took most of the actions that national guidelines recommend, and all but one plan adopted a written smoking cessation guideline and took systems-level actions to implement it. All of the plans offer some coverage for smoking cessation pharmacotherapy, most members are eligible for the benefit, and the cost to members is generally low. The health plans also offer behavioral programs for smoking cessation, including newer telephone-based cessation programs that may be able to reach more smokers than classes do. Some of the plans support community-level activities in schools and workplaces.

The actions reported by the 11 plans in this survey represent a higher level of tobacco-control activity than was documented by the recent Addressing Tobacco in Managed Care survey of a stratified random sample of 85 health plans (63% response rate) listed in the American Association of Health Plans database.[29] Only 56% of the 85 respondents to the Addressing Tobacco in Managed Care survey reported that their health plan had a written guideline for smoking cessation, compared with 91% of the 11 plans in this survey. Although the questions on treatment benefits were not directly comparable, the plans in our survey appear to provide more comprehensive tobacco-treatment benefits, in terms of both drugs and counseling, than did the plans in the American Association of Health Plans survey. The level of support for tobacco control in the 11 plans demonstrates the extent to which comprehensive approaches to tobacco control in MCOs are possible and offers a benchmark against which other health plans should be measured.

Despite their achievements, the plans in our survey fall short of full compliance with national guidelines. Contrary to the recommendation of the USPHS guideline, several plan guidelines do not recommend assistance with and follow-up on cessation beyond asking about smoking status and advising cessation. Only half of the plans have specific tobacco guidelines for special groups, such as adolescents, parents, and pregnant women. Only three plans target hospitalized smokers, one of the six strategies recommended by the USPHS guideline.[4] Although almost all plans provide tobacco-cessation training to their clinicians, these efforts did not reach the majority of providers in all plans. In addition, not all plans provided feedback and incentives to clinicians for adhering to tobacco guidelines. Actions that are monitored and rewarded should reflect all of the actions that the system is trying to promote, not just identification of smokers. Despite strong support for tobacco control on the part of the health plans, only 3 of 11 plans can systematically identify all or most tobacco users in the

TABLE 5

Plans That Provide Comprehensive Coverage for Tobacco-Related Pharmacotherapy

PATIENT BENEFIT	MANAGED CARE ORGANIZATIONS THAT COVER SPECIFIC BENEFIT, % (n)
Pharmacotherapy	
Bupropion	100% (11)
Nicotine-replacement therapy	
No product covered	9% (1)
One product covered	27% (3)
More than one product covered	64% (7)
Nicotine patch	82% (9)
Nicotine gum	45% (5)
Nicotine inhaler	27% (3)
Nicotine nasal spray	27% (3)
Smoking cessation counseling	
Individual counseling (≥ 30 minutes)	36% (4)
Telephone help line	55% (6)
Multisession telephone counseling	73% (8)
Group counseling	100% (11)

plan. A system to identify smokers within a plan facilitates system-level actions to reach smokers, whether such actions are delivered by a clinician at the time of a patient visit or directly from the plan to the member. Finally, plans differ considerably in coverage of tobacco treatments. Full coverage of all evidence-based treatments for nicotine dependence is a national public health goal for 2010,[30] and coverage for nicotine replacement has been found to increase cessation rates in the population.[31, 32]

These findings must be interpreted in light of our study's limitations. First, the 11 plans studied are not a representative sample of MCOs in the United States. They illustrate the vanguard efforts in tobacco control in managed care rather than the average achievement of health plans. Second, the study focused on only the staff-model delivery system at each participating MCO. These types of MCOs have more control over policy implementation than do independent-practice models and network-model MCOs, which provide care for about half of MCO members nationwide.[33] Third, MCOs are large, complex organizations. Within plans, subunits may vary greatly in tobacco policies and activities. Individual clinicians or practices probably have different policies and may do more or less than plans report. Fourth, these data reflect what MCOs report as their policies and procedures. We did not assess the actual extent of implementation of reported policies and procedures. Fifth, while the national guidelines as a whole have been shown to be cost-effective,[7] the marginal cost-effectiveness of each specific implementation strategy has not been measured.

In summary, these 11 leading MCOs located across the United States have implemented most of the tobacco-control policies and procedures recommended by public health organizations. Their actions demonstrate the feasibility of reducing tobacco use in a closed-panel MCO. Tobacco control efforts in primary care have a strong scientific basis and are highly cost-effective. In addition, providing smoking cessation advice and assistance during primary care visits increases patient satisfaction.[14, 34] By doing more to meet the challenge of translating the evidence base into clinical practice, health plans can contribute to reducing the burden of tobacco use for the U.S. population.

Take-Home Points

- **Little is known about actions taken by managed care organizations (MCOs) to facilitate use of evidence-based guidelines on tobacco treatment.**
- **A survey of 11 U.S. MCOs with strong tobacco-control records shows that the plans used multiple strategies to implement most evidence-based tobacco-treatment guidelines.**
- **Implementation of national tobacco-treatment guidelines is feasible in closed-panel MCOs, including system-level methods to support clinicians' efforts.**
- **Areas for further improvement include extending tobacco guidelines to special groups; offering more training, performance monitoring, feedback, and incentives to clinicians; expanding coverage of tobacco-dependence treatment; facilitating identification of smokers; and monitoring quit rates.**

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Acknowledgments

The authors thank key informants and staff at the participating health plans (Group Health Cooperative, Seattle, WA; Harvard Pilgrim Health Care, Boston, MA; Health Alliance Plan, Detroit, MI; HealthPartners, Minneapolis, MN; Kaiser Permanente Colorado, Denver, CO; Kaiser Permanente Hawaii, Honolulu, HI; Kaiser Permanente Southern California, Pasadena, CA; Kaiser Permanente Northern California, Oakland, CA: Kaiser Permanente Northwest, Portland, OR; Kaiser Permanente Georgia, Atlanta, GA; and Providence Health Plan, Portland, OR). The authors also thank the investigators of the HMO Cancer Research Network HIT (HMOs Investigating Tobacco) Project. The survey instrument can be obtained from Victor J. Stevens, PhD, Kaiser Permanente Center for Health Research, 3800 North Interstate Avenue, Portland, OR 97227.

Grant Support

Funded by grant U19 CA79689 from the National Cancer Institute. The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the National Cancer Institute or the National Institutes of Health.

Correspondence

Nancy A. Rigotti, MD, Tobacco Research & Treatment Center, Massachusetts General Hospital, 50 Staniford Street, 9th floor, Boston, MA 02114; telephone: 617-724-3548; fax: 617-724-3544; e-mail: Nrigotti@partners.org.