

**Addressing Tobacco in Health Care Research Network Think Tank
March 19, 2008 Meeting
Washington, DC**

Summary List of Discussion Points

This meeting brought together 23 experts in health care, health policy, tobacco control, research and research funding to brainstorm about priority tobacco control research questions and funding strategies. Attendees broke into four small groups to discuss:

- 1) Systems change research issues for tobacco control that are pertinent to health systems and purchasers of care,
- 2) Systems change research issues for tobacco control that are pertinent to researchers, and
- 3) Funding strategies for systems change research for tobacco control.

Each group reported back to the larger group the highlights of their small group discussion. The reporting-back was followed by a large group discussion. This document summarizes in bulleted format the issues and strategies identified by the participants and key comments from the large group discussions. The document is intended to be inclusive of all comments and does not reflect a consensus document from the Addressing Tobacco in Healthcare Research Network. A list of attendees is included as Attachment A.

Small Group Discussion #1: What are some examples of systems change research questions for tobacco control that are of interest to health systems or purchasers? Are there emerging opportunities in health care systems that warrant evaluation? What existing systems change strategies are (and are not) working for health care systems?

Aligning efforts and developing systematic approaches

- Tobacco cessation and prevention is a macrosystem. We need to be able to align all of the efforts in the health care system and the community to work toward prevention and cessation. Nevada is an example of how this can happen. In all of 2007, before the clean indoor air act, there were about 7,000 calls to the quitline. When the clean indoor law took effect at the start of 2008, there were 9,000 calls to the quitline during January and February 2008.
- Researchers tend to disaggregate prevention and cessation. We need to emphasize that it is a whole package.
- Research needs to emphasize the need for systemic change to support tobacco control rather than isolated changes.
- More research is needed on the supportive/inhibitory factors in the macrosystem (e.g., the health care system, employers) with regard to tobacco control.
- In routine medical care, we need to pay attention to multiple risk factors and connect smoking to these.

- Researchers should look at successful models for other preventive measures/preventive service delivery and examine how they might apply to tobacco.
- Changing social mores and policy changes may represent opportunities for health systems to systematically address tobacco use (e.g., adding cessation benefits and services when facilities go smoke-free). How can these models and strategies be applied more widely?

Communicating with patients and increasing demand for evidence-based treatment

- Are there better ways to communicate with patients (e.g. cell phones, through pharmacies)?
- We have forgotten the consumer in tobacco control. If tobacco cessation benefits are increased, we need to educate the consumer to generate consumer demand for the services. How can we increase demand?
- How can we address disparities among special populations (e.g., racial, income, education) with regard to tobacco prevention and cessation?
- Are there strategies that can be used to incentivize consumers to seek tobacco treatment?

Cost-effectiveness and return on investment (ROI)

- We need more cost effectiveness and ROI studies on tobacco cessation treatment. Let's examine the ROI for tobacco versus other kinds of treatment.
- Researchers should examine the impact of individual risk management related to tobacco use versus the approach of reducing risk for the entire population. What are the difference in cost and ROI?
- Insurers continue to be concerned about adverse selection. This issue needs to be evaluated and then taken off the table as a concern.

Developing research capacity

- We need more young tobacco researchers who may better understand trends among young tobacco users.
- Research funding needs to be able to respond more quickly to emerging trends in tobacco (e.g., fruit-flavored cigarettes that appeal to teens).

Incentives and performance measurement

- How can we better align incentives such as reimbursement and quality performance measures with desired outcomes?
- We need to examine the impact of performance measurement on patient outcomes.
- There is a need for more studies and data on performance measurement and performance incentives.
- We need to develop second generation standards for tobacco prevention/cessation (e.g., HEDIS, JCAHO, pay-for-performance) that directly link smoking to medical care and move the finish line ahead.

Innovative applications of technology

- What is the impact of Web-based cessation efforts? Where do they fit in the macrosystem?
- We need to continue to promote the electronic health record. You can't change what you can't measure and the electronic health record can help measure delivery of care. Cost of electronic health record systems is a major issue.
- Use existing systems such as the electronic health record to measure tobacco-related morbidity and its resultant costs.
- "Fax to quit" has not worked well. How can we improve it?
- What is the real impact of quitlines? They have been around for over a decade, but not much is known about their true impact.

Provider- and health system strategies

- The medical education system should address the need for primary care physicians to be taught how to do a "good" referral for treatment so there is continuity in the handoff and the responsibility for the patient's care is not dropped. What are the best practices?
- Tobacco prevention and cessation needs to be included in medical education and become part of Board questions for providers. How can this change occur?
- With so many time demands placed on primary care providers, tobacco prevention and control is more effective when entry to it does not solely rely on the primary care provider. Efforts are moving the same way in the obesity field. What might be effective?
- Are there more effective alternatives to the 5A's?
- What are the best practices for smokers who are hospitalized?
- Smoking should be linked to patient safety issues. Many smoking patients are trundling to smoking places with IV lines, etc. How can we make smoking a patient safety issue?
- Research should also examine closed systems (e.g., the military), looking specifically at risks and outcomes (e.g., morbidity). One example of this is the finding that people who smoke who have surgery have longer lengths of stay than do non-smokers.
- What would the impact be of establishing tobacco use as a chronic disease and applying the chronic disease model?
- What is the role of health plans in intergenerational connections related to tobacco control (e.g., kids passing information along to parents and grandparents)?

Transitions and referrals in the health care system

- Transitions and referrals in health care need improvement. There is a need for better linkages (e.g., from primary care physician to specialist; from inpatient to outpatient setting; from primary care to behavioral health). What are the best practices?
- There is a disconnect between the health care system and the community. The health care system does not access existing less expensive resources in the community. How can this be improved?

- Who holds the responsibility that the patient gets needed care once care transitions are made? Often the ball gets dropped because the connections and linkages aren't in place.
- There needs to be more coordination between quitlines and the health care system/employers. How can this be facilitated?

Other questions and comments

- We need to examine how to scale up effective interventions so they can be implemented more broadly.
- What's the best use of limited funds in tobacco cessation efforts? We don't do well with trade-off questions.
- Social mores helped with the tobacco cessation effort.
- The field needs to make sure that health care systems don't think the tobacco prevention/cessation problem is solved and give up.
- As more and more employers move to smoke-free campuses, employees need to be connected with cessation benefits.

Discussion:

- How can we segment the smoking population? Universal messages are not working.
- There is a gulf between broad public policy change and smoking cessation. Cessation and other targets are siloed. How can we bridge that gulf?
- It's good to see that pharmacies are part of the agenda. We need to go to where the smokers are. Unfortunately, there is no system now to engage pharmacies or to change the pharmacy system.
- Minute clinics are growing in number. Can we reach out to minute clinics to ensure smoking is addressed?
- Technology can be a powerful tool. The electronic health record is one tool. Are there other opportunities (e.g., targeted messaging at check-in)?
- Can a safety measure be created that links the issue of patient safety and smoke-free campuses? This may help drive policy and practice change.
- Some 85% of health care takes place in practices that have 8 or fewer physicians. How can we bring smoking prevention/cessation to this level? These practices tend to be the least involved with electronic health records.

Small Group Discussion #2: What are some examples of questions that researchers are interested in pursuing? Are there new or emerging topics to evaluate? Are there research paradigms that have been particularly successful in building the evidence base over the past 10 years?

Clinical practice research questions

- More research is needed on the translation of what works in physician practice to scaling up to systems.
- How can we connect public health resources with the health care system, especially where there are disparities in cessation and prevention?

- How can we make cessation routine and salient? It should not be a health care “extra.” How can we move toward holding physicians negligent if they don’t identify and counsel smoking patients?
- We need to change the paradigm of counseling so that it is a therapy provided by the physician and not an “extra.”
- How are referrals made? Is there a more effective way? Does it differ by population?
- How can we get other providers (e.g., other than physicians) to take responsibility for cessation? Examples include intervening in provider education, board certification including tobacco treatment. A challenge is that what is learned as best practice and the structure of the clinical practice setting can conflict.
- Should we even use the word “counseling”? Physicians don’t usually like to counsel. Might another term lower this barrier?
- The 5 A’s have been moderately successful (rates of asking and advising have increased, but rates of delivery of the rest of the 5 A’s need to improve). There is an opportunity to step back and see how the system can play a larger role in fostering delivery of the 5 A’s rather than just relying on the clinician.
- An alternative to a 5-A model might be a briefer model (e.g., Ask, Advise, Commit). Such models need evaluation.
- There is a need to evaluate quitline referrals and to determine what kinds of feedback are most helpful for referring clinicians.

Incentive and reimbursement research questions

- How can we integrate tobacco cessation into the pay-for-performance model?
- How did Medicare coverage for cessation counseling play out? Did some physicians more routinely provide counseling than others?

Methods and models research questions

- There needs to be a move toward establishing smoking as a health condition rather than just a lifestyle issue.
- We need new models that move beyond pay for performance and continuous quality improvement. The medical home holds promise. Other opportunities include the chronic care model and the sociological model.
- There is a need for new methods research. We need new methodologies and new outcome measures. For example, is cessation always the right outcome?
- A conference is needed to come up with outcome measurement standards for systems-level research (e.g., biochemical confirmation in systems research can be prohibitively expensive).
- Funding agencies need to move beyond their desire for randomized clinical trials to look at prevention and cessation. What about natural experiments? We can only take advantage of these if there is quick access to funds.
- Because of available databases, we can do more with program evaluation and surveillance. It’s possible to evaluate what’s happening in the “real world.”

- There is an opportunity for translational research. For example: scaling up from practices to systems; how to translate to scale and change an entire system; how to connect public health resources with the health care system; how to integrate tobacco into pay-for-performance; and community-level health report cards.

Potential partners

- We need more research on bringing other entities into the cessation effort. What role might faith-based communities play? What additional role could employers play? What roles can the Indian Health Service and tribal health systems play? How can hospitals be more involved? Each hospitalization can be a teachable moment.
- Funding brings non-traditional partners to the table. How can we create new linkages between disease management, public health and health care policy?

Prevention and policy research questions

- Research should examine smoking prevalence from the perspective of who does not start to smoke. What are the policies that prevent initiation?
- Let's examine the anthropology of smoking cessation. What worked in particular communities and why?
- What are the effects of differences in state policy on the delivery of treatment services?

Technology research questions

- Research should examine new and evolving treatment modes, such as on-line cessation support. Does it work? Who does it reach?
- Can prevention and cessation efforts bypass the physician as the starting point? Can health care plans do something differently and target smokers? Not all patients have computers so are there other ways to access individuals? What about cell phones?
- What is the right balance between human involvement and virtual involvement in prevention and cessation? This is a generational issue. The young are very wired.
- Research needs to keep up with technology trends.
- Technology is used differently by disparate populations. How can we use and understand the technology that is right for each population?
- How can we use the Internet to message and engage consumers?
- With electronic health records, can we systematically track referrals for treatment?
- How should smoking cessation figure into the electronic health record? We need to examine the work flow in the physician office. Is there a strategy that can be implemented into the electronic health record that systematically reviews smoking status and whether advice and follow-up was received?
- We need to encourage software developers to think about how tobacco cessation really works within the physician office. How does it work in a small rural clinic versus an urban hospital? What works everywhere?

- A challenge with research focusing on technology is the speed of technological evolution. By the time a grant proposal is written and funded with the current technology, the technology is often dated.

Other topics

- How can we get more entry-level researchers involved in cessation? What is the role of mentoring?
- Research on prevention and cessation should focus more on the mental health settings and co-morbidities.
- Cessation efforts need to focus more on community-based clinics and smaller practices to reach the populations where smoking is highest.
- Research needs to examine the black box warnings on medication for smoking cessation. There is a need to standardize them so that they are easier to prescribe.

Discussion:

- Who are we missing as a partner and in our research? We need to drill down more and determine who has been overlooked.
- What research methods are we underutilizing (e.g., interrupted time series, MOST framework)? Unfortunately, peer reviewers tend to downgrade applications that try to apply non-standardized research methods.
- Are there logical clinical condition partner studies (e.g., alcohol, obesity)?
- How do we infuse prevention and cessation in the medical training curriculum so they are pulled through to clinical practice?
- How do we make changes to the referral process so that there are connections and it is not a hand-off process?

Small Group Discussion #3: What strategies can funders employ to ensure that systems change research for tobacco control is incorporated into existing research funding portfolios? Are there questions of particular interest or importance to funders that the research and health systems/purchaser communities should be aware of?

Things to consider: applicants

- Applicants need to set the issue of tobacco control into larger prevention and systems questions. They should connect tobacco with the other priorities of funders.
- Applicants and funders need to consider funding partners so larger pools of money are available for research. The impetus could come from either the applicant or funder side. Applicants could submit application to multiple funders and encourage partnering to support the research. Or, funders could take an interesting, complex application to other funders to solicit additional support. However, these should be a more formal mechanism for multiple partners to fund a proposal.

- Applicants should speak with funders before submitting a proposal. Without the preliminary discussion, applicants don't have the benefit of knowledge that may help them shape their proposal so it is more likely to be funded.

Things to consider: funders

- When funders write RFAs, they should be explicit about the kinds of research they are looking for. For example, indicating that methods such as interrupted time series or natural experiments are appropriate would be useful. Including tobacco-related examples in RFAs would also be helpful.

Things to consider: environmental factors

- There are ebbs and flows in the availability of funding, and some times are leaner than others. Today the inflation rate of conducting research is much greater than the general inflation rate. The time is ripe to change the \$500,000 limit on NIH funding. It will take pressure from the outside to change this.
- More and more federal funding is getting earmarked for particular research issues, reducing the amount of funds available for research that is not tied to these earmarks or priorities.
- What if there was a rating system for funders on their impact on the population (e.g., the ratio of funding for discovery to implementation)? Would funders value and use this? Would this require alliances because no institute/agency has sufficient funding?
- The lag time between being approved for funding and actually receiving funding makes it difficult to take advantage of natural experiments. The R01 is not always the right funding mechanism. There need to be better mechanisms in place to fund timely research. It's often difficult for federal funders to fund "on a dime," so researchers may want to look to smaller, non-federal funders for this.

Things to consider: peer review process

- Are we locked into the current peer review process for grant applications? Maybe it's time to change the review process. Should we be mentoring reviewers? Are reviewers held accountable for their comments?
- There are many program announcements for health services research proposals (NIH has approximately \$1 billion for health services research), but few study sections have expertise in reviewing this type of research. How can we develop the expertise to help grow the field, in terms of qualified reviewers and qualified researchers?

Things to consider: additional research opportunities

- We need to encourage more secondary analysis of existing large databases. There is not presently enough funding for this.
- We should leverage the money being spent on evaluation by examining translational research questions such as, "Do state-level programs impact the behavior of the population?" How many states are collecting the data that make this possible? What is the mechanism to get this to happen?

- The results from randomized controlled trials don't translate well into the real world. How can this be improved?
- How do we need to change the system to it is possible to transition interventions from the inpatient to the outpatient setting? States with cessation resources are interested in this too. There are natural laboratories in some states.
- We need more individuals doing tobacco control research. How do we expand the field?
- Is the return on investment for tobacco control good enough?
- Payers need shorter term return on investment for prevention/cessation rather than longer term societal return on investment.
- Now there are multiple behavioral targets for research (e.g., obesity, alcohol, tobacco). Could tobacco get lost among the other issues?
- Dissemination of research findings should be a requirement. But researchers need help in doing this. They typically aren't funded for dissemination and often don't know how to do it.

Discussion:

- The CDC has a mechanism for timely funding through its special interest projects.
- Some RFAs have the potential for funding tobacco research, but they are not explicit about it. Opportunities may be missed. It would be better if funders were more explicit about the kinds of research they are interested in.

Final Discussion and Wrap-up:

- The current methods of funding don't lend themselves well to getting younger clinicians involved in the field. Are there other strategies that can be used to get and keep clinicians engaged?
- The skills of cessation counselors can vary. Is a "trade stamp of approval" for qualified cessation counselors?
- How do we encourage adherence to medication use? This is an ongoing issue in tobacco dependence treatment.
- Applicants may want to try to find matching funds prior to submitting their proposal. Some partners will fund if the applicant finds matching funds.
- How can we better help providers understand the clinical practice guidelines? Increased understanding may lead to increased delivery of evidence-based tobacco dependence treatment.
- Research is always local. There has to be a local hook to it. Show providers, health plans, and states that the phenomenon exists in their own data to increase its credibility.

Attachment A: Attendee List

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