Increasing Consumer Demand for Tobacco Treatments

Ten Design Recommendations for Clinicians and Healthcare Systems

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Abstract: Health professionals play an important role in addressing patient tobacco use in clinical settings. While there is clear evidence that identifying tobacco use and assisting smokers in quitting affects outcomes, challenges to improve routine, clinician-delivered tobacco intervention persist. The Consumer Demand Initiative has identified simple design principles to increase consumers' use of proven tobacco treatments. Applying these design strategies to activities across the healthcare system, we articulate ten recommendations that can be implemented in the context of most clinical systems where most clinicians work.

The recommendations are: (1) reframe the definition of success, (2) portray proven treatments as the best care, (3) redesign the 5A's of tobacco intervention, (4) be ready to deliver the right treatment at the right time, (5) move tobacco from the social history to the problem list, (6) use words as therapy and language that makes sense, (7) fit tobacco treatment into clinical team workflows, (8) embed tobacco treatment into health information technology, (9) make every encounter an opportunity to intervene, and (10) end social disparities for tobacco users. Clinical systems need to change to improve tobacco treatment implementation. The consumer- and clinician-centered recommendations provide a roadmap that focuses on increasing clinician performance through greater understanding of the clinician's role in helping tobacco users, highlighting the value of evidence-based tobacco treatments, employing shared decision-making skills, and integrating routine tobacco treatment into clinical system routines.

(Am J Prev Med 2010;38(3S):S385–S392) Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine

Introduction

Momentous strides have been made in addressing tobacco use and dependence in the delivery of medical care. Options for evidence-based treatment have never been greater, and now include nicotine replacement therapies, bupropion, varenicline, and behavioral counseling provided individually, in groups, or by telephone.[1] Insurance coverage for tobacco treatments has expanded across private and public enrollee populations.[2,3] Research on consumer-facing technology, such as tailored, interactive websites and social networking, is still developing and appears promising.[4] Many states have mobilized resources to increase tobacco taxes, enact smoking bans, educate health professionals, and enhance access to free counseling and medications to help smokers quit. In conjunction with, or perhaps as a result of such advances, health professionals increasingly talk to patients who smoke (and chew tobacco) about quitting.[5] Importantly, we know that brief tobacco interventions delivered by clinicians in a variety of settings lead to modest yet important reductions in smoking.[1,6] Despite this progress, 43.4 million (19.8%) adults in the U.S. currently smoke, with higher prevalence among those achieving less than high school education (33.3%–44.0%) or living below the federal poverty level (28.8%).[7]

The Consumer Demand Initiative challenges us to examine how our messages and services are provided to smokers, and to identify opportunities to increase patient demand for effective tobacco treatments.[8] Several consumer-centered design principles emerged from the Consumer Demand Initiative and are discussed in the accompanying paper by Orleans et al.[9] Most of these principles can also be applied to clinicians and healthcare systems. In this paper, we explore drivers and barriers to

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0749-3797/00/$17.00
doi: 10.1016/j.amepre.2009.12.003

Table 1. Recommendations to increase patient demand for tobacco treatments

Recommendation	Design principle	Target
1. Reframe the definition of success.	Lower the bar Make it tangible	Patients and clinicians
2. Portray proven treatments as the best care.	Make it look and feel good	Patients and clinicians
3. Redesign the 5A's of tobacco intervention.	Lower the bar Facilitate transitions	Clinicians and healthcare system administrators
4. Be ready and deliver the right treatment at the right time.	Integrate with their lives Connect the dots	Clinicians
5. Move tobacco from the social history to the problem list.	Connect the dots Facilitate transitions	Clinicians
6. Use words as therapy and language that makes sense.	Make it look and feel good	Clinicians
7. Fit tobacco treatment into clinical team workflows.	Foster community Facilitate transitions	Healthcare teams
8. Embed tobacco treatment into health information technology.	Connect the dots Lower the bar	Clinicians and healthcare system administrators
9. Make every encounter an opportunity to intervene.	Connect the dots Make progress tangible	Clinicians and healthcare system administrators
10. End social disparities for tobacco users.	Foster community	Healthcare teams and healthcare system administrators

increasing consumer demand for tobacco treatment through the lens of clinician-delivered interventions. We offer ten specific recommendations to foster tobacco treatment delivery, drawing on the Consumer Demand design principles but targeting primarily clinicians and healthcare systems. These recommendations, summarized in Table 1, are associated with design principles that include: (1) allowing people to **kick the tires**, (2) **lowering the bar**, (3) making progress tangible, (4) making it look and feel good, (5) facilitating transitions, (6) **connecting the dots**, (7) fostering community, and (8) connecting to the rest of peoples' lives.

The Healthcare Landscape

As more than 70% of smokers are seen by a clinician each year, there are important opportunities for health professionals to promote the use of effective tobacco treatments. This is important because among smokers who attempt to stop, only 20% to 30% use treatments that can double or triple their success.[10] A great deal is known about how providers address tobacco use in primary care settings. Studies from the 1980s identified many missed opportunities for clinicians asking about smoking and advising quitting. More recent evidence shows that most providers assess tobacco status and recommend quitting, but that then a subsequent "voltage drop" occurs, with quitting assistance (counseling, medication) occurring considerably less often.[5,11–13] Further, there is wide variability in provider performance across medical practices and specialties, and within offices.[14,15]

Many of the barriers to clinician-delivered interventions are simple and well-known. Primary care practitioners are overscheduled, with insufficient time to engage in discussions on issues not presented by patients.[16,17] Clinicians and staff are taxed with competing demands, providing care for large patient panels presenting with multiple chronic conditions and their complications.[18] Practices are challenged to find resources to help implement recommended office system changes, proactive communication, or effective follow-up. At an individual clinician level, limited training and education in tobacco dependence and treatment also serve as an important barrier.[19]

Other barriers are more complex, less well understood, and warrant further investigation. Despite recent efforts in medical education to increase training in communication skills, there remain considerable gaps in physicians' ability to understand what patients need, want, and notice.[20] The clinician–patient interaction is shaped not only by a professional's knowledge and skills, but also by their beliefs and values regarding patients who smoke. Clinicians may hold negative judgments about patients' inability or unwillingness to adhere to medical recommendations and further may not fully recognize how their words, tone, and body language can affect the patient– clinician relationship. Concepts such as shared decision making and the chronic-care model are relatively recent; with their emphasis on promoting self-care management, it becomes clear that a broad set of clinician communication skills are

needed to successfully partner with patients to improve outcomes.[21]

A closely related barrier is that real efforts of smokers may be hidden or not palpable to clinicians. A patient returning 6 months after using bupropion and telephone quitline counseling, who relapsed back to smoking the month before, is classified as a smoker in current clinical routines. This individual falls in the same category as another patient who made no attempt to quit during the previous 6 months. We know the first patient should receive an intervention that congratulates abstinence, reviews the quit experience, and offers another course of treatment. The second patient needs a very different approach. Our current cognitive classification schemes are not sufficiently sensitive to allow rapid assessment and adaptation, in part because the definition of success with patients who smoke— complete abstinence—may be too narrow to allow sufficient flexibility to be effective.

A third under-recognized barrier is that smokers perceive a price when seeing a clinician. Studies suggest that smokers have anxiety about talking to their doctors about smoking.[22] This cultivates a condition where smokers may not voluntarily seek help, nor disclose the truth about their tobacco use. Both the patient and the clinician may continue to perpetuate myths that smoking is a simple lifestyle choice, and quitting will be successful only "if wanted enough." Such beliefs serve to minimize the value of tobacco treatment, and can create unnecessary tension. This is amplified in the prenatal setting, where interactions are intensified with a focus on the health of the baby.

For clinicians to increase demand for tobacco treatment, they must understand and communicate to patients that such treatments are credible, effective, and accessible. Evidence-based treatments—medications, behavioral counseling, and social support—are not always well understood by clinicians or by patients. Effective telephone quitlines and local programs may be unknown,[23] or may be familiar yet considered ineffective.[24] Particularly worrisome are physician comments heard by these authors that treatments having a 15% to 20% quit outcome are "not good," while the comparative 5% to 10% quit rate with no treatment is disregarded. Finally, mental health providers may perceive quitting as harmful—with abstinence believed to worsen psychiatric conditions.[25] There needs to be a clear understanding among clinicians and healthcare administrators that tobacco use is a chronic disorder requiring repeated assessment and intervention, and that effective treatments are valuable and cost effective.[26]

Despite these challenges, there is tremendous opportunity for health professionals and health systems to increase consumer demand for treatment. Individual and practice-level interventions have demonstrated success in enhancing clinician performance.[27–29] Effective clinician-delivered tobacco intervention should achieve these specific goals:

1. understanding the clinician's role and impact in helping tobacco users
2. recognizing the value to the patient in using proven tobacco treatments
3. realizing the benefits of empathic, positive discussions about tobacco use and tobacco treatment
4. listening to and learning from the patient during every encounter.

We offer the following recommendations to increase consumer/patient demand for tobacco treatments.

Recommendations

Reframe the Definition of Success

When a clinician addresses smoking with a patient, he or she sees quitting as the goal. When a smoker tries to stop, he or she also believes the goal is quitting. Indeed, that is the most important goal. Yet when highly motivated patients use the most efficacious treatments, the likelihood of quitting is below 50%; realistically, the likelihood is less than 30%. In other words, most smokers who use treatment will fail in that particular attempt. In a typical follow-up to such a clinical encounter, the patient and the clinician could perceive their efforts as failure. Given this common scenario, it is important to ask, in the context of clinician–patient dialogue, is permanent quitting setting the bar too high for any given quit attempt? Further, because patients vary in their motivation and self-efficacy, success cannot be one-size-fits-all.

Perhaps a better approach is to reach for achievable and realistic goals, re-framing what success can look like for every clinical encounter. Success might be encouraging the smoker to **think** about stopping, or **try** to stop, or **use treatments** for the goal of achieving **abstinence for as long as possible**. Since many smokers who temporarily abstain but relapse remain interested in quitting, a successful intervention includes recycling or trying treatment again.[30] Recent research also suggests that smokers may follow a variety of paths to quit, including reducing smoking as a step toward stopping.[31] Thinking about quitting tobacco as a journey—rather than an event—**makes it more tangible** for patients and clinicians to move ahead. It **lowers the bar** for all involved.

Portray Proven Treatments As the Best Care

The approach with tobacco use must be the same as with any chronic condition. When a patient presents with a

new diagnosis of diabetes, best practice ensures treatment with glucose-reducing therapy, diet and physical activity counseling. After a heart attack, aspirin and beta blockers are prescribed as the standard of care. It is a patient's choice to subsequently take or not take the treatment. For every patient using tobacco, ensuring access to the best treatments— counseling and medications—should be the standard of care. If a smoker is ready to try to quit, medication and counseling should be presented unequivocally as offering the greatest chance of success. Conversely, smokers who intend to quit on their own should be cautioned they are not using methods that achieve the best outcomes. If a smoker is not ready to quit, he or she should, at a minimum, be informed about the most effective treatments available if they choose to quit in the future.

As we enter an age of burgeoning health information, patients are becoming more active in their own health care. The number of consumers online is increasing steadily, along with demand for high-quality, personally relevant health information.[32] Yet even among the most technology-savvy individuals, discussions with physicians are perceived to be essential.[33] As clinicians will continue to play a central role in presenting tobacco treatment as a credible choice, patients should clearly hear, "if you try to quit, consider using the best care available." This approach uses the design principle of **making it look and feel good** for patients.

Redesign the 5A's of Tobacco Intervention

The 5A's model is a framework for clinicians to deliver counseling interventions. The 2000 and 2008 Public Health Service *Clinical Practice Guidelines, Treating Tobacco Use and Dependence*, promote that clinicians **ask** about tobacco use, **advise** quitting, **assess** interest in quitting, **assist** with quitting, and **arrange** follow-up. Having a model clinicians can employ is valuable; yet as models, they are limited and can appear overwhelming in the context of practice. Promoting the 5A's in practice is not as simple as it may seem. A busy clinician must recall what each "A" means, and what he or she should do. Even with decision support or prompts, a clinician is challenged to be complete and effective. Most do well asking about tobacco and advising quitting. Beyond that, clinicians are less likely to provide help with quitting and assure treatment usage.[11] In the RWJF-funded *Prescription for Health* national program, practice research networks tested a variety of tools and methods to integrate preventive counseling into primary care practice. Among 17 practice networks, only four used interventions that included all 5A's.[34] Of note, these networks used a slightly different 5A's model, one that recommended clinicians **assess** for risk and interest in change, **advise** change, **agree** on goal setting, **assist** with intervention plans and treatments, and **arrange** follow-up.

The primary difference in these models is the term **agree**. The goal of this term is shared decision making, a critical component in dialogue about behavior change; any redesign of intervention models should have this concept at its center. Encounters that are relationship-centered focus on patient experience, beliefs, and confidence. This type of encounter does not always come naturally in a problem-oriented visit. Further, direct observation of primary care visits show that smokers accomplish some 5A tasks themselves, some are delivered explicitly, and some communications accomplish multiple 5A tasks simultaneously.[35] Therefore, overreliance on checklists or insistence on accomplishing all 5A's independently may miss positive activity occurring during visits. New models should incorporate design strategies that **lower the bar** for clinicians to deliver counseling, yet also **facilitate transitions**.

Be Ready to Deliver the Right Treatment at the Right Time

If patient interest in quitting tobacco is routinely assessed, some will be prepared to take action. Recent insights about smokers making quit attempts found that many do not make plans to quit but exhibit a more spontaneous, unplanned approach to quitting.[36] So, for any smoker who is willing to stop, practices must be prepared to assist at a moment's notice. Clinicians should provide counseling services and medication therapies, and have readily understandable information about these treatments available. Such information could include: (1) a list of medications covered by insurers common to their practice, including Medicaid coverage, (2) local pharmacies with lowest prices for prescription and nonprescription tobacco medications, (3) community services such as support groups and tobacco treatment specialists, and (4) tear-off sheets, prescriptions, or wallet cards with the state quitline (or 1-800-QUIT-NOW) and web-based programs available. After prescribing and/or linking to treatment, patients should be seen or contacted shortly, regardless of their tobacco status. It would be inconceivable to say "good luck" after treating asthma or depression and see a patient in 6 months. Because many patients relapse to smoking, effective methods are needed for clinicians to understand, manage, and learn from relapse. **Integrating with the lives of smokers** and **connecting the dots** for those ready to quit and who relapsed will ensure clinicians are primed and ready to help patients on their journeys.

Move Tobacco from the Social History to the Problem List

For decades, the tobacco industry has spent untold dollars convincing the public that smoking is a lifestyle choice. Yet most smokers, who start as children, are challenged for years during repeated quit attempts; some who try time and again may never succeed. Smoking is a complex behavior requiring serious and persistent attention. This is not a universal view, demonstrated by insurers who continue to block coverage for tobacco treatment, one of the most cost-effective interventions in health care today.[37] In a study of employers' views, one benefits manager stated, "Zyban® is not covered because we only cover pharmaceuticals that are needed for the care and treatment of an illness, and we do not consider smoking to be an illness."[38]

Health professionals are not sufficiently taught that smoking and heavy drinking are conditions worthy of intense understanding and aggressive intervention at every turn. Consider the taking of a comprehensive medical history, taught early in medical training. The assessment of tobacco use (and other drugs) is typically a component of the social history—along with marital status, occupation, and travel. What are the ramifications of having chronic conditions assessed during the social history? One impact is the likelihood of unmet patient needs. Indeed, one need only to examine the low frequency with which smokers undergoing elective surgery or tested for chronic obstructive lung disease are provided intensive tobacco treatment.[39] Identifying mechanisms that prompt placement of tobacco use on problem lists is not a simple recommendation, but an important one. **Connecting the dots** and linking tobacco use to problem lists offers a trigger for clinicians to intervene, and **facilitates transitions** to track patient status. The prominent display of tobacco use as a medical problem becomes imperative as electronic health information exchanges grow.

Use Words As Therapy and Language That Makes Sense

Consumer-oriented solutions to tobacco treatment should be cautious with choices of language and concepts. Problems with the term **cessation**, for example, were illuminated 10 years ago by the late John Slade, a physician and pioneer in tobacco treatment:

> It is time . . . the term *smoking cessation* be retired from active duty. In its place, the clinical activity to which it refers should be called *treating tobacco dependence*. Cessation is a throwback to the habit paradigm of tobacco use. Cessation is not a clinical activity . . . [it] refers to something the patient does.[40]

These statements reflect the importance of words and their influence on how people think. Other words are fraught with ambiguity, instill anxiety, or may be counterproductive. The term "anti-tobacco," used frequently by the media, can easily fall prey to a subtle conceptual change that becomes "anti-smoker" in meaning. This undermines any approach that aims to achieve an empathic, nonjudgmental attitude toward smokers. Even terms such as "quitline" and "counseling" can present barriers. A smoker may be comfortable about getting assistance or help, but not counseling (*I don't need a psychiatrist*). Further, the term "quitting" may strike fear in the heart of a smoker yet the concept "not smoking" may be acceptable. As such, several telephone counseling programs use terms such as "helpline" and "coaching." The word "nicotine" is also problematic. Many smokers believe that nicotine causes cancer and heart disease.[41] As treatment specialists we at times confound the situation when talking about nicotine addiction while promoting nicotine replacement. To make serious gains in raising consumer demands for tobacco treatments, all of these terms should be carefully scrutinized. Finally, our language must support the efforts of people struggling to make major adjustments in their lives. While we present quitting smoking as a health benefit, some smokers believe quitting is a loss and may find it difficult to focus on theoretical health gains. Words that reflect patients' view and are empathic are most warranted during the patients' most difficult time.[42] Presenting tobacco intervention as shared decision making engages patients in their own care and promotes trust—further increasing patient satisfaction and working to **make it look and feel good**. For clinicians, this approach lowers tension, increases skill in providing empathic care, and balances advice giving while fostering patient autonomy.

Fit Tobacco Treatment into Clinical Team Workflows

Medical practices have been studied closely in an effort to enhance care and improve outcomes. Earlier work focused on strategies directed at clinicians— education, reminders, and comparative data feedback. More recently, clinical offices are viewed as complex adaptive systems where all people in the practice work together in clinical microsystems.[43] Emerging studies reveal that both individual factors as well as team dynamic factors work to promote or hinder practice improvement. Regardless of a practice's size, and whether it is independent or part of a larger health organization, it is clear that it takes a team to achieve certain results. The key ingredients are (1) training, (2) staff roles, (3) clinical processes, and (4) communication. At the individual staff level, health workers can

learn to understand the value of helping tobacco users. All clinical staff should be trained to deliver brief interventions and promote use of evidence-based treatments. Specific roles should be identified, and expectations set. A medical assistant can assess tobacco status or environmental tobacco smoke exposure, entering information on the problem list. Some practices use nonclinical staff to call a quitline number on behalf of a patient during the visit, or fax a quitline referral so as to link directly to counseling. A nurse or practice manager can maintain information on tobacco medications and community services.

If resources are tight or schedules too strained, a flyer can be posted on exam room walls that includes actionable information (e.g., how to call the free quitline), is pleasing to the eye and easy to read. State and local public health programs may provide up-to-date treatment information, posters, and pamphlets to offer patients. All workers in the office can brainstorm ideas to fit tobacco treatment into workflows, supporting ways to prepare the practice for every tobacco user. In the process of making these changes, it is important to keep in mind that some staff may smoke or live with a smoker. We must also be ready to assist them in their efforts. A recent trial having medical assistants intervene found a significant effect on the number of smokers referred to behavioral interventions compared to usual care.[44] A team-based approach utilizes the design principles of **fostering community** and **facilitating transitions**.

Embed Tobacco Treatment into Health Information Technology

While many practices have yet to adopt electronic health records (EHR), their use is rising across the nation.[45] EHR implementation can positively affect the routine assessment of tobacco use, and foster delivery of treatment. At the Veterans Administration, where a national electronic record is used, clinicians are prompted to counsel smokers and offer evidence-based treatments. At some VA facilities, electronic prescribing of tobacco treatment medications is linked to the clinical reminders. However, such decision support tools are not routine.[46] To increase consumer demand and usage of tobacco treatments, EHR core functionality should include collecting and monitoring tobacco status, prompts and support for delivering brief intervention, and ideally, e-prescribing. Electronic referral to quitline services and patient-entered registration for telephonic and/or online services could achieve efficiencies and improve population reach of treatment.

Clinical decision support could also be embedded into specific clinical processes, such as hospital admissions and discharges. We also recognize the potential impact of novel methods to communicate and deliver care outside the office visit. Consumer-facing technologies such as personal health records, telemedicine, and secure messaging with clinicians are examples of care delivery vehicles that are expanding the definition of health care. Such patient-centered technologies are well positioned to deliver information that can increase demand for tobacco treatments. The greatest benefits are likely to result from integrating interactive, tailored health information along with systems offering shared patient records and secure patient–clinician communication. These strategies **connect the dots** and **lower the bar** to intervene.

Make Every Encounter an Opportunity to Intervene

Great strides have been made by including tobacco-related metrics into quality improvement efforts.[47] For patients who smoke and are hospitalized with pneumonia, heart failure, or myocardial infarction, we are expected to provide tobacco dependence treatments. At the hospital level, however, these goals can vary depending on how they are accomplished.[48] Resources and education may be limited, and understanding of what comprises "assistance" can also vary. In the ambulatory setting, brief interventions with tobacco users have been deemed a priority, among several measures now connected to pay-for-performance incentives. While tobacco-related benchmarks allegedly drive treatment utilization, more must be done across healthcare delivery systems.

Interventions with smokers at a younger age offers the highest level of health benefit and cost reductions. A number of care delivery opportunities have not yet been fully leveraged, including but not limited to: elective surgery; hemodialysis; diagnostic testing for cardiac, pulmonary, and other conditions; evaluation and/or management for malignancy; and care for chronic conditions, for example, asthma, diabetes, depression, hypertension, and chronic lung disorders. Each of these serves as a critical touch point where minor system change—**connecting the dots**—could result in substantial benefit for smokers by routinely offering or linking to treatment. Quality improvement professionals should recognize the value of evidence-based tobacco treatment, and recognize that intervention leads to greater patient satisfaction.[49] Finally, positive outcomes beyond stopping tobacco are certain to emerge, such as lower rates of surgical infections and reduced events related to chronic conditions, and these should be measured. By **making progress more tangible**, tobacco treatment is more likely to be supported.

End Social Disparities for Tobacco Users

As employers are increasingly focused on cost and quality, clinicians and healthcare systems are paying greater attention to employers' agendas. Across the U.S. there has been a noticeable shift in how employers think about smokers. This perception, brought on partly by public health advocates armed with meaningful data, is that employees who smoke incur excess direct and indirect health costs compared to nonsmokers. Solutions began that included worksite smoking bans and increased access to tobacco treatments. Some employers make genuine and rigorous efforts to lower barriers to tobacco treatment use. Over time, differentials in insurance premiums for smoking employees have become more common. Recently, however, some policies have been aimed directly at smokers' lives—eliminating them from employment. Worksites that are "smoker-free" rather than smokefree are increasing at a rapid pace, faster than the research and public health communities have been in addressing unintended consequences of such a policy.[50] Some hospitals and health systems, as well as organizations such as the World Health Organization have adopted no-hire policies for smokers.[51]

This troubling social trend has been accompanied by an eerie silence among the clinical professions. In fact, *tobacco use disorder* (ICD-9 305.1) is the only known diagnosis identified that may prevent a person from getting a job for which they are qualified. Other chronic conditions, such as risky drinking and depression, also are prevalent and lead to higher employer costs. Yet no one is advocating for eliminating employment opportunities for individuals with such conditions. Of greatest concern is the undermining of a public health approach that correctly presents tobacco and the tobacco industry as the problem. Now a new paradigm has emerged—coming through our own health center doors—that the smoker is the problem. We need to be mindful that these employment policies, particularly in the midst of an economic crisis, in fact results in discrimination for those who are most socioeconomically disadvantaged in terms of education and income. They have the highest current prevalence of tobacco use. We need to **foster community** and assist these populations with the best available treatments, not shut them out of economic opportunities.

Summary

More than half of the current 43 million smokers will die prematurely from a smoking-related condition unless they are able to stop tobacco use. Dissemination and implementation of treatments for tobacco use and dependence demand the highest priority from clinicians and healthcare systems. We articulate ten recommendations that can be implemented in the context of most clinical systems, where most clinicians work, incorporating consumer-centered principles that emerged from the Consumer Demand Initiative. These recommendations help to create a day when tobacco users attempting to quit use the best treatments available, maximizing their efforts and making success a common reality. These design principles propel healthcare systems to make it as easy for a smoker to receive proven treatments as it is to buy cigarettes. The time for action is now.

No financial disclosures were reported by the authors of this paper.

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