7. Integrating quit lines into health systems

Why should quit-line planners, promoters and service providers consider how their quit line could be integrated into health-care delivery systems in their country? The brief answer is that each can help the other achieve its strategic role in decreasing the population’s use of tobacco.

The World Health Organization has determined that incorporating tobacco cessation advice into primary health-care services is, along with easily accessible quit lines and free or low-cost medication, a key strategy in ensuring that countries offer help to those who want to quit using tobacco (the “O” in the MPOWER package) and in implementing Article 14 of the WHO FCTC. The long-term vision is that health systems and quit lines work together to ensure that tobacco users have easy access to a network of cessation services, including routine advice on quitting smoking in primary care clinical encounters, with referrals to quit lines and other specialist services combining counselling and medication.

Primary health-care providers have two vital roles when approaching patients who use tobacco.
• Increase patient motivation to quit. This is especially crucial in countries where the proportion of tobacco users attempting to quit each year is low. Trials in multiple countries have shown that if health-care providers routinely identify the status of tobacco use and give brief advice on quitting with minimal assistance, more people attempt to quit. Basically, if people are not motivated to quit, or do not see it as an important issue, they will not be interested in calling a quit line.
• Help motivated patients to quit successfully. This second role can be particularly challenging given the complexity of nicotine addiction as well as the lack of time, resources and tobacco treatment training in health-care settings. One increasingly popular option in fulfilling this role is to connect motivated patients with resources (such as a quit line) to help them be more successful in their quit attempts.

Health-care providers can play a direct role in driving calls to a quit line by referring their motivated patients to the quit line. There are two ways that this has been done.
• Patient-driven referral. Encouraging patients to call and giving them the quit-line number (often on a card or a brochure).
  – The advantage of this approach is that it is relatively simple and requires minimal provider or staff training. Clinics benefit from a brief tobacco intervention to refer patients, or referral can occur simply by making the phone number available.
  – The disadvantage is that it requires the patient to remember the quit-line number and make the initial call to begin services. Also this approach makes it difficult to give feedback to providers about referrals.
• Provider-driven referral. This is often done by fax, where the health-care providers, or their staff, send the name of the interested patient directly to the quit line with their phone number; the quit line then calls the patient directly.
  – The advantages of this approach are that referral does not require the patient to initiate the first call to the quit line, and the procedure may be more in line with other systems’ providers, which are already set up for specialty referrals. In addition, providers may receive feedback about whether or not the quit line successfully connected with the patient. Providers can use this feedback to offer follow-up and continue tobacco cessation interventions and discussions with patients.
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The disadvantages are that this type of system requires more work to set up, implement, and sustain. Work often involves training providers and staff, setting up or processing referral forms, and developing a referral procedure or system. In developed countries, often only about 60% of those referred are reached and, of these, 50–75% will enroll for services (NAQC, 2009a). However, quit lines that invest a significant amount of effort in health-care provider outreach and education, helping them learn the types of patient to refer, can significantly improve these numbers (Carlini et al., 2009).

7.1 HOW QUIT LINES CAN HELP HEALTH SYSTEMS

Many health-care systems have struggled to improve their services to tobacco users. Even when individual health-care providers are highly motivated to provide better care to patients, the barriers to routinely carry out such care can be quite challenging. One of the biggest challenges in implementing the recommendation is that health-care providers should offer assistance and follow-up to tobacco users who want to quit (Fiore et al., 2008).

Traditional brief intervention techniques, such as the “5As”, require a clinic or office to participate in all aspects of helping a tobacco user to make an attempt to quit – from essential health system tasks, such as asking about and documenting tobacco use status to taking time to assist the tobacco user in the quitting process, including making a quitting plan, setting a quit date and discussing strategies to break the addiction process as well as providing follow-up. Figure 2 outlines these steps.

Figure 2. 5A Brief tobacco intervention

Since tobacco dependence is a common condition, even if health-care providers do not need to start from “Assess” and end with “Arrange” every time with every patient, the provision of assistance can be time-consuming, require counselling skills with which providers are unfamiliar and resources that are not available in clinics and hospitals. Due to the chronic, reoccurring nature of tobacco addiction, sometimes providers do not perceive their intervention efforts to be worthwhile or rewarded. Evidence indicates that provider assistance can more than double the odds that a patient will be successful in quitting (Fiore et al., 2000). Yet, given these time and resource constraints, a minority of health systems and individual providers do assist tobacco users in making quit attempts (Schroeder, 2005) when tobacco status is not routinely collected.
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However, quit lines can provide a reliable, easily accessible alternative for doctors, nurses and dentists who may otherwise not have the time or resources to address tobacco dependence intensively. By providing more in-depth assistance and follow-up, quit lines can free up health-care providers to focus on identifying and motivating tobacco users to quit. This revised intervention model has been called the “2As and R” – Ask, Advise, Refer (Schroeder, 2005). This model includes the steps from the original 5A model, but they are distributed so that the health system refers to a resource (such as a quit line), which assists in the more intensive tobacco treatment counselling. Although patients can also be referred to in-person group classes or tobacco cessation clinics, these resources are much harder to make reliably available across an entire country. The 2A and R model is outlined below in Figure 3.

**Figure 3. 2A and R brief tobacco intervention**

Brief interventions that utilize the quit line are not only useful in primary care arenas. A number of other health-care specialists and health settings can benefit from the use of a quit-line intervention.

- **Dental or oral health and hygiene settings.** Dentists, hygienists and other oral health professionals can use brief intervention techniques with referral to a quit line. Interventions can occur in conjunction with education about the side effects of tobacco use on oral health. Tobacco screening and referral systems may be similar to those of primary care clinics.

- **Hospital discharge.** Patients can be referred to quit lines post-discharge from hospital (NAQC, 2008). In cases where a hospital has a smoke-free policy and cessation medications are offered to help inpatients who smoke to comply, calls to a quit line can even be made from a hospital room to begin or continue the quitting process.

- **Emergency or urgent care settings.** Time is even more compressed during these encounters, so having a referral resource, such as a quit line available, is critical in adopting protocols for the identification of tobacco status and brief advice.

- **Specialty and surgical care.** Almost every medical specialty is impacted by tobacco use. Where the impact is most profound, such as in cardiology and pulmonary departments, information about the availability of a quit line may be welcome. There is increasing information about the beneficial impact of quitting during surgical recovery and wound healing.
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• Integration into public health and chronic disease care management (NAQC, 2008). It is particularly important in some low- and middle-income countries to integrate quit-line referral into other major public health case-finding/management programmes, such as HIV/tuberculosis, which rely heavily on community health workers. This is crucial given the role that smoking plays in exacerbating these conditions. In countries where the health-care system utilizes chronic care or disease management approaches with databases and centralized telephone follow-up for people with conditions profoundly impacted by tobacco use, such as diabetes, chronic obstructive pulmonary disease, heart disease and asthma, quit-line referral can be relatively easily accomplished by the nurse or other health-care worker whilst talking to the patient about their chronic disease.

7.2 HOW HEALTH SYSTEMS CAN HELP QUIT LINES

The relationship between a quit line and a health system is mutually beneficial (PCHT, 2003). Health systems and providers can offer vital support to quit lines in a number of areas, some of which are described below.

**Referrals from health-care providers** are much less expensive than reoccurring mass media expenses. For example, in some states in the United States with active referral programmes, 40-60% of callers to quit lines are referred by health-care professionals. However, this type of arrangement may be enhanced by a number of specific programme characteristics.

- Ongoing service reliability. If the types of services callers receive change frequently, health-care providers may not trust the service and stop referring.
- Outreach to health-care providers about the quit line, combined with training on how to help their patients quit.
- Referral programmes (including fax-referrals) that allow health-care providers and systems to reliably refer their patients and receive some limited feedback about whether or not the patient used the service.

**Health-care systems can serve as resources** for quit-line callers who need support in health-related areas beyond tobacco treatment (Borland & Segan, 2006). For example, callers with significant mental health disorders may, in addition to receiving standard cessation support, be referred back to their mental health or primary care provider for assistance. Similarly, callers with diabetes, asthma, heart disease, or other chronic health diagnoses would be referred back to their primary care providers. By being cross-listed with quit lines as referral resources to help deal with a caller’s health-related problems, health-care systems can provide patients with continuity of care and assist quit lines in offering support for co-occurring conditions.

Quit-line counsellors should also be fully aware of and have available accurate referral information on various types of crisis situations, such as suicidal callers, or callers with medical emergencies such as heart attack symptoms.

**Health-care providers can complement services that quit lines offer** by providing additional cessation follow-up and support, in-person counselling if desired, and prescriptions for cessation medications not available through the quit line. Many quit lines have created complex relationships with health-care providers to improve access to and quality of care for those interested in, for example, pharmacotherapy (see Section 3.4 Medication).
In some populations that use tobacco, health-care provider follow-up support and counselling is not only encouraged but advised. These populations may include individuals with co-occurring mental health and/or substance abuse diagnoses. In these cases, providers can benefit by using a quit line as an adjunct to the care that they continue to provide to the patient.

Getting health-care systems and providers to systematically identify tobacco users and refer them to quit lines requires considerable attention and experience [see Appendix 8].

Finally, there are several new and advanced uses of quit lines that may have particular relevance in developing and transitional countries.

- Serve as a resource to help train health-care providers to conduct brief tobacco interventions and utilize the quit line as a trusted referral resource (Borland & Segan, 2006).
- Assist health-care systems to develop sustainable protocols for continued use of the quit line.
- Cost sharing between quit lines and health systems has the potential to reach more tobacco users (PCHT, 2003), as noted in Section 4.1 Public-private partnerships.
- Include non-traditional health-care workers in efforts to promote and integrate quit lines, as a large proportion of tobacco users may not see a doctor (McAfee, 2007).

An central issue here is that, if a quit line works with health-care systems or health-care providers to encourage quit-line referrals, providing consistency of quit-line services becomes more important so that health-care providers can reliably inform their patients what to expect.

Although the long-term benefits of working with health-care systems and providers are considerable, both parties must invest substantial time and effort to generate significant numbers of referrals and, ultimately, decrease people’s use of tobacco. While most quit lines rely on mass media or other techniques to generate immediate or initial referrals, by developing working relationships with the health-care community, quit lines can increase their sustainability.