QUITLINES HELP SMOKERS QUIT

There is more evidence than ever before that quitlines are effective in helping tobacco users quit and should be part of a comprehensive strategy to lower tobacco use and improve health in the United States. Unfortunately, because of the addictive power of nicotine, most smokers fail when they try to quit smoking on their own, and many do not have access to proven interventions that would greatly enhance their chances of success.

Studies show that only three to five percent of smokers are able to quit without any quitting assistance.[1] Quitlines greatly increase the chances that a smoker will quit successfully. The U.S. Public Health Service's recently updated clinical practice guideline found that quitline counseling can more than double a smoker's chances of quitting and quitline counseling combined with medication (such as nicotine replacement therapy) can more than triple the chances of quitting.[2] Quitlines are a cost-effective and efficient way to reach a large number of smokers and dramatically increase success rates in quitting.

While all states now provide some level of quitline services, these services are nowhere near the level that the U.S. Centers for Disease Control and Prevention (CDC) recommends and are therefore simply not available to the vast majority of smokers. With additional funding, we can reach many more smokers and save many more lives.

Quitlines Work to Reduce Smoking

There is more evidence than ever before that quitlines are effective in helping tobacco users quit. In 2007, the CDC issued a guidance document, *Best Practices for Comprehensive Tobacco Control Programs,* in which CDC recommends that a key component of any effort to reduce the toll of tobacco include action to sustain, expand and promote quitline services.[3]

Quitlines can serve the following important purposes:

- Reach a large number of tobacco users in a cost-effective way by reaching racial and ethnic communities as well as uninsured and underserved populations
- Reduce access-related barriers to treatment by providing a free telephone number that is flexible to the caller's schedule
- Serve as a gateway to other cessation resources (e.g. medications), and in some cases link tobacco users to broader health-related information and resources (e.g., care for diabetes or hypertension)
- Provide local health providers with a place to refer a smoker for help with quitting
- Offer a treatment service that is appealing to a broad spectrum of people regardless of race/ethnicity, education level or area of residence (urban vs. rural)

Telephone counseling services have proven effective in helping people quit using tobacco and remain abstinent.[4] An exhaustive review of the research literature in the U.S. Public Health Service's updated *Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline* (PHS Guideline) found strong evidence to support the use of quitline counseling to help people quit.[5]

- An analysis of quitlines published in 2006 found that quitlines significantly increase quit rates compared to minimal or no counseling interventions and the addition of quitline counseling to medication significantly improves quit rates compared to medication alone.[6]
- A 2006 study published in the *Archives of Internal Medicine* found that smokers who received counseling and medications through a quitline were more than three times as likely to remain abstinent after quitting compared to smokers who received self-help materials through the mail and had access to brief advice from a primary care physician.[7]

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- A 2005 analysis of Maine's HelpLine found that the program, which consisted of telephone counseling and free NRT, reached uninsured smokers who may have had limited access to health care. Forty-seven percent of smokers calling the HelpLine were either Medicaid beneficiaries or those without health insurance.[8]
- A 2000 study of the California quitline program, which was implemented in 1992, found that the quit rate for people who called the quitline was twice that of people who attempted to quit on their own. This difference could be attributed to the higher concurrent use of counseling and cessation medications.[9]
- Proactive counseling, in particular, helps smokers quit. Research suggests that one or two brief calls are less likely to provide a measurable benefit, while three or more calls increase the odds of quitting compared to brief advice, self-help materials or pharmacotherapy alone.[10]
- A 2007 study found that quitlines are an effective way to reach young adults, particularly those who smoke daily.[11]
- Quitlines are most effective when they offer connections to other treatment resources, especially medications.[12] For example, when Minnesota's QUITPLAN helpline offered free nicotine replacement therapy to callers, the volume of calls to quitlines increased dramatically. Likewise, the quit rate also increased because of easier access to medications and counseling services.[13]
- Research indicates that state quitlines are well-received and effective among callers regardless of their race/ethnicity, education level, gender or area of residence (rural vs. urban).[14]

Who Do Quitlines Serve?

The large variation in funding for state smoking cessation quitlines means that they differ in terms of the populations they are able to serve, but it is clear that they reach a broad diversity of smokers, including the Medicaid and un-insured populations. Due to budget limitations, many states limit the full range of services (multiple calls, medications) to the uninsured and Medicaid populations.

Data from Free & Clear, which provided services for seventeen state quitlines from July of 2007 through June of 2008, demonstrates the diversity of smokers served by the quitlines.[15]

- Fifty-four percent of callers to these state quitlines were either Medicaid enrollees or uninsured (17.5 percent and 36.5 percent, respectively), while 10 percent were covered by Medicare and 32 percent by commercial insurance.
- Fifty-five percent of the quitline callers had a high school education or less. Twenty-eight percent had some college, and 13 percent had a college degree or higher.
- Whites and Blacks/African Americans are represented roughly proportionately among quitline callers. Seventy-five percent of callers to quitlines in these seventeen states were white, and 12 percent were black. Nationally, 82 percent of smokers are white, and 13 percent are Black/African American. More than six percent of callers to quitlines in these seventeen states were Hispanic and 9.5 percent of smokers are Hispanic.

How Do Quitlines Work?

Quitlines are a telephone-based tobacco cessation counseling service that offer a variety of services to help tobacco users quit. Quitlines in each state offer different forms of assistance in varying degrees but are often constrained by budget issues. States determine what to offer based on the best evidence of what works, the needs of their population and budget constraints. The typical quitline model is a telephone counseling system where callers may speak directly with a counselor or callers are offered options from which they can select the services they need (e.g., self-help materials, counseling, medications, referral). Quitlines offer single or multi-session counseling to tobacco users. Multi-session counseling can be either proactive (the quitline proactively calls the smoker back for follow-up sessions) or reactive (the smoker has to initiate calls including any follow-up calls).

Quitlines are essential elements in the treatment process because they are free, flexible, can be tailored to the caller's needs and enable easy access for anyone who needs their services. A large majority of quitlines are open every day of the week, with a few offering 24-hour help, which increases convenience

and accessibility.[16] Most smokers prefer telephone services,[17] and, by providing somewhat-anonymous services, people who would be intimidated in face-to-face settings can get the help they need.[18] Eligibility criteria, length of counseling sessions and the number of sessions allowed vary across states.

To accommodate the range of needs from the variety of callers, quitlines provide services in many languages and tailor information to specific populations (i.e., pregnant women, smokeless tobacco users, different age groups). These services include:[19]

- Information mailed to the caller, including self-help materials
- Single-session counseling
- Multiple-session counseling with proactive follow-up to the caller
- Treatment aids, including medication, either free or at a discount
- Referrals to local services, including group programs or professional services
- Fax referrals from healthcare providers or other counselors that request quitline call smoker proactively
- Materials for non-smokers to provide to their healthcare providers and people they want to help quit
- Web-based information and services, including chat rooms, interactive counseling services, and emailing services with counselors

As noted previously, funding for state tobacco control programs varies widely across states and impacts the types and intensity of programs and services that are available. However, despite differences in current quitline funding, every state will benefit from the ability to offer enhanced quitline services. For example, with additional funding, states could choose from a number of potential enhancements:

- Extend the hours of operation
- Offer additional proactive counseling sessions
- Expand eligibility criteria so more population groups have access to the most intensive treatment
- Fully cover or discount the cost of FDA-approved cessation medications
- Offer counseling services in additional languages
- Promote the quitline more widely so more smokers know about it, and more are motivated to call

Current Quitline Efforts and the Need for Additional Resources

In 2004, the U.S. Department of Health and Human Services (HHS) established a toll-free, national telephone quitline network, 1-800-QUIT-NOW, to provide treatment support for people who wish to quit using tobacco.[20] As of June 2006, all states including Washington, DC, have their own quitlines, which are accessible through HHS's telephone number,[21] however the level and quality of services available vary greatly depending on funding. Current funding for quitlines comes from a range of sources, including Master Settlement Agreement funds, tobacco tax revenues, federal or state governments, and private sources (i.e., foundations, insurance companies, grants).[22]

Since the 1-800-QUIT-NOW network was implemented, more than 750,000 calls have been received and re-routed to states. Call volume grew by 54 percent between 2005 and 2006 and by another 49 percent between 2006 and 2007.[23] This volume, however, represents only one or two percent of all tobacco users. CDC has concluded that state quitlines could actually reach about ten percent of a state's tobacco users if the quitline is sufficiently promoted and nicotine replacement therapy is made more readily available.

Quitlines are a cost-effective way for states to provide a wide range of services for smokers who want to quit, particularly in light of the high cost of tobacco use to our health care system. Smokers, on average, have lifetime healthcare costs that are an estimated $17,500 higher (in 2004 dollars) than those who do not smoke, despite smokers, on average, living shorter lives.[24] Tobacco use costs the nation nearly $100 billion a year in health care bills, including more than $30 billion in federal and state government Medicaid program costs. Studies indicate that for every smoker who quits in response to tobacco control measures, such as through a quitline, their total healthcare costs over the next five years would drop, on average, by approximately $2,400.[25]

Unfortunately, despite all the evidence regarding quitlines and broader tobacco prevention and cessation efforts, the states in total are only spending about 20 percent of what the CDC recommends for these life-saving programs. The quitline components, like the broader programs, are severely under-funded.

Cigarette Tax Hikes Increase Demand for Quitline Services

Quitlines have been a crucial tool for smokers who wish to quit following a state cigarette tax increase. State evidence shows that cigarette tax increases have prompted many smokers to seek help in quitting. For example, after the most recent cigarette tax increases in Michigan (from $1.25 to $2.00 per pack) and Montana ($0.70 to $1.70), smoker calls to the state smoking quitlines skyrocketed. In the six months after the tax increase, the Michigan quitline received 3,100 calls, compared to only 550 in the previous six months; and in Montana more than 2,000 people called in the first 20 days after the tax increase, compared to only 380 calls per month previously.[26] Likewise, in Texas and Iowa, the numbers of calls to their state quitlines have been much higher after each increased their cigarette taxes by $1.00 in 2007, compared to the previous year.[27] Probably the most dramatic example is from Wisconsin, which received a record-breaking 20,000 calls to its state quitline in the first *two months* after its $1.00 cigarette tax increase went into effect on January 1, 2008 – compared to typically 9,000 calls per *year* prior to the tax increase.[28] The evidence from the states is clear – when states increase their tobacco tax, the demand for assistance in quitting increases, and in many cases, increases dramatically. Given current economic conditions we would expect that the demand for quitline services would be even greater.

Quitline Services Must Be Promoted

To reach its full potential in reducing smoking, a quitline must be widely promoted. It is not enough just to have the service. Smokers must not only be informed of the service but also motivated to call and understand enough about the quitline to be comfortable calling it. Promotions include a variety of activities to raise awareness about the service and increase call volume, such as mass media campaigns, promotion through community-based programs, education of healthcare providers to make referrals, and collaboration with other state agencies or programs to disseminate educational materials that include the quitline number. Promotions should strive to reach all populations who need quitline services, particularly those groups who are at high risk for smoking or are underserved. Of course, any promotion plan must include a plan to respond to an increase in demand for quitline services.

Several state examples demonstrate the importance of promotion to generate call volume:

- During 2005-2006, the Colorado tobacco control program targeted cessation interventions by employing different spokespersons in its televised promotions for the quitline. The number of African-Americans calling the state's quitline nearly doubled when the campaign featured an African-American sports celebrity.[29]
- The Ohio Tobacco quitline informed smokers about the quitline through a mass media campaign and broad outreach to a diverse set of partners which resulted in the quitline receiving more than 100,000 calls between 2004 and 2007.[30]
- California reached out to physicians and other tobacco cessation and prevention organizations to encourage them to refer patients or clients to the Helpline.[31]
- The DC Quitline received a record number of calls in July and August of 2007, after TV public service announcements advertising the quitline started airing in June.[32]
- After the West Virginia Tobacco Cessation Program launched its Save Face-Stop Spit Tobacco Program, which included a TV commercial, calls to the state quitline increased by 41 percent.[33]

As the evidence shows, quitlines are effective tools to aid tobacco users in the quitting process. The resources to which they connect callers and the services that they provide can significantly contribute in states' efforts to improve the public health of their citizens. Quitlines are not meant to replace existing treatment programs supported by health care delivery systems, but rather make successful connections and work with them to help tobacco users quit. They are far-reaching and enable people all over the country to receive the support and services they need to quit. Because of the limited reach and resources of individual programs or health care providers, providing a central place where people can call in and receive all of the services or referrals to services that they need is cost-effective and efficient.

The network of quitlines requires additional funding and resources to reach the largest number of smokers and to have the greatest impact on tobacco use in the U.S. Inadequate funding limits quitlines' reach and effectiveness, and hinders access to the highest quality care possible, particularly for uninsured and underserved populations. If properly funded, designed, and implemented, however, quitlines could greatly reduce the number of smokers in the U.S.

Campaign for Tobacco-Free Kids, December 19, 2008 /Meg Riordan & Ann Boonn

More information on tobacco cessation is available at
http://www.tobaccofreekids.org/research/factsheets/index.php?CategoryID=25.

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