11 Future Directions

Overview

Future developments in quitlines will likely occur in two main areas. First, the menu of services they offer will expand to include new counseling protocols for special populations and intervention strategies that go beyond counseling. Second, quitlines will increase their population impact as their current partnerships become better established and new opportunities for collaboration and provision of specialized services appear. Helping to drive these changes will be increased efforts among people in different states to provide mutual assistance with protocol development, operations management, and program evaluation.

Increasing the Menu of Services

Although research has shown telephone counseling to be effective in various settings, the evidence thus far has been limited to English- and Spanish-speaking adult smokers. As evidence becomes available on effective interventions for other populations, and as quitlines expand their capacity to provide culturally sensitive and language-specific services to more communities, the menu of evidence-based counseling services will broaden.

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Meanwhile, as quitlines accumulate clinical experience and respond to new challenges, they will make adjustments to their existing protocols. For example, smokers using newly developed pharmacotherapies may require different counseling schedules. Because each medical regimen has its own time frame, quitlines will need to adjust their protocols to support patients using these medications, assess their status at the end of the medication regimen, and help them as they transition off the medications to reduce the risk of relapse.

As quitlines become more institutionalized within their states, the number of repeat callers will grow, increasing the need for effective ways to help them. At the same time, the number of former callers

The ever-increasing number of former callers who have not yet quit for good will induce quitlines to find ways to help them move forward.

who relapse but never call back will also grow, which will induce quitline operators to find ways to help them move forward. The familiarity these former callers have with quitlines will present opportunities for reconnection, allowing quitline staff to help them build on their past quit attempts. Proactive protocols may prove especially effective with these smokers.

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As quitlines attempt to stretch their resources as far as possible, they will begin adopting intervention strategies to supplement self-help materials and telephone counseling. Strategies that would entail significant start-up costs but low marginal costs include Web-based activities, interactive voice response (IVR) services, and tailored mailings.

For example, as the proportion of people using the Internet increases, its potential as a medium for tailored cessation assistance also increases. It may be possible to direct some callers to a Web-based relapse prevention module in lieu of follow-up counseling, although this strategy has not yet been tested. Likewise, the proliferation of IVR services, through which callers access detailed and personalized information, raises the possibility of providing cessation information through this medium. Finally, the lower-tech but more widely applicable method of sending automatically generated tailored letters may enable quitlines to increase their level of engagement with callers to better support their efforts to quit. However, all of these innovative strategies would need to be evaluated before widespread use could be recommended.

Combinations of intervention strategies, whether current or emerging, may be managed using customer relationship management (CRM) software. This software is intended to make it feasible for organizations to serve a diverse clientele through a range of media (telephone, fax, e-mail, etc.) according to each individual client's preference. Although existing CRM applications have had limited success in helping organizations achieve this goal, refinements are ongoing, and quitlines may come to rely on such programs as their intervention strategies become more complex.

Increasing the Population Impact

States that have established comprehensive tobacco control programs face difficult choices as they balance priorities. The question of how much funding to devote to cessation, as opposed to other priorities, such as preventing youth access to tobacco or reducing exposure to secondhand smoke, is not easy to answer. Therefore, it

is incumbent on those who work on the cessation side of tobacco control to ensure that their efforts are not only effective at the level of individual tobacco users, but also have as big an impact as possible at the population level.

Quitlines have gained prominence because they have provided evidence of their clinical efficacy as well as their effectiveness in real-world settings, and because of their potential to make cessation services more universally available. However, research is still needed on the effect of the promotion and utilization of quitlines on the prevalence of tobacco use in states that have them.

Every existing quitline serves thousands of tobacco users per year—a volume rarely achieved by other behavioral services—and many quitlines have seen dramatic increases in usage over time. Even so, quitlines currently reach only 1% to 5% of the tobacco users in their states per year. Therefore, to have a more substantial population impact, utilization rates must increase even further. It has been suggested, based on the experience of private quitlines serving health plans, that statewide quitlines could potentially reach 15% of the tobacco-using population per year (McAfee 2002).

Partnering for Growth

The rate at which quitlines are utilized appears to be limited not by a lack of interest in quitting or by a belief that help is not needed (Zhu & Anderson 2000), but by the level of funding available for promotion and operations. The large spikes in call volume commonly experienced during promotional campaigns also indicate a large untapped demand for services. Consequently, as quitlines try to increase their population impact, they will look for new ways to increase public awareness and the use of services and new ways to pay for those services.

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One potential way for quitlines to accomplish both objectives is by partnering more fully with the health care system. About 70% of smokers visit their physicians at least once a year (CDC 1993a), but fewer than 5% have used a quitline (Zhu 2002a). As mentioned in Chapter 1, time constraints often prevent physicians from providing personal cessation counseling to their tobacco-using patients. Physicians can circumvent this barrier by referring these patients to a quitline (Schroeder 2003). Many state quitlines already work with physicians, but their collaboration tends to be limited to individual physicians who have a particular interest in cessation.

To dramatically increase health care-initiated utilization, quitline referrals must be instituted on a systems level. If clinics regularly identified tobacco users, advised them to quit, and obtained their consent to be contacted by a cessation specialist, quitline staff could proactively call them to provide counseling. Efforts in this area have already begun. In Arizona, for example, the quitline uses faxed referrals to identify clients from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to receive a proactive call. WIC identifies clients who smoke, obtains their written permission to have the quitline contact them to assist with smoking cessation, and faxes the referral to the quitline. Studies have shown that a proactive approach can dramatically increase the percentage of tobacco-using patients receiving cessation counseling. In one study, counseling utilization rates were increased from 3% to 35% through this approach (Cummins et al. 2002).

A system that allows clinic staff to enroll a patient (with his or her consent) into counseling by logging onto a secure Internet-based scheduling system while the patient is still in the doctor's office could make the referral process even more efficient. A cost-sharing model in which managed care organizations (MCOs) pay only for services directly attributable to this scheduling system, while the state continues to pay for all other services received, would demonstrate effective partnering between the public and private sectors and dramatically increase both the reach of quitlines and the treatment of tobacco-related disease.

It is worth noting that such collaboration between quitlines and MCOs could also improve the quality of treatment of tobacco dependence within the health care system. For example, quitlines could enhance patient compliance with physician-prescribed cessation treatments such as nicotine replacement therapy by providing patients with detailed information about its proper use, answers to questions about side effects, and so forth. Quitlines could even dispense quitting aids directly, removing barriers to access and addressing patients' ambivalence about following through with their physicians' recommendations. Some quitlines are already doing this (McAfee 2002), as studies have shown that reducing the burden of obtaining pharmacotherapies increases their usage (Hopkins et al. 2001).

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Quitlines also could support patient compliance with cessation treatments by helping them access other support systems available locally (e.g., culturally specific cessation classes), either alone or in combination with quitline counseling. In this way, a quitline could serve as the hub of a comprehensive statewide system of

evidence-based cessation services. It would then increase its population impact not only by providing effective counseling services, but also by enhancing the use of other available cessation resources, including pharmacotherapies and community cessation programs (Pacific Center on Health and Tobacco 2003).

As states work to broaden the reach of their quitlines, they must address the disproportionate burden borne by certain groups of tobacco users. They should not be content merely to increase overall utilization rates. They must also help address disparities in the prevalence of tobacco use and utilization of cessation resources. Quitlines have already been shown to reach more tobacco users of ethnic minority backgrounds than do traditional clinic-based programs (Zhu et al. 1995). With smoking increasingly concentrated among people of low socioeconomic status (SES), it is imperative that quitlines increase their efforts to help this segment of the population. Many low-SES tobacco users have inadequate medical insurance and do not use the health care system as frequently as others. Quitlines have functioned as "equalizers" in the field of cessation assistance because telephones are among the few things that most people own regardless of SES (Fiore et al. 2004). In addition, state quitline services are provided at no cost to callers. These two considerations make quitlines ideal for community-wide intervention in low-SES areas. For example, targeted billboard campaigns can be waged in ZIP code areas of low SES.

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The goal of increasing the population impact of quitlines could be strongly supported by policies such as those recommended by the Cessation Subcommittee of the U.S. Department of Health and Human Services' Interagency Committee on Smoking and Health (Fiore et al. 2004). In its National Action Plan for Tobacco Cessation, this federal advisory committee called for the establishment of a federally funded national network of quitlines that would provide universal access to evidence-based counseling and medications for tobacco cessation and a national portal to state or regionally managed quitlines. It also called for a level of financial support far exceeding what quitlines currently receive.

To help advance supportive policies, quitlines must consolidate their achievements and establish their value as an effective population-based approach to cessation. Continuing research and development are also needed to provide more comprehensive scientific support for such policies.

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Increasing Cooperation

With the goals of helping the field to consolidate its achievements and taking a more active role in reducing the prevalence of tobacco use in their states, quitline funders, researchers, and operators have formed a consortium to improve cooperation among states with quitlines (Ossip-Klein 2002, Bailey 2003). The consortium is intended not only to help the member organizations, but also to help advance the field itself.

Several important benefits should result from this type of collaboration. First, a consortium allows data and experience to be shared more efficiently and completely than is usually the case with the standard publication process. For example, practical information concerning quitline operations that is unlikely to be published in peer-reviewed journals can easily be disseminated through a consortium. Second, a consortium facilitates collaboration on research and education. Natural variations that exist among quitlines provide ideal opportunities for research. They also induce a need for the ongoing accumulation and quick dissemination of knowledge among quitline funders and practitioners. Third, a consortium can set minimum standards for service and promote appropriate quality assurance measures to ensure that member quitlines operate from a strong evidence base. Finally, a consortium can improve public and policy awareness of what quitlines can and should do to help reduce the prevalence of tobacco use.