SMOKING Cessation ROUNDS

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Quitlines for Smoking Cessation: An Effective and Available Referral Option for Healthcare Providers

By Scott McIntosh, PhD, and Deborah J. Ossip, PhD

Smoking remains the leading cause of morbidity and mortality in Canada, and smoking cessation is an effective prevention in disease and early death. To reach the Federal Tobacco Control Strategy goal of reducing smoking prevalence in Canada from 19% to 12% by 2011, several Canadian healthcare organizations have developed the following recommendations: improved access to affordable pharmacotherapies and behavioural counselling; better training of healthcare professionals; and the addition of system-wide implementation of cessation strategies.

This issue of *Smoking Cessation Rounds* describes the evidence base for telephone quitlines for smokers, and presents the benefits and opportunities for physicians and other healthcare providers of systematic referral to quitlines for patients who smoke. Increasingly practical, efficient, and time-saving procedures rooted in evidence-based data can be directly addressed by the use of telephone quitlines as a primary treatment-referral option. Telephone quitlines demonstrate effectiveness in providing access to behavioural counselling across large geographic areas and populations. The training of healthcare professionals to follow recommended guidelines, especially when combined with the implementation of system-wide cessation measures at the point of care (eg, routinely implemented screening questionnaires, staff training, identified referral strategies and procedures that trigger them, etc.), have a substantial effect on cessation. Healthcare providers may be more likely to intervene with their patients about smoking cessation if they have a quitline available as a referral source.

Introduction

In Canada and globally, smoking remains the leading cause of morbidity and mortality, and smoking cessation is one of the most effective measures in preventing disease and early death.[1-8] The updated "Clinical Practice Guideline" for treating tobacco use and dependence published by the United States (US) Public Health Service[2] currently recommends implementation of effective smoking-cessation strategies, which include brief tobacco dependence treatment (eg, at the point of care with physicians and other healthcare providers), individual, group, and/or telephone "quitline" counselling; and medications proven to be effective (eg, varenicline, bupropion SR, and nicotine replacement therapies [NRTs]).

In a recent review of tobacco control and nicotine addiction in Canada, McIvor[1] identifies nicotine addiction, unequal access to available support programs, and gaps in continuity of healthcare as some of the primary barriers to smoking cessation. He further notes the goals and recommendations that have been developed to overcome these barriers. Each of the recommendations – brief treatment, counselling availability, medications – is addressed with increasingly practical, efficient, and time-saving procedures that are rooted in the evidence, and can be directly addressed by use of telephone quitlines as a primary treatment referral option. Telephone quitlines are effective in providing extensive access to behavioural counselling and they can potentially provide NRT, sometimes at no cost to the smoker.[2,9-11]

Available on the Internet at www.smokingcessationrounds.ca

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Training healthcare professionals to follow recommended guidelines (including referral to quitlines), especially when combined with the implementation of system-wide strategies in specific settings at the point of care, have a demonstrable effect on quit attempts and long-term cessation success.[2] In addition, evidence suggests that healthcare providers may be more likely to intervene concerning smoking if they have a quitline available as a referral source.[12]

Telephone quitlines

Tobacco quitlines operate with various goals (eg, direct counselling services, awareness-raising initiatives, maximizing public-health impact, and reaching across large geographic regions); they may also use different quitline models (eg, reactive and/or proactive counselling, recorded messages, or information-based). Quitlines may also provide a range of services (eg, synergy with web-assisted tobacco interventions, mailed materials, access to NRT) and serve various populations segmented by age, cultural determinants, or medical condition.[10]

The services available are often common across various quitline programs, but may vary by emphasizing one component over another and the degree of synergy between components (eg, an associated website with more information, availability of medications, mailings of free materials). In research examining 29 quitlines in the US, Zhu[13] reported that at least 90% of these quitlines offered mailed materials, referrals to other resources, and reactive counselling (smokers call in to speak with a counsellor), 87% featured proactive services (counsellors call the smokers on a scheduled basis), about 42% offered help obtaining nicotine replacement/bupropion and web-chat services, and between 25%-33% provided information on nicotine replacement/bupropion and taped messages. Most of these quitlines offered at least some services for specific populations, with 90% providing services for pregnant smokers, nearly 75% for smokeless tobacco users, and about one-half (46%–50%) providing services for adolescent smokers and/or Medicare recipients.

Several quitline models are currently in use. Smoking-cessation services may be just one component of broader hotline services. The Cancer Information Service (CIS) hotline in the US, for example, provides general information and materials on cancer, as well as specific materials and reactive counselling for smoking cessation. For smoking-specific quitlines, there are a variety of approaches. Smokers may speak directly with a counsellor, or they may hear a brief, taped daily message and then have the option of holding to speak with a counsellor directly or to a dispatcher who contacts an on-call counsellor to return the call to the smoker within minutes.[14] Another protocol involves a telephone tree for services, which can offer choices including materials, messages, or counselling. Finally, a call-screening person may answer a quitline and either directly provide services such as mailings, or arrange for proactive telecounselling call-backs. Quitlines may also offer various combinations of mailings, reactive-call services, proactive calls, access to medication (eg, 2 free weeks of NRT available in the state of New York), and/or live chatting and other web-assisted services on an associated website. Since there are no direct comparisons available of these overall quitline models, the question of whether evidence suggests greater effectiveness for any particular strategy in grouping these services over another is not resolved.

Glossary of terms in this article:

Nicotine replacement therapies
Includes nicotine gum, patch, lozenge, and inhaler

Quitline
Telephone counselling service for 1:1 smoking-cessation assistance

Proactive counselling
Quitline counsellors call smokers to provide cessation assistance

Reactive counselling
Smokers initiate calls to quitline for assistance

The evidence base for proactive telecounselling has been demonstrated in the literature with meta-analyses and randomized trials and continues with ongoing trials.[10] Intervention effects have been demonstrated with both short- and long-term follow-ups (eg, 12-18 months), as a stand-alone or in combination with other interventions, and with various populations and settings such as region-wide populations, cardiac patients, general hospitalized patients, mid-life and older smokers, pregnant women, and adolescents.

For some populations, there may be a dose-response effect, with multiple calls producing higher abstinence relative to a single call. Promising results have been found in a small number of studies using telephone counselling to extend effects of other interventions, such as to support short-term abstinence among low-income smokers, among smokeless tobacco users,[15] and as part of a tailored intervention for specific ethnic groups.

Another approach involves using a private company, such as a vendor specializing in phone-based and web-based behavioural counselling and materials. These are in use, for example, to help employers, health plans, and governments improve the overall health and productivity of their employees, members, and residents using evidence-based approaches.[16-20] Such programs benefit from the easy referral of individuals to related services provided by their insurance company, employer health plan, or other specific benefits available to target populations.

In some models,[20] participants have access to the quitline as well as to an online component of the program that contains interactive tools and targetted content based on the participant's progress with the quit process. Features can include interactive exercises, educational content, a calendar to help support a specific quit date, and discus-

sion forums to interact not only with counsellors but with other smokers trying to quit. Telephone counsellors can have real-time access to information they have previously entered, or that participants themselves have entered on the website. Data needed for evaluation can be collected for all callers and/or web-users, including assessment results, call activity (number of calls, type of calls [proactive vs reactive], duration of calls, use of specific web-based features, materials sent out, etc.). Web-assisted tobacco interventions, as stand-alone programs or in tandem with telephone quitlines, are increasingly demonstrating effectiveness[21] and reveal incredible potential in both reach and adaptability as technology advances.[22]

A range of models for counsellor recruitment and training can also be found. Quitline counsellors vary in background; some have experience in counselling and related professional and paraprofessional fields, while others are peers recruited from the general population. Counsellors may also be referred to as "quit coaches," "intervention specialists," or "telecounsellors." People who have never smoked are often employed as counsellors, but ex-smokers may be specifically recruited. Although standards to identify and ensure training in core competencies have not been widely developed or disseminated, counsellors generally receive some type of training and quality assurance follow-up. As yet, there is no evidence for greater effectiveness of one counsellor type compared with others.

The Public Health Service (PHS) guidelines panel identified quitline effectiveness as a topic deserving a focussed meta-analysis for the 2008 update.[2,23] Nine studies were analyzed to compare the effectiveness of a quitline intervention versus minimal or no contact, or self-help materials. Unlike the previous meta-analysis in 2000 from the PHS guidelines, this analysis focussed on research study arms, using quitline intervention alone, rather than telephone counselling that may have been concomitant with other cessation interventions. Quitlines were defined as those providing telephone counselling where at least some of the contacts were "proactive," or those initiated by the quitline counsellor to deliver tobacco-use interventions,

Table 1: Effectiveness of and estimated abstinence rates for quitline counselling compared to minimal interventions, self-help, or no counselling: a meta-analysis of 9 studies[a]

Intervention	Number of arms	Estimated odds ratio (95% CI)	Estimated abstinence rate (95% CI)
Minimal or no counselling or self-help	11	1.0	8.5
Quitline counselling	11	1.6 (1.4–1.8)	12.7 (11.3–14.2)

[a] Articles used in this meta-analysis are available at www.surgeongeneral.gov/tobacco/gdlnrefs.htm.
CI = confidence interval

Table 2: Effectiveness of and estimated abstinence rates for quitline counselling and medication compared to medication alone: a meta-analysis of 6 studies[a]

Intervention	Number of arms	Estimated odds ratio (95% CI)	Estimated abstinence rate (95% CI)
Medication alone	6	1.0	23.2
Medication and quitline counselling	6	1.3 (1.1–1.6)	28.1 (24.5–32.0)

[a] Articles used in this meta-analysis are available at www.surgeongeneral.gov/tobacco/gdlnrefs.htm.

including call-back counselling. Previously, in the literature, proactive telephone counselling was demonstrated as an effective element of telephone quitline interventions.[2,24,25] The meta-analysis concluded that quitlines significantly increase abstinence rates compared with minimal or no counselling interventions (Table 1).

The 2008 PHS guidelines also included a second meta-analysis of quitlines examining 6 studies that compared the effect of adding telephone quitline counselling to cessation medication versus medication alone. Results indicated that the addition of quitline counselling to medication significantly improved abstinence rates (Table 2). The guidelines concluded that the findings demonstrate a robust effect of quitline counselling, which is consistent with the US Centers for Disease Control and Prevention's Guide to Community Preventive Services.[26]

Adolescents and quitlines

In a recent study by Peterson, et al,[27] 50 US high schools were randomized to receive either an experimental or a control smoking-cessation treatment (25 schools each). The experimental treatment group involved proactive telephone-based counselling using motivational interviewing and cognitive behavioural skills training. Previous randomized trials of both behavioural and pharmacological interventions with adolescents failed to find statistically significant effects from either intervention on abstinence from smoking for ≥6 months.[27,28] However, in the study by Peterson et al, daily smoking males and less-than-daily smoking females were more likely to be abstinent at 6 months than those in the control condition. As Leischow and Matthews[28] stated, this study provides a benchmark for a well-designed, successful intervention with adolescent smokers because it successfully reached the targeted study population and had notably high study-retention rates; as a result, the study will guide future studies of quitline intervention with various populations.

Canadian quitlines

Increasingly, smoking-cessation quitlines that provide intensive, specialist-delivered interventions are easily accessible to persons who smoke or use other tobacco

products. In Canada, quitlines began in Ontario in 2001 as part of a provincial tobacco-control strategy; by 2003, 4 other provinces had their own quitlines, and 5 had contracted services out. All smokers regardless of insurance status, or previous quit attempts can call these quitlines. Callers are provided with basic information, advice, motivational counselling, further information via mailed materials, and proactive calls based on their commitment to quit smoking plans. At the present time, no free or discounted cessation medications are provided. Although mass media, earned media (ie, free media exposure and promotion), fax referral, and community partnerships target smokers at all stages of readiness to quit, there is a primary focus on those ready to quit in the near future.

For Canadian smokers and others who need access to quitlines – such as physicians and other healthcare providers – the information on the Health Canada website (Table 3)[29] succinctly describes available quitline services along with quitline numbers for each province and territory.

Specific information on services provided by each quitline can be accessed on the North American Quitline Consortium (NAQC) website,[30] which provides a free online interactive map of quitlines in all Provinces. Information is updated based on NAQC surveys of quitlines, and includes such categories as hours of operations, types of counselling available (eg, number of sessions, if proactive counselling is provided), web-based services, and any resources for special populations.

Table 3: Canadian Quitlines

Newfoundland and Labrador residents	1-800-363-5864
New Brunswick and Nova Scotia residents	1-877-513-5333
Prince Edward Island residents	1-877-513-5333
Quebec residents	1-866-527-7383
Ontario residents	1-877-513-5333
Manitoba and Saskatchewan residents	1-877-513-5333
British Columbia residents	1-877-455-2233
Yukon residents	1-800-661-0408 (×8393)
Nunavut residents	1-866-877-3845
Northwest Territories residents: Call your public health unit or 1-800-O-Canada	

Quitlines give smokers twice the chance of quitting smoking. They offer support for smokers who want to quit, may be thinking of quitting, have quit and need support, or enjoy smoking and do not want to stop. Trained cessation specialists can help you develop a structured plan, answer your questions and refer you to other smoking cessation services in your community. They can also provide support for family and friends who want to help a smoker. You can order self-help materials through quitlines. And remember, there is no charge for quitline counselling services.

From: www.hc-sc.gc.ca/hc-ps/tobac-tabac/quit-cesser/now-maintenant/1-800/index-eng.php

The role of healthcare professionals

A widely utilized and evidence-based approach to training physicians and supporting clinical office activities of routine screening and intervention with patients is the 5As:[2] Ask (every patient at every visit), Advise (to quit smoking in clear and strong language), Assess (readiness to make a quit attempt), Assist (in making a serious quit attempt with behavioural and/or pharmaceutical support), and Arrange (for follow-up assessment and ongoing treatment). A shortened algorithm can be used, such as Ask, Advise, and Assist (or Ask, Advise, Refer) – as "Assist" encompasses identifying those ready to quit, providing medication, and referring to evidence-based ancillary support – such as telephone quitlines, web-assisted tobacco interventions, and other intensive evidence-based services.

Implementing straightforward and sustainable changes to healthcare provider office systems establishes an important context for successful cessation – both as a function of the strength of physician advice *per se*, and as part of an evidence-based approach with identifiable features that can be easily implemented.[2,21,31] Salient features with demonstrated effectiveness in this approach include chart reminders (hard copy and/or electronic medical record [EMR]-based visual cues about the smoking status and treatments given to the patient) and mechanisms for easy and efficient referral to evidence-based ancillary treatment options.

The structure of routine screening and advice to quit in the healthcare setting can be followed by systematic patient referral to quitlines – either directly or by using technology-assisted referral strategies such as a "fax-to-quit" referral procedure[32-34] or via electronic forms that are programmable within an EMR system.[25]

Fax-to-Quit

For quitlines with protocols to receive faxed referrals, simple 1-page forms are used that include provider information (practice name, provider name, contact information) and patient information (smoking status, readiness to quit, medications prescribed or recommended, contact information, permissions). For willing smokers, physicians or authorized office staff can complete and send the referral form to the quitline. Quitline counsellors then follow-up in a timely manner by contacting the smoker to initiate services.

Connecting private physician offices to regional quitlines is feasible and can be accomplished at low cost using minimal resources. Bentz et al[32] described a "quitline connection" model where the primary

role of the healthcare provider is to deliver clear, strong, and personalized advice to quit, determine the patient's readiness to quit, and refer interested patients to the quitline either by direct fax referral ("fax-to-quit") or a brochure. Upon fax referral, quitline counsellors proactively call the tobacco users, help them develop a quit plan, and further refer them to appropriate resources for pharmacotherapy and/or intensive-cessation programs. Brochure referral (or other "passive" referral) requires that the patient initiate contact, whereupon they receive the same counselling services.

EMR-based referral

EMRs can facilitate quitline referrals using similar strategies as the fax-to-quit; electronic referral forms are automatically tailored with both provider and patient information. The electronic form is then sent to the quitline as a fax (if printed out as a hard copy or sent electronically, but received by the quitline as a fax) or electronically (as an electronic form, e-mail, or e-mail attachment).

EMRs can be used to remind clinicians to document smoking status, deliver brief advice, prompt for prescription of cessation medications, and facilitate referrals to counselling. Linder et al[36] performed a cluster-randomized, controlled trial in 26 primary-care practices over 10 months examining an EMR-based intervention to improve cessation treatment in this setting. They developed and implemented a 3-part EMR enhancement that included smoking-status icons, cessation-treatment reminders, and a form to facilitate medication prescriptions as well as fax and e-mail counselling referrals. The primary outcome was the proportion of documented smokers who made contact with a smoking-cessation counsellor. They found that, although the prescriptions for cessation medications were the same in both treatment and control groups, the EMR-based system improved smoking-status documentation and increased counselling assistance to smokers.

As technology continues to advance, these options will become even more available, routine, and time-saving. Often, quitlines have accompanying websites (web-assisted tobacco interventions) that can work synergistically (mutual referral to services within each medium) or independently, in order to tailor cessation services and preferences. The line between website interventions and telephone quitline interventions will increasingly blur as these technologies merge. Video telephone interventions, for example, will have the advantage of direct (and/or recorded) one-on-one counselling protocols adapted from the evidence base of quitline research, coupled with web-based features such as links, testimonials, self-help quizzes, online chatting, blogs, and social networking.

Conclusion

Training in guideline-based tobacco-cessation treatment options for physicians and other healthcare providers is available and effective. Whether these healthcare professionals receive face-to-face academic, detailed, training associated with continuing- education credits, or self-study via the Internet or the literature, these strategies for screening, advice to quit, assistance with cessation, and follow-up are straightforward and easy to adopt. Given the nature of smoking as a chronic disease and an addiction, healthcare providers should be encouraged to take the steps necessary to ensure system-wide training and resources, including referral to cessation treatment that is both effective and easily accessible to smokers.

Opportunities for guideline-based office procedures should be found, and the procedures implemented and maintained. Patient referral to quitlines and websites is both time-saving and effective. Despite the availability of evidence-based guidelines and treatment options, physicians and healthcare systems often fall short in the identification of patients who smoke and in the provision of timely and effective treatment strategies. Reportedly, this gap is due to lack of time during a brief office visit, competing demands from other presenting complaints, and the lack of clinician training in evidence-based procedures. Strategies that facilitate patient screening and referral to evidence-based treatments will increase smoking cessation rates in a patient population. Healthcare systems and clinicians can provide efficient and effective tobacco treatment using health information technology such as fax-to-quit and EMR office procedures, with websites and telephone quitlines as ancillary treatment options.

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