

The Growing Link Between Quitlines and Chronic Disease Programs

Introduction

Epidemiological data indicate high cigarette smoking prevalence among persons with chronic conditions. This, combined with an increased interest in achieving program integration from funders and with a continued need to develop innovative, sustainable comprehensive programming, explains the growing link between state-funded tobacco cessation quitlines and various chronic disease programs.

In March 2007 the North American Quitline Consortium (NAQC) in partnership with the National Association of Chronic Disease Directors (NACDD) administered an online survey to all state-funded quitlines to gather information on:

- Types of linkages between quitlines and chronic disease programs that have been established or are emerging;
- Rationale for developing these linkages;
- Challenges to working together; and
- Measured impacts and lessons learned so far.

The survey was administered to the 50 U.S. states and the District of Columbia, with 21 states responding. Of the respondents, only two noted their quitline has not worked with chronic disease programs. The graph at right depicts the types of chronic disease programs with which survey respondents are currently engaged. The majority of quitline linkages are with diabetes, comprehensive cancer and asthma programs.

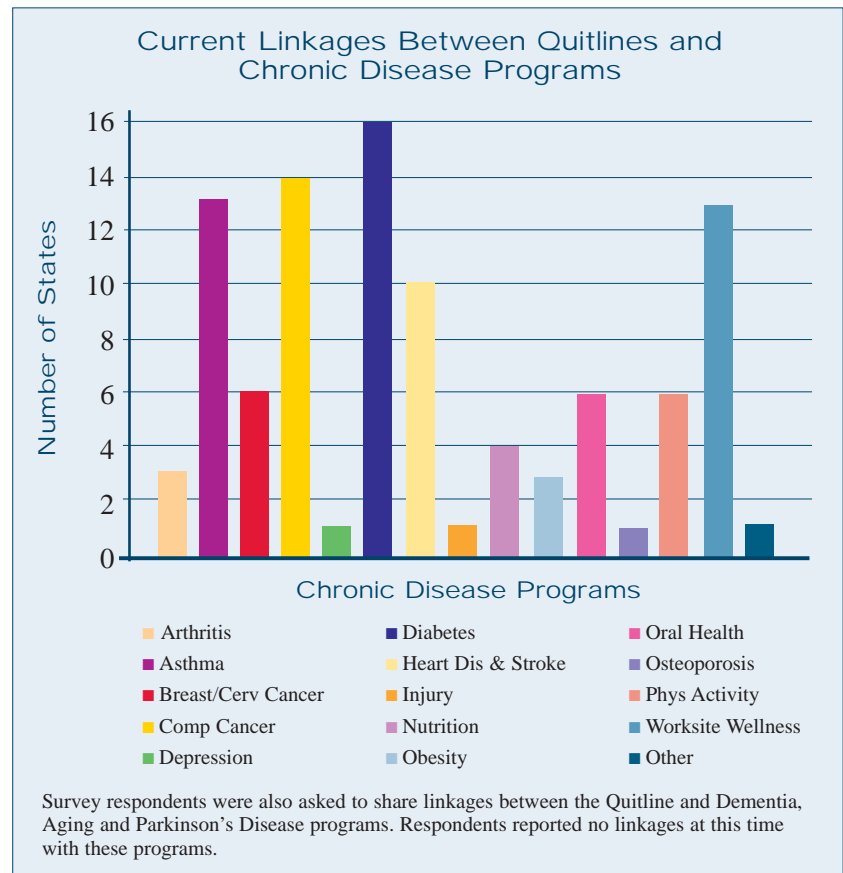
Chronic disease programs may also link with tobacco control programs to influence policy and systems change as they relate to secondhand smoke or even prevention efforts. An example would be collaborating to reduce the impact of tobacco on people with asthma through advocating for effective, sustainable smoke-free policies.

How are Quitlines and Chronic Disease Programs Working Together?

NAQC and NACDD wanted to gain a better sense of the exact types of linkages being formed between programs. Specifically, are there varying degrees of linkages, and could we find examples of programs truly working in partnership — sharing funds, staff and developing interventions based on mutually agreed upon goals and objectives? To this end, we asked survey respondents to note the types of work they do with chronic disease programs by selecting from the following categories:

- Promotion of quitline services to chronic disease program staff and/or their local partners

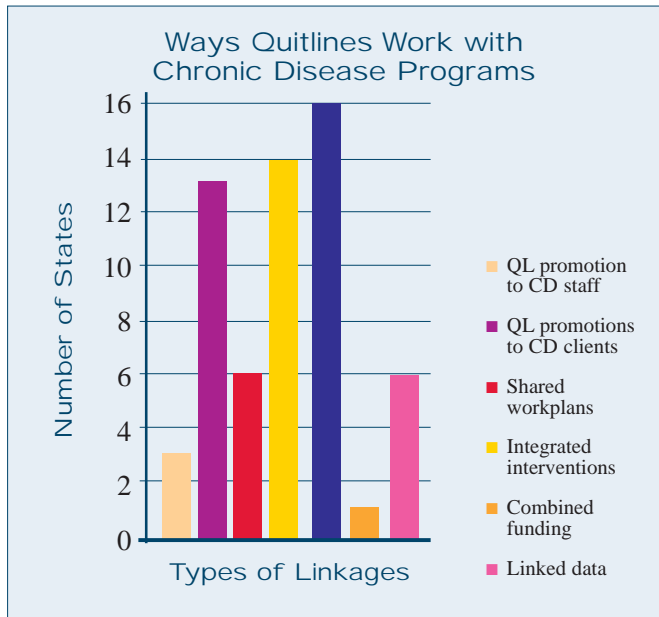
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The Growing Link Between Quitlines and Chronic Disease Programs

Introduction *(cont'd from page 1)*

- Quitline promotion and outreach to chronic disease program clients
- Development of shared work plans to implement activities built on common objectives
- Implementation of integrated interventions
- Combined funding to support integrated interventions and staff
- Linked data collections and analysis



As anticipated, the most common connection between quitlines and their chronic disease program partners is promotion of quitline services – to chronic disease program staff and their partners, as well as to chronic disease program clients. Survey participants reported attending chronic disease program staff meetings to provide information on the services available through the quitline in order to increase understanding of and confidence in the quitline. They also provide chronic disease staff with quitline promotional items to give away at events and to external partners. Survey respondents reported that in some cases a great deal of energy is spent convincing chronic disease programs of the effectiveness of quitlines and the important role quitlines can play in the treatment of people with co-occurring chronic conditions. Building relationships across programs and continually sharing information seems to be the most effective way to address these concerns.

Examples of quitline promotion by chronic disease programs to their clients include listing the state quitline number in media campaign materials and ads; sharing information about quitlines with grantees and ensuring that grantees refer to quitlines; and developing co-branded educational materials for healthcare providers. For example, the comprehensive cancer program in Mississippi recently

promoted the quitline by placing the quitline number on their lung cancer media campaign ads that aired on major television stations across the state.

Diabetes educators throughout California have joined forces with the California Diabetes Program, California Tobacco Control Program and the California Smokers' Helpline to assist their patients with diabetes to quit smoking. “Do you cAARd?” (Ask, Advise, Refer) challenges diabetes educators to give patients who smoke or chew the California Gold Card, a marketing piece that urges smokers to call the Helpline at 1-800-NO-BUTTS.

While the survey elicited fewer examples of robust programmatic integration (shared workplans, integrated interventions, combined funding and linked data), there were certain types of activities most commonly reported for these categories. For example, survey participants noted taking part in the development of specific chronic disease plans and working together to train healthcare providers – ensuring that cessation is a routine element of care. One state reported partnering with their Breast and Cervical Cancer program to develop a specific fax-referral form for partners to use in referring clients to the quitline. They are also tracking calls generated to the quitline as a result of this program in order to measure results. Another state works with their statewide diabetes professionals’ network to offer free nicotine replacement therapy to diabetics who call the quitline — a great example of combining resources and efficiently using existing infrastructure.

In Washington, the state tobacco program has developed a strong linkage with the diabetes program through their joint work with the Washington State Diabetes Collaborative. Not only does the tobacco program provide funds to the Collaborative, additionally one of the performance measures for Collaborative participants is intervening with patients and referring to the state quitline. Quitline promotion materials and information are available at all Diabetes Collaborative learning sessions and these materials are routinely distributed to the participating clinics.

Project Filter (the Tobacco Prevention and Control Program of Idaho) partnered with the Idaho Asthma Prevention and Control Program to develop an intervention to decrease smoking during pregnancy and exposure to secondhand smoke during pregnancy and infancy. The intervention, Keeping Infants Safe from Smoke (KISS), includes physician and public educational materials including educational brochures and posters/billboards and an educational gift package for new mothers containing cessation resources, namely promotion of the Idaho QuitLine.

“We also have routinely provided cessation self-help materials as well as quitline cards and information to the community outreach workers that work directly with the clients in encouraging positive behavior change.”

– Survey Respondent

Additional Highlights From Practice

Oregon Pools Resources to Address Chronic Disease Prevention and Management

Tobacco control efforts in Oregon are guided by the Centers for Disease Control and Prevention's (CDC) best practices. The reduction of tobacco use and exposure to secondhand smoke in Oregon demonstrates that policies and environmental and system changes are critical in changing social norms and behavior around tobacco use and exposure. This experience provides a solid foundation for expanding chronic disease prevention, early detection and management efforts for tobacco-related and other chronic diseases at the local level. In 2007, the Public Health Division's tobacco prevention and education, physical activity and nutrition, arthritis, asthma, comprehensive cancer, diabetes and heart disease and stroke programs agreed to pool resources and funding to address chronic disease prevention and management through a public health approach at the local level.

The collaboration resulted in Oregon's Chronic Disease Program: Building Capacity based on Local Tobacco Control Efforts, whose purpose is to assist local public health authorities (LPHAs) in planning a population-based approach to reduce the burden of chronic diseases most closely linked to physical inactivity, poor nutrition and tobacco use. Such chronic diseases include: arthritis, asthma, cancer, diabetes, heart disease, obesity and stroke. In Oregon, tobacco use is the single most preventable cause of death and disease; poor nutrition and physical inactivity together are second.

The Health Promotion and Chronic Disease Prevention (HPCDP) Section has selected 12 County Health Departments to participate in a nine month Chronic Disease Training Institute in 2008. The Training Institute will provide training and technical assistance on community assessment and planning for local chronic disease prevention and health promotion programs. During the Institute, County Health Departments will develop a work plan specific to each locality. Curriculum in the Training Institute will be based on CDC best and promising practices in tobacco control, physical activity, nutrition, arthritis, asthma, cancer, diabetes, heart disease, obesity and stroke.

At the local level, participants will work to develop capacity to address chronic diseases through a population-based approach. The Institute will focus broadly on policy and environmental changes that influence the prevention and management of chronic diseases, rather than individual services, health education or access to health care. Collaborating programs are hopeful that this endeavor will foster new partnerships between public health and

community partners and build local capacity to address major chronic disease risk factors in Oregon. While still very early in the process, this is one linkage to keep our eyes on.

Ohio Tobacco Quit Line Partnership with Ohio Hospital Association

One of the goals of the Ohio Tobacco Prevention Foundation (OTPF) was to increase referrals from the medical/health care community to tobacco treatment services, notably the quit line. The goal aimed to make referrals a standard clinical protocol, particularly in the area of chronic diseases. Additionally OTPF worked to sustain the Ohio Tobacco Quit Line, institutionalize tobacco treatment services in clinical practices and reach those with a higher risk of tobacco related morbidity and mortality. In order to enhance this work Quit Line Expansion funds from CDC (via the Ohio Department of Health) were used to write and distribute a Request for Proposal (RFP) requesting a cadre of outreach workers to: create "Ohio Quit Sites"; train health care providers in the use of the *Public Health Service Treating Tobacco Use and Dependence Clinical Practice Guideline (Guideline)*, including how tobacco use affects various chronic diseases and healing; and increase referrals to the Ohio Tobacco Quit Line.

An "Ohio Quit Site" was defined in the RFP as a site that included tobacco use screening systems that are integrated into the intake system of the institution and prompt providers to offer brief cessation advice to each tobacco user, including the use of the Fax Referral form. Several proposals were submitted, but the one of most interest came from the Ohio Hospital Association (OHA). Instead of creating a cadre of outreach workers, they proposed to provide large scale training to providers, predominantly those in cardiopulmonary and respiratory disease departments, in all hospitals throughout the state and offer incentives to become an "Ohio Quit Site." The Ohio Tobacco Quit Line was gathering information on callers who had asthma, chronic bronchitis, emphysema, COPD, history of seizures, history of heart disease or hypertension and diabetes, so OTPF was able to track quitline callers with chronic diseases.

In the first year, 243 hospital staff members from 91 hospitals attended a day-long training that included information on the impact of tobacco use on chronic diseases, tobacco addiction and treatment focused on the *Guideline*; how to become a quit site and information on the Ohio Tobacco Quit Line and use of the fax referral form to the quit line. In order to receive a \$1,000 incentive to become an "Ohio Quit Site" the hospitals needed to attend the one-day training,

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Additional Highlights From Practice *(cont'd from page 3)*

assign a designated person to be a liaison between the OHA staff and the hospital and sign a letter of agreement indicating the intention of the hospital to become a “Quit Site” by making systemic changes to integrate tobacco control into daily protocols. They also had to commit to implement the main components of the *Guideline*, make valid referrals to the quitline and track the number of referrals made. In addition, it was required by the hospital to provide education to all the respiratory and cardiopulmonary health care workers with direct patient contact on the 3A’s and R and also on the protocol for using the fax referral. Of the 243 hospital staff, over half worked in cardio/pulmonary and respiratory departments, 17% were in wellness and a third were in administration and patient services. Of the 91 hospitals in attendance, 48 signed on to be an “Ohio Quit Site.” Prior to the training most of the “Ohio Quit Site” hospitals had not been faxing referrals to the Ohio Tobacco Quit Line. Some did refer to the Ohio Tobacco Quit Line less formally, either by listing it on a brochure and/or personally telling patients about it. Fax referrals increased by the end of the first year and 100 referrals a month were added to the total by participating hospitals.

The following year, OHA wanted to not only increase referrals, but also increase valid referrals. Therefore, two trainings were provided and 42 of the 48 “Ohio Quit Sites” attended. Five monthly telephone conference calls were made with further training along with questions and answers, plus the listserv developed in year one was continued. Faxes did double and contributed to 15% of all faxes received by the quitline. Enrollment rate, unfortunately, remained around 20%. On the other hand, it was discovered that:

- Hospitals identifying and documenting tobacco users increased from 72% to 87%;
- Health care providers providing brief interventions increased from 56% to 70%;

- Referrals to the quitline increased from 43% of the time to 53%.

The percentage of callers with chronic disease did not increase, although the numbers did. The percentage of callers with chronic disease remained around 30% before and realized a slight increase after this endeavor, yet not one of statistical significance. Anecdotally, hospitals that were providing only pamphlets for cessation are now integrating tobacco identification and brief interventions and referrals into their system as a result of this grant without any further funding from OTPF. Some hospitals expanded their three critical pathways to all chronic diseases for smoking cessation services. OTPF hopes that these integrated systems have become and will remain institutionalized within hospitals throughout the state and mortality to those with chronic diseases are reduced and time spent in the hospital is limited.



What Have Been the Measured Benefits of Working Together?

The most notable measured benefit identified by survey respondents was the increase in calls to the quitline by the chronic disease target audience. Increased awareness of the quitline by chronic disease program staff and/or their clients was also an important measured benefit. Three survey respondents were impressed by the increased number of fax-referrals from health care providers trained as a result of a project with chronic disease partners. Many of these linkages are fairly new, so the ability to report measured benefits at this time is limited. However, we do know that tobacco programs, and quitlines in particular, are paying careful attention to measuring, evaluating and reporting success.

Why are these Linkages Happening?

Five of the 19 survey respondents with linkages to chronic disease programs mentioned a funding requirement of the CDC's Office on Smoking and Health Quitline Enhancement Funding Opportunity, which requires working with chronic disease programs as a primary impetus for finding ways to partner. Many more mentioned that they are seeing an increase in "collaboration and integration funding requirements" and anticipate this to be a future norm in public health funding administration.

Five survey respondents stated that their public health leaders' growing determination to find ways to integrate programs and develop shared solutions was a primary reason for linking. Rarely did survey respondents note that their primary reason for linking the quitline with chronic

disease programs was data-driven, although certainly many did note that once a linkage was formed, data review was important.

"Although it wasn't the product of a formal needs assessment, our section manager heeded the call to integrate. The impetus came from CDC and our own leadership, as well as from our local partners, who were sick of trying to address chronic disease one disease or risk factor at a time. We realized that with reduced disease-specific funding and increasing prevalence of most chronic diseases, our 'divide and conquer' approach wasn't working. The epidemiological data certainly bear the point out!"

– Survey Respondent

Barriers and Solutions for Moving Ahead

While increasing calls to the quitline by those with chronic conditions is a likely goal of linking quitlines and chronic disease programs, it is important to remember doing so without also increasing the capacity of the quitline to respond to these calls is troublesome. Many states may be hesitant to embark on additional promotions or partnerships as it may be challenging to sustain services under increased call volume due to budget constraints.

Linking with chronic disease programs simply may not include combined funding to implement strategies, especially in the first few phases of a project together. In fact, it is important to remember that a great deal of funding is disease or risk factor specific and may be unavailable to integrated programs. However, are there ways to integrate quitline promotion or quitline services into already-existing programs and materials? If so, this may be the best or only opportunity for linking.

Think Before You Leap

When deciding whether or not to link with a chronic disease program, take time to consider:

- The mission, vision and priorities of the specific chronic disease program. Is there any way to link these with the mission, vision and priorities of yours? Is there overlap? If not, what would have to change for both programs in order to work effectively together? Once a greater degree of common understanding is reached among programs, true movement toward integration can happen. Remember, starting small in order to promote the development of mutual interests is never a bad idea.

- **What the data tell you.** Know how the epidemiological data call for such a linkage – especially in light of many competing program priorities (yours and theirs). What are the tobacco use rates for the target population? What are the benefits to this population once they quit using tobacco? Do you have quitline data for this population (volume, satisfaction, quit rates)? You'll want a keen understanding of these data for your own planning and priority-setting processes, but you'll need these data to facilitate buy-in from chronic disease program staff as well.
- **How you will measure success.** Success should be jointly defined and the criteria for determining success measured routinely. For example, if the goal is increased calls to the quitline by those with a certain condition, you'll want to make sure that you consistently report quitline data for these callers back to your partners in order to measure success, plan for adjustments and anticipate future challenges. It goes without saying that you'll need to work closely with your quitline service provider to collect this information from callers and report it.
- **Misconceptions about the quitline.** Don't jump right in assuming that everyone knows exactly who the quitline serves, with what services and how well. Take time to share this information and be open to questions about the quitline's limitations (funding restrictions, programmatic boundaries, etc.) and those of the quitline service provider. The chronic disease program staff should have a good understanding of how you work together with your service provider to deliver quitline services to tobacco users throughout the state.

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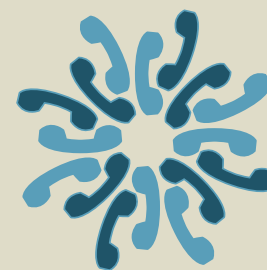
- **They know chronic disease and you know tobacco.** The chronic disease program staff with who are working are experts — not necessarily in tobacco cessation, but they know their clients, their systems and are trusted by these clients and systems, something that takes more time than you may have to build. Use it! A powerful question to start with is, “We know that X% of the people with diabetes smoke in our state and we know that at least some of them are calling the quitline. We want to ensure that they are receiving the best possible intervention when they call. What are your thoughts on this? Are there referrals to local resources that our quitline should be making? Should we take six months and collect information on the number of diabetics who call the quitline to gain a better sense of their use of the quitline?”
- **Preparing quitline staff.** Lastly, ensuring that the quitline has the capacity to serve an increase in callers as a result of an effective linkage is not the only type of “capacity” for which you will need to prepare. What is the capacity of quitline counselors to deliver a safe, well-informed intervention to a person with a particular chronic disease? Is there additional training on contraindications for nicotine replacement therapies and other cessation medications that needs to occur?

Conclusion

Developing and maintaining linkages with chronic disease programs is becoming more and more important for state-based quitlines. These linkages may stem from a funding requirement or may result from a review of data that highlights incredibly high prevalence rates for those with a particular chronic disease. Together quitlines and chronic disease programs are quickly learning how best to lay the foundation for this important work, engage partners with missions and priorities different from our own and ensure access to quitline services by those with chronic conditions that are further impacted by continued addiction to tobacco.

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The findings and conclusions in this report are those of the author(s) and do not necessarily represent the official position of the funding agency.



About the North American Quitline Consortium (NAQC)

NAQC is a nonprofit organization that strives to promote evidence based quitline services across diverse communities in North America. By bringing quitline partners together, including state and provincial quitline administrators, quitline service providers, researchers and national organizations in the United States, Canada and Mexico, NAQC helps facilitate shared learning and encourages a better understanding of quitline operations, promotions and effectiveness to improve quitline services.

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