Context
Between 1998 and 2004, the U.S. and Canada moved from having a handful of quitlines located in progressive jurisdictions to creating two robust networks of quitlines that span the U.S. and Canada. These quitlines are deeply rooted in public health and have become a foundational element of tobacco control activities. There has been a long history of referrals from medical care providers to quitlines and in some quitlines a very large proportion of the callers who receive treatment have been referred from the medical care sector. Given the current uncertainty regarding funding for quitlines at both the state and federal levels and the push to institutionalize quitlines and other cessation services as a regular part of medical care, it may be useful to consider the role of quitlines in each sector and identify characteristics that may distinguish quitlines in the public health sector from those in the medical care realm.

Goal
To better define the role of and responsibility for quitlines in public health and medical care; to consider ways in which public health and medical care may differentiate their quitline services while coordinating efforts to increase outreach to make services available to all tobacco users.

Importance of This Topic
Over the past 18 months, NAQC has been asked to respond to a growing number of state legislative inquiries about the rationale for funding state quitlines, given that the Patient Protection and Affordable Care Act (ACA) requires cessation to be included as a regular part of medical care. Whether this political inquiry is generated by a genuine concern about duplication of services or by a desire to free-up some funding in a tight state budget, it is a question that we are called to answer.

Existing Data
While limited quantitative data exists about quitline services in the medical care sector, NAQC staff has gathered qualitative data from key informant interviews with service providers, a recent webinar on the topic, and feedback from participants at NAQC Conference 2017.

During the January webinar, Optum presented a slide that sheds light on the types of services provided by state quitlines compared to the medical care sector.

<table>
<thead>
<tr>
<th>Services Offered</th>
<th>State Quitlines</th>
<th>Medical Care Quitlines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• State tobacco Quitlines are a public health approach</td>
<td>• Services are similar to state tobacco quitline but more comprehensive and consistent.</td>
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<td></td>
<td>• Single call and multiple call lines</td>
<td>• More comprehensive list of FDA approved cessation medications including prescription medications</td>
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<td></td>
<td>• Largely limited to providing OTC NRT starter kits</td>
<td>• Full regimen of cessation medications (as opposed to 2 or 4 week kits)</td>
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<td></td>
<td>• State quitline callers are more likely to be unemployed and low income than</td>
<td>• Client Services assists with promotional activity, engagement strategy and incentives</td>
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<tr>
<td></td>
<td>commercial participants</td>
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<td></td>
<td>• Quit rates are lower than commercial</td>
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<td>• Provide <em>coordination of care</em> by triaging Quitline callers to health plans and employers for more comprehensive services</td>
<td>• Higher participation rates with direct contract due to alignment with existing wellness promotions</td>
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*Source: Optum*

Optum and National Jewish Health also noted differences between public health and medical care in the reasons for purchasing services, knowledge about quitlines, and expectations of the services and service providers.

**Closing the Gaps**

Within the Consortium, the perspectives on the role of public health and medical care with respect to quitlines are diverse, as demonstrated by feedback received from participants at NAQC Conference 2017 (see excerpt 1-5, below).

1. What should be the role and responsibility of quitlines that serve the public health sector?
   - At a minimum serve uninsured/underinsured (which are harder to define)
   - To fill the gaps in services
   - Proactive outreach
   - Focus on high quality robust services with broad eligibility, i.e., effective population-based strategy
   - Frame the quitline as a safety net for uninsured/underinsure offering minimum recommended cessation services
   - Morph where the need is and provide a menu of services that meets people where they are

2. What should be the role and responsibility of quitlines that serve the medical care sector?
   - Referral/transfer caller to cessation services they are eligible for and raise awareness of those cessation services
   - Focus on high risk populations, integrate with chronic disease management
   - Shift responsibility of quitline referrals from physicians to mid-level providers and use EMR data on tobacco users to identify people for referral

3. What level of service should public health pay for?
   - Full safety net service
   - All levels of services (counseling and NRT) to meet the tobacco users where they are
   - Service and public education/promotion
   - Coordinate with medical providers and payers to find appropriate levels of services

4. What level of service should the medical care sector pay for?
   - More intensive services and integration into chronic disease management
   - Access to the service, the service itself. Incentivize tobacco assessment by providers with feedback reporting

5. How should the two sectors work together?
   - More data sharing to review level of service. Collaboration on reach.
   - Each state is different and the models for approaching the collaboration will vary
   - Medicaid coverage is the intersection of these two sectors and should therefore be a priority in terms of finding a service model that works across all states
   - Quitlines provide the best evidence based service and health care sector should “buy-in” to provide funding support to quitlines
• Service providers may be able to work together to triage callers to eligible services offered through employers/health plans

**Next Steps for NAQC to Consider**

Convening discussions among key stakeholders to gain an understanding of diverse perspectives will be important. Other activities may arise from the discussions.

• Continue discussions with quitline services providers and the state agencies that fund them to assess perspectives, determine how services may be differentiated, identify models that work across different types of states and that encourage collaboration with medical care, especially on reach and priority populations such as Medicaid. Create a digestible, short paper that describes the “state quitline” perspectives and includes an executive summary.

• Bring together the state quitline and medical care sectors to discuss the short paper that was developed above and ensure all perspectives are addressed. Enhance the paper to include the perspectives of the medical care sector. Identify opportunities to align the perspectives of state quitlines and the medical care sector. Engage people/organizations that have already successfully tackled this issue and have best practices.

• Consider ways to collaborate, possibly through pilot efforts in select states.

• Develop resources that will help educate the stakeholders and support collaborative efforts.

**References and Resources**

1. Key informant interviews with quitline service providers held in April 2017.