Published in final edited form as:
Prev Med. 2014 March ; 60: 134–135. doi:10.1016/j.ypmed.2013.12.025.

Leveraging the US tobacco quitline infrastructure to promote oral health: Feedback from key stakeholders

Jennifer B. McClure
Group Health Research Institute

Oral disease affects tens of millions of Americans. It results in unnecessary pain, physical disfigurement, emotional suffering, and puts individuals at greater risk for morbidity and mortality.[1] Treating oral disease and preventing future disease are important public health goals.

Tobacco users are an important target for oral health promotion efforts. Smokers are three-times as likely as non-smokers to have gum disease[1] and have a higher prevalence of untreated tooth decay.[2] They are also less likely to visit the dentist [3,4] and more likely to engage in other behaviors that increase their risk for oral disease, such as drinking alcohol [5,6] and eating a poor diet.[7] Nearly 20% of US adults are current smokers.[8]

Tobacco cessation counselors could prove an important ally in promoting better oral health among smokers, especially in activating smokers to see a dentist and engaging them in better oral self-care including quitting smoking, improved daily hygiene, use of fluoride, dietary change, and decreased alcohol consumption. Partnering with tobacco quitlines could be a particularly effective strategy to achieve this goal. Quitline counselors are already trained in motivating and supporting behavior change. Additionally, tobacco quitlines have broad reach. Nearly 440,000 Americans received free services from publically-funded quitlines in 2010 alone.[9]

Two recent surveys of tobacco quitline callers confirmed smokers' interest in improving their oral health, as well as opportunities to promote improved oral hygiene behavior (daily brushing and flossing) and utilization of regular professional dental care.[10,11] To explore the feasibility of partnering with U.S. tobacco quitlines to counsel smokers about better oral health, we interviewed key stakeholders from Alere Wellbeing (the leading US tobacco quitline service provider) and 21 of the states with whom they contract their services. Both groups were generally supportive of offering an integrated tobacco cessation-oral health promotion program and noted that the dual focus could open new sources of state revenue to support the quitline infrastructure (e.g., public funding for oral health promotion). The latter

Corresponding author: Jennifer B. McClure, PhD., Director of Research, Faculty, & Development, Group Health Research Institute, 1730 Minor Ave, Suite 1600, Seattle, WA 98101, Phone: +1-206-287-2737, Fax: +1-206-287-2871, mcclure.j@ghc.org.

Conflicts of Interest
The author has no conflict of interest to report.

has particular relevance in light of recent funding cuts to many state quitlines. However, several realistic concerns were raised. First, stakeholders agreed that the program should not improve oral health behaviors at the expense of decreasing tobacco abstinence rates. To be successful, both behaviors must be impacted positively. Next, all oral health promotion activities and materials should fit within the existing quitline infrastructure (e.g., brief phone counseling with supplemental intervention delivered by mail, Internet, and/or text messaging). Finally, since many quitline callers may not have dental insurance, the intervention should refer people to local low-cost dental professionals (e.g., local dental schools or other low-cost resources) and focus on what people can do on their own to improve their oral health outcomes, in the absence of professional dental care. In addition to stopping use of tobacco, the latter includes proper daily oral hygiene (brushing and flossing), use of fluoride, healthy nutrition, limited alcohol use (given the synergistic effects of tobacco and alcohol in promoting oral cancers),[1] and oral self-screenings to identify issues in need of professional dental care before they advance.

Future research needs to establish the effectiveness and cost-effectiveness of integrating oral health promotion counseling with standard quitline cessation counseling, but this feedback from relevant program stakeholders provides further confirmation that this strategy is feasible for many state quitline programs and worth exploration. The specific guidance offered can inform the optimal design of this program, as well as offer insight into the design of other dual-behavioral programs offered to quitline callers. With recent reductions in public health funding, leveraging our existing infrastructures to expand their impact with minimal additional costs may become increasing important. Public health officials, funders, and researchers are all encouraged to consider these opportunities for the future.

Acknowledgments

This work was supported by the National Institute of Dental and Craniofacial Research (R21 DE19525 & R34DE022784, J. McClure, PI). Thanks to Susan Zbikowski, PhD, Jackie Saint-Johnson, and Karin Riggs, MSW for their assistance with this work. Additional thanks to everyone at Alere Wellbeing and each of the participating state departments of health who assisted with this work.

References

1. Centers for Disease Control and Prevention. Oral health: Preventing cavities, gum disease, tooth loss, and oral cancer--At a glance 2010. Atlanta, GA: Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion; 2010.
2. Centers for Disease Control and Prevention. Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel flourosis--United States, 1988–1994 and 1999–2002. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2005.
3. Bloom, B.; Adams, PF.; Cohen, RA.; Simile, C. Smoking and oral health in dentate adults aged 18–64. U.S. Department of Health and Human Services; 2012.
4. Mucci LA, Brooks DR. Lower use of dental services among long term cigarette smokers. J Epidemiol Community Health. 2001; 55:389–93. [PubMed: 11350994]
5. Falk DE, Yi HY, Hiller-Sturmhofel S. An epidemiologic analysis of co-occurring alcohol and tobacco use and disorders - Findings from the National Epidemiologic Survey on Alcohol and Related Conditions. Alcohol Res Health. 2006; 29:162–71. [PubMed: 17373404]
6. Kahler CW, Strong DR, Papandonatos GD, et al. Cigarette smoking and the lifetime alcohol involvement continuum. Drug Alcohol Depend. 2008; 93:111–20. [PubMed: 17964082]

7. McClure JB, Divine G, Alexander G, et al. A comparison of smokers' and nonsmokers' fruit and vegetable intake and relevant psychosocial factors. Behav Med. 2009; 35:14–22. [PubMed: 19297300]

8. Centers for Disease Control and Prevention. Current cigarette smoking prevalence among working adults --- United States, 2004–2010. MMWR Morb Mortal Wkly Rep. 2011; 60:1305–9. [PubMed: 21956406]

9. [Accessed December 7, 2012] 2010 Survey final results (full report): U.S. and Canada. 2012. at http://www.naquitline.org/?page=survey2010

10. McClure JB, Riggs KR, St John J, Cerutti B, Zbikowski S. Understanding oral health promotion needs and opportunities among tobacco quitline callers. Public Health Reports. 2012; 127:401–6. [PubMed: 22753983]

11. McClure JB, Riggs K, St John J, Catz SL. [More] evidence to support oral health promotion services targeted to smokers calling tobacco quitlines in the United States. BMC Public Health. 2013; 13:336. [PubMed: 23577873]