Executive Summary

NAQC's Issue Papers aim to provide critical knowledge on important quitline topics and guidance for decision making.

Quitlines in the U.S.: An Exploration of the Past and Considerations for the Future

Executive Summary and Recommendations

INTRODUCTION

The North American Quitline Consortium (NAQC) has engaged its members, leadership and partners in a multi-pronged, multi-year approach to defining the future vision of quitlines and most importantly, identifying the role NAQC may play in making that vision a reality. *Quitlines in the U.S.: An Exploration of the Past and Considerations for the Future*, a NAQC issue paper authored by Dr. David Tinkelman, serves to outline the current status of state quitlines and describe how they are responding operationally to improve efficiency and serve as leverage points for broader cessation initiatives with new and existing partners. The issue paper also highlights best and promising practices for integrating quitlines into the broader healthcare landscape and serves to inform decision-making on strategic planning, determining specific goals and objectives of a state quitline and sustainability planning for the future.

This Executive Summary presents highlights from Dr. Tinkelman's paper and recommendations that were developed by NAQC staff in collaboration with NAQC's Advisory Council and Board of Directors. These recommendations express NAQC's priorities for moving toward the future vision for quitlines defined by NAQC in collaboration with it members, leadership and partners. As NAQC celebrates its 10 year anniversary, the quitline community remains committed to ensuring that tobacco users are encouraged to quit, that high-quality cessation services are readily available to all who want to quit, and that we stand ready to move collectively toward a future vision of the role we will play in this critical effort.

THE BURDEN OF TOBACCO ON HEALTH

The most recent Surgeon General's report, *The Health Consequences of Smoking--50 Years of Progress,* documents that nearly 42 million adults and more than 3.5 million middle and high school students continue to smoke cigarettes.[1] Over the past 50 years, the U.S. government attributes more than 20 million premature deaths to smoking and exposure to secondhand smoke and estimates the current annual smoking-attributable mortality in the U.S. as 480,000.[1]

However, tobacco smoke not only affects those who use tobacco products. It is clear that exposure to secondhand smoke is associated with both acute and chronic illness. Children of smokers experience a higher incidence of ear infections and asthma[2] and it is estimated that 7,500 to 15,000 hospitalizations of children annually are directly related to the effects of being exposed to their parents' tobacco smoke.[2] Effects of side-stream smoke (smoke emitted between puffs of a burning cigarette, pipe, or cigar) are better understood every year, and it is clear that those who spend a lot of time around cigarette smoke are at higher risk of developing acute and chronic affects because of it.

ADDRESSING THE TOBACCO PROBLEM IN THE U.S.

Over the past two decades, tobacco prevention and control efforts have dramatically increased and positive results have been achieved toward the goal to eliminate tobacco consumption in the U.S. Some of the more common, evidence-based programs include:

- *state and federal price and tax increases;*

- *smoke-free air laws;*
- *community-based face-to-face cessation counseling programs;*
- *school-based educational programs;*
- *employer-sponsored smoking cessation programs;*
- *state and private quitline programs; and*
- *subsidized or free pharmacotherapy programs.*

All of these efforts have gradually but dramatically reduced tobacco consumption from a nationwide smoking prevalence of 42% in 1965 to 18% in 2012.[1] While initially, over the past 10 years, the rate of decline in smoking prevalence was fairly significant, the rate of decline in the number of smokers has recently slowed.[3] With tightening budgets, these tobacco control programs need to be evaluated with respect to cost effectiveness and their ability to reach vulnerable populations. Having an understanding of how these programs were developed and have evolved will help shape the vision for the future of these important tobacco cessation resources.

STATE QUITLINES, PAST AND PRESENT

The first toll-free tobacco cessation services were developed as extensions of toll-free cancer hotlines in the early 1980's in Europe and Australia. In the following years, free telephonic programs were developed specifically to help smokers quit in both Australia (Quit Victoria) and in England (UK Quit). These programs became the model for the development of similar programs throughout Europe and the U.S.[4]

Although providing a service to smokers, quitlines of the 1980's were not initially subject to scientific evaluation or evidence-based. Over the next decade, numerous scientific papers were published evaluating the efficacy of state quitlines and the use of pharmacotherapy as part of these programs. A major result of the scientific efforts to evaluate the effectiveness of quitlines was the statement in the U.S. Department of Health and Human Services Clinical Practice Guideline, *Treating Tobacco Use and Dependence,* that quitlines are effective, citing a meta-analysis based on nine studies.[5] As a result of the emphasis on reducing healthcare costs associated with tobacco use, funding from state and federal governments and the Master Settlement Agreement (MSA), and the rigorous scientific validation of these programs, today there are 53 quitlines that offer a variety of services to help current tobacco users quit in the U.S.

GOALS OF STATE QUITLINES

Quitlines have the capability of reaching large numbers of individuals and, therefore, the potential to serve as an effective, population-based public health intervention reducing the impact of tobacco use on entire populations. NAQC has monitored the performance of state quitlines since 2004. Most recent data on key performance measures show:[6]

- *state quitlines received over 1.3 million calls, including approximately 488,000 calls from unique tobacco users in fiscal year 2012;*
- *state quitlines provided evidence-based treatment to just over one percent of smokers in fiscal year 2012; and*
- *states invested approximately $1.53 per smoker in quitline services in fiscal year 2012.*

However, it is more meaningful to focus on the specific tobacco control-related goals and objectives for each state when working to better understand the goals of individual state quitlines. States have varied priorities which dictate the goals and objectives for their quitlines and these are shaped by many factors which may include:

- *state demographics;*
- *tobacco-related healthcare costs affecting specific vulnerable populations within the state;*
- *relationships between public and private entities;*

- *Medicaid strategic goals;*
- *integration of the state quitline into the public health policies of the state;*
- *political priorities; and most importantly*
- *the availability of state and federal funds to promote and perform quitline operations.*

The differing goals between states shape the diverse services that are offered and influence the varied outcomes that are measured.

THE ROLE OF QUITLINES IN STATE PUBLIC HEALTH POLICY AND TOBACCO CONTROL PROGRAMMING

Quitlines are being utilized by states to maximize and support tobacco control and public health efforts in many important ways.

Quitlines support state government in tobacco control policy implementation. Having an existing, evidence-based cessation resource readily available has allowed states the ability to offer tobacco users free help with quitting, while at the same time promoting policy change.

Quitlines help state governments address the health needs of priority populations. States across the country have identified priority populations that have higher tobacco use rates and that have had inadequate access to healthcare. State quitlines allow for targeted promotion of tobacco cessation that is linguistically and culturally appropriate.

Quitlines help state governments build relationships and partnerships with the private sector. Difficult economic times are preventing many states from offering quitline services to all residents. To address the gap in tobacco cessation programming, several states have reached out to private industry to develop cost-sharing partnerships that would provide the quitline as a valued resource for a broader population of tobacco users.

Quitlines help support broader state government public health strategies. Several states are working toward integration of their quitlines into a more holistic approach to serving individuals with multiple chronic diseases and medical problems, as well as providing support to prevent the occurrence of tobacco-related chronic illnesses.

Quitlines help states build relationships with health systems and providers. For over ten years quitlines have been strategically placed at the center of states' health systems change, provider training, and outreach and referral network-building efforts. There are many ways that state health departments can enhance their work with health systems and providers in order to maximize their limited resources and obtain the best possible health outcomes for their residents.

DIVERSITY OF STATE QUITLINE SERVICE OFFERINGS

Funding for state quitlines varies considerably and quitline funding in a particular state may vary from year to year, depending on the state budget and the availability of federal funding.

The variety of services provided, as well as the variation in the populations that are able to utilize these publicly-provided services, depends on availability of funding by the states. The variability amongst state quitlines is most often seen in the categories below.

Eligibility criteria: Differences in the criteria for determining who is eligible to receive quitline services have significant impact on the ability to reach the target populations, as well as the potential quit rates that are achieved within different demographic groups.

Referral systems: As a service to healthcare providers, state quitlines have established communication systems that allow providers to refer smokers to quitlines for treatment. Although differences between quitlines have decreased in this area, there are vast differences in the ability to receive direct referrals from electronic medical systems and report patient outcomes back to referring providers.

Web-based services: Quitlines have been using web-based services as stand-alone programs or as adjuncts to their telephonic programs for about 10 years. New to this area of online support is the introduction of text messaging and social support networking.

Number of proactive calls offered: There is tremendous variability in the number of proactive calls provided from state quitlines. Not only does the number vary between states, it may vary during the year within the same quitline depending on the availability of funding. This variability results in different outcomes directly proportional to the level of service provided.

Types and amounts of tobacco cessation medications offered: Not all states have the funds to offer free cessation medications, and the types and amounts offered vary considerably. It is without question that the amount and types of medications affect the number of tobacco users reached by a quitline, as well as its quit rates.

Promotion: State budgets were severely challenged after 2008 and reducing and/or eliminating promotional messaging for tobacco cessation programs was a common occurrence for many states.

Detailed information on the service offerings in each state is provided in NAQC's profiles of state quitlines. Readers may also be interested in browsing NAQC's review of the evidence and recommendations on quitline service offering models.

THE ROLE OF ORGANIZATIONS IN THE FUNCTIONING OF QUITLINES

Various public (state and federal) and private entities affect the sustainability, operations, reach and outcomes of state quitlines. Understanding the roles played by stakeholders in the current functioning of quitlines is an important element of strategically planning for the future.

Role of State Tobacco Programs and Other State Agencies that Fund Quitlines

State quitlines function within a greater statewide framework of public health policies and systems and provide valuable tobacco cessation, disease prevention and information gathering services to the state. State tobacco control programs and other state agencies that fund quitlines played a key role in establishing quitline services in the U.S. and continue to be very involved in ensuring quality control of cessation offerings, coordination of efforts among other state government entities engaged in cessation and addressing sustainability through cost-sharing and other partnerships. Quitlines may function under state health departments, tobacco cessation agencies, as independent entities established by states as a result of the MSA with some state oversight, or as an agency residing within any of these but funded only by state-regulated tobacco taxes. In all cases, state governments have influence over the organization and operations of the quitline for their state.

Role of Quitline Service Providers

The primary function of quitline service providers is to perform the operations of the quitline (e.g., accept calls, offer various telephonic and internet-based services) to help it attain the broad goal of tobacco cessation. Service providers

vary throughout the U.S. with call centers operated by universities, academic medical centers, non-profit agencies, private for-profit companies, and large, publicly-traded corporations. Depending on the relationship between the state quitline funder and its service provider, the activities of service providers can vary considerably.

Role of the U.S. Department of Health and Human Services

The U.S. Department of Health and Human Services (HHS) is the principal federal agency for protecting the health of all Americans. Three of the HHS agencies – the Centers for Disease Control and Prevention (CDC), the National Cancer Institute (NCI) at the National Institutes of Health and the Food and Drug Administration (FDA) – all have played key roles in the development and advancement of state quitlines in a variety of ways, including as an important convener of multiple agencies and organizations to work on common interests, direct support for programs, and strategic leadership.

Role of the Centers for Disease Control and Prevention

Through its Office on Smoking and Health (OSH), the CDC is the lead federal agency for tobacco prevention and control. Its mission is to reduce the death and disease caused by tobacco use and exposure to secondhand smoke. It provides expertise and advocacy for tobacco control within HHS, leads strategic planning activities, provides funding for public health activities, conducts applied research and surveillance activities, and offers technical assistance to the states, territories and national organizations. For the past three years, the CDC has also played a major role in raising awareness of the tragic side effects of tobacco exposure to the entire country, through its national tobacco education media campaign, *Tips from Former Smokers*. This campaign has had a major impact on quitlines across the country.

OSH has played a pivotal role in advancing cessation and quitline services by providing national strategic leadership, making funding available for quitline services and technical assistance, establishing a national quitline data warehouse, launching a national tobacco education media campaign and publishing best practices for comprehensive cessation programs.

Role of the National Cancer Institute

The NCI, the federal government's principal agency for cancer research and training, is located within the National Institutes of Health at HHS. Within NCI, both the Cancer Information Service (CIS) and the Tobacco Control Research Branch (TCRB) have been active in advancing state quitlines for many years. Since 2004, CIS has operated the national portal (1-800-QUIT-NOW) that directs telephone calls from anywhere in the U.S. to the appropriate state quitlines. In 2013, NCI developed a new portal for Spanish-speakers (1-855-DEJELO-YA). The TCRB has played a role in funding quitline research and program activities, convening meetings of tobacco cessation researchers, leading development and maintenance of www.smokefree.gov (the HHS website for smoking cessation), and developing social media applications for cessation.

Role of the Food and Drug Administration

Two centers within FDA are relevant to the operations of state quitlines. The Center for Tobacco Products (CTP) oversees the implementation of the Family Smoking Prevention and Tobacco Control Act. Some of the Agency's responsibilities include setting performance standards, reviewing premarket applications for new and modified risk tobacco products, requiring new warning labels, and establishing and enforcing advertising and promotion restrictions. Recently, the FDA launched a youth tobacco prevention public education campaign. This activity directly affects quitlines with respect to the response of this campaign.

The Center for Drug Evaluation and Research (CDER) regulates over-the-counter and prescription drugs, including tobacco cessation medications. CDER recently held public hearings on actions related to nicotine replacement therapies and smoking-cessation products.[7] CDER's action may have an impact on the ease with which quitlines and their clients use cessation medications.

Role of Public Policy Makers

Federal and state public policy makers are responsible for adopting and implementing various aspects of tobacco control policy: clean-indoor air regulations, marketing restrictions, youth access laws, and taxation of tobacco products. In addition to setting and ensuring enforcement of these laws, policy-makers may also play a leadership or "influencer" role when it comes to tobacco use and quitting. They play a key role in presenting budgets and determining appropriations for tobacco control programs.

For state quitlines, policy-makers play a key role in ensuring funding and sustainability for services and promotion. More recently, both federal and state executive branch policy makers have begun to play a role in identifying new sources of funding for quitlines.

Role of Advocates and Other Partner Organizations

National advocates and non-profit organizations have played, and continue to play, a key role in the establishment, maintenance and growth of state quitlines. Such organizations provide leadership on national and state advocacy efforts, training and technical assistance, and specific targeted strategic efforts to help advance cessation and quitlines. Their general leadership within the field is viewed as both complimentary to, and encouraging of, governmental action on tobacco control at the state and national levels. Their actions have secured state and federal funding for tobacco control and quitline programs.

Role of the North American Quitline Consortium

NAQC is a non-profit learning organization, established in 2004, that seeks to increase the access, use and effectiveness of quitline services across diverse communities in North America. It is comprised of over 400 individuals and organizations that provide quitline services, fund quitlines, conduct research on quitline-related topics, advance national cessation policies and work in other areas of tobacco control. NAQC's U.S. members span the 50 states, the District of Columbia, Puerto Rico and Guam. NAQC has 115 members who work in state tobacco control programs and includes well-respected national organizations such as CDC, NCI, the American Cancer Society, American Lung Association, Campaign for Tobacco Free Kids, Legacy, Partnership for Prevention, and the Smoking Cessation Leadership Center.

Since 2004, NAQC has established mechanisms for sharing knowledge, creating resources and disseminating information with an aim to advance the reach and quality of quitlines, strengthen partnerships, improve sustainability and more recently, integrate quitlines into medical and behavioral health care. NAQC has engaged in program and research activities that have helped identify best practices, set standards for the field, led to trainings on, and adoption of, best practices, increase funding for quitline services, as well as encourage national policy-making that supports tobacco cessation and align the work of quitlines with that of partners in healthcare and chronic disease activities. NAQC has a track record of providing technical assistance and training on cessation interventions to state tobacco control programs and national organizations as well as quitline service providers, researchers and others. NAQC has a demonstrated ability to prepare high-quality guidance documents, technical assistance materials, case studies and scientific publications that are meaningful for practitioners. Noteworthy among the documents are NAQC's minimal data set for evaluating quitlines (MDS) which consists of standard intake and follow-up questions. NAQC's annual survey of quitlines has been fielded since 2004 and can be used to show trends in quitline services, budgets, utilization and quality.

NAQC plays an important part in presenting a common and evolving vision of quitlines to national and state agencies, advancing partnerships that position quitlines as an intricate part of cessation services and strategy, and being the representative of state quitlines to many of the stakeholders noted in this section.

Role of Health Plans and Other Payers

Private health plans utilize their own internal resources to help control tobacco use. Health plans train internal staff members who have direct contact with patients to treat tobacco dependence including complex case managers, behavior change managers, care coordinators, and disease managers. In some cases, health plans have developed or

contracted for their own private quitlines for their enrollees. A growing number of private health plans are open to building partnerships with public tobacco cessation agencies and service provider organizations if the relationship can provide effective, low-cost, quality programs with good tobacco cessation results. Public-private partnerships are being explored across the country in an effort to achieve greater levels of tobacco cessation in a more cost-effective and collaborative way.

State quitlines play an important role in the tobacco cessation process for Medicaid, a jointly funded, Federal-State health insurance program for low-income and needy people. In 2011, the Centers for Medicare & Medicaid Services (CMS) issued a statement that "allowable quitline expenditures are claimable as administration at State option at the 50 percent Federal Medicaid matching rate specified at 42 Code of Federal Regulations 433.15(b)(7)."[8] The guideline has encouraged state Medicaid programs across the country to provide quitline services and then obtain the 50% matching funds to help support the cost of these services. This was in addition to the section of the Affordable Care Act (ACA) that provides Medicaid recipients who smoke and are pregnant with tobacco cessation counseling and pharmacotherapy without cost-sharing and expanded cessation counseling to all Medicare enrollees.

Role of the General Public

The general public, comprised of smokers and non-smokers, plays a significant role in the existence and the future of quitlines. Their tax dollars help support state quitline services. For these programs to exist however, the general public has to be informed of the dangers and costs of tobacco use and the potential for harm-reduction and cost-reduction resulting from cessation programs like quitlines.

THE DYNAMIC LANDSCAPE WITHIN WHICH STATE QUITLINES OPERATE

Changing Demographics of the Smoking Population

A noteworthy factor in the changing demographics of tobacco users is the changing "face" of the potential tobacco user. According to the most recent Surgeon General's Report, significant disparities in tobacco use persist not only among certain racial/ethnic populations but also among those with low education and income, certain geographic regions, LGBT populations and those with mental illness.[1] This will result in many new potential tobacco users within certain populations that already suffer disproportionately from the health consequences and economic hardship caused by tobacco use. How to effectively prevent, reach and treat tobacco use within populations targeted by the tobacco industry and disparately impacted by tobacco's harm will require new paradigms for promotion, messaging and service delivery.

Additionally, there are several studies that have been published that indicate that economic hard times, as well as other stressful conditions, are associated with increased alcohol and tobacco use. Concurrent with trying economic times are increased efforts by the tobacco industry, as described below, to develop and market new products to broader, younger populations and employ new tactics to keep smokers addicted.

The Introduction of New Products by the Tobacco Industry

The tobacco industry spends approximately $27 million each day in advertising and promotions and has been trying to attract new tobacco users by promoting "safer" smokeless products.[9] These products do not fall within the prohibitions established by clean-indoor air regulations. Products such as e-cigarettes simulate the smoking of an actual cigarette and release high levels of nicotine. These products are not regulated by the FDA and are widely advertised commercially, particularly to teens and young adults.[10] The emergence of new, unregulated tobacco products presents a significant challenge to state quitlines to keep up with the new products, the marketing strategies that are employed by the tobacco industry to sell them, the changing younger demographic that feels these are safer alternatives to smoking cigarettes and new approaches to cessation treatment that may be needed.

Healthcare Reform

Healthcare reform has presented many new opportunities for state quitlines to play a role in the broader context of tobacco control and healthcare delivery. As health plans and employers move toward compliance with the ACA and hospitals work to meet Joint Commission[11] standards, state quitlines have become a focal point in discussions between public and private sectors. It is important for state tobacco programs to become more engaged in discussions, both before and after laws are passed, to highlight the evidence base for the various cessation interventions, the cost-effectiveness of state quitlines and the services that they can provide. Integrating quitlines into the routine healthcare delivery process and utilizing it as a leverage point with partners to achieve the comprehensive cessation coverage standards set by new laws and regulations is at the heart of the future of state quitlines.

Dollars and Funding Priorities

It has long been apparent that state health departments cannot and should not bear full financial responsibility for the delivery of cessation services to all tobacco users, regardless of insurance status. With the economic climate of the past four years, state governments have had to look at their funding of tobacco cessation programs closely, resulting in significant cutbacks for some programs. As dialogue on the ACA unfolded over the past year, it has become apparent that the new law requires health plans to include cessation coverage as a required preventive service. State agencies have given thoughtful consideration to this dialogue and the role that state agencies should play in funding quitline and cessation service delivery moving forward. The changing funding priorities within state budgets have pushed state quitlines to seek out cost-sharing, reimbursement and other partnership relationships to support operations and future sustainability. Federal agencies and private organizations have begun to provide more resources to support state quitlines.

Technology

State quitlines have been introduced to, and have taken a lead in assessing scientifically, the effects of technological innovations on their tobacco cessation programs. Studies in the past few years have shown varying cessation rates associated with the different technologies used, but overall results indicated that technology may have a role in enhancing the effectiveness of quit attempts.

Technology is also likely to have a role in improving the referral of smokers from healthcare settings to quitlines and in the return of information to providers about the patients they refer to quitlines. The Health Information Technology for Economic and Clinical Health Act, part of the American Recovery and Reinvestment Act of 2009, is intended to accelerate the adoption of electronic medical records (EMRs) by healthcare providers.[12] As the ability of healthcare providers to directly refer patients to state quitlines via EMRs expands across the country, it will have a positive impact on quitline reach and quit rates.

THE FUTURE VISION OF QUITLINES

The dynamic landscape within which state quitlines operate provides many opportunities to shape a positive future vision for quitlines, a vision that will encourage more of the 42 million current smokers in the U.S. to make a quit attempt and will assure that high quality cessation services are available to them. The future vision must take into account the changing landscape of tobacco cessation and make the most of opportunities that exist. Together with its members, leadership and partners, NAQC offers this future vision:

An increase in the availability of evidence-based cessation services, including quitline services:

As we head toward 2020, quitlines will continue to be an important component of comprehensive cessation programs for states and should become an important component of growing cessation services offered by health plans and employers. The ACA, if appropriately implemented, will help make this a reality.

Sharing the cost of services between the public and private sectors: The responsibility for paying for state quitline services will shift from the public sector to a more evenly shared public-private model. This shift may take several years to occur and will require leadership from the state tobacco control program and other state and national agencies that fund quitlines. Ultimately, the cost of services should be borne by the health plans responsible for covering the care of particular populations. This may involve a health plan contracting with the state quitline, contracting directly with a quitline service provider or developing an internal quitline for their enrollees who smoke. The state tobacco control program should continue to assure services for the uninsured and underinsured.

An increase in the proportion of smokers who use services: By engaging in partnerships with health systems and healthcare providers, quitlines will increase the number of referrals they receive, thereby increasing the number of smokers who use services to quit. Promotion of quitlines by national, state and private entities will increase the number of tobacco users, particularly to otherwise underserved populations, who will hopefully now use services. Together, these strategies will ensure that 8-13% of all tobacco users are reached, consistent with CDC's Best Practices goal.[13]

Enhanced skills for reaching and treating special populations: Through targeted partnerships, quitline service providers will enhance their knowledge base about best practices for treating and reaching all tobacco users, with an emphasis on special populations such as racial/ethnic groups, LGBT and those with mental illness.

A growing role for the state in coordination and quality assurance: The state tobacco control program and other agencies that fund quitlines should play a leadership role in assuring that high quality and coordinated cessation services exist within the state. This may involve strategies such as education of the healthcare industry and consumers, legislation and regulation, better assessment tools, and partnership activities.

A growing use of technology in quitlines: Quitlines will continue to adopt and use technologies that help them reach, engage and provide services to tobacco users. This not only includes chat rooms, click-to-call, interactive voice response (IVR) systems and texting but also electronic referrals (with electronic medical records) and registries for re-engaging smokers in quit attempts.

A well-funded research enterprise to spur innovation and advancement: A well-funded research enterprise will ensure innovation and advancement of quitlines. Research findings about new products like e-cigarettes and strategies for better reaching tobacco users are needed by the field.

RECOMMENDATIONS

Quitlines in the U.S.: An Exploration of the Past and Considerations for the Future's Executive Summary with Recommendations reflects on the past and present of quitlines, a dynamic policy landscape shaped by recent recession and ongoing healthcare reform, and the Consortium's best thinking about a future vision for state quitlines. To encourage progress toward this vision, NAQC offers the following recommendations. It is our hope that readers will support the recommendations outlined below and will work with NAQC on implementing them.

1. To increase the availability of evidence-based quitline and cessation services, we strongly recommend that:
    a. HHS, the Department of Labor, and Department of the Treasury provide guidance to the healthcare industry that clearly defines a comprehensive tobacco cessation benefit in the ACA regulations as requiring i) coverage of all medications that are FDA-approved for smoking cessation, ii) coverage of at least four hours of cessation counseling, to be available in individual and group formats (health plans should also refer to state quitlines for phone counseling, or can provide their own phone counseling program); and iii) coverage of these benefits at least twice per year for members without cost-sharing.[14] Issuing this guidance may be the single most important action for ensuring that ACA

results in an increased level of cessation services for those seeking help in quitting. There is tremendous support for such action, as evidenced by the February 19, 2014 letter to HHS Secretary Sebelius signed by 30 national organizations.[15]

b. Once guidance has been issued, NAQC should work with its members, state-based organizations and other national organizations to encourage implementation of the guidance. This may involve education of healthcare industry and consumers, legislative and regulatory strategies, report cards, surveillance and other activities. It will also require support for direct partnership activities between quitline service providers, state agencies and private healthcare payers.
c. NAQC should develop and disseminate standards for quitline operations and services that will help ensure that quitline practice, regardless of the service provider or funder, are evidence-based and of high quality.
d. The federal government, states and foundations should play a role in funding, developing and disseminating resources that help ensure all quitlines provide high quality and evidence-based services.

2. To appropriately share the cost of quitline services between the public and private sectors, we strongly recommend that:
   a. States engage in a process for developing cost-sharing and/or reimbursement agreements with public and private entities (including the state Medicaid program, health plans, employers and others) that: i) clearly defines the populations the state quitline will cover at no cost; ii) the time frame for implementing changes to the funding model and service population; iii) provides information about opportunities for public and private entities to contract with the state quitline or quitline service provider for coverage; iv) provides staff support for working with the healthcare industry advancing such partnerships; and v) establishes reliable measurements of effectiveness of tobacco cessation programs that are available to all parties.
   b. NAQC should enhance its capacity to offer technical assistance and develop resources related to developing funding partnerships with the public and private sectors. NAQC should also help identify solutions to challenges that arise as funding partnerships are implemented, such as the state's capacity to monitor quitline utilization data; access to cessation among its population and barriers faced by small employers.
   c. NAQC and other national organizations should engage with national healthcare industry leaders to develop appropriate research activities that will lead to the development and implementation of strategies for advancement.
   d. The federal government, states and foundations should play a leadership role in funding, developing and disseminating information about funding partnerships between quitlines and healthcare payers.

3. To increase the proportion of smokers who use quitline services, we strongly recommend that:
   a. State quitlines enhance their capacity to engage health systems and healthcare providers in referring tobacco users to quitlines. All quitlines should make their healthcare partners aware of fax referral programs and encourage them to make referrals. In addition, to take advantage of meaningful use of certified Electronic Medical Records by healthcare providers, all quitlines should make electronic referral available to the healthcare sector by 2016.
   b. NAQC should support state efforts to enhance their electronic referral capacity through working groups, technical assistance and toolkits to meet the needs of quitlines.
   c. CDC should more aggressively promote cessation through national media campaigns (including promotion of 1-800-QUIT-NOW, 1-855-DEJELO-YA and the Asian National Quitline). States and private sector entities should also promote cessation.
   d. FDA should move forward with enhanced graphic warning labels that include a quitline number.
   e. The federal government, states and foundations should play a role in funding, developing and disseminating information about referral to state quitlines and promotion of quitlines.

4. To enhance state efforts to reach and treat special populations with quitline services, we strongly recommend that:
    a. Increasing consumer demand for evidence-based tobacco cessation treatment among racial/ethnic minorities, sexual/gender minorities and low SES individuals be a priority for all states. State leaders must develop the resources and capacity to promote quitlines to specific population groups through tailored promotion and targeted outreach initiatives.
    b. States and NAQC collaborate with the CDC/OSH National Networks to identify statewide, regional and local organizations that serve specific populations. States should build relationships and establish partnerships with these organizations in order to promote quitline services in collaboration with community-based partners and healthcare systems and providers.
    c. National resources, including the National Networks funded by CDC/OSH, be fully engaged in quitline outreach campaigns that provide information and training on quitline services and promotion/referral methods in order raise awareness of, and build faith and confidence in, quitline services through their networks and to their constituents nationally.
    d. Quitline service providers utilize the expertise and existing infrastructure of local, state and national organizations to improve the understanding of their counseling staff of the specific, unique cultural and ethnic needs of each population that impact on their tobacco use, secondhand smoke exposure and barriers to quitting in order to ensure the delivery of a culturally relevant counseling intervention.

5. To ensure that high quality cessation services exist within the states and are coordinated, we strongly recommend that:
    a. State tobacco control programs and other agencies that fund quitlines play a leadership role in assuring that high quality and coordinated cessation services exist within the state and are widely promoted to tobacco users. This may involve strategies such as education of healthcare industry and consumers, legislation and regulation, report cards, and partnership activities.
    b. NAQC and other national organizations should provide technical assistance and resources to support state efforts and progress.
    c. The federal government, states and foundations should play a role in funding, developing and disseminating resources as well as ensuring that progress is made in this area.

6. To ensure adoption and use of technologies by quitlines, we strongly recommend:
    a. NAQC should assess the current use of technology by quitlines and develop case studies on best practices for using technology to reach, engage, re-engage and provide services to tobacco users. This should include evaluation and appropriate promotion of chat rooms, click-to-call, IVR, texting, registries of tobacco users and other applications of technology.
    b. NAQC should assess the current use of technology by quitlines for referral with the healthcare sector and develop case studies and other resources for supporting the adoption of technologies to increase referrals.
    c. The federal government, states and foundations should play a role in funding, developing and disseminating information about the effective use of technology in increasing utilization of evidence-based cessation services.

7. The translation of research into practice has ensured innovation and advancement of quitlines. To spur continued innovation and advancement through research, we strongly recommend:
    a. The federal government, states and foundations should fund research that answers important questions about new tobacco products like electronic nicotine delivery systems (ENDS) and to identify effective strategies and technologies for better reaching and treating tobacco users. Program activities to disseminate research findings and encourage adoption of best practices should also be funded.
    b. NAQC should facilitate research with quitlines and play a leading role in translating and disseminating research findings for the field, and monitoring adoption of these findings by state quitlines.

SUMMARY

State quitlines have advanced in the past two decades in so many ways. This is due in large part to the leadership and efforts of state and federal government agencies, many non-profit organizations that have nurtured and supported their growth and the work of many academic scientists who have provided the needed scientific evidence. State quitlines must now evolve even further and engage the full weight of public and private healthcare payers and providers in a comprehensive tobacco cessation enterprise that together continues to promote, offer and deliver evidence-based, cost-effective cessation treatment to the millions of tobacco users who remain. The dynamic national landscape provides many opportunities to advance quitlines and future changes in the landscape, including healthcare reform and FDA regulatory actions. Undoubtedly, ongoing scientific discovery in this field will offer even more opportunities in the near future. Therefore, the state quitline community's careful consideration of the opportunities to partner with both public and private entities to maximize available resources and achieve meaningful treatment reach is imperative.

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