Results from the 2011 NAQC Annual Survey of Quitlines “Highlights”

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“Full” results, including detailed tables, are available online at http://www.naquitline.org/?page=2011Survey
2011 Annual Survey Methods

Budget Survey fielded from August 15 to October 30, 2011

- Web-based survey with email and telephone follow-up:
  1) Quitline budgets
  2) Funding sources

Additional Survey Sections fielded from January 25 to March 31, 2012

- Web-based survey with email and telephone follow-up:
  1) General Information, hours, services offered
  2) Utilization
  3) Evaluation

Additional Information from CDC’s Quarterly Services Survey and NAQC quitline profiles also included in analysis

Slide 3
UPDATED FOR FY11

All data in this presentation from the NAQC annual survey of quitlines unless otherwise noted.
**2011 Annual Survey Response Rates**

**Budget Survey:**
- 65 quitline funders were asked to respond; 50 of 53 US quitlines responded (94%); 12 of 12 Canadian quitlines responded (100%)

**Additional Survey Sections:**
- 65 quitline funders and their service providers were asked to respond; 53 of 53 US quitlines responded (100%); 10 of 12 Canadian quitlines responded (83%)
Strategic Goals for 2015

GOAL 1: INCREASE THE USE OF QUITLINE SERVICES IN NORTH AMERICA

Objective 1: By 2015, each quitline should achieve a reach of at least 6% of its total tobacco users.

GOAL 2: INCREASE THE CAPACITY OF QUITLINE SERVICES IN NORTH AMERICA

Objective 2: By 2015, on average $2.19 per capita ($10.53 per smoker) should be invested in quitline services.

GOAL 3: INCREASE THE QUALITY AND CULTURAL APPROPRIATENESS OF QUITLINES IN NORTH AMERICA

Objective 3a: By 2015, each quitline should have an overall quit rate of at least 30%.

Objective 3b: By 2015, each quitline should achieve a reach of 6% in priority populations.
Slide 6
Budget Summary

- US quitline budgets and budgets for services continue to rise or stay the same; Canadian budgets are showing a sharp decline
- Most US quitlines cited the end of CPPW funding as either having already impacted them, or anticipating future impacts
- Most Canadian quitlines decreased promotion in anticipation of the national toll-free quitline number
The median budget for medications and outreach declined between FY2010 and FY2011, while the median budget for services, promotions, evaluation, and “other” increased.

Budget survey #3. FY11 Budget: What was your budget at the start of the fiscal year 2011 for the following? g. Total quitline budget
Note that given the small N, the variation in sum of quitline budgets from year to year may be more influenced by the number of quitlines reporting than anything else.

Budget survey #3. FY11 Budget: What was your budget at the start of the fiscal year 2011 for the following? g. Total quitline budget
Slide 13
UPDATED FOR FY11

Despite the decline in median medications budgets, the combined services + medications budgets increased very slightly from FY10 to FY11, (could be considered to be level with FY10)

Budget survey #3. FY11 Budget: What was your budget at the start of the fiscal year 2011 for the following?
A. Quitline services
B. Quitline medications (including NRT)
Slide 14

UPDATED FOR FY11 **included average, since median can be dramatically influenced by small N.

Median budget for services has declined for Canadian quitlines by 84% since FY2008. (Average budget for services declined by 33% since FY2008)

Note: no Canadian quitlines reported a budget for quitline medications in fy11, although Quebec reported providing medications through a collective prescription for the province. The medications are paid for separately, and are not included as part of the Quebec quitline budget.

Budget survey #3. FY11 Budget: What was your budget at the start of the fiscal year 2011 for the following?
A. Quitline services
B. Quitline medications (including NRT)
### Impact of change in budget from FY11 to FY12

<table>
<thead>
<tr>
<th>Change Description</th>
<th>US (N=50)</th>
<th>Canada (N=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Impact</td>
<td>30%</td>
<td>33%</td>
</tr>
<tr>
<td>Decrease in media, promotions, or outreach</td>
<td>16%</td>
<td>50%</td>
</tr>
<tr>
<td>Increase in media, promotions, or outreach</td>
<td>16%</td>
<td>0%</td>
</tr>
<tr>
<td>Decrease in amount of NRT provided per caller, fewer people served with NRT, or eligibility for NRT restricted</td>
<td>16%</td>
<td>0%</td>
</tr>
<tr>
<td>Increase in amount of NRT provided per caller, or eligibility for NRT broadened</td>
<td>16%</td>
<td>0%</td>
</tr>
<tr>
<td>Counseling services reduced, counseling provided to fewer people or eligibility for counseling restricted</td>
<td>28%</td>
<td>0%</td>
</tr>
<tr>
<td>Counseling provided to more people or eligibility for counseling expanded</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Increased cost sharing (including health plans and Medicaid)</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>Other: Increased hours of operation (US 1); Decreased hours of operation (US 1); Added/expanded web services or social media (US 1); Decreased evaluation (US 1, Canada 1); Increased quality assurance (US 1)</td>
<td>10%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Slide 10
UPDATED FOR FY11

7. Please describe the impact of any budget changes either during FY2011, or from FY2011 to FY2012, including, but not limited to, increases or decreases in amount or level of promotions; widening or narrowing of eligibility criteria for counseling and/or medications; or increasing or decreasing the number of counseling sessions in the quitline protocol:

Survey responses were free-response, and were coded into categories by NAQC staff.
National spending per smoker was calculated by taking the sum of the budget lines for services and medications, and dividing by the sum of the number of adult smokers in the states/territories reporting budget lines for services and medications.

Number of adult smokers in the states/territories was calculated using US Census data and BRFSS smoking prevalence estimates for the calendar year matching the fiscal year being reported (e.g., FY08 spending per smoker calculated by using 2008 US Census population estimates and 2008 BRFSS smoking prevalence estimates). **Note FY11 spending per smoker calculations were made using 2010 US Census population estimates and 2010 BRFSS smoking prevalence estimates. These numbers will be revised once 2011 population estimates and 2011 BRFSS smoking prevalence estimates are available.

Budget survey #3. FY11 Budget: What was your budget at the start of the fiscal year 2011 for the following?
A. Quitline services
B. Quitline medications (including NRT)
Despite the decline in median (and average) spending on quitline services, spending per smoker stayed constant from FY2010 to FY2011.

National spending per smoker was calculated by taking the sum of the budget lines for services, and dividing by the sum of the number of adult smokers in the provinces/territories reporting budget lines for services.

Number of adult smokers in the states/territories was calculated using Canadian Census data and CTUMS smoking prevalence estimates for the calendar year matching the fiscal year being reported (e.g., FY08 spending per smoker calculated by using 2008 Census population estimates and 2008 CTUMS smoking prevalence estimates). **Note FY11 spending per smoker calculations were made using 2010 Census population estimates and 2010 CTUMS smoking prevalence estimates. These numbers will be revised once 2011 population estimates and 2011 CTUMS smoking prevalence estimates are available.
Budget survey #3. FY11 Budget: What was your budget at the start of the fiscal year 2011 for the following?

A. Quitline services

B. Quitline medications (including NRT)
Slide 17
Updated FY11

Note: less than 1/3 of US quitlines receive state general funds, while nearly all Canadian quitlines receive provincial general funds. Most states receive CDC funds, but CPPW funding is ending. More US states are reporting receiving state Medicaid funding than ever before, as well as third party reimbursement through an insurance company.

NOTE: Majority of US quitlines report receiving funding from CDC or MSA, but highest percent comes from MSA, state general funds, and tobacco tax funds.

Majority of Canadian quitlines report funding from state/provincial general funds (FY10 and FY11) but Health Canada funding is declining in FY12.

4. In FY2011 (FY2012), what types of funders supported your quitline’s operations, services, promotions, outreach, medications, staff, or other infrastructure?
Select all that apply.
Note: While nearly all US quitlines receive funds from CDC and ARRA/CPPW stimulus funds, not all reported it here for several reasons, including: some applied the funds to their FY2011 budget, not their FY2010 budget; some received funds but did not include them in their “quitline” budgets because of their supplemental nature or the specific purpose for which funds were used; and some did not receive funds from CDC at all.

4. In FY2011 (FY2012), what types of funders supported your quitline’s operations, services, promotions, outreach, medications, staff, or other infrastructure?
Select all that apply.
4. In FY2011 (FY2012), what types of funders supported your quitline’s operations, services, promotions, outreach, medications, staff, or other infrastructure? Select all that apply.
Note: Decrease in # of quitlines receiving funding from Health Canada in FY11; increase in those receiving funding from charitable foundations.

4. In FY2011 (FY2012), what types of funders supported your quitline’s operations, services, promotions, outreach, medications, staff, or other infrastructure?
Select all that apply.
The proportion of funding from health canada (for those reporting it) is decreasing over time. The proportion of funds from provincial funds is increasing over time. One quitline reported getting most of its funding from a charitable foundation in FY11; that quitline did not report budget source information for FY12.

4. In FY2011, what types of funders supported your quitline’s operations, services, promotions, outreach, medications, staff, or other infrastructure? Select all that apply.
Slide 29
Updated for FY11—UPDATED USING NAQC online PROFILE DATA (not asked in mini survey)

3 US open, 3 Canada open on holidays
NAQC current profile data set
N=53 US, 12 CAN

Questions from previous surveys:
G4. Please provide the days and hours of service of your quitline for the following categories of service for FY10:
   Counseling service
   Live pick up of incoming calls (may or may not have counseling services available)
   Voicemail / answering service pick up of calls

G5. Was your quitline closed on holidays during FY10?
Several US quitlines stopped providing multiple proactive counseling sessions in FY10; this service was provided by 100% of quitlines until FY2010.

FY11 Mini Survey question: Which of the following services were funded by your state / province during FY11? *(Select all that apply.)*

Note: Counseling here refers to a person-tailored, in-depth, motivational interaction that occurs between cessation specialist / counselor / coach and caller. For any interaction with a counselor lasting less than 10 minutes, select the minimal / brief intervention below.

#4. Telephone counseling  indicate which type(s). *(Select all that apply.)*

Minimal/brief intervention (1-10 minutes)
Single session counseling (more than 10 minutes)
Multiple sessions (i.e., proactive, cessation specialist / counselor / coach calls client for follow up)
Multiple sessions client initiated (i.e., reactive: client calls in for each follow up)
Multiple sessions counselor initiated (i.e., proactive: cessation specialist / counselor / coach calls client for follow up)

Note: Counseling here refers to a person-tailored, in-depth, motivational interaction that occurs between cessation specialist / counselor / coach and caller. For any interaction with a counselor lasting less than 10 minutes, select the minimal / brief intervention below.
Internet-based services and other technologies - indicate which type(s).

(Select all that apply.)

Please check the box that indicates whether the service is provided as an integrated part of your telephone counseling program (e.g., the quitline and web-based databases are combined, or quitline counselors have realtime access to the web-based service data) or whether they are standalone programs.

Examples: A quitline that encourages clients to simultaneously use a web-based cessation program that is also paid for by the state’s or provinces tobacco control program, but where quitline counselors do not have any access to the client’s activity online, would not be considered an integrated program. A text messaging program that is only used for tobacco users who register for telephone counseling is an integrated program; one that tobacco users can register for independent of participation in any other program is standalone.
6. Which of the following internet-based services does your tobacco control program provide?

- Information about the quitline
- Information about tobacco cessation
- Self-directed web-based intervention to help tobacco users quit
- Text messaging to cell phones*

*Definition: text messaging includes short message service transmissions to mobile devices that contain content related to helping people quit. Message content might include tips for coping with cravings, motivational messages, resources for additional help, or other related topics. Select this option regardless of whether the text messaging is interactive (communication can either be two-way between the program and tobacco user, or one-way from the program to the tobacco user only)]

7. Does your tobacco control program provide any of the following features of a self-directed web-based intervention? (select all that apply)

- Automated email messages
- Chat rooms (e.g., online community to share quit stories, information, advice. May or may not be moderated.
- Interactive counseling and/or email/instant messaging to cessation specialist / counselor / coach to help tobacco users quit
- None of these
One quitline uses the IVR system to provide NRT to callers; another
Follow calls to quitline clients who have set a quit date and/or receive NRT; to
contact referrals to Quitline

8. Does your quitline use interactive voice response (IVR) technology?

Definition: Interactive voice response is a technology that allows customers to interac
t with a company’s database via a telephone keypad or by speech recognition, after which they can service their own inquiries by following the IVR dialogue. IVR can be used with quitlines to direct callers appropriately (such as to a Spanish speaking counselor), or can be used for much more complex functions such as collecting intake data or fulfilling requests for cessation materials. If your quitline uses IVR in either or both of these capacities, please select "yes" below.

9. Is IVR used to triage calls only (e.g., to direct callers to the right person based on the reason for calling), or is it used to handle provision of some requested
services, for example, requests for cessation materials?
11. Other services indicate which type(s) of other services are provided by your tobacco control program. **Select all that apply.**

- None of these
- Voice mail with call backs
- Recorded messages for help with quitting (e.g., phone tree)
- Referral to any other cessation services (quit smoking group programs, face to face counseling, professional services) [Note: referral indicates a formal process for transferring information about a potential client to another service. It is more than providing a phone number or information to the caller him/herself it could include mailing, faxing, or emailing a client's information to the other service directly, making direct contact with the other service while the client is still on the line (i.e., warm transfer), etc.]
- Referral to any other (noncessation) services (mental health services, diabetes prevention programs, etc.) [Note: referral indicates a formal process for transferring information about a potential client to another service]

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**Nearly all US and Canadian Quitlines Have Voice Mail With Call Backs and Mail Information to Tobacco Users FY11**

<table>
<thead>
<tr>
<th>Other services</th>
<th>US (n = 53)</th>
<th>CAN (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice mail with call backs</td>
<td>93% (49)</td>
<td>80% (8)</td>
</tr>
<tr>
<td>Recorded messages for help with quitting (e.g., phone tree)</td>
<td>72% (38)</td>
<td>20% (2)</td>
</tr>
<tr>
<td>Referral to any other cessation services</td>
<td>30% (16)</td>
<td>30% (3)</td>
</tr>
<tr>
<td>Referral to any other non-cessation services</td>
<td>11% (6)</td>
<td>10% (1)</td>
</tr>
<tr>
<td>Mailed information or self help resources (provided through the quitline)</td>
<td>93% (49)</td>
<td>80% (8)</td>
</tr>
</tbody>
</table>
services. It is more than providing a phone number or information to the caller him/herself; it could include mailing, faxing, or emailing a client's information to the other service directly, making direct contact with the other service while the client is still on the line (i.e., warm transfer), etc.

- Mailed information or self-help resources [provided through the quitline]
- Other services (please specify):
12. Does your quitline recommend that callers visit your state or territory’s cessation website or a national website such as www.smokefree.gov or www.becomeanex.org [or the website listed on Canadian cigarette packs]?

Yes [CONTINUE TO #13]
No [SKIP TO #14]

13. When is the national website mentioned by quitline staff to tobacco users? (select all that apply)
- At all times regardless of the call volume level
- Only during periods of peak call volume
- Only in response to smoker questions
- Other (please specify):
From NAQC online profile data

**Available referral methods:**
- faxed form
- e-mail or online
- EMR with electronic submission

**Other services available to referring providers:**
- quitline and/or referral brochures
- customized referral/consent forms
- patient progress reports
- customized provider feedback reports
- staff training
- quitline/referral program newsletter
Slide 45
Updated, from NAQC
US, n=53
Canada, n=12
Current, from NAQC profile data

Note: this doesn’t include 3rd party translators

Language Counseling Service
English
Spanish
French
Arabic
ASL
Cantonese
Hindi
Italian
Korean
Mandarin
Russian
Taiwanese
Vietnamese

Data source: NAQC Quitline Profiles
Korean
Mandarin
Russian
Taiwanese
Vietnamese
US Primary Service Providers
June 2012

The figure below shows the organizations (n=15) that were the primary service provider of counseling services for US quitlines.

Data source: NAQC Quitline Profiles

US Service Providers (15)
- Alere Wellbeing
- American Lung Association of Illinois
- Avera McKennan Hospital and University Health Center/ Black Hills Special Services
- beBetter Health, Inc.
- Ceridian Health & Productivity Solutions
- Healthways
- Information & Quality Healthcare
- JSI Research & Training Institute, Inc.
- MaineHealth, Center for Tobacco Independence
- National Jewish Health
- Roswell Park Cancer Institute
- Teledmedik
- University of Arizona/Arizona Smokers' Helpline
- University of California, San Diego
- University of Nevada, Reno
There were a total of 4 Primary Service providers for Canadian Quitlines.

- Alberta Health Services
- Canadian Cancer Society, Ontario
- Lung Association of Newfoundland and Labrador
- Sykes
Canadian quitlines answered the following questions (NAQC Annual Survey):

12. Many quitlines have eligibility criteria for receiving services based on state of residence, age, insurance status, being a member of a special population or readiness to quit. Are there eligibility criteria for receiving proactive counseling through your quitline?

Yes/No

13. The eligibility criteria include: SELECT ALL THAT APPLY

- Resident of state
- Age: (Please specify required age for services in Q14 below)
- No insurance
- Underinsured
- Medicaid
- Medicare
Privately insured (or private insurance holders)
Length of time quit: (please specify the eligibility criteria in Q14 below)
Readiness to quit: (please provide your quitline’s definition of readiness to quit in Q14 below)
Special population: (Please specify which populations in Q14 below)
Other (please specify):

U.S. quitlines answered the following questions (CDC Quarterly Services Survey):

17. Many quitlines have eligibility criteria for receiving services based on state of residence, age, insurance status, being a member of a special population or readiness to quit. Are there eligibility criteria for receiving proactive counseling through your quitline?

Note: Counseling here refers to a caller-centered, person-tailored, in-depth, motivational interaction that occurs between cessation specialist/counselor/coach and caller.

Yes
No, there are no restrictions on receiving proactive counseling – skip to Q17

18. The eligibility criteria include: **Select all that apply.**

   Resident of state
   Age: (please specify required age for services): ________ years and older
   No insurance
   Underinsured
   Medicaid
   Medicare
   Privately insured (or private insurance holders)
   Length of time quit: (please specify the eligibility criteria):__________
   Readiness to quit: (please provide your quitline’s definition of readiness to quit):__________
   Special population: (please specify which populations):__________
Other (please specify):_________
Canadian quitlines responded to the following question (NAQC Annual Survey):

15. If you provide different levels of proactive counselling services for different groups (i.e., one proactive call for everyone but 3 calls for pregnant women) please describe them below.

Note: Many quitlines have different levels of criteria for different types of services which may be based in-part on budgetary pressures. This question is designed to address this issue. Please reply fully so we can understand the different types of eligibility for the different levels of service.

U.S. quitlines answered the following question (CDC Quarterly Services Survey):

19. Do the different levels of proactive counseling services for different?
Note: Many quitlines have different levels of criteria for different types of services which may be based in-part on budgetary pressures. This question is designed to address this issue. Please reply fully so we can understand the different types of eligibility for the different levels of service.
No Canadian quitlines provide medications to tobacco users as part of their services. However, both Quebec and British Columbia make over-the-counter nicotine replacement products available to all provincial residents.

US quitlines answered the following question (CDC Quarterly Services Survey):

21. Did your quitline provide free quitting medications to clients?

Canadian quitlines answered the following questions (NAQC Annual Survey):

17. Did your quitline provide free or discounted cessation medications during FY11?
Yes [CONTINUE TO #18]

No [SKIP TO #19]

18. Please describe the type of medications provided, the amount of medications provided, and eligibility criteria for providing medications through your quitline:
US quitlines reported answers to the following questions: (CDC Quarterly Services Survey)

24, 28, 32, 36, 40, 44, 48. How many weeks of free nicotine patches/gum/lozenge/bupropion/varenicline/inhaler/nasal spray per quit attempt did your quitline provide to clients? Please fill-in as many blanks as needed.

**Note:** if your quitline provides varying amounts of free nicotine patches/gum/lozenge/bupropion/varenicline/inhaler/nasal spray depending on eligibility criteria, please specify your eligibility criteria.
UTILIZATION
How many total DIRECT calls came into the quitline during FY11?

Note: Direct calls are calls to the quitline, not referrals that generate an outbound call from the quitline. Please report on number of CALLS, not number of callers/unique individuals. This should include proxy callers, wrong numbers, and prank calls and other calls to the quitline that are not accounted for in these categories.

Include click to call calls here for services that offer a “click to call” service where a call is automatically generated to a tobacco user when they “click” a button online. Those calls are handled and reported in Telecom data, so would be included in this item.

a. Calls answered by a live person
b. Calls that went to voice mail
c. Calls that went to a pre recorded message directing callers to a cessation website [could be a self directed online program, becomeanex.org, smokefree.gov, etc.]

d. Other calls (e.g., listening to taped cessation messages, etc.)

e. Calls hung up or abandoned

f. Total direct calls (sum of first five categories)
Slide 60
Slide showing total call volume over time (2005-2011) from NAQC annual survey (note that total calls does not equal total served)
Demand is rising when we look at the total call attempts to 1-800-quit-now as well. The red “projected” call volume for the remainder of 2012 was estimated by taking the average of the first three months of 2012 and assuming a similar call volume for the remainder of the year. The blue “actual” call volume was taken from 1-800-quit-now reports (via NCI) through June 2012. (Monthly 1-800-quit-now reports are available on the NAQC website at http://www.naquitline.org/?page=800QUITNOWstats.

Note: 2009 showed a large increase in calls in part due to the increase in the Federal tobacco tax.
Anyone calling 1-800-quit-now will get to their state or territorial quitline. Some state quitlines promote a different number other than 1-800-quit-now, so this does not represent total calls to quitlines. This represents individual CALLS not individual CALLERS, but it is a good measure of changing demand for quitline information and services over time.

Given that CDC and other federal agencies may be planning similar media campaigns in the future, these are important trends to be aware of.
CCS – Ontario Division provides quitline services to seven provinces and territories. Call volume has remained much higher than the same time in 2011 since the new tobacco package labels have begun to be sold in stores.

Since May 2012, more than 70% of callers to the seven quitlines served by the Canadian Cancer Society – Ontario Division have reported hearing about the quitline from tobacco package labeling. The same pattern holds in British Columbia (services provided by Sykes Assistance Services).
Of the total DIRECT calls into the quitline during FY11 (reported in 14f above), how many UNIQUE tobacco users called the quitline during FY11?

Note: Tobacco user can be smoker, chewer, etc. and can be a current user or recent quitter interested in staying quit. Please include all tobacco users who called, including those who had questions only, those who requested materials, and those who requested services. Tobacco users who entered the quitline through referrals, online registration, or other mechanisms, should not be reported here. Please count each tobacco user ONLY once.

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### Number of unique tobacco users (direct callers) FY11

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Missing</th>
<th>Min</th>
<th>Max</th>
<th>Median</th>
<th>Mean</th>
<th>Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>US (n=53)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total unique tobacco users</td>
<td>46</td>
<td>7</td>
<td>151</td>
<td>49,941</td>
<td>5,940</td>
<td>9,746</td>
<td>448,307</td>
</tr>
<tr>
<td><strong>Canada (n=10)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total unique tobacco users</td>
<td>9</td>
<td>1</td>
<td>179</td>
<td>5,359</td>
<td>410</td>
<td>1,349</td>
<td>12,144</td>
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</table>
The number of unique tobacco users calling the quitline increased (both sum and median) between 2005 and 2009; and decreased (both sum and median) from 2009 to 2010. Promotional reach was calculated by taking the number of unique tobacco users calling the quitline and dividing by the estimated number of smokers in the states and territories that reported a number of unique tobacco users (using BRFSS data). Note: both 2010 and 2011 reach rates are calculated using 2010 BRFSS smoking prevalence estimates. While 2011 BRFSS estimates are now available, the methodology used to arrive at smoking prevalence estimates changed in 2011, making prevalence estimates up to 2010 incomparable to estimates in 2011 and later. The number of states and territories reporting on the number of unique tobacco users calling the quitline is reported below.

The sum of all unique tobacco users calling quitlines is reported on the chart; the median is reported below.
2005 n=41; 2006 n=47; 2008 n=47; 2009 n=49; 2010 n=48; 2011 n=46

MEDIAN
2005=2675; 2006=3078; 2008=4847; 2009=6143; 2010=5990; 2011=5940
The number of unique tobacco users calling the quitline increased (both sum and median) between 2005 and 2009; and decreased (both sum and median) from 2009 to 2010. 2011 saw a slight increase in both total (sum) and median number of callers, although promotional reach has been steady since FY2009.

Promotional reach was calculated by taking the number of unique tobacco users calling the quitline and dividing by the estimated number of smokers in the provinces and territories that reported a number of unique tobacco users (CTUMS 2005-2010). Note: promotional reach rates were calculated for both 2010 and 2011 using 2010 CTUMS smoking prevalence estimates. 2011 CTUMS estimates were not yet available at the time these data were reported. The number of provinces and territories reporting on the number of unique tobacco users calling the quitline is reported below.

The sum of all unique tobacco users calling quitlines is reported on the chart; the median is reported below.
2005 n=3; 2006 n=8; 2008 n=9; 2009 n=10; 2010 n=8; 2011 n=9

MEDIAN
2005=1669; 2006=878; 2008=591; 2009=507; 2010=322; 2011=410
Number of referrals received by the quitline in FY11

<table>
<thead>
<tr>
<th>Referrals</th>
<th>N</th>
<th>Missing</th>
<th>Min</th>
<th>Max</th>
<th>Median</th>
<th>Sum</th>
</tr>
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<tbody>
<tr>
<td><strong>US (N=53)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax referrals</td>
<td>51</td>
<td>2</td>
<td>0</td>
<td>11,368</td>
<td>1,079</td>
<td>97,504</td>
</tr>
<tr>
<td>EMR referrals</td>
<td>22</td>
<td>31</td>
<td>0</td>
<td>1,000</td>
<td>0</td>
<td>1,000</td>
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<tr>
<td>Other referrals</td>
<td>43</td>
<td>10</td>
<td>0</td>
<td>8,606</td>
<td>145</td>
<td>19,204</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>51</td>
<td>2</td>
<td>39</td>
<td>11,368</td>
<td>1,365</td>
<td>117,714</td>
</tr>
<tr>
<td><strong>Canada (N=11)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax referrals</td>
<td>9</td>
<td>1</td>
<td>53</td>
<td>3,181</td>
<td>601</td>
<td>8,888</td>
</tr>
<tr>
<td>EMR referrals</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>855</td>
<td>81</td>
<td>1,515</td>
</tr>
<tr>
<td>Other referrals</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>11,360</td>
<td>5,685</td>
<td>11,370</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9</td>
<td>1</td>
<td>54</td>
<td>14,042</td>
<td>611</td>
<td>21,773</td>
</tr>
</tbody>
</table>

Slide 70
Updated for FY11

Note: “total” referrals was reported independently from the number of individual types of referrals. The sum of the “total” referrals does not add up to the sum of the sums of the individual types of referrals due to some quitlines reporting on individual types of referrals but not the total, or vice-versa.

Large number of referrals coming into the quitline, notably fax and web referrals. No EMR referrals in Fy2010, but we are starting to see some in FY11.

How many REFERRALS did the quitline receive during FY11 from the following?

Note: please account for each item. If there were no referrals received from a given source, enter a zero for it. Check “Unable to report” only if you do not know the amount for the item. Referrals reported here are not expected to be
unique tobacco users.
Referrals are total referrals, including fax referrals, e-referrals, web referrals, and other referrals.

Total direct calls from tobacco users are the number of unique callers calling for help for themselves to quit using tobacco.
Slide 72
Updated for FY11

Indicate the total number of UNIQUE tobacco users who completed an INTAKE or REGISTRATION process in FY11. (If your quitline did not have a formal intake or registration process, indicate the number of tobacco users indicating an interest in receiving services from the quitline.) This should be a combination of the total number of referrals reported in Q16 above AND the total number of tobacco users calling directly as reported in Q15 above, in order to account for the multiple ways tobacco users can enter a quitline system.
Slide 73
Updated for FY11

Registration reach is the term applied to reach calculated by taking the number of tobacco users completing an intake survey (indicating an intention to enter into counseling) divided by the estimated number of smokers in the state, province, or territory. Registration reach is NOT a NAQC-recommended metric, but it is presented here due to the fact that promotional reach as it has been reported by NAQC only includes direct inbound callers to quitlines, and does not include tobacco users who access quitline services through any other mechanisms (e.g., referrals, online registration, etc.).

National “actual” reach measures were calculated by dividing the sum of all tobacco users completing an intake survey (for all states or provinces reporting) divided by the sum of the estimated number of smokers in the states or provinces reporting the number of tobacco users completing an intake survey. Mean reach was calculated by taking the reach numbers for each state or province reporting, and taking the average of those numbers. Actual reach takes the population of the state or province into consideration.
Estimated number of smokers was taken from 2009 (for 2009 reach) and 2010 BRFSS (for 2010 and 2011 reach) and 2009 (for 2009 reach) and 2010 CTUMS (for 2010 and 2011 reach) for the US and Canada, respectively.
*18. How many UNIQUE TOBACCO USERS who called or were referred to the quitline received the services listed below in FY11?

Report only on those who received service, not those who requested service.

Report current or recent tobacco users only; not those calling for help for a friend or family member or other nontobacco users.

For the purposes of this question, we define “received” service as anyone who received quitline selfhelp materials and/or began at least one counseling call with the quitline and/or received medications through the quitline.

**INSTRUCTIONS:** include each tobacco user in EITHER column A OR column D regardless of the number of times they registered for services. Report each person only once, and in the column for the TOTAL (highest cumulative)
amount of service they received during the fiscal year.

EXAMPLE: If a tobacco user registered for services twice in FY11, received materials only the first time, and received telephone counseling the second time, ONLY report them in column B (and D). If a tobacco user received telephone counseling for a first registration and NRT for a second registration, they would be counted once in column B, once in column C, and ONLY ONCE in column D. The only tobacco users who should be reported in column A are those who ONLY received selfhelp materials during the fiscal year, and did not receive any counseling or medications.

Note: 18a and 18d are mutually exclusive categories.

a. Selfhelp materials with no counseling
b. Counseling (began at least one session) [Do NOT include intake or registration as counseling]
c. Medications (NRT or other FDA approved medications for tobacco cessation)
d. Total tobacco users provided counseling OR medications OR both counseling and medications [Do NOT include those who received only selfhelp materials here.] (Note: This is the number that will be used to calculate treatment reach using the NAQC standard calculation.)
26. How many UNIQUE TOBACCO USERS who called or were referred to the quitline received the services listed below in FY11? Report only on those who received service, not those who requested service. Report current or recent tobacco users only; not those calling for help for a friend or family member or other nontobacco users.

For the purposes of this question, we define “received” service as anyone who received quitline selfhelp materials and/or began at least one counseling call with the quitline and/or received medications through the quitline.

**INSTRUCTIONS:** include each tobacco user in EITHER column A OR column D regardless of the number of times they registered for services. Report each person only once, and in the column for the TOTAL (highest cumulative).
amount of service they received during the fiscal year.

EXAMPLE: If a tobacco user registered for services twice in FY11, received materials only the first time, and received telephone counseling the second time, ONLY report them in column B (and D). If a tobacco user received telephone counseling for a first registration and NRT for a second registration, they would be counted once in column B, once in column C, and ONLY ONCE in column D. The only tobacco users who should be reported in column A are those who ONLY received selfhelp materials during the fiscal year, and did not receive any counseling or medications.

Note: 26a and 26d are mutually exclusive categories.

a. Selfhelp materials with no counseling
b. Counseling (began at least one session) [Do NOT include intake or registration as counseling]
c. Medications (NRT or other FDA approved medications for tobacco cessation)
d. Total tobacco users provided counseling OR medications OR both counseling and medications [Do NOT include those who received only selfhelp materials here.] (Note: This is the number that will be used to calculate treatment reach using the NAQC standard calculation.)
Treatment Reach FY09-FY11

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>3</td>
<td>0.24%</td>
<td>1.90%</td>
<td>0.80%</td>
<td>0.37%</td>
</tr>
<tr>
<td>2010</td>
<td>9</td>
<td>0.17%</td>
<td>1.79%</td>
<td>0.49%</td>
<td>0.31%</td>
</tr>
<tr>
<td>2011</td>
<td>10</td>
<td>0.07%</td>
<td>1.45%</td>
<td>0.23%</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>46</td>
<td>0.05%</td>
<td>7.25%</td>
<td>1.57%</td>
<td>1.19%</td>
</tr>
<tr>
<td>2010</td>
<td>50</td>
<td>0.05%</td>
<td>6.66%</td>
<td>1.45%</td>
<td>1.09%</td>
</tr>
<tr>
<td>2011</td>
<td>51</td>
<td>0.16%</td>
<td>6.44%</td>
<td>1.53%</td>
<td>1.15%</td>
</tr>
</tbody>
</table>

Slide 76
Updated for fy11

Treatment reach is calculated by dividing the total number of tobacco users receiving evidence-based services (counseling or medications) by the estimated number of smokers in the state, province, or territory.

Estimated number of smokers is taken from the 2009 and 2010 BRFSS (US) and 2009 and 2010 CTUMS (Canada). Note: 2010 smoking prevalence estimates (BRFSS and CTUMS) are used for both 2010 and 2011 treatment reach calculations.

National “actual” reach measures were calculated by dividing the sum of all tobacco users receiving counseling or medications (for all states or provinces reporting) divided by the sum of the estimated number of smokers in the states or provinces reporting the number of tobacco users completing an intake survey. Mean reach was calculated by taking the reach numbers for each state or province reporting, and taking the average of those numbers. Actual reach takes the population of the state or province into consideration.
Treatment reach has remained fairly steady, holding right around 1.2% for US quitlines since FY2009.

Treatment reach is calculated by dividing the total number of tobacco users receiving evidence-based services (counseling or medications) by the estimated number of smokers in the state, province, or territory.
Treatment reach for Canadian quitlines has remained right around 0.3% for FY2010 and FY2011. Due to the small N in FY2009, we recommend being cautious about any interpretation of trends using FY2009 data.

Treatment reach is calculated by dividing the total number of tobacco users receiving evidence-based services (counseling or medications) by the estimated number of smokers in the state, province, or territory.
Slide 80
Updated for FY11

*Treatment reach is calculated by dividing the total number of tobacco users receiving evidence-based treatment (counseling OR medications) by the estimated number of smokers in the state or territory using 2010 BRFSS estimates.*
Slide 81
Updated for FY11

*Treatment reach is calculated by dividing the total number of tobacco users receiving evidence-based treatment (counseling OR medications) by the estimated number of smokers in the province or territory using 2010 CTUMS estimates.*
Slide 82

Pearson’s r=0.84, strong correlation between spending and reach; consistent over time

Note: “best fit” line may not be linear. However, a linear relationship indicates that we may need to spend more than $10.53 per smoker to reach 6% of tobacco users. This may be due to inefficient use of funds, or a changing environment that makes it harder to serve people for the same amount as when CDC made its original calculations in 2008.
Pearson’s r=0.84, strong correlation between spending and reach; although with small N be cautious about drawing any conclusions from this.

Note: “best fit” line may not be linear. However, a linear relationship indicates that we may need to spend more than $10.53 per smoker to reach 6% of tobacco users. This may be due to inefficient use of funds, or a changing environment that makes it harder to serve people for the same amount as when CDC made its original calculations in 2008.
Slide 84
The number of quitlines reaching NAQC strategic goals is not increasing.

It is no surprise that we are not making progress toward the goal, given the relationship between reach and funding. This is another reason why it is important to seek additional cost-sharing solutions for quitlines (e.g., public-private partnerships, and Medicaid reimbursement).

### Number of U.S. Quitlines Reaching NAQC Strategic Goals FY2009-11

<table>
<thead>
<tr>
<th></th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td># quitlines &gt;= $10.53 per smoker</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td># quitlines &gt; $5 per smoker investment</td>
<td>12</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>FY 2009</td>
<td>FY 2010</td>
<td>FY 2011</td>
</tr>
<tr>
<td># quitlines &gt;= 6% treatment reach</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td># quitlines &gt; 3% treatment reach</td>
<td>9</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>
Slide 85
The number of quitlines reaching NAQC strategic goals is not increasing.

It is no surprise that we are not making progress toward the goal, given the relationship between reach and funding. This is another reason why it is important to seek additional cost-sharing solutions for quitlines (e.g., public-private partnerships, and Medicaid reimbursement)
DEMGRAPHICS OF CALLERS

Note: Our original intention was to ask quitlines to report demographics on ONLY those tobacco users who received counseling or medications. Some quitlines were only able to report on the population of tobacco users completing an intake questionnaire. Due to this inconsistency, the numbers reported in this section may be slightly larger than the population who received counseling or medications. Treatment reach for priority populations may be similarly inflated, albeit slightly.
US: 55% of smokers in the US are men; only 43% of quitline callers are men.
## Utilization FY11 – Age

<table>
<thead>
<tr>
<th></th>
<th>Quitline</th>
<th>Callers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Missing</td>
</tr>
<tr>
<td><strong>US</strong> (N=53)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>42</td>
<td>11</td>
</tr>
<tr>
<td>Minimum</td>
<td>43</td>
<td>10</td>
</tr>
<tr>
<td>Maximum</td>
<td>43</td>
<td>10</td>
</tr>
<tr>
<td><strong>Canada</strong> (N=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Minimum</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Maximum</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

* For the US, the number of callers on which the mean, minimum and maximum age were based ranged from a low of 12 to a high of 84,024.

**For Canada, the number of callers on which the mean, minimum and maximum age were based ranged from a low of 1,189 to a high of 1,189.

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Slide 89
Updated for FY11
Slide 91
Updated for FY11

Just over half (52%) of tobacco users receiving evidence-based services had HS educations or lower. (n=49)
Slightly more than half had HS educations or lower (51%). Note: n=2; be cautious about interpreting findings.
Slide 95
Updated Fy2011
There is only 1 Canadian QL that reported 3 of the 7 the race items. All others were 'Unable to report'. due to the high level of missing data we have not provided a pie chart with these data.
27 quitlines able to report on this variable
50 US quitlines (94%) reported that they collect information on the insurance status of callers who receive services. 46 were able to report on the breakdown of insurance type.

Medicaid broken out individually for the first time – 25% of the tobacco users being served by US quitlines report being Medicaid beneficiaries. Suggests a really good argument for engaging with state Medicaid agencies to figure out a way to take advantage of the Federal medicaid match at 50%. Also note 30% have private insurance. Also a great argument to engage in conversations with health plans – are there ways that health plans could cover the costs of their members? Do they have better benefits they provide internally?
Slide 101

Too few Canadian quitlines were able to report on the number of tobacco users served for various sub-populations, so progress toward goal 3b is not reported for Canadian quitlines.

For both FY2010 and 2011, US quitlines collectively are serving a smaller proportion of tobacco users who are African American, Asian, Latino, and with low educational attainment than the overall treatment reach for all tobacco users. The one exception is American Indian/Alaska Native populations, where treatment reach exceeded that of the general population in both Fy2010 and Fy2011.

Reach for the priority population groups shown here was calculated using the following methodology:

The reach for priority populations was calculated using the following data sources to estimate the number of smokers within each population group for each state:
- 2009 population estimates from the US Census for Black/African American,
Asian, Native American/Alaska Native, and Hispanic/Latino. Note that the only estimates used here were those for single-race selection; no estimates for multiple race selection were included. The total population in any state indicating more than one race was quite small, ranging from 0.6% to 15% (Hawaii) with an average of 1.4%. This will not change reach rates significantly for any state, with the exception of Hawaii. For that reason, Hawaii’s calculated reach rates and rankings should be considered separately. They are reported with all other quitlines here, but this issue will be examined more closely prior to releasing state-specific reach rates to members.

- Adult population size was calculated for “less than high school education” by American Community Survey (ACS) 2005-2009 estimates
- Smoking prevalence was calculated for Black/African American, Asian, Native American/Alaska Native, Hispanic Latino, and less than high school education using 2007-2009 BRFSS survey data, combining three years of data to compensate for small sample sizes for most of the groups mentioned here. (See NAQC issue paper on calculating tobacco use prevalence for small populations.)

Treatment reach was then calculated by dividing the sum of total number of tobacco users within each of the population sub-groups who received counseling or medications from quitlines, divided by the sum of the total number of adult tobacco users within each of the population sub-groups for all states reporting data for that sub-group.
Updated for FY11

Note: all registrants are unique registrants; any quitline reporting registrants in both categories of integrated and standalone web-based services confirmed that the registrants are independently unique, and are not double-counted.

QUESTION WORDING:

Note: For question 27, report ALL registrants for web-based cessation services, regardless of whether they received telephone counseling or medications. The total number of unique registrants for web-based services will be reported as the sum of 27A+27B.

For 27a INTEGRATED report ONLY telephone counseling enrollees that were automatically enrolled in web-based services (integration of the phone and web programs, i.e., cannot register for one without registering for the other)
For 27b STANDALONE report ONLY enrolments for web-based services where the service was independent from enrolment in telephone-based services.

If your state offers both standalone and integrated phone/web programs: Report each tobacco user enrolled for web-based services in only one category (integrated or standalone).

EXAMPLES:
1. If a tobacco user has enrolled for the standalone web service AND was also enrolled in the integrated phone/web in the same fiscal year, report them ONLY in integrated phone/web services.
2. If a tobacco user enrolls for standalone web services first, and later to switches to the integrated phone/web program, report them ONLY in Integrated.
3. If a tobacco user enrolls twice in one fiscal year and enrolled either time for integrated phone/web services, report them ONLY in Integrated. [Note: this item applies the same rationale as used with item 18 – report someone only once and in the category for the most intensive/cumulative level of service received.]

*27. How many tobacco users registered for web-based services in FY11?

a. Registrants for web-based cessation services that are integrated with the telephone quitline (i.e., cannot register for one program without registering for the other, or “automatic” enrollment in both programs unless they explicitly opt out. Databases are shared for both programs and coaches can see utilization data for both.)

b. Registrants for web-based cessation services that are STANDALONE programs (not integrated with the telephone quitline)
Slide 103  
Updated for FY11  

QUESTION WORDING:  

Note: For question 27, report ALL registrants for web-based cessation services, regardless of whether they received telephone counseling or medications. The total number of unique registrants for web-based services will be reported as the sum of 27A+27B.

For 27a INTEGRATED report ONLY telephone counseling enrollees that were automatically enrolled in web-based services (integration of the phone and web programs, i.e., cannot register for one without registering for the other)

For 27b STANDALONE report ONLY enrolments for web-based services where the service was independent from enrolment in telephone-based services.

If your state offers both standalone and integrated phone/web programs: Report each tobacco user enrolled for web-based services in only one category (integrated or standalone).
EXAMPLES:

1. If a tobacco user has enrolled for the standalone web service AND was also enrolled in the integrated phone/web in the same fiscal year, report them ONLY in integrated phone/web services 27a.

2. If a tobacco user enrolls for standalone web services first, and later to switches to the integrated phone/web program, report them ONLY in Integrated 27a.

3. If a tobacco user enrolls twice in one fiscal year and enrolled either time for integrated phone/web services, report them ONLY in Integrated 27a. [Note: this item applies the same rationale as used with item 18 – report someone only once and in the category for the most intensive/cumulative level of service received.]

27. How many tobacco users registered for web-based services in FY11?

a. Registrants for web-based cessation services that are integrated with the telephone quitline (i.e., cannot register for one program without registering for the other, or “automatic” enrollment in both programs unless they explicitly opt out. Databases are shared for both programs and coaches can see utilization data for both.)

b. Registrants for web-based cessation services that are STANDALONE programs (not integrated with the telephone quitline)
EVALUATION
Slide 105
Updated for FY11

QUESTION WORDING:
For the Evaluation Section below, please provide information using evaluation results that most accurately reflects the status of your quitline in FY2011. The evaluation may include tobacco users who registered for services in FY2010 or FY2011, or even earlier. The evaluation may have been conducted in FY2011, FY2012, or earlier. The flexibility in defining the time period for the evaluation is designed to allow quitlines to report evaluation information while acknowledging that evaluations are not conducted according to any set schedule, and may not nicely line up with the beginning or ends of fiscal or calendar years.

*33. Do you have evaluation data you are able to report on for your quitline? If yes, please follow the instructions below.

No [skip to #44]

Yes, we have evaluation data to report for our quitline. Please describe the time
period during which the evaluation took place, both when evaluation participants registered for services, and when the evaluation surveys were conducted. Example: “The evaluation results below include tobacco users who registered between January 1 and July 31, 2010. Evaluation surveys were conducted between August 1, 2010 and February 28, 2011.”

If you checked “yes” for Q33, Enter time period for registration and evaluation surveys here:
NAQC Standard Quit Rate Methodology

- 30-day point-prevalence-abstinence measured at 7 months after registration
- Quit rate should be calculated on all tobacco users seeking treatment who register for services and consent to the evaluation and receive at least minimal evidence-based treatment.

Reminder: quit rate calculations based on response rates less than 50% should be interpreted with caution.
Only one Canadian quitline reported a quit rate in each of FY2010 and FY2011, so Canadian data are not presented here.

Differences are not statistically significant.
Slide 109
We need to interpret these results cautiously due to the small number of quitlines NOT providing free or reduced NRT.

Average quit rate was calculated by taking the mean of the quit rates reported among quitlines providing free or reduced NRT, and among quitlines NOT providing free or reduced NRT. Data for quitlines not reporting either quit rates or information about medication provision were not included.
The number of quitlines reaching NAQC strategic goals is not increasing, although we wouldn’t expect quit rates to rise dramatically over time given where we started.

*only one Canadian quitline reported quit rates in either FY2010 or FY2011, so Canadian data are not reported here.
Questions For You

- What has NAQC done well, and how could we improve:
  - Reporting survey results back to members
  - Making survey results available publicly (profiles and other reporting mechanisms)
  - Responding to requests for data from researchers and others
  - Collecting data from quitlines (time, clarity, data interface, frequency)
Next Steps

- Final powerpoint presentations will be posted on the 2011 survey page
- Quitline-specific tables will be posted on the 2011 survey page
- FY2011 Fact Sheet will be posted online
- FY2011 benchmarking data will be sent to individual quitlines
- Quitline Profiles will be updated (metrics section)
Quitline Profile Metrics

- Quitline Metrics
  - # Direct Calls
  - # tob users receiving counseling or medications
  - # Registrants for Web-based services
  - # Referrals to the quitline
  - Spending per smoker (services & medications)
  - Spending per smoker (media & promotions)
  - Promotional reach
  - Treatment Reach
  - NAQC Standard Quit Rate
  - Context for quitline metrics

Quitline Profiles available at
http://map.naquiline.org/
Funding Sources for the FY 2011 NAQC Annual Survey of Quitlines

Centers for Disease Control and Prevention, Office on Smoking and Health

American Lung Association

NAQC Membership Dues
Recommended Citation:
For more information on the survey or on NAQC’s data request and review process, please contact:

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Director of Research
North American Quitline Consortium
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Oakland, CA 94612
Ph: 800-398-5489 x702
Email: jsaul@naquitline.org

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