



Best Practices:

How Can Quitlines Help Smokers with Behavioral Health Conditions Quit?

Wednesday, November 28, 2018

3:00 – 4:30 PM EST

Questions & Answers from Webinar Chat

Questions for Michael Dutro, PharmD

Q1: I was wondering if they'd also compared those with behavioral health conditions vs. those without behavioral conditions by medication (vs. within-group comparisons to placebo)? I wondered if that might have implications for which medication providers should try first. It seemed like Varenicline resulted in the largest difference in the number of events between the two cohorts. Since it was also the most effective, it seems like that information could be useful for weighing risk/ benefits and setting expectations with clients.

A1: For questions concerning the EAGLES Study portion of the Webinar or the study itself, please contact Michael Dutro, PharmD at (505) 235-1235 or michael.dutro@pfizer.com.

Q2: Was there any accounting for other factors (i.e., chronic disease) in participants that we know affect quit success?

A2: For questions concerning the EAGLES Study portion of the Webinar or the study itself, please contact Michael Dutro, PharmD at (505) 235-1235 or michael.dutro@pfizer.com.

Questions for Robert Vargas- Belcher, MSW, MPH

Q1: On the last slide related to events, was there any statistical difference when comparing those with behavioral health conditions vs. those without behavioral conditions by medication (vs. within group comparisons to placebo)? I'm just curious if there was inclusion/exclusion criteria for any comorbidities.

A1: I believe this question was for Michael Dutro.

Q2: Are callers who enroll in the special protocol eligible for online services (and if so, do they use them at similar rates as others?)

A2: Callers who enroll into our specialty program are eligible to receive support through online services. In addition, participants are also able to enroll through our online registration portal. This program is primarily a phone support program, but we are beginning to look at how this population uses this online support.

Q3: Is there an estimate of how many quit line callers were "filtered out" after asking the interference question?

A3: What we saw from our pilot and what we are seeing with our current callers is that about 30-40% of people will respond 'yes' to the question when asked. Of those participants, about 80% will accept the offer of the program.



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Q4: What suggestions do you have for measuring quit rates among behavioral health clients when you have very low follow-up survey response rates?

A4: I reached out to our evaluation team to help get a better answer for this question. We have the following suggestions:

- Including/looking at the numerator, denominator, and % for the response rate and quit rates to make sure the whole picture is being taken into account.
- Looking at the 95% confidence interval to avoid giving too much weight to the specific “rate” (this is a good idea in general, regardless of response rate). It’s often more appropriate to say, e.g., “the 95% confidence interval for the respondent quit rate ranged from 15% to 45%”, as opposed to “the respondent quit rate was 30%”.
- Looking at both the respondent and intent-to-treat quit rates—the “true” quit rate likely falls somewhere between the two and the ITT rate will help provide some context with the response rate taken into account.
- What we have found out is that low survey response rate means that the quit rates have a lot of caveats attached, so it’s important to use the recommendations above to make sure you’re describing/reporting them responsibly.

Q5: Are you able to disclose which states have implemented the enhanced services for BH populations?

A5: We currently operate this program in Minnesota, Florida, South Carolina, and Kansas.

Q6: Provision of 8-12 weeks of NRT has more successful outcomes than giving 2 weeks supply. Is that difference in success rate statistically significant?

A6: In our pilot program all participants who received NRT were eligible for 12 weeks of combination NRT. As we have begun to roll this program out with different states we are seeing a variation in what states are choosing to provide. At this time we have not done a full evaluation, including quit rates, which would allow us to see how different NRT offerings might be affecting quit outcomes. This is data is something we would begin

Q7: To what extent has Optum and/or the states using the BH program tried to streamline the registration/enrollment process through provider referrals (e.g., through FAX)?

A7: As we look to improving this program for our states and callers, this is one area that we reviewing. The ability to get caller connected to services with reduced barriers is a priority not only for this program, but for all of our programs.

Q8: Has there been an assessment done for the cost per call for the enhanced services?

A8: We have completed an assessment of a cost per call on this enhanced service. While we work with every one of our states to keep the cost of these services low, we have realized that providing this service does require more resources and therefore would incur a higher cost.



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Questions for Chad Morris, PhD

Q1: Any recommendations for how NAQC or individual QLs can better partner with behavioral health care providers and organizations?

A1: NAQC can provide guidance on how individual quitlines can outreach to state/local BH organizations. BH agencies/providers are typically unfamiliar with quitlines, what they offer, and what to expect during a first call. There is a lot of inaccurate information out there. I would suggest the QLs reach out to the state BH department/division and ask if there are opportunities to educate BH orgs at state annual conferences or other naturally occurring gathering of key clinical personnel. You can also offer to go to BH orgs for in-services or disseminate videos on what to expect during the first call etc. Many local public health agencies have a scope that includes outreach to BH- so I would suggest contacting the state Tobacco Program lead to determine how you might best leverage the work local public health agencies are doing.

Q2: Do you foresee issues with enrolling and serving inpatient folks through the BH program (vs. outpatient)?

A2: The answer to this will depend on the type of inpatient or other congregate setting involved. My advice would be for BH program staff/leadership to call the state quitline, tell the quitline you are representing a specific agency and potentially multiple callers, and ask to speak to the quitline's customer service representative. They will work with you determine if any barriers exist to coaching calls and sending medications. My experience is that the quitlines are more than happy to do so and are very helpful in working with inpatient and other congregate settings.